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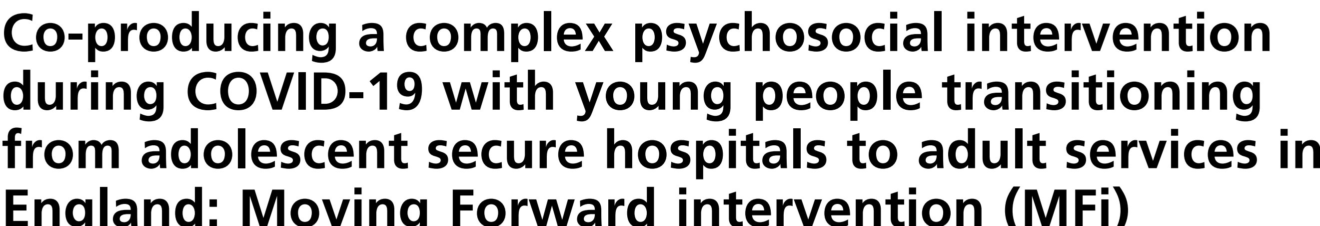

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Co-producing a complex psychosocial intervention during COVID-19 with young people transitioning from adolescent secure hospitals to adult services in England: Moving Forward intervention (MFi)

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Background: Young people moving from adolescent secure hospitals to adult care present with multiple and complex needs which often remain unmet during transition periods. This paper delineates the process of developing and co-producing the moving forward intervention (MFi), which aims to address the psychosocial needs of transitioning youth who have limited access to well-researched and tailored service provisions. **Method:** An extensive search of the relevant literature was conducted to generate themes and guide the co-production phase. Fourteen Advisory Group Meetings were held virtually during COVID-19 to design the MFi module content with 17 keyworkers, 2 parents and 13 young people aged 17–18 years across six adolescent secure hospitals in England. Thematic analysis was used to reflect on the field notes discussed in the Advisory Groups. **Results:** Co-produced themes from the literature and the Advisory Groups informed the development of the proposed intervention. Three overarching themes pertinent to expectations in adult services, improving communication gaps between services and facilitating the *letting go period* emerged from the co-production phase. It was suggested the MFi is co-delivered by a peer with lived experience to build trust and create hopefulness among young people. The importance of promoting graded transitions through standardised procedures was highlighted. **Conclusions:** The current findings promote evidence-based initiatives and build robust practice frameworks that inform treatment and policy guidelines. The young people, parents and keyworkers found the MFi supportive and valued the co-production experience. As such, co-production has been a vital tool in promoting patient engagement and empowerment, and reducing service inequalities, especially in adolescent secure hospitals.

Key Practitioner Message

- Young people in adolescent secure hospitals present with multiple comorbidities, developmental trauma and complex needs which remain unmet during transition periods.
- Keyworkers across services should collaborate with young people and their families in service and research development to improve current practice and transition outcomes.
- The moving forward intervention (MFi) aims to support transitioning youth with standardised transition preparation modules which account for emotional, psychological and neurodevelopmental needs and are aligned with attachment-based therapy and trauma-informed care.
- Voicing the experiences of detained and research excluded groups can change the scope and current narrative of future interventions in adolescent secure hospitals.

Keywords: Young people; transitions; co-production; intervention; adolescent secure hospitals

Introduction

Transitional care from paediatric to adult services has been identified as a global priority for chronic physical and mental health conditions (Campbell et al., 2016). However, mental health transitions are much more complex and challenging for young people and their families due to service gaps and a lack of robust transition models (Livanou, Singh, Liapi, & Furtado, 2020). The National Institute for Health and Care Excellence (NICE),

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which provides evidence-based recommendations for health and social care in the United Kingdom (UK), defines transitional care as the gradual process of preparing and supporting adolescents to transition from Child and Adolescent Mental Health Services (CAMHS) to adult services (Willis & McDonagh, 2018). Institutional transitions co-occur with physical, mental and social changes pertinent to late adolescence (Singh, Paul, Ford, Kramer, & Weaver, 2008), which is a critical period for the emergence of mental health difficulties (Reder, McClure, & Jolley, 2000). Poorly managed transitions can increase the risk of relapse, rehospitalisation and reoffending, representing a great economic burden on governmental resources due to the financial costs associated with secure inpatient services (Völlm, Bartlett, & McDonald, 2016).

In England and Wales, young people with complex clinical presentation at risk of harming themselves and/or others and/or with offending history are referred to adolescent secure hospitals based on risk level (low or medium secure unit) and are detained under the Mental Health Act. However, only 16% of young people receive mental health treatment in secure hospitals in England, despite increased rates of 46%–81% custody youth presenting with mental health problems (Hindley et al., 2017). Adolescents in secure hospitals (Tier 4) present with high-risk, emerging personality disorders (Hill et al., 2014), complex mental health issues, developmental trauma (Mcara & Mcvie, 2010) and offending histories (Livanou, Furtado, & Singh, 2017), which are additional risk factors to poor mental health, high reoffending, and reinstitutionalisation rates (Hales, Holt, Delmage, & Lengua, 2019). Adolescent secure hospitals provide inpatient care, specifically tailored to these high-risk youth, where treatment and nursing address acute needs which are otherwise not manageable in general adolescent inpatient hospitals (National Health Service; NHS, 2018).

There is currently a dearth of shared transitional care guidance, policy and standardised practice, and readiness monitoring procedures that inform transitions from adolescent secure care to adult-oriented services (Livanou, Lane, D'Souza, & Singh, 2020). Longitudinal findings show poor transition outcomes for young people leaving secure hospitals due to delayed and abrupt transitions, lack of containment and disruptive therapeutic relationships (Livanou et al., 2021). The most recently published report by NHS England shows that by 2016, 1283 young people were admitted in secure adolescent hospitals across England and 43% of this cohort had not secured a community placement by the time of their transition to adult provision (Hales et al., 2016).

