

Young people's secure care:

**Professionals' and parents' views of its
purpose, placements and practice**

Annie Bartlett

Louise Warner

Heidi Hales

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1. Executive summary

This is the third report on secure care for young people in England. It should be read in conjunction with the scoping report which established the location and nature of secure care facilities for young people and the census report which describes the detained population in terms of their health and social care characteristics and pathways into care.

This report is based on the analysis of 53 semi-structured interviews with secure care staff (N=36) and parents of detained young people (N=17). These explored their views of:

- the characteristics of the multi-agency system of secure care
- why a young person might be detained in the system
- who these detained young people might be

1.1. Key findings included:

- Despite the notional clarity of the three components of secure care¹, respondents thought detained young people in all types of setting often shared similar, disadvantaged backgrounds and characteristics, including mental health difficulties
- Vulnerable young people might be placed with those who posed a significant risk to others and those who only posed a risk to themselves might be detained in medium secure hospital services
- Staff involved in the care of young people in secure care and parents' had different views on care quality
- Staff involved in the care of young people in secure care and parents were critical of the process determining a young person's secure placement, seeing it as a consequence of failures in prophylactic health and social care (particularly child and adolescent mental health services (CAMHS)) and based on the availability of a placement rather than its suitability, to the point where the system's decision could appear arbitrary
- Respondents were united in their concern that young people were often placed far from their support systems and that this was detrimental, even when specialist care was required
- Many respondents thought young people had had multiple placements and moves leading to difficulty trusting staff or emotionally investing in care and to feelings of rejection

¹ The three legal frameworks under which young people can be deprived of their liberty in England are: The Mental Health Act (1983, as amended 2007) placing them in hospital, Section 25 of the Children Act (1989) placing them in a secure children's home, or under the Youth Justice System on remand or serving a sentence in a secure children's home (SCH), secure training centre (STC) or young offender institution (YOI).

- Parents considered the attitudes of staff towards their child, specifically with regards to their interest in and knowledge of their child's history, to be unhelpful
- The widespread use of agency/temporary staff was uniformly considered to exacerbate difficulties in trust and communication and care delivery
- Insufficient recruitment and poor retention of staff allied to the absence of bespoke training contributed to the widespread use of agency staff
- A range of practical ideas about units and the system of care were put forward

These findings led to themes, explored in the Discussion and Conclusions, for further consideration by key stakeholders:

- Parents and professionals: language and its significance
- Consistent Approaches to Care Delivery
- Looking Out not just Looking In
- Risk and Vulnerability
- Geography and Parity of Esteem

2. Introduction

This is our third report on secure care for young people in England. The three legal frameworks under which young people can be deprived of their liberty in England are: The Mental Health Act (1983, as amended 2007) placing them in hospital, Section 25 of the Children Act (1989) placing them in a secure children's home (SCH), or under the Youth Justice System on remand or serving a sentence in a secure children's home (SCH), secure training centre (STC) or young offender institution (YOI).

Our first report (Warner et al 2018) identified all the secure units, in England, in which young people (under the age of 18 years at the point of detention) are detained. Most of the placements available to young people are within the Youth Justice System (YJS) but more therapeutic input is available for those in secure hospitals. Our second report (Hales et al 2018) was of census data obtained on the population of young people detained in these units. It established: the distribution and size of the population of young people in the secure system: the pathways into secure care of the young people: the needs of those detained in different institutions under different legislation: the extent to which the needs of detained young people differ according to type of institution.

This report is based on interviews with key stakeholders, including parents but not including young people, which established their views of:

- the characteristics of the system of secure care
- why a young person might be detained in the system
- who these detained young people might be

2.1. Method of Inquiry

The questions were designed following a strengths, weaknesses, opportunities, and threats (SWOT) structure. This was in order to evaluate the current system of secure care in respondents' own terms. The interviews were conducted between March and June 2017. We aimed to get views from a variety of people with involvement in different aspects of the system of secure care. The content of 53 interviews were included in this analysis. In total, 23 interviewees were working directly in secure services in health or social care or the YJS (secure hospital or other setting clinicians, discipline staff, SCH staff, education providers). Five interviewees were from Youth Offending Teams (YOTs), 2 were solicitors, 17 were parents of detained young people who were mainly in secure mental health hospitals at the time of interview, 2 were specialised commissioners from NHS England, and 4 were directors of children's services. We did not interview young people for this part of the project. We are confident that the methods employed generated an accurate portrayal of the participants' views, substantially in their own words. Terminology used by participants occasionally deviated from that of the organisations involved e.g. prison rather than YOI. We have retained the participants' terms in quotations even if it is not that formally used in relation to children and young people's services. The names of all individuals and units have been anonymised.

Analysis of the transcripts followed principles of thematic analysis (Braun & Clarke, 2006²). The findings in this report are based on five of seven overarching descriptive codes which were most relevant to the original aims of the study and shed further light on themes in the first two reports (see coding framework in Appendix). The following text contains multiple quotations from respondents. These were chosen as illustrative of key ideas, to represent a range of views from respondents in different sectors and to identify views from parents and professionals.

The strength of the method as actualised was that it generated respondents with experience of all the types of secure care and multiple domains of professional activity. It also provides the views of a cross section of parents, albeit that most had children who had been detained only in secure hospitals. Parents or carers of young people in other settings were difficult to identify and recruit. Respondents who were underrepresented in terms of the workforce in contact with detained young people were primarily YOI and STC discipline staff.

The following sections (3.0-9.0) report the interview analysis:

- Systems of care and control
- Determination of secure placements
- The consequences of placement
- The nature of transitions
- Family and staff relationships
- Staff attributes
- Funding and resources

They are based on key topics raised by respondents, after which there is a section of discussion and conclusion (10), drawing together key findings and considering their implications. For ease of reading the quotations indicate the agency of origin of the respondent and are also colour coded as below³: this may be different from the agency referred to within the quotation.

² Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101.

³ Red: secure hospital clinician or clinician working in another setting. Green: YJS staff. Purple: SCH staff. Yellow: lawyers. Pink: education staff. Orange: parents. Black: commissioners (directors of social services or health commissioners).

3. Findings – Systems of care and control

3.1. Paradoxes of principle and practice

The multi-agency system of care and control in England for young people deemed to require secure conditions is comprised of three parts; these are legally, financially and organisationally separate, with different stated purposes. This study was interested in how these systems were understood by respondents who spoke from different vantage points; professional or parental; welfare, criminal justice or mental health; providers or commissioners.

Three paradoxes came out of the analysis:

- The system was understood to have separate parts in theory but in practice there was a perception that needs and characteristics of young people, wherever detained, overlapped
- Risk to self is managed by detention and young people who posed a risk to no other person could be placed alongside those who were a risk to others
- The primary purpose of all these units must be to prepare a young person for independent life but staff and parents more often explained it in terms of risk management and containment

3.2. Paradox 1: separate but similar

There was recognition of the distinctive functions of the components of the system, even when professionals' experience was limited to their own field.

Clinician, secure hospital: I understand there's a secure estate which comprises YOIs, secure training centres, secure children's homes, and they're through the YJB. They decide where young people in need of secure care should go within the estate, most due to offending. Then there's mental health secure which is a separate NHS provision, for when a young person's specialist needs can't be catered for in the mainstream secure estate.

But there was a paradoxical perception that the young people located in different parts of the system had, to some degree at least, overlapping needs, including mental health needs. Their backgrounds were characterised repeatedly as involving: disrupted families, vulnerability, aggression, trauma, sexual exploitation, poverty, risk to others and to self and neglect.

YOT worker: Well, I think what's apparent is the cross-over of the cohort. It does appear to some extent pot-luck which route they go down.

STC clinician: I understand there's a three level kind of network – secure children's homes, STCs, YOIs. You can get welfare beds in secure children's homes. There's supposed to be criteria, so in terms of age and being more vulnerable they work their way up, starting in secure children's homes, but it feels a bit arbitrary the way it works out.

SCH manager: There's probably a lot of young people who should be in mental health provision.the local authorities get desperate to place young people with severe mental health problems in welfare places to keep them safe, but we aren't able to meet their mental health needs. We can keep them from self-harming, but we don't have the specialist help they need available.

Equally, there was a view that once contact with a particular component of the system had happened this alone might shape the perception of the young person's needs i.e. that they were understood less as an individual and more as a type of young person inevitably suited to the first agency that had considered them.

Commissioner: Once they're in one place, then they become that kind of problem.

