The College

The Need for Secure Provision for Adolescents within the NHS

1. Remit

In 1981, the document *Secure Facilities for Psychiatric Patients*, a report of a Special Committee of Council of the Royal College of Psychiatrists, was published. Paragraph 12 of this document read as follows:

> The College has been concerned to review the need for secure treatment facilities for all groups. Adolescents have been excluded from most proposals for secure units, but some believe that there is need for special units for them. The Child and Adolescent Psychiatry Specialist Section has been asked to examine this question in detail and to report independently.

This report* considers the need, if any, for secure psychiatric (NHS) provision for adolescents aged between 12 and 18 years. A number of problems have been identified, many of which do not arise in the provision of secure accommodation for adults. The present situation, the need for such provision and the possible problems of providing it, are considered in this report.

2. Existing provisions

A number of adolescents are currently placed in Special Hospitals, not always appropriately. Otherwise, within the NHS, facilities for providing treatment for older children or adolescents under secure conditions are very scarce. Some adolescent units are able to provide physical security for a short period by locked doors or by increasing the staff-patient ratio. Some use is made of adult wards in an emergency.

Social Services Departments in England provide four special regional units for young people in care (or detained under Section 53 of the Children and Young Persons Act 1933) requiring care and treatment in security. These are at: Aycliffe with 36 places (mixed); Redhill with 28 places (boys); Redbank with 26 places (boys); and Kingswood with 20 (+5) places (boys).

A small number of closed Assessment Centres operate and there are, in addition, a number of units attached to Community Homes with Education (CHE) or 'Observation and Assessment' Centres, providing security or intensive care for periods ranging from hours or days to weeks, or more rarely, months. Consultant psychiatric support and advice is available to a number of such units, enabling them to accept a wide range of young people.

The DHSS directly manages two Youth Treatment Centres (YTC): St Charles YTC with 31 places (mixed) and Glenthorne YTC with 46 (+7) places (mixed). Delinquents (including those who have committed grave crimes) form part of the YTC population, but there are also a significant number exhibiting neurotic or personality disorders, or organic brain damage. Psychiatric and psychological support and consultation enables individual treatment programmes to be developed.

The Home Office, through the Youth Custody System, provides secure facilities for a large number of adolescents, some still of statutory school age.

Psychiatric opinion and recommendation play an important part in placement of young people in the above establishment, but direct admission by or at the request of psychiatrists (of the NHS) is not possible. (An analogous situation is where a social worker considers hospital admission desirable, but must route the application through medical channels.)

Joint funding has been used in a few instances to enable a young person to be admitted to and treated in a private psychiatric hospital, with a service for adolescents and secure facility (see 3 (ii) below).

Prestwich Hospital has an NHS secure unit which will open in the near future. At the present time, so far as we know, there is no secure NHS adolescent unit.

There is, therefore, a gap in the provision of services for young people who are in need of psychiatric/medical care in secure premises. This gap can lead to inter-service discord or even in some cases to inappropriate placement. The use of many existing adolescent units is limited since they may operate on a basis of agreed family contracts or are open only for a five-day week. Most of these units are planned to meet the needs of particular client groups, incompatible with those requiring security and being discussed in this report.

Separate administration, and in particular, separate financing, are a serious handicap to the use of some existing local authority or DHSS facilities. A major obstacle in the use of the Social Services or YTC accommodation is that Social Services Departments or the family would be asked to meet or contribute to the costs of placement.

3. Estimated size of the problem

This has been found extremely difficult. In Manchester a secure unit will shortly open at Prestwich Hospital with up to 20–25 places, but there is no experience yet of the demand to be made upon it. However, since demand for NHS secure places might arise in the event of requests from the YTCs, or from the Department (since the places taken at St Andrew's Hospital suggest such a need—see para 3 (ii)), we would suggest a maximum of 10–15 places per Region, the precise numbers depending upon particular Regional populations.

* *Members of the Working Party were:* Drs I. Berg; Lorna Brierley; John Evans; Harvey Jones (deceased); K. Padamsee; Ian Sinclair and W. Lumsden Walker (Chairman).