Fundamental differences in treatment approaches and care priorities have created a substantial disconnect between child and adult services. When coupled with inadequate transition preparation, this presents major barriers to positive transition outcomes (O'Connell & Petty, 2019). Research shows that community transitions are particularly challenging for young people due to abrupt moves from highly supportive and structured milieus to independent care. A national 6-month study of young people showed that 65% transitioned to adult hospitals and 35% to community settings and 3% returned home (Livanou, 2018). The same study found that the average length of stay was 19 months and 27% of young people experienced delayed transitions. However, this is the only study that followed up a discharged cohort from adolescent secure hospitals to adult-oriented care over the course of 6 months.

To develop meaningful evidence-based interventions, and to improve transitional processes and outcomes for young people moving from inpatient adolescent care to adult services, it is vital to involve young people with lived experience in the design and production of research projects (Bradley, 2009). Engaging experts by experience in research, known as patient and public involvement (PPI), is widely used, and prioritised in applied health research (Hayes, Buckland, & Tarpey, 2012). Experts by experience can identify needs, care gaps, meaningful outcomes and increase transparency (Madden et al., 2020). Service users' active participation in research and service development can enhance implementation of complex interventions for challenging groups, such as young people in secure care.

More recently, co-production practice has been encouraged within health research, particularly in service design (Denegri et al., 2015) and qualitative studies (Goldsmith et al., 2019). Co-production is a form of PPI which refers to the creation of a space where service users, family members, carers and service providers engage in a collaborative alliance to improve their own care and service provision (Norton, 2019). Co-production places high value on empowering individuals' journey of recovery (Norton, 2021) and sense of autonomy by actively involving them in research planning, delivery and development. Further, co-production challenges existing power dynamics through enhancing partnerships between service users and healthcare providers, shifting the role of healthcare providers from delivering a service to facilitating the recovery process (Slay & Stephens, 2013). Recent policy guidelines highlight the key role of self-efficacy for adolescents in contact with mental health services (NICE, 2016), by fostering co-production in the development of evidence-based interventions. However, including high-risk youth detained in secure care is an uncommon practice in co-production research and there is little knowledge about good practices to increase meaningful engagement with service development in this group.

Patients within secure hospitals may be more difficult to access ('hard to reach') due to limited staff, time and resources, as well as existing geographical barriers between patients and stakeholders (Webb, Girardi, & Stewart, 2021). Specific restrictions within secure services also require a flexible co-production approach, owing to a heavy reliance on healthcare staff for recruitment in co-production (Pinfold et al., 2015). Challenges specific to secure hospitals include lack of staff confidence in co-producing research and care plans, and patient risk presentation (Webb et al., 2021). However, it is difficult to overlook power imbalances between service users and service providers that may impede co-production practice (Lambert & Carr, 2018), and become more pertinent when service users lack capacity to co-design research (Pilgrim, 2018). Another consideration is the lack of co-production research involving carers (Clark, 2015). The importance of shared decision-making and parental involvement within mental health services is evidenced in an extensive literature review by Kelly and Coughlan (2019).

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The need for PPI and research co-production is central to meaningful service transformation and improvement (Batalden et al., 2016), and yet to the best of our knowledge, no studies have been conducted that co-produce complex interventions within adolescent secure hospitals. Little is known on how co-production approaches are impacted by challenges relating to the COVID-19 pandemic, such as restrictions on face-to-face discussions, requiring more time and effort to engage understudied groups and building rapport remotely (Demkowicz et al., 2021). To address these gaps both in services and research, in the present study we aimed to co-produce a complex psychosocial intervention that is the moving forward intervention (MFi). We aimed to develop the MFi module content through reflective discussions (Advisory Groups) with the research team, the lead participating site and virtual Advisory Groups comprised of young people, parents and transition keyworkers. This study aimed to explore the potential challenges in the design and content of the proposed intervention. In addition, we aimed to trial co-production with young people within secure hospitals in the context of COVID-19, identifying challenges and facilitators to co-producing research at this time. The themes discussed in the Advisory Groups were based on previous research conducted with young people moving from adolescent secure services to adult provision, parents and transition keyworkers (Livanou, Bull, et al., 2021; Livanou, D'Souza, Lane, La Plante, & Singh, 2021). The present paper describes the collaborative steps of the MFi co-production and development. The MFi will be tested out in a future feasibility trial to assess its clinical- and cost-effectiveness and will be used as a psychoeducational tool in the form of workshops to prepare young people moving from adolescent secure hospitals to adult services.

Methods

Design

We adopted an asset-based approach, where all individuals involved in the co-production plan were treated as equal partners to mitigate power imbalances and potential biases towards the researchers (Weaver, Lightowler, & Moodie, 2019). The Advisory Teams were selected based on recent (within a year pre/post-transition) and/or current lived experience with transition services in adolescent secure hospitals. Fourteen Advisory Group Meetings were held online via Zoom or Microsoft Teams platforms with three distinct groups: youth (six distinct group meetings), parents (two distinct meetings) and transition keyworkers (six distinct group meetings). The Advisory Groups were conducted separately based on the type of respondent and facility. An inclusive approach was employed which considered the personal accounts of those with lived service experience. We included young people with comorbid mental health problems and neurodevelopmental needs, as well as high-risk presentation which are perceived barriers in service-user involvement (Weaver et al., 2019).