The early points of agency contact do correlate with longer term trajectories, for good or for ill. This state of affairs generated some frustration in those who named it.

3.3. Paradox 2: risk issues

Respondents were most likely to see the system as a whole as designed to manage risk and to provide safety. This was both risk to self and risk to others and included an idea of vulnerability. Respondents working in secure healthcare were clear that self-harm could be the sole basis of admission, including to medium secure hospital settings, and that might not be appropriate even if it was then well managed.

Commissioner:young people in Tier 4 go there because of self-harm and suicide attempts,

Commissioner: There's been a change in the cohort in secure health care from those who are a risk to others, to those who area risk to themselves.

Clinician, Secure Hospital: Obviously whether they end up in forensic is about the level of risk to others and how that is managed.

Clinician: Secure Hospital: Well, it's necessary when a person becomes in a position requiring ongoing treatment for the safety of themselves or others, for example meeting criteria for detention under the Mental Health Act and not wanting to have that treatment. For prisons, it's somewhere someone can receive rehabilitation to correct their views on society and reduce their crime rate. In secure children's homes, they look after the physical and emotional needs of the young people, because there's no direct parental role.

Several respondents pointed out that the combination of risk to others and vulnerability could make for a toxic mix in a single environment.

Clinician SCH: it means violent and dangerous young people going into the welfare system and mixing with very vulnerable young people

Parent: The problem with secure children's homes is that they have some children who are there for their own protection, and are highly vulnerable, and then in the same home you have children who are fairly ingrained in a life of crime. It's a difficult mix of people.

3.4. Paradox 3: unit purpose

Importantly, the function of units was not expressed primarily as preparation of the young person for life after the unit in the community, although many staff went on to discuss the process for discharge or release, often to say that it could be fraught with problems. With so many young people moving from placement to placement rather than to the community and where unit-based staff have little influence over the speed or suitability of community options, perhaps it is understandable. Arguably, it helps normalize the regrettable reality of multiple placements away from home. The focus of professionals was more on what happened internally inside particular setting; what was achieved

depended in part on the nature of the setting and was not universally understood as useful.

YOT worker: Secure training centres, I'm not sure how well they work. And YOIs, they're not doing anything to change behaviour, they're just containing them.

Some professionals did explicitly address the need to start planning for life beyond the unit.

Clinician, Secure Hospital: I think we have a higher rate of discharge to the community than others – partly because it's what we aim to do.

In contrast, parents were usually skeptical about what happened inside units and seldom saw it as adequate preparation for their child to move on successfully.

Parent: I don't think the mental health of the young people was at the forefront. It was seen as a holding pen. There was no sort of plan for moving forward and getting better. They just saw it as that's where they were.

3.5. Care quality

Most parents expanded on their understanding of the care within units by explaining what their own child had received, mainly in secure hospitals. Frequently this was comparative; their child's journey had involved more than one placement away from home. They were, almost without exception, critical of care delivery and even those who praised care remarked on poor care at other times.

Parent: The ones that were good take a complete picture of her, from way back. They review all her drugs, or take her off all of them to see what happens. They have regular art therapy, and yoga. I couldn't fault any of those therapists. At one particular private unit,the care she received was so bad that we lodged a formal complaint.

Key themes were insufficient or un-stimulating daily activity (e.g. little exercise, music, art or access to nature) and a lack of safety.

Parent: They didn't even care for the basics.she was left in a room for the whole day and didn't eat or drink. Their attitude was that she knew where the dining room was, if she wanted to eat. For activities, they had a fantastic lounge with pool tables and things, but it was locked and they weren't allowed to use it, so all the day was run around the corridors.

Lawyer: They've got a new unit, it's just been set up, and it's state of the art, they have leisure facilities and OT, and great staff who are well motivated. Others are in the dark ages. They're in the middle of nowhere, there's nothing for the young people to do, and they're bored. So, it's no wonder they kick off.

Lack of safety might be due to poor safeguarding practice, to physical violence in the unit or a failure to share risk assessments between staff groups.

Parent: You think they'll be safe, but they get attacked. Threats were made towards my son, but I thought he'd be safe in that environment.

Parents could also be worried about aspects of practice such as the impact of restraint or what they saw as an over-reliance on medication.

Parent: Universally, they've been very bad, in the sense of the level of care, compassion, the level of knowledge, and the level of respect towards parents, and that they are

so heavily dependent on medicating the children. They have a very punitive approach,.....

Parent: My daughterwas allowed to head-bang. She was left with items that were unsafe.

Professionals' comments were strikingly different. Most commented positively on what they thought units did, whether or not they actually worked in the one being described. No consistent themes emerged but positive comments were made in relation to mental health units and SCHs about the quality of care, speed of response, provision of a safe environment the involvement of young people in their own care, the range of activities and less restrictive practice (including restraints) than previously.

Clinician: SCH: I think of secure children's homes very highly. Young people hate being here when they come in, but by the time they leave they don't want to leave. They say it's their home. They've never had protection, boundaries, safety before – they have it here.

These remarks only echoed parents' views in isolated views on the lack of therapy and safety in YOIs and the imbalance between assessment and treatment.

Clinician YOI: ... I don't think, for the large majority of young men in YOIs, that it's a suitably therapeutic setting,it cannot provide even what it sets out to do. It's a very inadequate environment, particularly for young people who show vulnerabilities – which is all of them, really, if you look beyond the surface. STCscannot provide a sufficiently therapeutic environment with current levels of staffing or training.

Even then, no professional volunteered comments on serious breaches in standards of care.

Educational progress is critical to a young person's life chances but it featured infrequently in respondents' views, even though it is integral to the experience of detention in all kinds of secure care. Multiple placements could put educational goals at risk:

Education staff: Every time they move, their education suffers. They move from one school to another, and have to start all over again every time, so by the time it comes they aren't able to sit their GCSEs because they haven't had the last 18 months of stable education.

Equally, detention might allow a young person access to education they had previously missed and praise for individual young people if they battled against the odds to achieve formal qualifications.

Education staff: We make sure they are educated to the best of their ability. We can stabilise them enough to access qualifications they might not have done otherwise.

But there was also concern at times, from parents, about the availability and adequacy of education in healthcare settings.

Parent: The education is very, very poor.It's almost like they don't expect them to be able to – but before, he always went to school. The expectation is not for them to go on to GCSE or A level. The clinical staff don't know about or value the education; when the children have mental health problems, the staff don't seem to value education.

3.6. Commercialisation of care

Care quality was in part understood as determined by the overarching commercial practices. The handful of parents and professionals who raised the issue of the commercialisation of care generally agreed. They saw the involvement of the independent sector groups of hospitals and the practice of local authorities of inviting bids for young people's placements as unfortunate. The independent sector was seen as bad in principle and poorly scrutinised but also picky about which young people it accepted, a luxury the NHS could not afford. The local authority processes were construed as not person-centred.

Clinician, Secure Hospital: Young people bounce around these providers and training and governance are not up to scratch. I'm not a fan of the private providers.. and the units are often not properly equipped.

3.7. Key points:

- Despite the notional clarity of the three components of secure care⁴ respondents thought detained young people often shared similar, disadvantaged backgrounds and characteristics, including mental health difficulties
- Vulnerable young people might be placed with those who posed a significant risk to others and those who only posed a risk to themselves might be detained in medium secure hospital services
- Staff involved in the care of young people in secure care and parents' views on care quality were divergent
- Respondents' perceptions are matched by the census data that indicates that in terms of health (physical and mental) and social care needs (evidenced by the numbers of looked after children) there is indeed considerable overlap of needs, as well as some distinctive features in each type of setting.
- Census data also supports respondents' views that the nature of a young person's current placement correlated with their previous involvement with statutory services (YOTs, CAMHS) from the same part of the system
- Scoping information indicated that education is offered in all kinds of unit but secure hospitals offered less time for education than other units and parent respondents were most familiar with secure hospitals perhaps informing their view on educational adequacy

⁴ The three legal frameworks under which young people can be deprived of their liberty in England are: The Mental Health Act (1983, as amended 2007) placing them in hospital, Section 25 of the Children Act (1989) placing them in a secure children's home, or under the youth justice system on remand or serving a sentence in a secure children's home (SCH), secure training centre (STC) or young offender institution (YOI).

