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Local authority use of secure placements

Research report

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Executive summary

Introduction

Secure children's homes (SCHs) are specialist placements authorised to care for children in a locked setting. This study is concerned with the small number of children who are placed there by local authorities on 'welfare' grounds in order to prevent the children from harming themselves or others[1]. The study aimed to address the following questions:

- What is the purpose of secure care?
- What informs authority decisions about using (or not using) SCHs?
- What alternative forms of provision are used in authorities where SCHs are not/rarely used?
- Is there any evidence to suggest that too many young people are placed in secure care?
- Is there a need for more (robust) evidence on the costs, benefits and outcomes from secure accommodation and its alternatives, and how can this be collected?

Evidence for the study was gathered through: a desk based review of the international evidence on welfare secure accommodation; interviews with senior managers in 12 English local authorities; and 16 children's case studies in five of these authorities. While our sample was small and may have not captured the full range of experiences of secure care, many of its key findings are supported by previous research.

Circumstances when secure care is used

It is thought that some local authorities use secure care more frequently than others. Gaps in the data did not allow us to confirm this but, however rarely it was used, there was a consensus that welfare secure placements would continue to be needed.

In all the study authorities, senior managers responsible for deciding when to apply for a secure placement described the factors that they took into account. Whatever their stance, there was a consensus that restricting a child's liberty is a 'draconian' step and respondents were rigorous about applying s25 criteria. The **factors that influenced decision-making** were:

[1] In these cases, an application must be made to a family court under s25 of the Children Act 1989 to authorise the child's detention.

- **The likely effect of a secure placement on children's outcomes**. Professional anxiety was never seen as a good enough reason to restrict a child's liberty: there had to be grounds to believe that it could/would bring about benefits for the child.
- **Differing views about thresholds**. Respondents agreed that other means of managing the child's risks must be considered first but there were differences in perception about when to draw the line. These were essentially individual decisions, based on professional judgement on a case by case basis.
- **Whether an authority has its own SCH, or one nearby**. There were perceived to be benefits in placing a child close to the home authority because it helped with transition planning. Nevertheless, distance was not generally cited as a reason for not using them.
- **Personal and authority beliefs**. Although no-one ruled it out completely, some respondents expressed their reluctance to use secure care because they thought it was 'wrong' and likened it to a prison-like environment.
- **Tolerance of risk**. There can be pressure to use secure care because practitioners – and parents – 'can't sleep at night' in case a child comes to harm. The stance of senior managers and councillors is important in determining whether staff feel supported to manage risky situations or, conversely, become risk-averse.

The **children considered for secure care** reflected those described in other studies. They displayed a range of risky behaviours, including self-harm, violence to others, having been sexually exploited or associating with dangerous adults. This was often accompanied by a lack of insight into, or denial of, the risks. Many of the children were also said to have mental health, emotional or developmental disorders. There were no clear gender patterns, with boys and girls both vulnerable to this range of risks.

Although the sample size was too small to draw firm conclusions, the findings confirmed previous research in that most children had been known to social care services since early childhood but were late entrants to the care system. They then found it difficult to settle and had a number of disrupted placements. The period from entering care to being considered for a secure order was less than six months in several cases.

Previous reviews have referred to **'alternatives' to secure care** but this study found a more complicated picture. There was a consensus that there is no direct alternative because no other placement can legally restrict children's liberty. It is more useful to think of a continuum of services, with secure care at the end when other options have failed to reduce the risks. Authorities described the services they used to try to avoid children's difficulties escalating to the point when secure care was the only option. These included:

- Engagement and relationship-building work to tackle the child's difficulties.

- Strengthening existing placements through good matching and additional support to sustain fragile arrangements.
- Specialist placements designed to manage problematic behaviour and keep children safe without restricting their liberty.

Purpose and outcomes of secure care

The evidence currently available does not allow any firm conclusions to be drawn about the effects of secure care on children's outcomes. Professionals in the reviewed literature reported that some children did well and they believed them to have benefitted: others did not do well, and they described the placement as having been ineffective or even making things worse. The participants in this study agreed that **secure placements could be expected to**:

- keep children safe;
- restore some stability to their lives;
- assess their needs and identify the supports needed in the future.

At the point children were admitted, they may have been leading very chaotic lives and were usually disengaged from the services needed to support them. Secure care provided the opportunity to 'hold' them so that this engagement work could begin. There was less agreement about the extent to which SCHs could tackle the underlying causes of children's risk-taking behaviours and bring about sustainable change in the short time available, particularly given the deep-rooted problems that most children had.

Case studies showed that, on the whole, by the time children left secure care they had achieved the **short-term outcomes** that had been hoped for: the placement had succeeded in keeping them safe, stabilising their behaviour and identifying some of its underlying causes, and engaging them in support.

The information provided by social workers on **longer-term outcomes** was, however, more mixed and children had not always managed to sustain progress after they returned to the community. A short settled period following a period of secure care was common, although not universal. However, some children then reverted to previous destructive patterns of behaviour, requiring intensive supervision and specialist support, and in some cases another period in secure accommodation, in a mental health setting or a youth justice placement. For other children, the settled period seemed more sustained, albeit in the relatively brief period we had information on.

It could be difficult for respondents to disentangle the effects of secure care versus other influences on children's trajectories. However, as far as respondents were able to make these links, the factors more strongly associated with success or failure of a placement were, predictably:

- Whether secure care had been the right option for the child or whether their behavioural problems were primarily due to mental health problems that would have been better treated in a psychiatric setting.
- Whether the location and facilities of the placement matched the child's needs, including the length of stay and effectiveness of the transition arrangements.
- The quality of the placement: practice in some SCHs was seen as more likely to support improvements in the children's long-term outcomes than others.

Long-term benefits were also seen to be crucially dependent on the quality of social work input and support services, during as well as after secure care, and the suitability of the arrangements following release.

The qualitative information from this study has helped to map the expectations and outcomes from secure care but there is a need for evidence to explore the prevalence of these experiences. We have outlined options for collecting statistical information on an ongoing basis in order to support future practice improvement.

Contextual challenges

There are a number of challenges facing local authorities in meeting the needs of children with very risky behaviours and which can affect their decision-making.

Firstly, some authorities described the **current regulatory framework** as being somewhat inflexible. If there were scope for a less rigid approach towards security, it might increase the options for keeping children safe in environments less restricted than SCHs and may also support the development of better 'step-down' arrangements. Because of the wish not to restrict children's liberty unless absolutely necessary, the legislation states that children must be released if the s25 criteria are no longer met, even if the order has not expired. This can make it difficult to plan: the timescale for a secure placement is driven by the reduction in risk, not the child's needs, which means that more fundamental – and lengthy – work on the underlying causes of the child's difficulties cannot be undertaken.