Procedures

Twenty public and independent sector adolescent secure hospitals in England were eligible for inclusion and were contacted via email to determine interest and capacity for involvement in the co-production process (seven hospitals rejected the study and seven did not follow up email correspondence). Six NHS sites (three medium secure units (MSUs), two low secure units (LSUs) and one psychiatric intensive care unit (PICU)) agreed to take part. We used established networks with three sites to facilitate virtual meetings with the multidisciplinary teams (MDTs) and to explain the objectives of the co-production plan. Next, we met online with potential key collaborators (three clinical psychologists and three psychiatrists) to plan our next steps for co-production and address service needs. Key collaborators were used as local contacts to support with identifying potential co-producers (young people, parents and keyworkers) to take part in the Advisory Groups and obtaining consent from all participants. Young people were between 17 and 19 years and met the legal criteria in England and Wales to provide consent. The study was reviewed and approved by the institutional Research Ethics Committee at Kingston University. The research team extensively discussed the participation of potential co-producers with the key collaborators based on vulnerability and mental health presentation. Young people with acute mental health symptoms and currently high-risk presentation were not invited to take part in the Advisory Groups. All co-producers were reminded about their right to leave the groups any time they wished and/or not answering any questions that make them feel distressed. The Advisory Groups were all held online and lasted 30–80 min. Key collaborators also participated in the Advisory Groups with service transition keyworkers. Young people from secure hospitals attended remotely, with the presence of keyworkers. The impact of having a keyworker in the virtual room was considered during data analysis and interpretation stages; yet young people openly shared their thoughts about prospective transitions and what elements should be included in the transition intervention based on their personal frustrations and expectations. We conducted group-based meetings to encourage active participation and exchange of views and perceptions.

Materials

Bespoke leaflets for young people, parents and transition keyworkers were developed outlining the tasks and format of the Advisory Groups. The leaflets explained the collaborative process and highlighted the co-producer role, involving sharing thoughts about the proposed intervention and what is significant to consider and prepare for in the move to adult care.

Local collaborators distributed the leaflets to the young people and transition keyworkers on the wards and contacted eligible parents with young people close to transitioning age (18 years) to adult services and/or community. Adult care included secure hospitals or supported community accommodation. All co-producers (young people and parents) were asked the same questions: *how long they have been in that service; whether they knew they had to move to adult services and why; how they felt about this transition; and what kind of support they had received and/or would like to receive; what challenges they encountered throughout the transition process; whether they would participate in a series of transition preparation workshops 6–12 months prior discharge to adult care; what recommendations they had about the content of such workshops (*e.g. *content, activities).* Keyworkers were asked about barriers they encountered throughout the transition process and recommendations about standardising transition preparation with the use of an intervention. Co-producers were presented with the initial literature-based themes of the intervention such as transition literacy, future planning, goal management and expectations in adult services and were asked about their views on these topics and whether these were pertinent to their lived experience. A research team member (RL) was taking detailed notes during the conduct of the groups.

Co-producers

We conducted 14 Advisory Groups with keyworkers ($n = 17$), young people ($n = 13$) and parents ($n = 2$) between May 2020 and July 2021. Five females and eight males participated in the Youth Advisory Group, two mothers in the Parent Advisory Group, and 10 females and seven males in the Keyworker Advisory Group comprised of three nurses, six psychologists, five psychiatrists and three family therapists. The mean age for young people was 17 years and age range varied between 17 and 19 years. Included young people presented with multiple

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comorbidities and complex needs (social adversity, developmental trauma, neurodevelopmental problems, self-harming and conduct disorder) and were anticipating transition to adult services. We included two young people and two parents of young persons, who had moved to the community and had lived transition experience within the last year. The low participation rate of parents is echoed in previous research with carers of young people in secure settings. Carers are a hard-to-reach group in research which reflects their poor engagement with services and is an ongoing challenge (Brooks et al., 2015). The key collaborators invited 10 parents initially but only two responded positively. Parents often feel shame due to their child's offence status and seem to lack confidence in services, given they are often excluded from treatment plans and have little access to information (Tingleff et al., 2022).

Module development

The MFi module content was further developed in line with elicited themes from the Advisory Groups. After documenting the feedback from the co-producers, meetings were held with the research team members and organised with keyworkers and local collaborators to reflect on the content and discuss themes. These reflections and discussions were a key step in refining and developing the modules in line with Advisory Group input. Themes were refined and expanded in collaboration with the lead site's local co-production team based on the team's extensive experience delivering psychoeducational interventions with young people in adolescent secure hospitals. The module themes and aims had been standardised, but adjustments to the content and model of delivery were made based on mental health and developmental needs explored by the aforementioned Advisory Groups. Timings and frequency of module workshops were discussed considering the vulnerabilities and multiple comorbidities of this group of young people and their attention span.

Analysis and interpretation

The analysis process included three steps: literature search by the research team, co-production and Advisory Group consultation, and collation of literature-driven and co-produced themes. First, we searched the relevant literature on transitions of youth from secure (MSUs) hospitals to adult care in a UK context. Three databases were searched: Google Scholar, Psych Info and PubMed. We discussed and reflected on predetermined themes for the MFi based on previous findings (Livanou, Bull, et al., 2021). We identified only four papers in this area due to the lack of research about young people discharged from MSUs to adult care in the UK (Livanou, Bull, et al., 2021; Livanou, D'Souza, et al., 2021; Livanou, Lane, et al., 2020; Livanou, Singh, et al., 2020). There is only one national study (Livanou, 2018) as part of a doctorate thesis which followed up young people in adult services and community settings postdischarge from all national medium secure services for adolescents. The findings of this research highlighted the need for new models of transitional care aiming for flexible and graded transitions, family involvement, prioritising young people with neurodiversity and enhancing transition readiness to improve transition outcomes. Second, we developed the main Advisory Group questions based on the literature themes we identified in the first step. These themes were built on previous work with a national sample of young people across all medium secure hospitals in England due to transition to adult care. During the co-production phase, we explored the reactions and reflections of stakeholders and young people in the MFi intervention that is under development. Data included field notes, conversations with the co-producers (young people, parents and transition keyworkers), collected by ML and RL, although all participants were treated as co-producers and advisors of the current intervention. RL and ML read the field notes multiple times and discussed them with the local collaborators from the lead site to become familiar with the content (Braun & Clarke, 2006) and to ensure they had a thorough understanding of all of the data in its entirety. The co-produced and literature-driven themes were reiterated with all local collaborators, young people and parents across the six participating sites. The MFi-finalised content was presented to the three young people, who had not moved out from adolescent secure services by that time, and two parents. This stage lasted 6 months and underwent an iterative process resulting in the gradual development of the intervention. This process was aligned with community-based participatory research (CBPR) principles, which was evidenced in collaborative assessment of the challenges presented during transition, and co-producers serving in advisory capacity throughout the MFi development. We prioritised equity, mutual learning and social justice by working in partnership with otherwise research-excluded groups such as young people hospitalised in secure adolescent hospitals (Duke, 2020).