4. Findings - Determination of secure placements

Multiple factors were considered to account for the particular placements in which young people were detained. These were expressed by professionals in terms of the process and its strengths but predominantly in terms of its weaknesses. For parents the issues were deeply personal and involved their own child's story; with this came a longitudinal picture of the relationship of the most recent placement to those that went before as well as accounts of the circumstances that had brought them into contact with services often over several years, critical ones in terms of their child's adolescence.

4.1. Relationship to community care

The need for secure care was seen in part as a failure of services that were designed to help young people before they required secure care of any kind. From the parents came a strong sense that secure care could have been avoided had community services, notably CAMHS, been more robust and responsive as well as practical ideas as to how that might have worked:

Parent: Adults have self-referrals, peer support, and drop-in centres. But there's nothing like that for teenagers.

Parent: There needs to be small respite units, linked to CAMHS, outreach, and maybe also early intervention for psychosis teams, for critical crisis care for maybe just 24 or 48 hours, to avoid them ending up in hospital for months.

Parent: My daughter only got referred to the unit because there was no community care. There should never have been any admissions, let alone PICU.

Parent: .. There's no training or education for parents around self-harm, and there's no preventative measures.

SCH worker: These young people have nothing in the community that can really get to them.

Clinician secure hospital: We need to put more resources into the community, before they get locked up.

Some professionals were also concerned that not enough had been done soon enough and opportunities to intervene early were missed.

4.2. Limited availability of placements

At the point where secure care became inevitable, the dominant issue was the limited availability of a placement rather than the actual needs of the young person. This applied regardless of the legislation used. Some parts of the country were recognised by more than one respondent as very poorly served. Interestingly, the lack of money to fund more placements and interventions was infrequently expressed: only two respondents mentioned this. To many professionals and parents the shortage of available placements seemed wrong and could also contribute to the identification of a placement with significant drawbacks, a situation that was thought more likely in urgent cases.

Commissioner: Often, they end up coming back to us, because social care have no spaces, so they end up back with us, blocking beds for people who actually need them.

Clinician, secure hospital: Social services do find secure placements in the community where education and healthcare are on site.⁵ There's a few where I've referred young people in the past, but there's not enough nationwide.

YOT worker: Many of them meet the criteria for welfare, but there's no beds available, so soon they end up on remand – but they did meet the criteria for welfare/secure.

Parents recognised that the systems were flawed:

Parent: We have no mental health units in (County) at all for teenagers. We've been promised we're getting one, in about 2 years. There's no prisons either.

Parent: My daughter had to wait a week in a general hospital, because there were no beds.

However, this was qualified by considerations of the wider system, notably in relation to patient mix in hospital.

Clinician, secure hospital: There's a lot of pressures on beds in medium secure, with people waiting to come in and people who are very complex already here, so we can't admit to full capacity because we have to keep them safe.

However, for some professionals, limited availability was only one of a number of factors believed to influence final placement. Other factors included age, risk, gender (young men were thought more likely to go into the YJS, young women into welfare or mental health) and offence. Or, as one parent put it more cynically:

Parent: I think you're more likely to go to hospital if you're a girl, or have parents willing to fight for you. They're more likely to go to a secure children's home or a youth offending institute⁶ if you're a boy or don't have parents fighting for them. And it depends on where there is space and how much it costs. It's focused on that, not on their needs.

4.3. Placements and needs

Needs were not considered paramount in placement decisions by many of our respondents, even in discussion of specialist needs such as Learning Disability or Autistic Spectrum Disorder and even if they were, the result was not necessarily uncomplicated.

Clinician, secure hospital: But it may also be necessary at times, to go to a setting that meets their needs. It can also set them back, but can still be necessary to find the right placement.

Clinician, secure hospital: Obviously whether they end up in forensic is about the level of risk to others and how that is managed. ...However, we also see young people wrongly placed in medium secure due to risk to themselves that can't be managed elsewhere.

Parents with experience of the secure hospital system above could understand the theory of needs based placement but could find the reality less satisfactory:

⁵ Terminology unclear but in context respondent seems to be referring to SCHs

⁶ Young Offender Institution is the official term but this respondent, like others uses a variation on this

Parent: From the point of view of her care, she has been in the right kind of place. Both facilities she's been in have realistically assessed what she needs,But I would say that the treatment has been really slow.

4.4. Arbitrary placement

There is a lack of consensus about how placements are decided, whether the respondent is a parent or a professional and regardless of the sector of origin of the professional. Multiple respondents correspondingly openly expressed the view that where the young person ended up could be hard to fathom and might well appear arbitrary. This could apply to the nature of the placement or the legislative framework for detention.

Clinician, secure hospital: You can get a young person with a history of violent offences and crime and they come to welfare. Or a boy who commits one crime goes to a YJB secure children's home, obviously it depends on the severity of the crime, but dangerous young people come to welfare system and you think why not an STC or YOI?

Clinician, secure hospital: Some young people also struggle between local authority secure and mental health secure – it can be quite arbitrary where they end up.

Some parents' views simply echoed those of these professionals.

Parent: But where they end up is completely random.

Parent: It seems fairly arbitrary if they end up in a secure children's home or hospital or youth offending institute. In some secure children's homes, the children seem to have incredibly significant mental health problems, but they aren't in hospitals.

Parent: In X's case, it felt like someone had chucked sticks in the air and just saw how they fell..... It does seem like a bit of a roll of the dice. It doesn't seem like there's clear cut criteria

4.5. Key points

- Staff involved in the care of young people in secure care and parents were critical of the determination of a young person's secure placement, seeing it as a consequence of failures in prophylactic health and social care, particularly CAMHS, and based on the availability of a placement rather than its suitability, to the point where the system's decision could appear arbitrary
- Scoping information echoes the respondents' views that some areas of the country have few placements. The Southwest of the England has few secure hospital placements. There are no STCs in the north or southwest of England

5. Findings - The consequences of placement

5.1. Concerns about geography

Respondents, both professionals and parents were similarly concerned about the geography of placements and how it was that young people were placed far from home and their family and friends. This was thought to be wrong in principle and created difficulties for the young person, family and professionals involved in their care.

Clinician, SCH: Often they are very far away from home, hundreds of miles.
Lawyer: No, too many are placed too far away from home. It's a massive problem.
Parent: None of the places they go are local. How can that be right?
Clinician, secure hospital: most medium secure units don't take girlsSo geographically, girls have to travel far.
Clinician, secure hospital: I think almost 90% of young people here are not local to this area.

Professionals' attempts to monitor young people in distant placements were hampered by long journey times.

Commissioner: We have children at the moment in Norfolk, which is a seven hour drive. It's very hard to properly review their care, because it takes two days out of our working week. Commissioning and clinical oversight both improve when they're closer to home.
YOT worker: There's an issue around lack of appropriate and close to home beds, particularly in a welfare setting. Also, for YJB beds there's an issue around how close to home they are – it works better if they're close to home and we can go there to see them.

The process of transportation of children worried both professionals and parents.

Commissioner: Can a placement 300 miles away be called 'best', however good it is? I know there are often issues in transporting people to secure – it must be difficult and stressful for young people waiting in cells for transport.
Parent: The fact that my daughter, at age [<15], was placed 250 miles away is appalling, in this day and age. It made her worse. They used secure transport, even though she was calm and collected. They sent her in what I'd call prison transport. She called it a 'cage'. It was like a black box, with no seat-belts.

Parents might struggle to see their child and to have sufficient oversight of the placement not to be anxious.

Parent: He's 100s of miles away, so I can't be as involved as I want to be, so the services can do what they like. You're never quite sure what they're doing, and it's very worrying.It would not happen if a child had leukaemia.
Parent: One of the really big problems is they're often far away from home. We have other children, but all our weekends were spent travelling to see her. We have a young son who we couldn't leave at home, so he had to come with us, so he wasn't doing things with his peers.

Key to this is respondents' understanding that this follows from the limited availability of beds. Family members reported dismay at how they were expected to be grateful for

placements that made it hard to visit their child and about which they had little prior information.

Parent: ...wherever it is you'll just have to accept it, even if it's 200 miles away – she's really unwell, so you just have to deal with it. ...The attitude is that you're lucky to get a bed.

5.2. Getting the help they need

Some, but not many, respondents recognised the difficulties agencies had in balancing the distance from home of a placement against a young person being able to access appropriate help.

Parent: I think she has been placed where she needs to be, for the time being, although it takes me an hour and a half to get there.

Parent: ..she's now 120 miles away, and in five weeks she's managed to do some family therapy, get out of bed, go to education, she's eating, and not dosed up on PRN medication, and she's not self-harming as much.