Local authorities were largely reliant on the **market to provide suitable placements**: not only SCHs but also specialist units that could keep children safe without depriving them of their liberty. Our findings indicate that this market has not been working effectively. The supply of secure and open specialist placements was reported to be insufficient to meet demand, constraining choice and potentially limiting the quality of provision required to meet children's needs. This confirms other work being undertaken by the Department for Education and partners, and a reform plan has recently been announced (Department for Education, 2016).

Some local authorities were making greater use of in-house residential resources to allow more control over the quality and quantity of provision, and to ensure continuity of care by keeping children in the local area. However, local services could not meet some highly specialist needs. There was agreement across most of the study local authorities that a national strategy is required for secure care and that there should be central co-ordination to ensure that planning and provision will meet changing needs.

Problems were compounded by difficulties in securing **adequate mental health support**. There were reported to be problems in accessing psychiatric beds for those children who needed them and insufficient options for treatment. Some non-secure units describe themselves as ‘therapeutic’ but there is no agreed definition as to what this means, and a degree of mistrust across local authorities as to the validity of the claims.

Conclusions

Whilst some local authorities see secure accommodation in a more positive light than others, we found no evidence to suggest that secure placements were used unless the criteria were met *and* professional judgement was that the child would benefit. In fact, our findings suggest that more children are likely to technically meet s25 criteria than are ever placed.

For most children considered for a secure placement, the origins of their risky behaviour lay in early childhood experiences, such as abuse, neglect, parental rejection or loss, but they were late entrants to the care system. This raises questions about whether more could have been done, both prior to their becoming looked after and in previous placements, to prevent their distress from escalating to the point where they needed to be ‘held’ in order to keep them safe.

Whilst a secure placement was usually seen as effective in stabilising children and keeping them safe, subsequent outcomes were mixed and there were different opinions as to whether SCHs can realistically be expected to address the underlying causes of the children's behaviour. There appears to be a particular gap in services for children with attachment, conduct, emerging personality or post-traumatic stress disorders, with these children falling between social care and health provision.

Although numbers of children eligible for secure care are small, the stakes are high. The level of disturbance amongst the children we came across during this study was striking, as was the commitment of staff in trying to support them. The forthcoming reforms are to be welcomed in providing the opportunity to ensure they are better supported.

1. Introduction

1.1 Background

Secure children's homes (SCHs) are specialist placements authorised to care for children (aged between 10 and 17 years) in a locked setting. This restriction of liberty is not permitted in other types of children's homes and there are legal safeguards to make sure that SCH placements are only used where specific criteria are met. There are two main pathways into a secure placement: the youth justice or 'welfare' routes.

- a child is remanded or sentenced to detention through youth justice legislation;
- a family court authorises a child to be detained under s25 of the Children Act 1989[2] either because, if the child was in an open placement s/he would be likely to abscond and would then be at risk of significant harm, or the child would be likely to injure her/himself or others.

Some SCHs take children from only one of these categories whereas others are mixed. Children who are placed through youth justice legislation are primarily in beds block-purchased by the Youth Justice Board (YJB) whereas welfare placements are arranged on a case by case basis.

The number of children placed in an SCH is low. On 31st March 2015, only 194 children were in an SCH placement (Department for Education 2015a). Of these, 82 (42%) were placed by local authorities on welfare grounds – the subject of this study. This constitutes only 1.25% of the total 6,570 looked after children across England who were living in children's homes, hostels or secure accommodation and 0.1% of all looked after children.

Overall, the number of SCH places in England has declined significantly since 2004 when there were a total of 435 approved beds across more than 25 SCHs. On 31 March 2015, there were 232 beds and only 14 SCHs remaining. This change has been driven by the reduced demand for youth justice placements as fewer children have been remanded or sentenced by criminal courts. Subsequently a number of local authorities decided that they could no longer operate an SCH without the predictable revenue that the YJB block-booked beds provided. This had a knock-on effect on the availability of placements on welfare grounds. This is set to change from April 2016 when the number of YJB beds in English SCHs will reduce to 113, freeing up more capacity for welfare placements.

[2] For some children over the age of 16 and not subject to a Care Order, Wardship proceedings may be used rather than s25.

Figure 1: Places available in English Secure Children's Homes 2007-2015

Of the remaining 14 SCHs in England, all but one are operated by individual local authorities but this model is under strain. In response, the Department for Education (DfE) has been working with the Association of Directors of Children's Services (ADCS), the Local Government Association (LGA), YJB and other sector partners to consider how the supply of placements could be better co-ordinated and planned. This short, focused research study was commissioned to help inform this ongoing review work.

Although the demand for youth justice placements has declined, it is difficult to estimate the true demand for welfare placements, and the extent to which these differ across authorities. Statistical returns do not have a separate category for placement in an SCH on welfare grounds by individual local authority (Department for Education, 2015b). Furthermore, the numbers may not reflect need because they record actual placements rather than requests: places may not have been available for some children.

Reviews have suggested that authorities vary in their use of secure accommodation, although this was based on perception rather than statistical evidence (Held, 2006; Deloitte, 2008; Mooney et al, 2012). A number of practical and philosophical reasons were suggested for these differences, but it raises questions about the place of SCHs within the overall service for looked after children. If some authorities appear to make little use of them, could we manage without them?

1.2 Aims of research

The study was designed to understand more about the use and need for secure welfare placements, about the groups of children for whom secure works best and where secure

provision fits within the broader spectrum of looked after children provision. Specific questions were as follows:

- What is the purpose of secure care? Is there a consensus among local authorities about the circumstances when secure care is the best and most appropriate setting for a child; how it should be used; which children benefit most and where it fits in the broader continuum of care? If there is not a consensus, what are the main different viewpoints on this?
- What informs authorities' decisions about using (or not using) SCHs: what are the triggers in terms of children's needs, and the availability and suitability of secure placements?
- What alternative forms of provision are used in authorities where SCHs are not/rarely used? Is there a consensus among local authorities on when a community-based home could help prevent a young person going into secure care?
- Is there any evidence to suggest that too many young people are placed in secure care?
- Is there a need for more (robust) evidence on the costs, benefits and outcomes from secure accommodation and its alternatives, and how can this be collected?

1.3 Methodology

This short, focused study conducted between October 2015 and March 2016 was designed to draw together the existing research evidence and to complement it with a small-scale qualitative investigation of current practice. Due to the small sample size and weighting towards authorities with an SCH, the findings may not reflect the full range of local authority experiences.

Data for the study was gathered through: a desk based review of the international evidence on welfare secure accommodation from 2004 onwards; interviews with senior managers in 12 English local authorities; and children's case studies in five of these authorities.