This process led to reflective interpretation ensuring that the themes were co-produced, and service informed. We followed the Braun and Clarke (2006) reflexive approach to thematic analysis. We read the field notes line by line to identify meaningful data and coded them in relation to the wider context of the intervention and the relevant literature. Themes from the Advisory Groups were refined, and a thematic map was developed with overarching themes and subthemes based on research team reflections and interactions with young people, parents and keyworkers (Figure 1). A follow-up meeting with the lead site enabled theme review and refinement. Themes were then developed and reviewed, which led to the third stage of the analysis process. At this stage, we collated the literature-driven and co-produced themes to inform the MFi development. Timings and frequency of module workshops were discussed considering the vulnerabilities and multiple comorbidities of this group of young people and their attention span.

Results

Step 1. Results of the initial framework based on the literature

We identified four papers about young people moving from adolescent secure hospitals to adult care in the UK based on first author's (ML) previous work in the area including two qualitative studies with young people, carers and mental health professionals, a case note review audit and a service scoping exercise (Livanou, Bull, et al., 2021; Livanou, D'Souza, et al., 2021; Livanou, Lane, et al., 2020; Livanou, Singh, et al., 2020). These papers were extracted based on sample selection which includes young people moving from MSUs to adult settings and is one of our subgroups of interest for the MFi. We elicited the following themes from the literature search pertinent to barriers and facilitators during transition periods: delayed transitions, risk escalation, heterogeneity of needs among subgroups (emerging personality disorders, neurodevelopmental problems, psychosis and developmental trauma) within secure services, abrupt transitions, emotional readiness, lack of familiarisation with adult placements and psychosocial functioning in the community. The literature also stresses that young people in secure hospitals often present with neurodiversity and, therefore, would benefit from additional preparation, structure and resources in place. Neurodevelopmental problems require additional care and individualised plans to accommodate special needs.

Step 2. Themes from the co-production process

Three overarching themes and eight subthemes of relevance emerged from the Advisory Groups (Figure 1) and informed the MFi modules (Table 1). The quotes presented below constitute the formative steps towards further refinement and phase-piloting of the MFi. The

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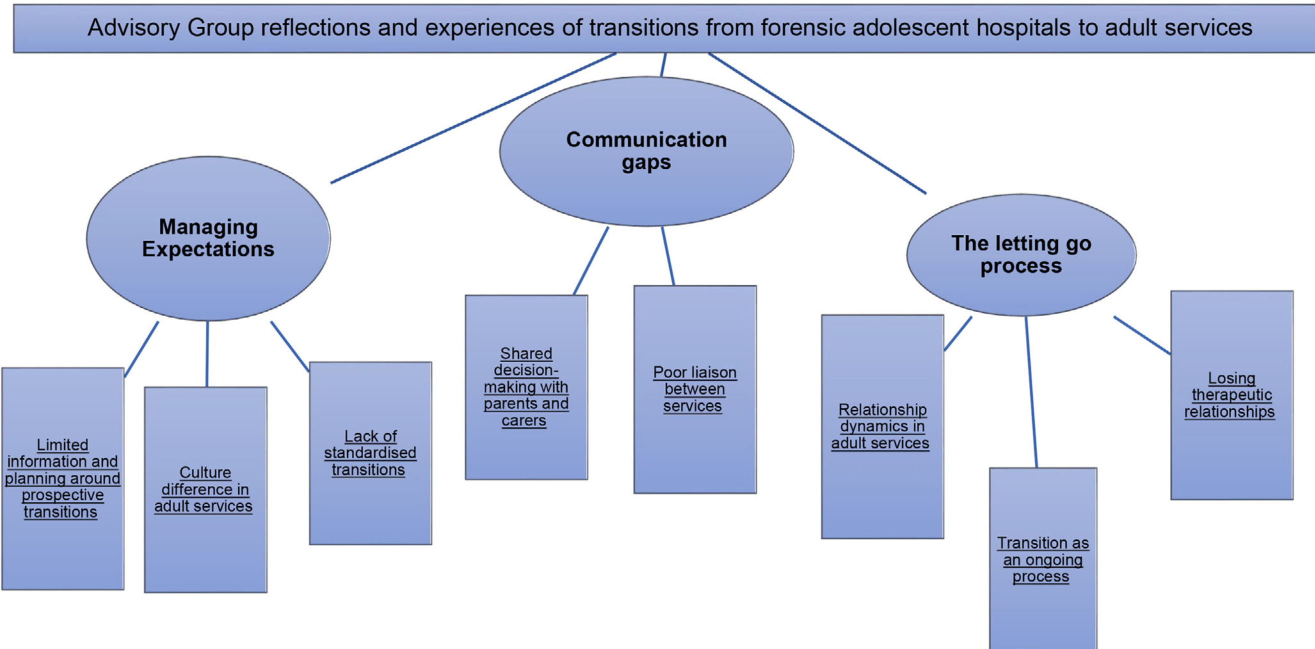

Figure 1. Thematic map showing the co-produced and literature-driven subthemes

selected quotes build up the narrative of the ongoing transition challenges faced by young people, parents and keyworkers. Selected quotes are included to showcase the areas highlighted by the co-producers.