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(i) *Existing NHS facilities*

Both Broadmoor and Rampton Hospitals rarely admit young people under 18 and provide a much greater level of security than we envisage, and would therefore be providing for a different client group. Young people are admitted to Moss Side Hospital. In the age group of 12–17 years the average would be 10 per year (12 per year including 18 year olds). Annual numbers have varied between 4 and 13 in different years. It is noted that the opening of the Youth Treatment Centres has led to a decrease in requests for admission of this age group to Moss Side.

(ii) *Private facility*

St Andrew's Hospital, Northampton, provides a *private facility* which is used by the DHSS and local authorities in the absence of NHS facilities. Admissions in this age group average 30 per annum and in addition there are currently three young people detained under Section 53 (Children and Young Persons Act 1933).

(iii) *Possible variables*

(a) A number of CHEs (former Approved Schools) are being closed throughout the country. Some of the young people in these institutions were in units whose staff had regular support of visiting psychiatrists. It is expected that a small number of these young people may not prove suitable for community care or may break down in non-residential care; and that the local authorities will request NHS psychiatric help.

(b) Amending regulations to the Child Care Acts necessitates Juvenile Court approval at three or six monthly intervals to children under 18 remaining in secure accommodation. This is likely to lead to an increased demand upon the DHSS or NHS psychiatric intervention.

(c) There is a steady increase in Section 53 cases (4 in 1966; 109 in 1982). The number in care establishments has risen from 19 in 1978 to 66 in 1982, and in Secure Units, from 18 to 46 in the same period.

(d) This document advises that Section 53 cases would not normally be considered for admission since security demands might override treatment, but experience of St Andrew's Hospital suggests a small number of those with determinate sentences might be admitted to NHS Units.

4. Legislation

It is unlikely that the new Mental Health Act will affect this issue. Psychotic youngsters are generally treated in open units. Psychopathic disorder is only very rarely a diagnosis of the child and adolescent psychiatrist, if only because a child is by definition immature and the child/parent interaction is only slowly in process of being resolved.

(i) Amending regulations to the Child Care Legislation (see above)

This may lead to an increase in demands upon the NHS.

5. Nature of security

Having indicated a gap in existing provision for adolescents, we attempt to define our concept of such security. Security may be considered as a continuum from the high walls of a high security establishment to a unit with a lockable outside door, or alternatively a unit operating with few physical barriers, but where security depends upon a high staff ratio and the development of relationships with staff members. Our own attempts to define what is required have varied between considerable levels of physical security, through to 'anything which made it difficult to get away from the place'. We conclude that while premises should be lockable, they should not be regarded as maximum security units.

It is felt that, in the main, security should depend upon continual skilled supervision in premises which are very difficult to leave. The emphasis, therefore, should be on premises which are staffed on a seven-day per week basis, and where security would depend principally upon an adequate ratio of well-trained staff. We emphasize that 'security should be used in the service of treatment', and that Management should be aware that treatment was more important than security.

6. Criteria for admission to a secure NHS facility

It is envisaged that patients will be young people of both sexes aged between 12 and 18 years, for whom no appropriate treatment can be given in the community and who, therefore, require in-patient management. Furthermore, there will be those seen as in need of help, including control, for whom open adolescent units are unsuitable. This will include young people creating continual problems of management in the community and in other units.

Length of stay may be short or long-term, varying with the age on admission, level of maturity, education needs, and severity of the disorder (perhaps from a few weeks to two to three years).

In particular, the following may be seen as problems appropriate for admission to such a unit, but in each case, only when complicated by repeated and persisting seriously anti-social behaviour or violence, or by repeated absconding: (a) medical conditions, for example, epilepsy or diabetes, which in themselves would cause great anxiety to non-medical institutions, but only when combined with complications as above; (b) patients with brain damage or multiple handicaps, where there is a need for highly skilled staff and clear external controls; (c) psychotic illness, for example, schizophrenia, with behaviour producing a risk for the patient or others; (d) repeated serious self-injury; (e) those in serious danger of dependence on alcohol or other dependency producing drugs; and (f) some cases of arson, certain sexual offenders and perhaps compulsive car thieves, who consequently endanger others.

These criteria are not seen as totally inclusive. We add that the use of security may well be to ensure or at least

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improve the chances of involvement in a therapeutic programme.