Telephone interviews were carried out with senior local authority managers (e.g. Directors and Assistant Directors of Children's Services, Placement Co-ordinators) in 12 local authorities. We aimed to select a sample of authorities that reflected different levels of use of secure care based on information provided by DfE, although problems with the accuracy of this data are described in Chapter 3. The sample included five authorities that had their own SCH and two where one had recently closed. Authorities were geographically spread throughout the country and covered both urban and rural areas.

The interviews explored authority practice in supporting children at very high-risk and the place of secure accommodation in keeping these children safe.

From the interviews we selected five areas to carry out case studies (in January-February 2016) to analyse the care histories of 16 high-risk children who were judged to meet the criteria for secure care. Of these, 13 had been placed in an SCH and three had been diverted to other care settings. The case studies involved an in-depth exploration of the children's circumstances and risks, the packages of support provided in an attempt to keep them safe, decisions about the appropriateness of secure accommodation and, as far as possible, the children's transition plans and outcomes. Data was obtained through an examination of children's case records and interviews with the children's social worker and/or manager, and other staff within the authority who were familiar with the case.

1.4 Report outline

Chapter 2 reviews existing research evidence on the use of welfare secure care, the profile of the children concerned and their outcomes.

Chapters 3, 4 and **5** present the findings from this study, based on the interviews with local authority managers and the children's case studies.

Chapter 3 describes the circumstances in which authorities consider using secure care and the factors that influence their decision-making, including the children's profile and the concept of 'alternative' placements.

Chapter 4 sets out the perceived purpose and potential benefits of secure care, including the outcomes of children who have been placed, and considers how the evidence base could be strengthened.

Chapter 5 describes the contextual challenges facing authorities in caring for the high-risk children who may be considered for secure care, including the legal and policy framework, supply and demand problems and gaps in provision.

Chapter 6 offers conclusions about the current use of secure care and its place in meeting the needs of vulnerable children.

2. Lessons from the literature

There has been very little research in England on the use of secure care for welfare reasons. Although some reviews have looked at aspects of the secure estate, such as the use of restraint (Carlile, 2006; Hart, 2008); admission and discharge arrangements (Ofsted, 2010); health needs (Mooney et al, 2007), or 'solitary confinement', (Children's Commissioner for England, 2015) these do not fully differentiate between children placed on welfare or justice grounds. Studies specifically on welfare placements have focused on the 'market' (Deloitte, 2008; Mooney et al, 2012), or on the perspectives of local authority managers (Held, 2006). There is, therefore, no reliable evidence in England about the profile, experiences or outcomes of the children who have been placed in an SCH. Nor, as noted earlier, is there any regular data collection on children in secure care. There are, however, a number of studies in Europe, Scotland, Ireland and Northern Ireland. In spite of some contextual differences, the nature of the children's problems and the service response are similar enough to make the findings of relevance.

2.1 Circumstances in which liberty can be restricted

The need to restrict children's liberty in order to protect them or others from harm seems to be recognised in most developed countries, and is supported by legislation setting out how this can be done. In Finland, for example, there is some provision for staff in open children's homes to prevent a child from leaving the premises for up to seven days if to do so would 'seriously endanger their health or development' (Child Welfare Act s71). Most restrictions of liberty, however, take place in specialist, closed settings such as Special Care Units or Secure Children's Homes. This is usually acknowledged as an extreme measure that must not be undertaken lightly, and is surrounded by legal and policy restrictions.

In all countries, a secure placement is usually requested as a result of 'risky' behaviour that may result in the child being harmed (such as vulnerability to sexual exploitation, substance misuse or self-harm) combined with an inability to hold or support the child in an open setting. Where there are some differences between countries is in the risk a child may pose to others through aggressive or criminal behaviour. This distinction is not a problem in Finland: criminal behaviour is seen as a child protection issue because of its impact on the child's development. Theoretically, this is also the case in Scotland although Smith and Milligan (2005) argue that an increase in secure beds there was really a response to an increasingly punitive approach towards children rather than being in their best interests.

In other countries, including England, there are different routes into secure care through either a 'justice' or welfare pathway although, in practice, the children may be detained together in the same placement and receive the same interventions. This is the case in

most English SCHs, and some studies have suggested that this mixed population is unpopular (Mooney et al, 2012). Ten years ago a study of local authority managers' perceptions about the use of secure placements (Held, 2006) found that:

> *Most local authority's felt the mixture of youth justice provision and welfare provision in most units is unhelpful and would be more confident about using a SCH for a welfare placement if it is solely providing welfare placements. This is despite their recognition that the young people placed have many of the same problems* (Held, 2006: p.5).

Other countries use separate establishments for their welfare and 'justice' placements. For example, the Netherlands created new establishments in 2008 to prevent children in crisis being placed in 'correctional' institutions (Boendermaker, 2008). The reality, however, is that a proportion of children engaging in risky behaviour will also be committing crimes. In Northern Ireland 63% of children were subject to justice orders or facing outstanding charges at the time a welfare secure placement was being considered whereas, in Ireland, there are procedures to prevent children actively involved in the criminal justice system from being placed in Special Care[3] (Brierley, 2010).

Similar concerns arise about the interface with mental health services. Managers in Held's (2006) study expressed concern about the use of SCH placements for children who could not be admitted to Tier 4 mental health provision because of a lack of beds or disputes between health and social care agencies. Similarly, in Spain, Rodríguez (2013) questioned why children with a diagnosed 'conduct disorder' were being cared for in child welfare settings rather than the health system and Walker et al (2005) reported a lack of specialist mental health and substance misuse services in Scotland. Many countries do have residential treatment for children with these difficulties whereas, in the UK, there is no model for specialist treatment outside the NHS and a crisis in availability of those services that are provided within the NHS (NHS England, 2014).

This suggests a blurring of the boundaries between children who require secure accommodation for different reasons, with SCHs being expected to take them all.

2.2 Thresholds and decision-making

Some local authorities are reported to use welfare secure placements more than others. Assuming that every authority will encounter children whose behaviour meets the criteria for a s25 application at some point, what are the reasons for some authorities to rarely

[3] The Irish equivalent of an SCH.

use secure placements? Mooney et al (2012) suggested that the drivers affecting demand at the time of their study were:

- *Costs and impact of the comprehensive spending review;*
- *SCH placements seen as a 'last resort' rather than a positive choice;*
- *Use of alternative provision, particularly small residential units;*
- *Concerns about quality of the secure sector and achieved outcomes;*
- *Managing risk and thresholds for intervention; and*
- *Location* (Mooney et al, 2012: p.7).