Equally, professionals were clear about the services they offered and what were the key ingredients for success. These seemed to be less about specific programmes and more about consistency in relationships.

Education staff: ...these young people need as much stability as possible. They've had a lot of upset already in their lives, and it gives them no chance to build therapeutic relationships. Often here is the longest placement they've had and the safest they've felt.

SCH worker: I see that by the end of their stay they feel like it's been quite a good placement. They've built relationships, they have a bit more trust in adults, and there's intensive support from staff available 24/7.

5.3. Key points

- Respondents were united in their concern that young people were often placed far from their support systems and that this was detrimental, even when specialist care was required
- These findings tally with Census data that indicated 64% of young people in MHA placements, 84% of those in welfare placements and 59% of those in YJS placements were in units outside their region of origin

6. Findings - The nature of transitions

Ironically, a key finding from the census report was that many young people had multiple placements, rather than stability, but the data available did not explain how or why that happened. Young people are received into or admitted to placements, moved on to another placement, often to another secure placement, and some are ultimately able to return home or go to another community setting. Others will graduate to adult services.

Continuity of care has been thought desirable as part of health and social care work for many years as well as built into aspects of the work of the justice system. What the census report tells us is that this may be jeopardised by the sheer number and unhelpful geography of placements; respondents have already commented on the deleterious effect of distant placements in terms of family relationships and professional oversight. In addition, respondents commented specifically on the nature of the young people's transitions; they identified delays, movements to adult services and to community provision as well as discussing what prompted crisis moves.

Mental health units could have delays in admissions caused by delays in discharges. At times this required them to hold onto young people who had reached the age of 18 years.

Clinician, secure hospital: ..there's pressures on beds so we can't have smooth transitions in the way we would like. There's two or three patients over 18 at the moment, but no provision available.

Parent: On the day of her 18th birthday, she got moved to an adult unit. It was an absolutely horrific transition. She was sent to a unit where most of the patients were in their 40s or 50s, and had been unwell for most of their lives. She found it terrifying.

Units with strong links, early in episodes of care, to relevant, less secure services felt they handled step-down well with careful planning, but this was far from universal as services that would sustain rehabilitation might be absent or full.

Clinician, Secure Hospital: Another weakness is that transition for young people is extremely slow. There's two young people we have here who could step down to the community tomorrow, but I perceive a poor exit strategy from the get-go is holding up their progress.

In YOIs, a young person might only get an address days before release, compromising ongoing health and education and much the same could apply in SCHs.

Education staff: What I think is really lacking is forward planning for when young people are leaving secure. There's a huge amount of uncertainty for young people. There's often no plan, and social workers are struggling to find provision. Due to the lack of placements available in open settings, young people have to be released when their court order expires.....

Parent: He had a delayed discharge. He needed a step-down unit, but there were none available.

The presentation of young people can be challenging to staff and trigger a move.

Lawyer: They're there because they have emotional or behavioural problems, then they get kicked out when they get aggressive.Because these children can't be controlled, they get shifted around until there's enough aggressive behaviour that someone says they can go into hospital, where they can be restrained more.

Clinician, SCH: We had a young person who had been here twice and moved around all over the country. They find themselves in a pattern, where they reach crisis point and get moved on rather than dealing with the crisis.

6.1. Young people's experience of multiple placements

Regardless of the type of secure care such frequent and/or unplanned moves were seen as unhelpful, leaving the young person feeling rejected and less likely to engage with future care givers. Such moves might be precipitated by units not coping with particular young people, by staff becoming burnt out or by funding being withdrawn. Both staff and parents were aware that a proportion of young people had been in multiple placements and that this created both feelings of rejection and difficulty trusting staff.

YOT worker: A lot of young people in the care system have tons of placements, and placement breakdowns. It becomes a way with them – a rejection thing – they know that's the way it is, that it's not going to last. They take that attitude with them – they push and push for rejection, because they know it's going to happen. The older they get, the easier it is to just move them on to another placement.

Commissioner: You get a child who is being constantly rejected and moved around places, and that can lead to attachment difficulties, anxiety, depression – so they can end up in secure because the system has failed them.

SCH worker: We see a lot of people come from multiple placements on the way up to secure, because their behaviours escalate. It's quite damaging and young people can feel rejected by it, they don't build any relationships because they know the staff won't always be there, and there's a sense of hopelessness.

Clinician, secure hospital: There's a lot of young people who have usually had about 10 other placements, and there's a real sense of "no-one can look after me, no-one will stick with me in the long term".

YOT worker: It's really difficult. The biggest issue for children who are in care is that there's no consistency – there's a lack of consistency in workers, and in placements. They blow it really quickly, and people want to get rid of them.

Parent: He's nearly 18, and hasn't lived at home since he was nearly 13. The first 2 years he was constantly moved around, he had about 13 moves in 2 years. It was totally horrendous.They're passed around like a parcel. If I had a choice, I wouldn't put my goldfish in one of these places.

6.2. The perils of institutions

Over time, multiple episodes could also contribute to institutionalization where the young person was unmotivated and deskilled in terms of community-based life.

Parent: She always liked to be doing things, but that's not what happens in hospital. Her way of dealing now is to stay in bed and sleep.

Parent: He started off in a secure children's home and just carried on in that cycle. Institutionalised. He'd had 19 transitions from ages 11 to 18. He didn't know how to function in the community, in terms of basic life skills like knowing how to pay for something in a shop.

Clinician: secure hospital: .. as they move towards discharge risk taking behaviours can escalate as anxiety about discharge and the fear of losing that safe base overwhelm a young person.

Within institutional settings there was a concern from staff and parents that young people could get worse, specifically by learning new methods of self harm. Parents also expressed concern that young people could become demoralized, not engage in available interventions and deteriorate.

Parent: She came out with more ways to self-harm – ligature, head banging, aerosol burns – beyond what I'd ever seen, or what my daughter knew existed. What she didn't learn, doesn't exist.

6.3. Key points

- Many respondents thought young people had had multiple placements and moves leading to difficulty trusting staff or emotionally investing in care and to feelings of rejection
- Census data reinforces respondents' views that the secure hospital system can be rigidly unresponsive, with waiting times for admission being over a month in half of cases and discharges delayed
- Census data is in line with the concerns of all kinds of professionals and parents about discontinuity and unstable placements as data showed 1 in 20 young people have had 10 or more previous placements. Young people in welfare placements were most likely to have experienced this. Half of those in secure hospitals and half of those in the YJS had a previous secure placement.

7. Findings - Family and staff relationships

Most reflections on the relationship between staff and family members of the young people detained came from the parents. Their children were largely detained in hospital units at the time of the interviews but had experience of other types of placement. Their comments did not always make it possible to delineate the nature of the unit to which they referred. In contrast, comments from staff could more readily be understood as reflections on particular parts of the overall system of care.

Parents' experiences of multiple units and/or multiple types of unit allowed for them to make comparisons. Importantly, many felt that the attitude of staff to parents was unhelpful.

Parent: Parents warn hospitals but they are seen as neurotic.

Parent: There's lousy communication with parents. They're incredibly defensive,and find reasons not to believe parents or patients.

Parent: But they wouldn't listen to me, it was like I was making it up and didn't know one thing about my child. ...They see parents as inconvenient.

Parent: There was a sense that as the family, we must be part of the problem.

Parent: Families were not encouraged to visit [name of unit]. They told us not to worry about coming to see her.

Parents felt more positively towards services where they felt treated with respect and kindness. They uniformly wanted to be kept abreast of their child's progress. Almost all professionals agreed with them that the involvement of parents in their child's care was helpful, tempered by the recognition that some families might not be well placed to be involved or the young person might not wish them to be involved.

YOT: In other places it's all about the young people and they keep the young person and their family in the loop.

Clinician, secure hospital: Thinking about the roles of family, there have been CQUINs over the past 3 years about family. It's a mistake to think that these young people all have broken relationships with their families. We do a lot of work with families and then the young people can end up going back to live with their families.

Lawyer: I'd like to see more money going into home visits or funding families to come and visit. There's a lot to be said about being near families.

Some parents felt that they, too, needed support and that this should be a component of their involvement with the unit. This for some might have usefully included discussion of the nature of their child's problems and how best to address them. Parents valued openness, contact with staff and an understanding of how the units worked.

Parent: If I could take all the units she's been to – the ones I liked best were where they let parents on the wards, because it felt like they weren't trying to hide anything

Parent: you could speak to nurses and they gave you an update, and they wanted you to go in and talk to them. We were supporting what they were doing, and they were supporting what we were doing. We worked together.