Theme 1. Managing expectations. Through conversations with young people and their parents it was evident that a more standardised and consistent procedure surrounding transition planning was needed to create a safe and improved transition experience. For example, one parent shared:

> There definitely needs to be something around the specific changes to expect.

Parents felt that their transition journey would become more meaningful if services provided important information about their child's adult placement. Managing expectations in adult care and reducing uncertainty was frequently discussed and parents stressed that a supportive approach that focuses on transition education would make a difference in the care trajectory of their children.

Subtheme 1: Limited information and planning around prospective transitions. Anxiety about the prospective transition was exacerbated by very limited information and/or knowledge regarding the receiving adult service, including where it might be. A lack of familiarisation with the new settings and staff in adult services was identified as a major concern. One young person from the Young People Advisory Group specifically echoed these concerns:

> They didn't know what beds would be free, but they said they couldn't plan in the future.

This young person expressed their frustration and anxiety around infrastructural processes and reflected on lacking hope for future service transitions.

Another young person explained:

> Not even discussing where we go is frightening.

Anxiety has been described as an overwhelming and persecuting experience which was intertwined with limited information about transition placements.

For one young person reported that in their experience:

> Maybe two months before transition, CAMHS started looking for a bed in secure or adult PICU though they were aware for about a year that the transition was close.

Young people acknowledged that their service providers should identify an adult placement before their 18th birthday, and they felt that their need to be securely transferred to a suitable placement was not met.

This suggests that transitions are often rushed due to lack of service availability. A keyworker corroborated these reports in stressing that:

> More needs to be done to show our young people what it's like to experience an optimal transition.

This mental health professional felt that service provision and transition delivery could improve by joint and parallel working between adolescent and adult services.

A mother spoke about how scary it was not knowing what to expect and had insufficient information about the new service and care provision. This fear was described to be intensified as her son has been diagnosed with autism spectrum disorder (ASD):

> There is a lot of uncertainty around my son's transition due to his ASD.

Young people also appeared worried about their transition and explained that its nature depended on the unit they would be transferred to or the professionals they would work with. A young person reckoned:

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Table 1. MFi themes and workshop content

Intervention	Theme	Aims	Module delivery	Materials & mode of delivery
Module 1 *I can see the opportunity*	1. Transition education	Participants will be asked if they understand the purpose of moving to adult services or an adult-oriented community and how they envision a positive transition. The elicited themes will inform the following stages of the intervention. Participants will also get familiar with delayed transitions (psychoeducation) and how to deal with the 'slow' process and how to manage frustrations and related anger.	Participants will be presented with materials portraying adult hospitals and community settings to become familiar with the structure. The terms of transition and handover planning, transition management and preparation will be delineated and explained with the use of examples.	The following activities will be integrated across all modules: Role playing, vignettes/ scenarios, videos, reflective discussion and practice exercises, skills management. Visualisation exercises Peer support will be aimed with one peer trainer with lived experience as role model co-delivering the workshops. Progress will be monitored with self-report questionnaires postcompletion of workshops 2 and 4 in self-management and emotional readiness. Self-reflection (recognising strengths and areas for improvement) time following each session. The development of the self-reflective journal will be introduced from the first workshop (e.g. reflecting on young people's time in adolescent services). Participants will develop their own transition handbook to keep after transitioning from adolescent services.
	2. Hope, Agency, and Opportunity	Participants will be encouraged to build on their own skills and strengths (Good Lives Model) to promote self-belief and confidence about the prospective transition. Nurturing hopefulness by focusing on strengths.	Participants will learn how to manage their uncertainties and anxieties around prospective transitions and how to create a positive narrative that relies on their strengths. They will learn to focus on what is in the sphere of their control.	
Module 2 *Becoming my own life coach*	1. Goal management and learning boundaries.	Participants will be introduced to mental health symptoms and risk management when in crisis, relapse and reintegration, assessments, support services, peer support, and role models and mentors. Emotional regulation will be discussed in relation to boundaries in therapeutic and interpersonal relationships.	Participants will be presented with case-based scenarios, and they will be prompted to discuss and reflect and provide their perspectives. Tips will be shared about emotional regulation, symptom management, and crisis response. Self-awareness will be promoted as an important tool to achieve self-regulation.	
	2. Self-management plans & introductory Wellness & Recovery Action Plans (WRAP), psychosocial adjustment	Participants will be prompted to co-develop their personalised self-management plan including coping mechanisms when negativity is prevailing. These personalised plans will be built around each young person's individualised needs, whereas validation and appreciation (trauma-informed approach) of preexisting coping strategies will be considered.	Wellness and recovery strategies will be introduced and practiced with the group focusing on breathing exercise, yoga, dance movement (art therapeutic techniques) and self-coping mechanisms (CBT; mindfulness techniques) that have worked while in adolescent services.	
Module 3 *Planning my journey*	1. Future planning (practical issues)	Participants will focus on education, employment, overall well-being, housing and community living. Managing the basics of independent living. Consulting Assertive Transition Services for building the activities.	Possible job opportunities and college education options will be explored and discussed based on the participants interests. Participants will be prompted to design and plan their career journey. Employability and job opportunities will be prioritised. Different routes and examples of young people will showcase potential journeys.	
	2. Building my personalised identity flower	Participants will develop their personal plans either for education or employment and identifying what steps will need to be taken.	The analogy of the flower will help participants build their identity through self-recovery. Visualisation will aid this process of exploring self-identity and removing institutional stigma.	