Mooney et al (2012) found that most local authority managers said cost was not a determining factor in deciding whether to apply for an SCH placement, and that 'alternatives' were not necessarily cheaper. Analysis did show, however, a seasonal fall in demand in the last quarter of the financial year and following the Comprehensive Spending Review in October 2010, although it was not possible to attribute this as a direct cause.

Held (2006) found differences in the way English authorities interpreted the guidance then in force, with two-thirds of respondents seeing it as a 'last resort' rather than a positive intervention that can be in a child's best interests. This could lead local authorities to try other, less suitable, placements first because they felt the law required it, even when the criteria for a s25 application were met and the child's needs could be addressed more effectively in a secure setting. The remaining third of local authorities saw secure placements in a more positive light: they still considered alternative options, but did not feel obliged to use them if their professional judgement indicated that an SCH would be preferable. Interestingly, this did not necessarily mean that they used SCHs any more frequently and Held speculated that these local authorities may have had more effective assessment and care planning processes.

More recent Statutory Guidance has sought to clarify the question of whether all other options must be tried first (Department for Education, 2014a). Whilst stressing the seriousness of a decision to apply for a secure accommodation order, it also states that:

> *This does not mean, though, that restriction of liberty should only be considered as a 'last resort'. Restricting the liberty of a child could offer a positive option. A decision to apply for an order under s25 of the Act should be made on the basis that this represents the best option to meet the particular needs of the child* (para 41).

2.2.1 Risk assessment

Children can only be placed in secure care if their behaviour presents a risk to themselves or others, but this is not a scientific test. It is partly dependent on the nature of the child's behaviour, but mediated through agency culture and individual professional judgement and, crucially: 'the level of risk decision makers' are willing to tolerate' (Walker et al, 2005: p.7).

Roesch-Marsh (2014a) examined the nature of risk assessment in Scotland, and the process of deciding what action to take. She observed decision-making meetings in one Scottish authority when secure care was being considered for 110 children and interviewed a number of the managers, social workers and children concerned. The study suggested that participants saw the children's 'out of control' behaviour differently. Managers were primarily concerned with the need to manage the risk and were driven by wanting to prevent an adverse outcome. Practitioners were also concerned about risk, but tended to see the behaviour as a 'cry for help' in response to past abuse, neglect and loss, with the children wanting adults to control/protect them. The children described themselves as 'off the rails' and understood why adults had been worried about them but attributed their behaviour to unhappiness with their current experiences in care.

2.3 Which children are thought to need secure care?

2.3.1 Gender and age

Most studies have found that boys are associated with the risk of harm to others and girls with harm to themselves (Held, 2006; Roesch-Marsh, 2014b). How far this is based on genuine differences in behaviour and how far on the perceptions of practitioners is difficult to decipher. Roesch-Marsh suggests a degree of gender stereotyping in these labels, with boys' sexual vulnerability being under-recognised. Other studies suggested that girls were more likely to be admitted to secure care on welfare grounds in Scotland (Walker et al, 2005) and England (Held, 2006) but not in Northern Ireland where the gender balance was more even (Sinclair and Geraghty, 2008). Although the way official statistical data is recorded in England does not allow for separate analysis of children placed in SCHs on welfare and justice grounds, the average age of all residents is increasing, with 16 year olds now constituting the largest single age group for the first time (Department for Education, 2015a).

2.3.2 Child and family background

There is no data on the characteristics of children detained in England on welfare grounds, although a study describing the population as a whole from the perspective of SCH managers outlined a catalogue of problems (Justice Studio, 2014). More evidence

is available from other nations within the UK. For example, in a Scottish study of girls at risk of sexual exploitation, Creegan et al (2005) found that their lives were characterised by 'neglect, abuse, family dysfunction and breakdown and the attachment and relationship difficulties associated with such problems' (p.3).

Interestingly, both the Scottish and Northern Ireland studies reported unusually high rates of bereavement amongst the children. Over a third of the boys in Walker et al's (2005) sample and 40% in Sinclair and Geraghty's (2008) had experienced the death of a parent compared with an estimated 4% of children in the general population. In some cases, this was said to be linked to a deterioration in the child's behaviour.

It is impossible to establish how far the children's difficulties stemmed from adverse experiences, or from inherent health or developmental problems. Sinclair and Geraghty (2008) found that 37% of the children had special educational needs and 44% were disabled but some of these conditions were described as emotional or behavioural difficulties, with conduct disorder being cited most frequently. The Justice Studio (2014) collected information from SCH staff about the psychological and physical health of children in SCHs, although it must be noted that this included those placed through the justice system. Problems included undiagnosed conditions such as heart murmurs, visual and hearing impairment, poor dental and sexual health as well as developmental delay, Attention Deficit Hyperactivity Disorder (ADHD) and dyslexia.

2.3.3 Social care history

Given these difficult backgrounds, it is not surprising that most children had a long history of involvement with social care services, although this was often characterised by poor engagement (Walker et al, 2005; Sinclair and Geraghty, 2008; Brierley, 2010). School problems were even more prevalent: either non-attendance or disruptive behaviour, and many children were no longer in mainstream school.

Children considered for a secure placement were predominantly already in care although most had been late entrants (Walker et al, 2005; Sinclair and Geraghty,2008). Once in the care system, the children tended to have difficulties settling and a number of placement moves. Most were in a residential rather than family placement at the point when secure care was considered: over 80% in Walker et al's (2005) study, most of whom had experienced a placement move within the last year.

> *The case files reveal a sense of rising need and increasingly risky or antisocial behaviours by the young people in the previous year. There is also a sense that managing the crisis that these behaviours generated, tended to deflect efforts to deal with the inherent underlying causes of much of the behaviours* (Sinclair and Geraghty, 2008: p.4).

2.4 Life in a secure placement

2.4.1 Purpose

Children had usually been causing considerable anxiety to their families and professionals by the time secure care was considered, and expectations about what it could achieve were high. There were three main aims identified in the literature:

- Ensuring the child's immediate safety. This was the most pressing priority and the importance of simply keeping the child alive was often cited.
- Providing a thorough assessment of the child's risks and needs that would enable the social worker to coordinate future service delivery more effectively.
- Reducing the child's risk-taking behaviours then and in the future. This could be through the use of 'routine, structure and boundaries', which allowed the child to calm down, reflect and regain some self-control but also through individual interventions to tackle the underlying causes of the behaviour (Walker et al, 2005; Held, 2006; Sinclair and Geraghty, 2008).

Given that children should only have their liberty restricted for the minimum time necessary, these expectations were high and some raised doubts about whether SCHs could fulfil them.

> *In the short-term it keeps young people safe and meets their basic needs for food, shelter and security. It provides structure and an opportunity to break a destructive cycle of behaviour... However, it is less evident that secure care can achieve all that is expected in the longer-term, especially in bringing about lasting changes in behaviour that will alter the young people's care trajectory and transform their life chances* (Sinclair and Geraghty, 2008: p.5).