Parent: One of the best things was that on the day she moved there, a social worker called me and spoke to me for about an hour, addressing all our questions. I felt like he

was there for us, and our daughter, not for the hospital. But in other places it feels more like them against us.

Parents objected to being ignored:

Parent: They had a placement meeting, and we ...had to speak to the duty social worker who said there was a placement meeting, and we weren't invited. We decided to go anyway, and the staff welcomed us, but no-one had actually invited us.

Parent: We don't get enough feedback from the wards on our child's progress. I've had a situation where my daughter was taken in to hospital, and they didn't bother to ring me.

Parents identified an array of practical issues that, if dealt with, might have made things easier both for them and their child. These included: dislike of intrusive security measures when they visited repeatedly: the inability to provide home cooked food for their child when they visited: the inability to take pictures of their child: the inability to see where they slept: difficulties speaking to them on the phone: an inability to use Skype: not being allowed to be alone with their child: an inability to share family photos or videos with their child.

7.1. Key points

- Parents considered the attitudes of staff towards their child, specifically with regards to their interest in and knowledge of their child's history, to be unhelpful
- While the Scoping Report suggests family therapy is offered in 89% of secure hospital units and most YOIs, although not in SCHs or STCs, it is striking that parents comments centred on day to day communication and practical issues rather than therapeutic intervention involving them

8. Findings - Staff attributes

Parents necessarily formed their views of the care offered their child in part through their ideas about the staff, predominantly clinical staff. Key themes were: what constitutes a good or bad practitioner in secure care: working in a challenging environment: agency staff.

8.1. What makes good and bad practitioners

A narrative about what is valued in a practitioner (whether residential care worker, mental health clinician, or discipline staff) appeared throughout these interviews, through a range of comments about both the perceived positive and negative aspects of individuals and groups of staff (role, attributes and skills). These varied with the setting and depended on who was speaking; parents of young people in secure care and professionals working in the field did not share the same views. Parents spoke at length about this topic suggesting it might be more important to the parents of children in secure care rather than to those who work in the system.

Parental opinions often focused on the interpersonal characteristics of staff looking after their children – whether positive or negative interpersonal attributes – whilst professionals appeared to place more emphasis on the clinical skills and training of these staff, and their dedication to the profession. The parental focus on interpersonal characteristics of staff also extended to the way they perceived these professionals interacting with them as family members.

Commissioner: So there's a question around the skill level of staff, and the changing needs of the population they're being asked to look after – and the changing cohort requiring mental health services and the capacity of those services to respond.

Parent: Pretty much everyone I've encountered on the staff side has a genuine desire to try and help these young people get better, and they try their best. That's from the psychiatrists, down to the healthcare assistants. It's not necessarily something tangible, but they really care.

The word 'care' was often used in the context of a good practitioner and could mean different things to different people.

Parent: I've seen some very good consultants too – one recently left because it became too much – she really cared.

The professional groups who had the most direct daily contact with both the young people and their parents were most often the focus of any criticism (largely, nurses and health care assistants). However, the basis for negative views was ambiguous. Perhaps, as the front-line staff working with these young people on a daily basis, criticisms from parents might also come from a general sense of anger at their child being locked up, rather than any specific problems with the professionals themselves or their style of communication.

Parent: The nurses are a law unto themselves.

Parent: ..they were used to dealing with people displaying her sort of problems, and so they were much more compassionate, whereas other units were much more judgemental, like 'do you know what she's done?'

However, some parents had experienced more positive interactions with direct care staff.

Parent: They were fantastic, and it was down to the way the children were treated by the nurses, the boundaries they put in place, and the training they'd had.

There were few grey areas in views of professionals; they were not perceived as being average or having a mix of faults and positive qualities.

Missing from these comments is what the young people living in secure settings value in the professionals who work with them on a day-to-day basis. This study did not interview young people themselves but, equally, there is an absence of their views explained by either parents or professionals. If young people themselves are the ones whose views should hold the most weight in this conversation, this is a significant gap in understanding.

8.2. Working in a challenging environment

The sense that working in secure care is a difficult job is present throughout these interviews. In many cases, the overriding view that comes through is that the professionals working in secure care are doing as good a job as possible, within the constraints of such a challenging and restricted environment. This includes staff working, relatively unsupported, to the point of burnout, due to the challenges faced working in the secure environment.

Commissioner: I think most placements, whatever, type, the workers in them try and do very good jobs in difficult circumstances, they don't go into work to do a bad job. There's some very thoughtful approaches for the child, thinking about what motivates them and what presses their buttons. And there's skilled management and de-escalation strategies

Parent: They really love their job, and genuinely want to help the patients and have the children's best interests at heart. It's a very difficult job.

YOT worker: The professionals have to draw the line because they can't do everything. That's the case across many services. There's a fatigue that I don't really want to admit to myself, but I'm tired of motivating my team to work with our remit constantly expanding.

Clinician, secure hospital: I'm hugely admiring of the professionals I've come across, not just in health but also education.....Shortfalls aren't due to lack of enthusiasm or innovation, it's more difficulties with recruiting and sustaining an expert team.

Clinician, YOI: Things like having a personal officer for each young person are really helpful, but only if these officers can be released from their other duties to build these relationships.

The absence of bespoke or recognised training for the tasks involved with a complex group of young people led to respondents' calls for training of care staff, discipline staff and agency staff.

SCH manager: One other thing is about recognition of professional qualifications for people working in these settings – the care staff. These people work with very vulnerable children and have very little knowledge about these young people. It needs to be for government to have some kind of recognised qualification for these people.

YOT worker: A lot of mental health issues are low level and Tier 2 practitioners could address it, if mental health practitioners would let them in on some of the knowledge and theories.

One consequence appears to be a high turn-over of staff, which not only has an impact on staff morale and wellbeing but also on the lives of the young people in terms of regular changes to attachment figures.

Parent: My daughter had seven key workers in 14 months. One of them didn't even say goodbye. Classic.

Parent: She's been away three years, and she's on psychiatrist number 14.

It is also important not to lose the voice here of those who saw trying to do a good job under difficult circumstances as an excuse for perceived poor performance. The language used by parents who participated in these interviews was often one of anger, particularly towards the professionals they met but also the system as a whole.

Parent: They're incredibly defensive, and they have this self-image of 'we're doing a good job under difficult circumstances'.

This also links to the range of ideas about what makes for a good or bad practitioner. Some professionals spoke of being able to keep the young person alive as being a positive outcome suggestive of staff doing their jobs well. Parents often appeared to have a different measure for staff performance e.g. educational success, getting home, being independent. This dichotomy of views links back to the earlier discussion about what secure units are for in the absence of shared outcome measures.

Commissioner: There's some really good approaches around managing challenging behaviour and keeping young people alive – by being caring. People try to do what they can, and don't underestimate the difficulty.

Clinician, secure hospital: I think most units do very good practice most of the time. Suicide rates would be much higher if people weren't doing a good job.

Parent: Another problem is the lack of education available. My daughter is very bright, she has a high IQ, but she barely came out with any GCSEs, and they had no staff to teach A levels.

8.3. Agency staff

Across the board a prominent view, shared by parents and professionals, was that agency staff dominate the secure care system, particularly within mental health. This was attributed to the lack of permanent staff choosing to work in this field, or difficulties retaining permanent staff. This can lead to a number of difficulties. The transient nature of agency work means staff often do not stay in one place for a long time, and perhaps lack specific training for the particular work environment in which they find themselves. In turn, this appears to have consequences for the relationships that can be built with the young people. Staff who are temporary and move on quickly do not have the opportunity to build strong relationships with the young people for whom they care and perhaps they do not even attempt to do so. This is seen as a different approach from that of permanent staff.

Parent: They're so reliant on agency staff who don't know the units, and so the quality of care is massively affected.

Parent: The less agency staff, the better. Some units have hardly any, and that's better. Agency staff don't know the patients, and they may not have the same knowledge of managing these patients, and they don't know how to deal with certain behaviours. It's very easy to escalate some behaviours if they deal with it in the wrong way.

Clinician YOI: We've lost lots of experienced staff recently. We have agency staff and staff who come in and find it's not for them.

Clinician secure hospital: One of the major criticisms is job retention and job morale is quite low... because we're battling a retention crisis.