(continued)

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Table 1. (continued)

Intervention	Theme	Aims	Module delivery	Materials & mode of delivery
Module 4 *Moving forward and taking the good things*	1. Expectations, attachment and self-efficacy	Participants will focus on what to expect in adult services, what difficulties they might encounter, what being an adult encompasses, what new responsibilities they will face depending on the type of placement they are admitted to, how the therapeutic style and alliance might change, parental involvement, hospital/community routine and structure and older peers. Social isolation on adult wards and/ or community settings-dealing with older peers.	The trainer will explain how the structure differs from adolescent services in terms of activities, therapeutic relationships, self-occupation, and daily routine. Participants will discuss how they can build new relationships with staff and peers and how to overcome feelings of isolation as being the youngest on the ward.	
	2. Therapeutic endings and moving forward	Participants will reflect on the series of workshops they received, and they will be directed to discuss how they would like the therapeutic ending with key workers. Loss management and letting go will be emphasised (attachment).	Participants will use the self-reflective journal where they will report their progress and time they have spent in secure adolescent hospitals and what they have learnt from this experience. Their thoughts and feelings will be explored in the group session. Participants will be prompted to discover new channels of relational approaches through existing experience.	

> Either been incredible or really terrible, dependent on the team or unit. Some interactions have been really helpful, and some have been traumatic.

These conflicting feelings were commonly cited among young people who appreciated keyworkers being supportive throughout the transition process. Service inconsistencies across different teams and units were reported.

Subtheme 2: Culture difference in adult services. Many shared that the service culture and approaches to care were significantly different between CAMHS and adult services, and that young people were not sufficiently prepared. One young person reported:

> [I] asked for time to meet the staff, understand what kind of ward, how long will I be there –but CAMHS said they couldn't do that.

Young people also referred to the differences between adolescent and adult services:

> *'Going from colourful ward to a hospital'* and further described this traumatic experience as: *'One of the nastiest shocks of a lifetime'*.

Young people experienced a culture shift as well as an emotional shock when moving to adult services which impacted their emotional well-being.

They voiced their needs about what a smooth transition would look like and what they expected to contain their anxieties and frustrations:

> . . .tell us about the differences between the wards, even a leaflet. So, it's not such a shock, at least you have a chance to prepare yourself a little bit.

Some suggested adult services provide information on their service and care that can be shared with young people approaching transition. Young people asked for active participation in the process that will help them build self-confidence and autonomy.

Subtheme 3: Lack of standardised transitions. All Advisory Groups highlighted the need for more regulated transitions, as the environments that the young people are moved to differ drastically from adolescent settings but also from each other, with some looking like:

> '. . .prisons, others large mansion houses', as described by one parent.

Co-producers suggested standardised transition preparation with consistent care approaches tailored around young people's needs. Young people reported the lack of a structured schedule in adult services and explained the differences between adolescent and adult services:

> In CAMHs had structure to my day, therapy and education which is not like here that I have free time I don't know what to do with.

Parents stressed how impacted they are from lack of standardised transition across adolescent and adult services and lacking the emotional and psychoeducational resources to cater for young people's needs. For instance, two shared:

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> Transition back home is scary –went from knowing everything that was going on to having x home not knowing risks etc.

> It's unsafe to do that so suddenly, more gradual would be better.

The need for a more gradual process was emphasised as there are drastic differences between adolescent secure hospitals and adult care.

> There definitely needs to be something around the specific changes to expect – maybe young people doing a video or something about their experience or showing a video of the ward.

Young people emphasised the urgent need to receive more information about adult services prior to their transition and also suggested a few ways to succeed in this:

> Visit to the unit if possible, know who their key nurse is going to be – even video or welcome booklet.

One young person noted:

> While I thrived, other people could have died.

This quote clearly demonstrates the impact of the huge leap between services as well as the magnitude and the impact of transitional care on young people's well-being.

Theme 2. Communication gaps. Subtheme 1: Shared decision-making with parents and carers. One of the parents highlighted:

> . . .there was a massive disagreement, including parents, ward managers etc. . . and I would like to have more support as a parent where my needs are voiced and taken into account before decision-making.

There was a lot of discussion across Advisory Groups regarding the views of the young people and their parents about services disrupting their engagement in the transition process and feeling unheard.

One parent referring to her daughter's transition highlighted that:

> We were expected to look after her at home. Yet, at the time she didn't want to come home and we didn't want her home.

Parents often felt helpless throughout the transition process and lacking the skills to manage their children's emotional and behavioural difficulties.

Subtheme 2: Poor liaison between services. A keyworkers stressed:

> The lack of communication between adolescent secure services and adult settings prevented smooth and optimal transitions.

One young person reported the lack of communication and joint working among professionals from both adolescent and adult services which led to their rejection from the adult service:

> But on day of transition, I was all packed and there was an issue with transition as adult service hadn't realised that I was in CAMHS PICU and then refused for me to go to the general adult ward as not deemed safe.

Adult services staff members were not informed of this young person's background in time and only received this information on the day of their transfer. As a result, this young person was unable to complete their transition as the adult ward was not considered a safe space. These barriers were identified as anxiety-provoking events for both parents and young people, and turned transitions into confusing experiences.

A young person described their transition as 'quite disjointed and alarming'.

Clear communication and consistent care planning were not recognised as common practice. Lack of communication between services was identified a barrier to consistent care.

One young person recalled:

> I did write to my service to say that they spend years stripping young people from responsibility and become dependent and then next day expect them to be an adult.

Young people felt they were ill-prepared to self-manage their emotional needs and respond adequately to the demands of everyday life postdischarge from adolescent secure services due to the high level of dependency on keyworkers.

Theme 3. The letting go process. Subtheme 1: Losing therapeutic relationships. According to transition keyworkers, losing therapeutic relationships in CAMHS were reported as key challenges and areas of distress during the transition process, with one parent sharing:

> . . .young people are losing key figures.

One of the most harmful experiences was the loss of contact with their key nurse who was their main attachment figure while in adolescent secure services:

> The letting go period is especially challenging for young people losing CAMHS keyworkers.

Therapeutic and service endings can be extremely triggering for young people in secure adolescent services given developmental adversities they have experienced in early years.

Another young person also reported:

> My biggest heartbreak was losing key nurse from CAMHS.