2.4.2 Interventions

'Therapeutic' services

Although the literature indicates what local authorities hoped to get from a secure placement, there is little to suggest *how* they thought this would be achieved, or how it would link to the work the authority would be doing whilst the child was placed. Some respondents in Held's (2006) study referred to an expectation that SCHs would provide 'treatment' but this was not elaborated upon.

> *There is a lack of confidence in the ability of SCH providers to provide high quality, purposeful, outcome focussed services with the right individual input and treatment/therapeutic input* (p.5).

Two-thirds of local authorities had therefore funded additional services within an SCH to meet the needs of individual children, such as counselling, educational support or a higher staff ratio. Six years on, little seemed to have changed. Local authority respondents in Mooney et al's study (2012) said that they worried about the quality of some SCH provision, particularly the lack of in-house therapeutic input.

This was also a concern in Scotland where the Rossie-Elms Project attempted to strengthen the therapeutic service to children there by permanently locating mental health practitioners within two secure units. An evaluation found that it was well-received by both staff and children (Lerpiniere et al, 2006).

Other interventions

In terms of specific interventions within secure care in Scotland, Walker et al (2005) found considerable variation. Some used structured Cognitive Behavioural programmes, others relied more on establishing positive relationships; arrangements for input from external specialisms such as mental health or substance misuse were not consistent, and neither was the level of involvement by social workers. Creegan et al (2005) suggested that the evidence-based programmes used in many secure units in Scotland were designed for young, male offenders rather than girls vulnerable to sexual exploitation and no substitute for the intensive support that was needed – preferably in the community. They felt that 'relational security' was preferable to 'physical security'.

SCHs in England described the service they offered in the Justice Studio study (2014). These included individualised learning programmes, therapy and ‘key work' or group interventions as well as recognising the centrality of trusting relationships and pro-social modelling, facilitated by their high ratio of staff to children. The authors also analysed recent Ofsted inspection reports and stated that SCHs tended to be rated more highly than open children's homes, suggesting that quality was *not* a concern.

Relationships

In a study of the role of key working and the quality of relationships in secure accommodation in Scotland, McKellar and Kendrick (2013) found considerable instability, with changes of worker and inconsistent contact. The role had become predominantly administrative rather than providing the opportunity to undertake direct work on the child's difficulties. They also noted that the involuntary nature of the placement could be a barrier to engagement, as did Barclay and Hunter (2007). Some of the children felt that the workers did not trust them and would have preferred more of a say in the key worker allocated to them. Sinclair and Geraghty (2008) felt that a secure placement could actually make things worse for children who did not develop positive relationships with staff: it increased their anger and resentment and made them less likely to trust professionals in the future.

A number of European studies have also looked at the quality of relationships between staff and children in secure settings, although it is difficult to know if the populations are directly comparable. Harder et al (2012; 2013) found that children do use staff as secure attachment figures, and that the qualities that enhance a positive relationship are a good balance between empathy and support alongside working together on tasks and goals. They also found that a positive relationship was important in maintaining motivation: even those children who were motivated to change on admission could lose this if staff did not engage them.

Overall, there is no firm evidence showing that different types of intervention can be linked to particular outcomes, either in the short or long-term, although there is some limited evidence about their impact on children's general perceptions of the placement.

2.4.3 Children's perspectives

Children have had the opportunity to describe their experiences of secure care for themselves (Walker et al, 2005; Barry and Moodie, 2008; Sinclair and Geraghty, 2008; Children's Rights Director for England, 2009; Justice Studio, 2014).

Being admitted to secure care for the first time was often a frightening experience, particularly when children hadn't been told where they were going, as seemed to happen sometimes both in Scotland (Barry and Moodie, 2008) and Northern Ireland (Sinclair and Geraghty, 2008). Children found it challenging when they first arrived to be searched, locked into their room and having to work out the rules of the establishment (Walker et al, 2005; Children's Rights Director for England, 2009).

Safety was a major theme, but it is hard to know if this was because the children had repeatedly been told that's why they were there, as this exchange shows:

> Child: *It keeps you safe*
> Researcher: *[Safe from what?]*
> Child: *Safe from whatever, what's outside – I don't know what's out there but that's what they are always on about when you run away you are putting yourself at risk, sure I don't know* (Sinclair and Geraghty, 2014: p.68).

Most children did report that they felt safe, however, and some expressed relief at the opportunity to break a pattern of running away or offending that they had lost control of. 'You're safe and can't get into trouble' (Children's Rights Director for England, 2009: p.6).

Many children were positive about the support they had received, and the care shown by staff. Two-thirds of children told the Children's Rights Director for England (2009) that they were being looked after well, or very well. They did differentiate, however, between 'good' and 'bad' staff. The three things that most characterised 'bad' staff practices were:

judging children for what they had done before admission; ‘winding them up’; and reminding children that they were locked up. The qualities that children appreciated in staff were: a good sense of humour; being a good listener; easy to talk to; not aggressive or bossy; calm (Children's Rights Director for England, 2009) sensitivity and reliability (Justice Studio, 2014) or just being 'normal' with them (Walker et al, 2005). Children disliked it when staff did not apply the rules consistently, over-reacted to minor infringements or abused their authority through excessive restraint, unfair sanctions or single separation:

> *It’s a power thing I think. If you don’t say sorry or accept what you have done, then you won’t get out of your room* (13 year old girl: Barry and Moodie, 2008: p.23).

Children valued some aspects of the regime, particularly the opportunity to catch up with education and sort out health problems (Barry and Moodie, 2008; Children's Rights Director for England, 2009). Some appreciated individual therapy (Sinclair and Geraghty, 2008) or specific programmes (Barry and Moodie, 2008; Justice Studio, 2014) but there were also complaints about boredom, limited opportunities for activities or contact with the outside world (Barry and Moodie, 2008; Children's Rights Director for England, 2009). Others had clearly not engaged:

> *No really man, I didn’t listen to them, programmes is just something you do, tell them what they want to hear to get through it* (15 year old boy: Barry and Moodie, 2008: p.39).

A few children had been in secure care more than once – particularly in Northern Ireland where there seemed to be a pattern of repeated, short admissions. For these children it held fewer fears, or was even welcomed, which carried its own risks.

> *You just feel safe in here … you get institutionalised … when you go back outside… I can’t go anywhere on my own because I don’t feel safe* (child quoted in Sinclair and Geraghty, 2008: p.72).