It must be emphasized that the unit staff must have control over those who are admitted. The mix of patients in any therapeutic unit is always of the greatest importance and overloading the unit with any particular type of problem would be self-defeating. At the same time, it must be emphasized that such a unit could become quite unhelpful if it became over exclusive.

Young people detained under Section 53 of the Children and Young Persons Act would not normally be regarded as suitable for admission to such a psychiatric unit.

Owing to special management needs and other problems such as the risk of exploitation by their more able peers, the mentally handicapped would not normally be considered suitable for admission. Their needs may require special consideration.

7. Needs and location of a unit

It is felt to be important that such a unit should not provide more than 15 to 20 places. There must be adequate facilities for appropriate education, as the majority of these young people are envisaged as being of school age, and those who are older are often in need of remedial help. There will have to be facilities for general and specialist medical investigation and treatment, particularly in view of the client group envisaged. There will also be a requirement for social and psychological investigation and treatment. There would be considerable advantages in links with a university, as there is considerable need for research in this type of problem.

A unit of its own, unattached to any existing NHS services, particularly if sited in rural districts, would have difficulty in meeting these criteria. It will also have problems of staff requirement and support, and general administration. The unit would, therefore, be best sited in an urban area, although probably preferably not an 'inner city' urban area, and attached to an existing NHS facility, either an adolescent unit or an adult psychiatric hospital, the former being preferable.

8. Legality of secure detention

It has been assumed that at least up to the age of 16, a request by the parents or guardian will be valid and enable staff to lock doors and prevent patients from leaving. The problem will arise more clearly where young people, aged 16 and over, will have to give their own informed consent to such detention or treatment and on those occasions where parents are reluctant to participate in the treatment process.

In many, perhaps a majority, of cases a more formal admission procedure may be required. Many of the patients may well not fit into any defined category of the Mental Health Act 1983, which only rarely would be the appropriate authority. It is envisaged, therefore, that there will be a need for close co-operation with Social Services Department. It seems likely that some of these young people, if they are to be detained, will have to be under Care Orders, or perhaps a Supervision Order with a condition of treatment included (Children and Young Persons Act 1969, Section 12). This will require very close co-operation between the NHS facility and the Local Authority Social Services Departments, particularly their senior staff. Discussion will be required, preferably at the planning stage, between the NHS and the Social Services Departments as to the problems of the requirements for intensive care in a psychiatric unit where adolescents are placed under Care Orders. Relevant to these problems is a report recently published by the Children's Legal Centre, entitled *Locked Up In Care*. It is possible that even under the age of 16, the young person's consent to treatment may be paramount even over the parents, other than in cases of emergency, in contradiction to our earlier comment. The DHSS is reviewing the policy in light of views expressed by the European Court of Human Rights.

9. Further problems and conclusions

Patients who are admitted to such a psychiatric secure unit will be those seen as having some chance of responding to a therapeutic programme. A major problem in establishing such units will be contact with families and, more usually, work with the total families, particularly of the younger adolescents, in the hope of modifying the environment for the better. Since we envisage the units as being Regional, or perhaps serving two or more regions, the problems in arranging this contact are obviously great. Travelling expenses, for example, could be a major difficulty, and regulations may require modification or clarification.

Treatment has to be viewed in quite a wide sense as including not only the ability to respond to a therapeutic milieu, but in addition, or alternatively, the ability to benefit from a variety of other treatment procedures, as for example, behavioural modification techniques, social skills training programmes, or any of a wide variety of group therapeutic techniques. Appropriate medication may be required in certain conditions. Ideally, this unit will be seen as *enabling attachment bonds* to be developed with key members of staff, thereby aiding emotional development towards maturity.

It is accepted that provision of facilities such as we describe is unlikely to abolish the problem of placement for all categories of adolescent disturbance. It is important that there is on-going evaluation of any such unit. In the first instance, perhaps one or two such units might be established to evaluate their effectiveness and facilitate research. Indeed, it is possible that there are existing NHS seven-day units which, with some degree of modification of their facilities for physical security and with a perhaps higher staff/patient ratio, may be able to modify their function and accept many of these problem young people.

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