Young people explained that, although they were used to spending some fun time with keyworkers in adolescent secure services, staff from adult services lacked empathy and overlooked their individual needs.

A young person highlighted:

> You go from being with staff who play with you to staff who are rude and don't seem to care.

Staffs in adolescent services were described as more accommodating of young people's needs and having a greater capacity to understanding their developmental history.

Young people also reported a lack of empathy from professionals in adult services even in their most vulnerable moments:

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> Even during checks, staff in adult services don't come and say hello how are you but would just look through the window.

Lacking a containing environment was described as a significant barrier to optimal transitions in adult services. Parents also suggested that it is of great importance to their children to feel adult services as a familiar and holding environment before making their final transition to their home environment.

Subtheme 2: Transition as an ongoing process. Keyworkers explained that:

> Transition is not an abrupt event; it is a letting go process.

This statement highlights that young people in adolescent secure hospitals have experienced amplified service trauma due to the following characteristics: high risk, high harm and high vulnerability. This group presents multiple and complex needs which are exacerbated during periods of change while their needs are often poorly understood and met.

For example, a keyworker reported:

> Young people in adolescent secure services are an undesirable group, and are constantly being rejected, re-traumatised through services, given certain adult services do not want them due to behavioural issues and lack of bed availability.

In regard to this situation, keyworkers across all different sites addressed attachment-based elements as important aspects to embed in the developing intervention.

Subtheme 3: Relationship dynamics in adult services. It was evident throughout participant discussions that substantial changes in young people's relationships occurred during their transition from adolescent secure to adult services.

There were distinct dialogues across Advisory Groups about the new environment of adult services which consisted of much older people with different needs and presentations compared to the young people attending adolescent secure services.

One parent reporting on her daughter's experience of transition shared:

> She's with old men, not made to feel welcome.

This was corroborated by young people's accounts, with one reporting:

> [you] Go from being around other young people who are self-harming to adults who are psychotic and scary men and women up until 60–65.

This was described to be amplified by young people's developmental and emotional readiness. A young person explained:

> ...if someone hasn't been in the real world for a few years – going to be a few years younger than [their] age.

Young people expressed their worry about leading an independent lifestyle and commented on the demands of the real world compared to ward life. Parents advocated for the use of mentoring support to help young people adjust to these abrupt relationship changes.

Step 3. Collated themes to form the MFi (Figure 1)

All the emerged themes and MFi modules were presented to our co-producers, including young people who had not moved out from adolescent secured services, and they provided further input about the structure and content of the modules. A follow-up meeting with the lead participating site enabled theme review and refinement. This process lasted 6 months and underwent an iterative process resulting in the gradual development of the intervention. Module 1 was amended to include the theme of hope and agency to increase confidence in the young people. Young people valued recovery and hope, and felt assertive about their future. This module was also developed based on the relevant literature which stresses the importance of educating young people and parents about the transition process and what it entails (Livanou, Bull, et al., 2021). Module 2 was updated with adding self-management and the development of an action plan towards wellness and recovery. Module 4 was built around therapeutic endings and suggestions to move forward. Managing expectations was a major theme discussed in the Parent and Young People Advisory Groups which informed modules 3 and 4. We consulted a co-production group of three young people with lived experience at the lead-participating site about the content of the transition workshops. The young people suggested the MFi focuses on the key differences between adolescent and adult services in terms of structure, clinical contact and self-occupation, involvement in handover planning, building new relationships with staff and peers, managing parental anxiety, visualising and re-building self-identity. These were addressed with the inclusion of a reflective journal in Module 4. The Keyworker Advisory Groups suggested the intervention be informed by attachment-based therapy, trauma informed care, cognitive behaviour therapy (CBT) and psychoeducational elements, which target self-efficacy and management of mental health problems. Elements from these can contribute to behaviour change (strength-based approach) in young people by improving skills and building a goal-oriented approach towards discharge. All modules and activities were structured and developed in alignment with these therapeutic principles.

Discussion

This is the first known attempt to co-produce a complex psychosocial intervention for young people transitioning from adolescent secure services to adult hospitals and community settings with young people, their carers and keyworkers. Thirteen young people, two parents and 17 keyworkers participated in this co-production research that took place across six secure hospitals in England during COVID-19. Collated themes from an extensive literature search and virtually conducted Advisory Groups were identified to inform the core module content of the MFi. The findings highlight related challenges, such as the loss of secure attachment relationships and the lack of involvement of parents and youth in decision-making during the transition process. Consistent with the previous literature (Hill, Wilde, & Tickle, 2019), our findings underline the lack of person-centred approaches that aim to empower young people in respect of their

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individual health needs. As one of the parent's echoed 'she's with old men, not made to feel welcome', it was clear that individuals struggled with losing peer support as a result of their transition. Previous research stresses that loss of peer support is a common phenomenon during transitions to adult services and can pose a barrier to young people's recovery journey (Livanou, Bull, et al., 2021). Further, these findings are in line with previous patient participatory research into transition preparation which has shown that young people prioritise peer support in their transition preparation activities (Dunn, 2017). Peer support was acknowledged as a key element to facilitating engagement, building trust and creating hopefulness among young people. The delivery mode of the MFi is based on this principle aligned with NHS transition guidelines (NHS, 2020). As such, the modules will be co-delivered by a peer that is seen as a role model to identify with (Ocloo, Garfield, Franklin, & Dawson, 2021). 'Buddy-systems' are recognised as key tools towards a recovery-oriented approach (Lambert, Matharoo, Watson, & Oldknow, 2014) that aims for reduced relapse and shorter hospital stays. Participative approaches have the potential to positively impact young people's transition trajectories through the support of a trusted adult figure.