This issue can only exacerbate the problems for young people who are also being subject to frequent placement moves. It is hard to disagree that the use of agency staff negatively influences the type and quality of care provided in secure settings.

8.4. Key points

- The widespread use of agency/temporary staff was uniformly considered to exacerbate difficulties in trust and communication and care delivery.
- Insufficient recruitment and poor retention of staff allied to the absence of bespoke training contributed to the widespread use of agency staff.
- This issue of temporary or agency staff did not emerge in the Scoping Report but its importance to care delivery means that it could be considered as part of routine monitoring in all settings.

9. Findings - Funding and resources

Funding constraints are a reality within the public services that commission the system of secure care for young people. Having said that, within the NHS, a major transformation of CAMHS services and young people's secure services in particular is mooted, in recognition of their current limitations. The three projects have ear-marked funding of £21 million and are designed

- to build capacity to deal with complex children and young people in the community via forensic CAMHS (FCAMHS)
- support trauma-informed care and whole systems approaches to children and young people in secure care
- to simplify the existing complex commissioning arrangements for children and young people and improve pathways of care.

Within the wider Criminal Justice System the loss of staff since 2010 and the limited success to date in replacing experienced staff even with individuals new to custodial care has been well rehearsed.

Commissioner: The current financial issues are well documented – in local authorities, criminal justice system, and health.

Clinician, YOI: Cutting resources to prisons⁷, and low numbers of officers, means young people get less time out of their cells, have less meaningful relationships with staff, less trust, fewer opportunities to develop themselves, and become more isolated and aggressive. There's nothing good about that, it probably doesn't, in the end, save money; and it leads to a revolving door population of dangerous and damaged people.

Local authorities have seen budget cuts affecting a wide range of social care at the same time as demand, e.g. for the care of the elderly, accelerates.

YOT worker: Local government cuts have meant an increase in neglect and abuse, and service thresholds have been raised.

In this broader context our respondents observed cuts in funding, notably in Secure Children's Homes and YOIs but were more mixed in their views on NHS funding to children's mental health care, partially recognizing that money had been identified but only sometimes seeing it arrive on the frontline.

Clinician, secure hospital: It's quite bleak at the moment, given the NHS situation on funding. They're saying money is going into CAMHS, but it's not visible at our level. Money is going into early intervention and eating disorders, but within our organisation the economic climate is not great and it's likely we will have less beds in future, but hopefully we will still be able to offer a quality service.

Lawyer: It's a funding thing, funding is being cut. It all comes down to funding.

SCH manager: We got additional funding from the NHS – we've moved to having a full time clinical psychologist and our mental health practitioner is going full time too. My

⁷ The YJS provides YOIs, not prisons, but the respondent may be making a general point about the adult estate as well

understanding is that we will be further developing physical and mental health services. We could always do with more, but for us things are looking much better.

Commissioner: There's a continued lack of investment in local services, and continued stripping out of respite and secure children's homes.

Clinician, secure hospital: B..... managed to have quite high level provision of psychology and psychiatry, but now they've cut back.

Clinician, secure hospital: It's hard to get off thinking about resources. The prison service is always in the media – the privatising and cutting agenda is a real threat.

Clinician, YOT: The budget here has been cut by a third, so we've lost huge numbers of therapy staff. The gang and keep apart issues have exploded in recent years, so it's very difficult to run therapeutic groups.

This could be understood as exacerbated by increased demand.

Commissioner: So, I think the three main things are: funding, the growing cohort with emotional wellbeing problems, and the growing lack of experience in the system.

Within this understanding of the financial backdrop, comments on provision largely fell into two categories: first that provision was limited because of insufficient funding and second that the configuration of services did not match need.

YOT worker: For the young person we have at [YOI], we've seen that there's not enough resources, the professionals have to draw the line because they can't do everything. That's the case across many services.

YOT worker: We have 170-plus boys to plan for here – so inevitably we miss stuff.

Parent: In my own personal opinion, the problem is that therapeutic interventions in this country and the NHS are limited..... there's a four to six month waiting list to access DBT.

This led to a number of concrete suggestions as to how provision could be altered to address young people's problems earlier, locally and in a way tailored to some, currently neglected, specialist and non-specialist needs. Respondents touched on the economics of secure care, arguing that detention in hospital was costly and that preventative community options must be cheaper and that for those necessarily detained, efficient provision of aftercare would also be cost saving.

Table 1: Recommendations for improved service provision

Foster placements	Step down/half way house units
Local YJB units	One to one support
Respite admissions locally	Funding increase for home visits and family visits
Small secure units	Specialist care for those with learning disability, autism and eating disorders
Inreach to justice and care settings	Peer support

Drop in services	Outreach out of hours crisis service
Life coaching/skills	16-25 year old services

9.1. Key points

- A range of practical ideas about individual units and the operation of the wider system of care were put forward, many, if implemented, would be prophylactic as they would enhance community options.
- These practical ideas are particularly pertinent given the Census report of high numbers of young people with neurodevelopment disorders (learning disability, autistic spectrum disorder and attention deficit hyperactivity disorder(ADHD)) in the YJS, many of whom go there directly from community settings and who are excluded from most secure hospital services according to the scoping report.

10. Discussion and conclusions

These interviews are helpful as they provide a more nuanced understanding of the systems of care for young people in secure care than is achievable in either of the two related reports which rely on quantitative data and which lack any of the voices of those who have had personal contact with the system over years, as have many of both the parent and professional respondents. Key topics that have emerged, echo, in part, those raised by the other data sources on which we have already reported. They are:

- Parents and professionals: language and its significance
- Consistent approaches to care delivery
- Looking out not just looking In
- Risk and vulnerability
- Geography and parity of esteem

10.1. Parents and professionals: language and its significance

The analysis reveals a difference in the tone of professional and parental responses. Few, if any, of our interviewees are sanguine about the current functioning of the system but how that concern is expressed depends on whether you work in it or your child is detained by it. These parents, who are most familiar with the healthcare components of secure care, are often deeply critical while also profoundly engaged with it. While they do praise individual practitioners or units, much of what they say is negative. We are not in a position to comment on the representativeness of their views in relation to other parents of young people detained either in mental health units or other parts of the wider secure care system. Their emotional language sits in this report juxtaposed with the more neutral tones of professionals from all parts of the system who are worried but perhaps more distanced from how defects in care systems can impact on real young people. It seems important to understand why the language of these respondents is so distinctive and how best to respond to what they are saying and how to integrate that with the views of the professionals.

There is perhaps a role for the distinctive parental voice to influence the working of the system. They report not being valued in terms of immediate care delivery and some told the researcher this was the first time anyone had invited their views on the wider care system. Yet from them came not only domains of concern that often matched those of the professionals - notably about limited local availability of placements and the failure of the local CAMHS services to prevent escalation into secure care, but also a range of practical suggestions about the structure of care and the running of secure services. So, one question for stakeholders is how to embed this perspective in service improvements and service evaluations.

10.2. Consistent approaches to care delivery

Some of what these parents said related to very practical issues in the functioning of secure units, at different tiers of security. Although these largely related to hospital settings, the general issue may apply more widely. They expressed concern about the basis of rules that made it harder to maintain a sense of normality with their children. These rules included food, photos and skype. They also raised the issue of consistency

in units both about ordinary components of life but specifically about access to materials that could be used for self-harm.

No doubt units under different agency control will differ; so too will the different tiers of security within a given system. But, it is easy to see that this could be very confusing for young people and their parents. One response might be consistency between units of the same kind and level of security and a published rationale for particular limits on freedom and ordinary activities.

10.3. Looking out not just looking in

Our previous report drew attention to the movement of young people from unit to unit rather than being readily reintegrated into the community and we raised the related issue of the absence of outcome measures. The views in this report from parents and professionals on the function of units suggest that there is a preoccupation with admission/assessment/stabilisation and risk reduction but less focus on what it takes to get out of the unit. In practice of course this may be different but we argue that our conclusions follow from what our interviewees actually said when asked about the purpose of units. When allied to the well-recognised difficulties in achieving step down or uncertainty and lack of control over accommodation on release it is a concern.

Focus on reintegration could be supported by more local units, funding for home visits and pro-active maintenance of ties with peers and family when detained. Equally, stakeholders might usefully articulate and agree on intended outcomes against which a young person's individual progress might usefully be transparently benchmarked.

10.4. Risk and vulnerability

Respondents' discussion of risk was multi-faceted and included comments on risk to others, vulnerability and risk to self. Their responses raised two particular issues. First, whether self-harm alone should be the basis for the detention of young people in secure care and second, whether those who solely pose a risk to themselves should ever be detained alongside those who are a risk to others.