On the crucial question of whether the secure placement had helped them, Justice Studio (2014) reported a number of positive responses, although the source of this information is not always clear. For example, children were said to have reported improved health, reduced self-harm and good intentions for the future. Three-quarters of the children who completed an exit interview in Barry and Moodie's study (2008) also thought the stay had helped them, helping them to 'get their heads straight'. For example:

> *Aye, it’s helped me, I can sit and talk to somebody now instead of going: ‘get out my sight’… or doing something stupid. It’s made me notice there’s a lot more stuff in the world than the next drug* (15 year old girl: Barry and Moodie, 2008: p.50).

The perception amongst the children who did not feel it had helped was that, although they had been safe and prevented from using drugs or offending whilst in the placement, nothing had really changed.

2.5 'Alternatives' to secure care

The use of the term 'alternative' to secure care is not straightforward. It sometimes seems to mean a direct alternative at the point when the criteria are met for a secure placement: at other times it seems to be used as a means of preventing the need for such a placement – or as somewhere to go on release. There are three situations when it could be a *direct* alternative:

- as a positive choice where it is thought to better meet the child's needs;
- in 'last resort' authorities that believe they must try all other options before they can apply for a secure placement;
- where no suitable secure bed is available or an application is rejected.

In Held's (2006) study managers reported all three of these scenarios. The types of placement used instead were often 'highly staffed single-child units'. Specialist foster care was also seen as a viable alternative by some, but only if it was well-supported by social work, mental health and educational services. In an emergency, one authority had resorted to an 'outward-bound'[4] service with three staff to one child. In some cases, although it was difficult to quantify, the arrangements broke down and the child was placed into secure care at a later point. This was more common when the decision to use an alternative had not been taken for positive reasons.

There has been concern in the past about the potential isolation and loss of liberty experienced by children in one-person children's homes (Commission for Social Care Inspection, 2007). Although staff have no authority to restrict children's liberty other than to address immediate risks, there have been concerns that the child may not feel able to leave because they are outnumbered by staff or in a remote location. In Deloitte's (2008) report on the future development of SCHs, they referred to these placements as 'semi-secure': a category for which there is no legal basis.

> *'Semi-secure' accommodation, as it is referred to in this report, is said to have, for example, a higher staff-to-children ratio and place more restrictions on a child's ability to leave the home than a residential children's home. Semi-secure*

[4] These usually involve a staff group taking a child away on a trip to a remote location or activity centre, with intensive physical activities.

accommodation is not subject to regulation in the same way that secure children's homes are (Deloitte, 2008: p.5).

Both reports recommended more research into the operation and effectiveness of single child homes, but this does not appear to have been pursued. In England, 6% of homes are now registered for just one child and 13.5% for two (Department for Education, 2014b). Mooney et al (2012) found that some local authorities viewed such placements as more effective than an SCH whilst others were dubious, expressing concern about the lack of scrutiny, quality of services, child outcomes and cost.

Although the term 'alternative' usually refers to an actual placement, this is not always the case. As described earlier, children's homes in Finland can restrict children's liberty in some situations and, in the UK, intensive support can be put into place to support an existing placement. In Scotland, a policy decision was taken in the late 1990s to develop direct alternatives to secure care (Social Work Services Inspectorate for Scotland,1996). As a result, a range of new provision was developed, including specialist fostering, 'close support' residential care, intensive support and monitoring in the community and electronic tagging (Walker et al, 2005). In fact, they found that these services were complementary rather than true alternatives to a secure placement. They tended to be used at an earlier point in order to prevent the child's risky behaviour escalating to the point when secure care would be needed or, alternatively, to support a child's transition back to the community following a secure placement. The authors concluded that it was more useful to consider children's pathways through services rather than each element in isolation, and identified three key resources that would reduce the need for secure care:

- residential provision, which could manage young people in crisis;
- intensive community-based support;
- social work and project staff who were able to effectively gauge and manage risk (p.6).

Some services that were developed as alternatives to secure care in Scotland have been evaluated, such as the Community Alternative Placement Scheme (CAPS) providing specialist foster care for children who would otherwise have been placed in secure care (Walker et al, 2002). The findings were mixed. Seventy-five referrals were accepted: some children moved to the scheme from a secure placement and others were engaging in risk-taking behaviours in the community. The pathways of 20 of the first children placed were examined in detail. Although all the children were thought by social workers to have benefitted in some way, this was not necessarily evident in improved life circumstances, such as subsequent accommodation, work or education.

> *After two years, overall outcomes for CAPS placements were in most respects no better and no worse than outcomes for a comparison secure sample* (Walker et al, 2002, p.201).

Only six of the 20 placements ended in a planned way: the remainder were disrupted by a combination of the children's problematic behaviour, or refusal to stay, exacerbated by a lack of support services. Some children struggled with living in a family setting or had conflicts in loyalty to their birth family. Fourteen placements had lasted for over six months, however, and had allowed positive relationships to develop between the child and carers. The researchers concluded that a family placement was not always preferable as a direct alternative to secure care, although it might be if targeted at those children who *want* to be fostered and where carers are willing to make a personal commitment. Some children in extreme crisis need the additional safety that only secure care can provide. CAPS could, they concluded, be developed as a useful complementary service.

The organisation Includem provided Intensive Support and Monitoring services for children in five Scottish authorities who might otherwise have been placed in secure accommodation because of their anti-social behaviour[5] (Khan and Hill, 2007). They worked with each child for about 15 hours a week, and also offered an out-of-hours and crisis service. Some of the children were also subject to a movement restriction order. The children reported that offending and anger were the things they most needed help with. An evaluation was undertaken, based on the perceptions of the children, parents and other professionals working with them, and assessments of the children's attitudes to offending. Most participants were positive about the service and reported improvements in the children's behaviour but no evidence about the children's outcomes was presented to support this.

Perhaps the Northern Ireland study (Sinclair and Geraghty, 2008) sums up the situation effectively. They concluded that *by the time a child was considered* for secure care, there was usually little alternative, but that preventative work might have stopped them from getting to that point. Their recommendations included:

- the development of preventative services to provide intensive inputs for 'troubled and troubling' children and their families;
- greater continuity and stability of service provision within the care system;
- enhancement of the skills of residential and fieldwork staff in engaging with children and managing risk, and recruiting staff with the right skills, attributes and motivation;

[5] Anti-social Behaviour (Scotland) Act 2004

- the use of research to support staff in the management of risk;
- clear statements of purpose for secure facilities, including expectations about therapeutic intervention (pp.8-9).

A more recent study in Northern Ireland (Regulation and Quality Improvement Authority, 2011) suggests that problems persist with children still not receiving the timely support that could have avoided the need to consider a secure placement.