Our findings showed that one of the hardest challenges that young people experienced were the loss of therapeutic relationships during the transition process. Young people highlighted the *fun time* they had with keyworkers in adolescent secure services in contrast to the lack of empathy experienced from staff members in adult services. Previous research has underscored the critical role of a trusted key adult on mental health and educational outcomes in adolescence (Pringle, Whitehead, Milne, Scott, & McAteer, 2018). It appears that the young people who participated in this study had developed positive relationships with adolescent keyworkers; however, their transition to adult services resulted in the loss of secure attachment relationships that made them feel included and accepted. A recent systematic review by Hill et al. (2019) also highlighted the urgent need to facilitate the continuation of long-term and positive relationships during young people's transition to adult services, as well as the development of new trusting relationships with staff members. According to Hill et al. (2019) this could be achieved through continuous communication and joint working between professionals from both adolescent and adult services.

The '*Managing expectations*' theme emerged where young people and parents explored their lack of control over and insight into the transition process. They voiced their frustration with lacking knowledge about their adult placement or adult services more broadly, and having no input in the process. Patient self-management and control are of great importance within the recovery model (Anthony, 2007) in mental health, and the NHS strives to embed these key elements within all aspects of mental health care (NHS, 2016), including graded transitions from CAMHS to adult services (NHS, 2020). Dunn (2017) has previously found that young people long for processes that build their confidence, and provide them with adequate information, autonomy and responsibility over their transitions and future prospects. Patients who have a degree of autonomy over their care show better recovery outcomes across short and long-term trajectories (Dawson, Rhodes, & Touyz, 2014). As such, this theme has informed several aspects of the MFi, including module content and focus, mode of delivery and included activities.

Keyworkers placed importance on young people's heterogeneity of needs in terms of transition requirements and practice approaches. The main aim of the MFi is to promote an inclusive practice-based model for all young people transitioning from adolescent secure services to adult settings. However, as the relevant literature and the co-produced themes suggest, in line with current policy outlines (NHS, 2020), transitions should be tailored around individual needs and be flexible. Accordingly, the MFi is aimed to be delivered in an agile and dynamic manner that accounts for individual strengths and vulnerabilities.

Previous research and policy recommendations highlight those services can become more relevant and of better quality when researched and designed 'with' the target group as opposed to 'for' them (Hoddinott et al., 2018; NIHR, 2013). Target service groups, such as young people in adolescent secure services, are often found to be marginalised and service-resistant and lack trust in the support systems in place (NICE, 2017). This may result from traumatising relationships with keyworkers and multiple transitions across services. Therefore, service-user empowerment, service engagement and trust associated with co-production (Ocloo et al., 2021), can enable young people to voice their experiences and actively participate in their care pathway decision-making. The adapted modules in the MFi will now be more relatable and engaging for service users as they were co-designed by their 'expert' peers who may have similar transition experiences with services and keyworkers.

Limitations

Young people with multiple comorbidities and complex needs were central in the co-production phase aiming for a representative sample. Numerous challenges were identified during the co-production phase which were pertinent to COVID-19, online Advisory Groups and forensic facilitiy security restrictions. Considering that Advisory Groups with young people were conducted online with the presence of keyworkers due to risk and security concerns, their responses might have been skewed. Young people might have felt more confident sharing their views without the presence of their keyworkers who may be regarded as key attachment figures.

It is also important to mention that only two parents/carers participated in this co-production research, which could result in decreased trustworthiness of the conclusions drawn about parental perspectives. However, our findings derived from parental quotes are consistent with the findings of recently published research focusing on the experiences of parents whose adult children are supported by forensic inpatient and outpatient facilities (Tingleff et al., 2022). Similar to our study, the parents who participated in Tingleff et al.'s study also asked for their further involvement in their adult children's care and treatment and reported the lack of joint working among families and professionals. Therefore, although the parental sample of our study is limited, it may represent the views of parents whose children are currently supported by adult services.

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Another limitation of this study that should be addressed in future research is the lack of involvement of keyworkers from adult services in the advisory groups. Although transition keyworkers had a clear picture of young people's transition needs, including the perspectives of the reception system could help us better understand the current situation in adult services and take a more holistic approach in the development of the MFi. Current research also suggests interventions that are collaboratively developed with mental health professionals and service users achieve optimising outcomes (Pearson, Sibson, & Carter, 2021).

Future directions

Overall, co-production has the potential to bridge existing service gaps such as inconsistent communication between young people, parents and keyworkers. The value of experiential knowledge can break scientific convention restrictions and promote empirical and theoretical conceptualisations that empower mental health services (Goldsmith et al., 2019). The conduct of Advisory Groups enabled keyworkers, young people and their parents to participate in research and service development. To our best knowledge, this is the first research project to address the issue of developing an evidence-based intervention in secure settings through the voicing of young people's and carers' experiences. The current findings promote evidence-based initiatives and build robust practice frameworks that inform treatment and policy guidelines. As such, reducing service inequalities especially in adolescent secure hospitals should be prioritised by using the reflective tool of co-production and open responses. The development of patient-informed, co-produced interventions such as the MFi promotes a balanced dialogue between service providers and service users and helps overcome existing power imbalances in secure services. In the case of complex interventions, co-production should be planned early in the process to increase impact. Voicing the experiences of detained and otherwise research-excluded groups can change the scope and current narrative of future interventions. A two-armed feasibility cluster randomised trial is in the process of development across six adolescent secure hospitals to test out the practicality, acceptability and sustainability of the proposed transition programme. Additional input about the finalisation of the MFi will be sought during future planned PPI meetings with the young people, parents/carers and keyworkers. We have advised other keyworkers and collaborators from the lead site to produce the MFi course training and delivery materials for young people and mental health professionals.

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Ethical information

Key collaborators were used as local contacts to support with identifying potential co-producers (young people, parents and keyworkers) to take part in the Advisory Groups and obtaining consent from all participants. Young people were between 17 and 19 years and met the legal criteria in England and Wales to provide consent. The study was reviewed and approved by Kingston University Research Ethics Committee.

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