It was clear from multiple responses that some young people who self-harmed but were not a risk to others were escalated up tiers of secure care, with a proportion ending up in medium secure hospital care. The exact numbers are unknown and did not form part of our census data.

However, this situation is similar to that found in the first Ashworth Inquiry (⁸DH 1992) where self-harming women were detained in high secure care as no facilities at lower levels of security were available for them. Newer formulations of their problems, notably the recognition that trauma was often turned inwards, resulting in serious and self-mutilating and persistent self-harm, led to trauma-informed care and ultimately the closure of both Ashworth and Broadmoor's women's services. Research on low and

⁸ Department of Health 1992 Report of the Committee of Inquiry into Complaints about Ashworth Hospital Vols I and II. London HMSO

medium secure services revealed this still to be an issue at lower tiers of security (⁹Bartlett et al 2014). The DH was a powerful proponent of care in which newer, women-centred models of care, were advanced. Young people are not adults and they and their rights are different. However, this historical lesson should give care providers pause for thought. Consideration of positive risk taking around self-harm and addressing the apparent failure of CAMHS to provide psychologically rather than physically containing care, within a coherent framework of understanding, would increase the chances of young people to be cared for without detention e.g. through parental education, crisis teams and other community options. It would also be helpful to have this ethically contentious domain of care quantified in any future study.

The detention of young people who are deemed only to be risk to themselves alongside those whose violence is externally directed is another controversial issue. Once again a version of this has been rehearsed and resolved within adult mental health. There, the supposed normality of mixed gender services led to the housing of men with significant histories of violence alongside women who had suffered sexual and/or physical violence from men. The gender dimensions of this issue are unclear in the young people's estate. The more general issue has been remarked upon by respondents. It invites further understanding of the composition of particular units and how young people are accepted into services with a possible mix of vulnerable and violent/predatory individuals. Exploration and adoption of practices in different services that could mitigate against the risks inevitably associated with such a mixture would be wise.

The rollout of 13 FCAMHS will build capacity in the community to manage a greater degree of complexity and to improve pathways for young people. As well as liaising with Secure Stairs in secure care settings as young people enter and leave, it is intended to assist in preventing the escalation of vulnerable young people and to the identification of gaps in existing CAMHS and YOT services.

10.5. Geography and parity of esteem

Young people in secure care, regardless of the basis of detention, are at risk of being placed sometimes hundreds of miles away from anyone who knows them, friends, family or professionals. In a system that conspicuously articulates the importance of attachments, trusting relationships and stability, this is bizarre, particularly when combined with multiple moves, none instigated by the young people themselves.

Specialist care in the UK often involves a balance between getting that help and travel distance from home. For some of the young people this is a relevant issue. For the majority it is not. The problem is not the style or substance of intervention but the fact that the closure or historical lack of local units means they cannot access a local service be it a SCH, hospital or STC or YOI. This can be seen and was named by some respondents as a problem with the parity of esteem of physical and mental health problems but it is more than that; for young people who do not have life-constraining mental health problems it is jeopardising their reintegration into society even if, as is claimed by many professionals, they benefit from the actual placement because of the specialist

⁹ Bartlett,A., Somers,N., Fiander,M. and Harty,M. Pathways of care of women in secure hospitals: which women go where and why *The British Journal of Psychiatry* (2014) 205, 298–306. doi: 10.1192/bjp.bp.113.137547

skills of the professionals. It is hard to see that this compensates for the lack of family work/visits/access to local training/education that would follow from locally based placements. Graduated return to the community would be more feasible if young people were not frequently located far from their communities of origin and social networks.

APPENDICES

A. Interview information sheet and schedule

Pathways project: Information sheet for stakeholder interviews

What is the purpose of this study?

We are conducting a national service evaluation study looking at pathways into secure care for young people, and their clinical needs whilst in these secure environments; this is funded by NHS England. We define secure environments as including secure hospital wards, secure children's homes, secure training centres, and young offender institutes. The aim of this study is to gain an overview of the current system of secure care, and to promote discussion on which types of unit are best suited to reducing risks and meeting the needs of these young people.

What does this study involve?

This study has involved 3 parts:

- A scoping exercise conducted in April-June 2016: this was to find out information on what is available within the current secure system
- A census, conducted on 14/09/16: this was to gain a snapshot of the young people who are in secure services, recording the number of young people in secure units on this date and collecting detailed data on their placement histories, clinical needs, and demographics.
- Stakeholder interviews, February-March 2017: this will involve semi-structured interviews with people who have a good understanding of the current secure system, and we are interested to find out people's opinions of the system as a whole.

What will the interviews involve?

We are asking people who are involved with the system of secure care for young people to participate in a semi-structured interview. This interview will take place over the phone, and will last approximately 30 minutes. If you agree to take part, it will provide an opportunity for you to tell us your views on the current system of secure care for young people, and to think about what you would like to see improved within the system. We are interested in people's understanding of and opinions on the current system of secure care, as well as how young people end up in specific parts of the system and where is best to meet their needs.

What will happen with the information from the interviews?

Notes will be written by the research assistant conducting the interview, and these notes will be sent to you following the interview, to allow you the opportunity to confirm that it represents what you said, and to make any additions or changes where you see fit. Where relevant, we will use anonymised quotes from these notes in reports and any publications arising from this study.

All information from these interviews is confidential, and any information used in publications and reports will be anonymised. Data will be kept on a secure laptop and any paperwork (e.g. notes from the interviews) will be kept in a locked cabinet in a locked office at St George's, University of London. You have the right to withdraw from the interview at any point, including after the interview has been completed.

Funding and approvals:

This national service evaluation has been funded by NHS England, and has been approved as a service evaluation by the Health Research Authority (HRA).

If you have any further questions, please contact:

Louise Warner (Research Assistant): louise.warner1@nhs.net

Pathways project: stakeholder interviews:

Thank you for agreeing to be involved in this interview. As you know, we are interested in your views on the current system of secure care for young people. Can I just check if you have read the information sheet? Everything you say will remain anonymous; any quotes we use in reports and publications will not have your name or unit name attached. You can withdraw from this interview at any point, including after it is finished. I will be writing some notes during the interview, and afterwards will send you these notes so that you can confirm that it represents what you said, and add or change anything if wanted. Does that all make sense, and do you give your consent to being involved in this interview?

Great, so to start with, I'm going to ask some general questions about your understanding of the system of secure care as a whole, based on your individual experience and knowledge. We are interested in your understanding of this system, and what you think about how young people end up in different parts of the system, so the questions will then focus on these aspects.

Context

What do you understand the system of secure care for young people to be?

Who do you think the young people in the system are?

Which part of the system do you know most about?

Opinion

Can you tell me your opinion of the system as you understand it?

What would you describe as the strengths and weaknesses of the current system?

- Do you have any thoughts on the adequacy of mental health input in the current system?

What opportunities do you see for change within the current system?

What threats do you see to the current level of functioning of the system?

In terms of the place that you know best, in general do you think the young people there are in the right place?

- What is good / not so good?

- What else might be better?

What factors do you think determine where a young person ends up within the system?

- To what extent is this system of placement young person centred?

- How would you improve the process of decision making about placements?

- *PROMPTS: shortage of placements, delays in assessment, issues in transition, distance of families from placement, length of stay, purpose of placement, young person's needs, money, the law*

We know many young people move around from placement to placement. Do you have any thoughts about this?

Are there areas of good practice in secure settings that you would like to highlight?

- *PROMPTS: system as a whole, individual units, movement of young people through/out of the system, staff support*

Is there anything else you would like to add to what you have said?

Thank you for taking the time to talk to me; that was really interesting. So now I'm going to type up the notes that I've written, and I'll send them to you later today. It would be really helpful if you could confirm that you are happy with this representation of the interview, and make any additions or changes you want, before next Wednesday (15th). And if you have any questions, you have my email and phone number.

B. Methodology in full

Questions and interview protocol

The questions were designed following a strengths, weaknesses, opportunities, and threats (SWOT) structure. This was in order to evaluate the current system of secure care in respondents' own terms. The questions were open-ended, to allow participants to respond freely. The final list of questions was completed with guidance from members of the Steering Group for this project.