2.6 After secure care

2.6.1 Transitions

There is a tension in planning for children's departures from a welfare secure placement, because they ought to be released as soon as the s25 criteria are no longer met, even if the order has not expired. Ofsted (2010) noted that this was problematic if the child was not ready to return to the community or adequate arrangements were not yet in place. Yet effective planning for release is widely acknowledged to be essential if an admission to secure care is going to improve the child's outcomes (Walker et al, 2005; Sinclair and Geraghty, 2008; Hart, 2009; Ofsted, 2010).

> *Secure interventions are by definition short-term and regarded by respondents, including secure unit staff, as being at best, only one stage in a much longer process. Their effectiveness was thought to be dependent upon the young person's needs being adequately addressed once they left the unit* (Creegan et al, 2005).

In the Scottish and Northern Ireland studies, most children returned to some form of residential care – sometimes the same placement as before admission – and were offered support packages of varying intensity. Walker et al (2005) found that there were benefits if these services had been established whilst the young person was still in the secure setting. Education or work were important elements in post-release support but proved difficult to arrange.

The importance of continuity was widely recognised, with research participants often referring to 'step-down' arrangements with a graduated move from a closed to an open setting, but this could prove difficult to achieve, with only about half of the children in Walker et al's study having had at least some elements of a phased return to the community. Ofsted (2010) cited a case where a child had not been able to cope in an open unit and was returned to secure care. She felt that she had needed ongoing support from the secure unit, including visits, in order to make a successful transition. Similar views were expressed in Sinclair and Geraghty's (2008) study, where respondents said it would have been useful if the secure unit could have offered 'outreach' work. The Secure

Transitions Fund was established in Scotland to enable secure units to provide exactly this service and was positively evaluated. One boy described what ongoing contact with his secure unit had meant to him:

> *It shows that they (residential staff) really care for me especially if they are willing to travel a long distance for me and come and spend time with me to see how I'm doing. That says something* (Vrouwenfelder, 2008: p.48).

In the context of the decline in SCH places that English authorities have experienced in recent years, and the consequent distance from home for many children, this could be difficult to achieve with any consistency.

2.6.2 Outcomes

There have been no robust follow-up studies of children who have been in a welfare secure placement in England. Held (2006) asked local authority managers what should be used as the measure of a good outcome. Keeping the children alive was the lowest common denominator here, but about half said the placement had also helped to stabilise the child and reduced adult anxiety about them. No evidence was provided about the numbers/proportions of children with different outcomes: 'a few' were said to be doing well in a family or open residential setting but only one had gone on to further education. Some children had spent prolonged periods in secure care, including repeat placements, whilst others had gone to prison or were still involved in risky behaviour. As a whole, their outcomes were said to be worse not only than their peers, but also other looked after children. Creegan et al (2005) also based their study about the effectiveness of secure care as a response to sexual exploitation on practitioner perceptions and concluded that 'physical security' had not added any value to intensive, community-based support.

The Scottish and Northern Ireland studies followed up both the children who had been admitted to secure care and a comparison group of children who had been referred but not admitted. Walker et al (2005) had intended to compare the outcomes for these two groups in a quasi-experimental study but, in reality, only 23 children in the comparison group were sustained in an open placement for at least six months after secure care had been authorised as against 53 children who were admitted so that the sample sizes were too disparate to allow meaningful comparisons. They also concluded that the characteristics of the two groups were not directly comparable, and that children had received other services alongside or following their placement making it impossible to attribute good outcomes to the setting itself. For example, the 23 children who were sustained in the community had received intensive support while their peers were in secure care.

Walker et al (2005) collected information on the secure sample approximately two years after admission and rated their outcomes based on:

- whether they were in a safe and stable placement;
- whether they were in work or education;
- whether the risky behaviour that prompted admission had been modified;
- social worker's rating of their well-being compared with that on admission.

Only those with a positive rating for all four measures were considered to have had a 'good' outcome (26%): if all ratings were negative this was a 'poor' outcome (28%) and anything in-between was 'medium' (45%). No single factor could account for all of these outcomes. The researchers looked at where the child had been admitted from, where they went on release, number of placement moves, type of educational provision and additional support services, but concluded that it was how these elements worked together that made a difference. However, none of the children where a 'step-down' approach had been taken to their transition from secure care, such as daily contact with an after-care worker, had a 'poor' outcome. Other factors that social workers considered to have been helpful in achieving better outcomes were having an appropriate placement and education on release and a good relationship with a key worker because it had boosted self-esteem. The factors that seemed to be associated with the poorest outcomes were problematic substance misuse prior to admission, and these children also tended to see their secure placement in negative terms, suggesting that more specialist provision might have been needed.

Of the 23 children in the comparison group who had been formally considered for a secure placement but not admitted within the first six months, sometimes because there was no vacancy, none went on to be admitted within the subsequent year. In comparison with the secure sample, there was a higher proportion of boys with 'externalising' behaviours, and lower rates of absconsion at the point secure care was considered. Nevertheless, intensive support had enabled a high level of risk to be managed in a community setting.

In Sinclair and Geraghty's (2008) study in Northern Ireland, there was a consensus amongst social workers, other professionals and the children themselves that secure care achieved good short-term outcomes in terms of the child's immediate safety, meeting their basic needs and providing an opportunity to break destructive patterns of behaviour. Respondents were much less clear about its longer-term impact. This was partly due to the need for improvements in the secure facility itself but partly because of weaknesses in the care children received before and after the placement. Crucially the authors thought the purpose and expectations of secure care needed to be clarified. Unlike the Scottish experience, those who were not admitted to secure care did not receive adequate support and a significant proportion were back at home or in custody

six months later. A subsequent study in Northern Ireland of five children who had been admitted to secure care and five who had been considered but not placed, found that three of the latter had entered the Juvenile Justice Centre within two weeks of the decision (Regulation and Quality Improvement Authority, 2011).

Outcomes were also mixed in Ireland. From a one-year cohort of children admitted to Special Care, the equivalent of an SCH, social workers reported a beneficial effect for just over half and reported that it had at least provided a place of safety for another fifth (which was all that they wanted and expected), but that it had a negative effect on the remainder (Brierley, 2010). Even where children subsequently settled down, some had 'run amok' immediately after release and many reverted to their risky behaviours.