Participants

The interviews were conducted between March and June 2017, and all but one were carried out over the phone with the Research Assistant (LW). The additional one interview was carried out in person, at the request of the participant. The questions and style of interview remained the same. We aimed to get representation of views of a variety of people with involvement in different aspects of the system of secure care. We identified the following groups of people to contact:

- Mental health clinicians working in secure care
- Secure unit managers
- Senior education staff in secure care
- Commissioners of secure services (health, social care)
- Parents / carers of young people in secure units
- Solicitors (mental health and criminal justice)
- YOT managers

In total, 55 people were interviewed across these categories, although 2 were later removed from the analysis due to lack of clarity about whether these people had actually experienced contact with secure services as defined by this study. This includes secure hospital wards, secure children's homes, STCs, and YOIs. It is also recognised that police custody and immigration removal centres constitute a secure environment, but these were out of scope for other parts of this project. Therefore, the content of 53 interviews were included in this analysis.

Professionals associated with specific secure units

Contacts from each secure unit identified for the census stage of this project were asked to provide a list of one or more names of people (senior managers, senior education staff, and senior mental health clinicians) who might be interested in taking part in an interview to provide their views on the current system of secure care for this project. Each unit that did not respond was sent a second email again asking for interest in participation. No more reminders were sent, and it was assumed that anyone who had not responded was not willing to take part.

For the list of names from each individual unit, a number was allocated to each name (for example, if there were three names then these names were given a number from 1-3). A Google-based random number generator was then used to generate a number from this range, and this would be the person contacted for interview. This pro-

cess was repeated for each unit, to ensure representation from all types of secure setting. Where only one name was provided, this person was selected. The randomised process was used to enable representation across professions within secure units. As this study focuses on young people in England, only one individual was selected from the lists for Scotland, and similarly only one from Wales.

The selected individuals were then contacted to arrange a time for the interview.

Youth offending teams (YOTs)

Another group of professionals who were identified for participation in interviews were YOT managers / practitioners. A similar process was used for identifying a random sample of YOTs; a list of all YOTs in England was found (<https://www.gov.uk/government/collections/youth-offending-team-contact-details>), split into regions (London, Midlands, North East England, North West England, South East England, South West England). We aimed to have representation from a variety of regions. Each YOT within a region was allocated a number (for example, if there were 20 YOTs in a region, they were allocated numbers 1-20). The same Google-based random number generator as previously mentioned was then used to select one YOT from each region based on its allocated number. It was hoped that this would provide representation from both rural and urban based YOTs. Of those YOTs that were selected, all were contacted. Initially we specifically requested to speak to YOT managers, and one YOT manager who participated also requested a practitioner (social worker) take part, in order to provide a different perspective; therefore in one case two members of the same YOT participated.

Solicitors

A legal contact on the Steering Group for this project provided the names of a couple of solicitors, who in turn provided names of other solicitors who might be interested in taking part (names were gathered using a snowballing approach). Clinicians at some secure hospitals were also asked for names of mental health solicitors who might be interested in taking part. From this list, each name was assigned a number and a random number generator was used to select the sample. In total, two individuals took part in the interview.

Parents / carers

Parents and carers of young people who have been (or are currently in) secure settings were also asked to participate. This was via three routes. Firstly, each person associated with a secure unit who was interviewed (clinicians, managers, teachers) were asked to see if any parents / carers would be willing to take part. Secondly, a parent representative on the Steering Group for this project asked for names of interested people from her network. Thirdly, the charity Young Minds sent out an email to via their relevant data base asking for interest in participating. It was decided that all parents who responded and met criteria (having a child who is currently, or was previously, in a secure unit as defined by this study), would be invited to take part.

As the majority of parents to be interviewed were found through Young Minds, an organisation focused on mental health, this meant the majority of parents interviewed had experience of secure hospitals, rather than other settings but some had had experience of SCHs. One parent spoke of experience with their child being taken into police

cells whilst experiencing a mental health crisis. Two of the parents interviewed were unclear about whether the unit their child had been in was actually a secure unit, as defined in earlier stages of this study. Therefore, these 2 have not been included in this analysis as it is not clear if the experiences related to secure settings or open ones.

Health Commissioners

Specialised commissioners from NHS England were also asked to participate in these interviews, to provide their opinions on the current system of secure care. A representative from the Steering Group for this project provided a list of names, each of which were allocated a number, and the aforementioned Google-based randomised number generator was used to identify the numbers of those who would be asked to participate. Two individuals eventually participated.

Directors of Children's Services

A contact at the Association for Directors of Children's Services was asked for names of Directors / Commissioners to interview. Due to small numbers, all people who expressed interest were interviewed. This amounted to four people, from different regions of the country.

The content of 53 interviews was included in this analysis. In total, 23 were individuals working directly in secure services in health or social care or the YJS (secure hospital or other setting clinicians, prison staff, secure children's home staff, education providers). Five participants were from YOTs, two were solicitors, 17 were parents of detained young people who were mainly in secure mental health units at the time of interview, two were specialised secure hospital commissioners from NHS England, and four were directors of children's services.

Several respondents had previously worked in other types of secure settings than their current employ and therefore included relevant opinions on multiple types of settings within their interviews. It was also requested from YOIs and STCs that prison staff volunteer to take part. However, only one member of custodial staff took part.

Young people

We did not interview young people for this part of the project.

Analysis

The Research Assistant conducting the interviews wrote detailed notes during the conversations to capture as much of the content as possible, in the participant's own words. The transcript was then sent to the participants, who could amend or add to their transcripts. We are confident that the transcripts include an accurate portrayal of the participants' views, substantially in their own words. The names of all individuals and units have then been anonymised.

Analysis of the transcripts followed principles of thematic analysis (Braun & Clarke, 2006). Initial coding of transcripts was conducted by three individuals (two members of the study team, LW, AB, and one external researcher from St George's University, MR). A framework for coding was collaboratively developed, in order to reduce subjectivity of the analysis and revised as an analysis emerged. AB led the write up, checking and reviewing the emerging analysis with other team members and against the full interview

texts, to which the coding framework had been applied. The findings in this report are based on five of seven overarching descriptive codes which were most relevant to the original aims of the study and shed further light on themes in the first two reports (see coding framework in appendices). The following text contains multiple quotations from respondents. These were chosen as illustrative of key ideas, to represent a range of views from respondents in different sectors and to identify views from parents and professionals. The choice of final quotation was checked against source interviews to avoid overuse of any individual respondents.

The strength of the method as actualised was that it generated respondents with experience of all the types of secure care and multiple domains of professional activity. It also provides the views of a cross section of parents, albeit that most had children who had been detained only in secure hospitals. Respondents who were underrepresented in terms of the workforce in contact with detained young people were primarily YOI and STC discipline staff.

C. Final coding framework

Systems of care and control

- Paradoxes of principle and practice
- Care quality
- Commercialisation of care

Placements

- Relationship to previous community care
- Limited availability
- Relationship to needs
- Arbitrary decision making
- Other factors (gender, cost, silo thinking, urgency)

Consequences of placements

- Bad geography
- Getting relevant help

The nature of transitions in placement to adult services

- Crisis
- Delays

Young people's experience

- Multiple placements
- Getting better
- Getting worse

Family and staff Relationships

- Attitudes
- Practicalities
- Nature of the young person's problems

Problems

- Level of involvement

Staff attributes

- Good and bad practitioners
- Working in a challenging environment • agency staff

Funding and resources

D. Glossary

ADHD: Attention deficit hyperactivity disorder

BPD: Borderline personality disorder

CAMHS: Child and adolescent mental health service

CD: Conduct disorder

Co-morbidity: the simultaneous occurrence in one individual of two or more disorders

CQUIN: Commissioning for quality and innovation

DBT: Dialectical-behaviour therapy

DH: Department of health

HDU: High dependency unit

Informal patient: Patient in hospital voluntarily, not detained under the Mental Health Act

LAC: Looked-after child

LD: Learning disability

LOS: Length of stay

MBT: Mentalisation-based therapy

MDT: Multidisciplinary team

MH: Mental health

MHA: The Mental Health Act 1983, amended 2007

NDD: Neuro-developmental disorder

OCD: Obsessive-compulsive disorder

ODD: Oppositional defiant disorder

PD: Personality disorder

PICU: Psychiatric intensive care unit

PRN: pro re nata = as required

Psychotic Disorder: a summary term for a range of major mental illnesses where abnormal perceptions and beliefs are dominant

SCH: Secure children's home

STC: Secure training centre

YJB: Youth justice board

YJS: Youth justice system

YOI: Young offender institution