2.7 Key points

- There is no routinely collected information and little robust research in England about the profile, interventions and outcomes for children who have been subject to a welfare secure placement, but there is some evidence from other countries in the UK and Ireland.
- There appear to be variations in local authority use of SCHs. Possible reasons for this include differing ideas about how best to meet children's needs, the effectiveness of services in preventing children from reaching the point when secure care is needed and a perceived lack of suitable provision.
- There is a gendered element to risk assessment, and the level/types of risk that agencies can tolerate.
- A 'typical' child considered for a secure placement emerges from the literature. There is likely to have been long-standing concern about the family, with lengthy social care involvement, although not necessarily effective engagement, difficulties at school and a greatly increased incidence of bereavement. As the child gets older, concerns shift from parenting problems to the child's behaviour. In girls, this is likely to include the risk of harm, particularly sexual harm, whereas boys are perceived as more of a risk to others. The child becomes a late entrant to the care system and, after a number of disruptions, is placed in a residential setting where they do not settle.
- Expectations of what secure care can achieve are high, and possibly unrealistic. Beyond keeping the child safe, it is hoped that they will tackle the causes of the child’s risky behaviour in a way that will bring long-term improvements in their well-being, in spite of the short time children spend there.
- Secure units work in different ways, using a range of formal programmes and therapeutic approaches. The relationships between staff and children are recognised as important, but not all children are engaged in the services on offer.

- There is a lack of information about ‘alternatives’ to secure care, some of which may be better described as complementary services rather than direct alternatives, but they can potentially enable risks to be managed in the community.
- Secure care should be viewed as part of the child's care journey and transition is vitally important, with indications that a 'step-down' approach can improve the child's chance of success.
- The evidence currently available does not allow any conclusions to be drawn about the effects of secure care on children's outcomes. Professionals in the reviewed literature reported that some children did well and they believed them to have benefitted: others did not do well, and professionals believed that the placement had either made no difference or even made things worse.

3. When is a secure ‘welfare’ placement considered?

This chapter describes the circumstances in which local authorities may consider a secure placement for children on welfare grounds, and the factors that influence their decisions. This includes differing patterns of use and thresholds, the profile of the children considered and the nature of the risks that cause concern.

3.1 Patterns of use

It is not possible to provide statistical evidence on local authority variations in the use of secure accommodation because of the way data is currently collected by DfE. There are two separate data returns relating to children in SCHs:

- the Secure Accommodation return (SA1), completed by SCHs
- the main SSDA903 on looked after children, completed by local authorities.

The Secure Accommodation return provides a snapshot of children placed in SCHs on 31 March rather than the total for the whole year. It includes data about children’s age, gender, length of stay and whether they have been placed on youth justice or welfare grounds, but not the individual local authorities they have come from. Neither does it include English children placed in Scottish SCHs, which is an emerging trend.

The annual report on Children Looked after in England (Department for Education, 2015b) provides data for individual local authorities but SCHs are included in the same category as other children’s homes and hostels when describing placement type. The national tables break this down further and specify how many children are placed just in secure units, but these include both children placed on welfare grounds and those subject to a secure remand (Department for Education, 2015c).

3.2 Factors influencing decisions about secure care

As part of this study, senior managers within the 12 participating authorities were asked about their use of welfare secure placements and the factors that influenced them. Respondents were often those with delegated responsibility for making decisions about s25 applications and knew the cases well. Some had been involved in reversing previous trends within their authority. This was usually in terms of reducing secure placements through measures such as more senior management scrutiny, the development of preventative services or emphasising the need to ‘get alongside’ young people. In one authority, an incoming manager had taken the opposite approach because she perceived that children had been left too long in risky situations and applications therefore increased.

Whatever the stance, there was a consensus that restricting a child's liberty is a 'draconian' step and respondents were rigorous about applying s25 criteria. This usually involved discussion at a specially constituted 'secure' panel, sometimes with multi-agency representation, and access to legal advice. It was generally acknowledged that simply meeting basic criteria was not enough in itself, otherwise there would be far more applications:

> *The likelihood of significant harm and absconsion fits the bill for most of my kids!*

Respondents cited examples where they had refused to sanction a s25 application in spite of high levels of risk and pressures from the professional network. A number of additional factors were taken into consideration when making decisions, as follows.

3.2.1 Likely effect of a secure placement on child's outcomes

Professional anxiety was never seen as a good enough reason to restrict a child's liberty: there had to be grounds to believe that it could/would bring about benefits for the child:

> *We have some very robust debates – particularly focused on how the placement in secure will improve outcomes for the young person. This isn't a solution unless we can think of an exit plan – they can't stay there indefinitely.*

Opinions differed about how likely it was that a secure placement would bring about positive change, rather than just containment. In one authority the manager was very clear:

> *We don't use it because we don't think it works!*

Others took the opposite view and described cases where children had achieved excellent outcomes that they believed could not have been achieved in other, less restrictive, placements.

3.2.2 Differing views about thresholds

Previous reviews have talked about welfare secure placements being used as a 'last resort' (Held, 2006; Mooney et al, 2012) and the possibility that some children were not being adequately protected as a result. Children Act guidance (Department for Education 2014a) states that consideration of a secure placement *isn't* necessarily a last resort and can be a positive choice. The findings of this study suggest that judgements are more nuanced: respondents agreed that it is an extreme step that must not be taken lightly, and that other means of managing the child's risks must be considered first. They talked about 'exhausting every possibility'; 'having no other alternative' or 'trying a wide range of provision first – not just considering it'.

We usually will have exhausted all options prior to getting to that point so we'll have used foster care, therapeutic foster care, residential and probably even looked at secure hospital provision via the health services. Whatever's the most appropriate route.

This did not mean, however, that they did not also see it as a positive option at times. Ultimately all guidance is open to interpretation and must be mediated by professional judgement in determining thresholds. There were clearly some differences in perception – not just across but within authorities – about when it is time to draw the line but this was not clear-cut. One manager had never agreed a secure placement because she believed it was only right to do so if there was a risk to life, and no cases had met that threshold. Others appeared to have lower thresholds, based on weighing up the likely damage to children's health and development if they continued to put themselves at risk as against the consequences of restricting the child's liberty. Ultimately, every case was said to be considered on its merits because what is worth trying for one child may not be suitable for another.

3.2.3 Whether an authority has its own SCH, or one nearby

Five of the 12 authorities in this study operated their own SCH but this did not always mean that they made more secure placements. It was just one factor amongst many. Although running an SCH no longer offers a guarantee that there will be a bed available, even for the authority's own children, it is likely that they will have better access than others. Where they could place locally, there were perceived to be significant benefits in enabling support from local agencies and making transition back to the community smoother. Authorities with no local unit had to balance the short-term benefits of keeping the child safe with the longer-term challenges of maintaining continuity and care planning in a distant placement. Nevertheless, for those authorities with no local SCH, distance was not usually cited as a reason for not using them: 'If you need a place, you need it'. There was some frustration about the difficulty of working with children placed miles away, with placements increasingly being made in Scotland, but the quality of the provision was more important than location.

An additional factor for authorities operating a SCH was that they may have a more informed stance on the potential benefits. Sometimes this was essentially positive but one authority with its own SCH said it made them less likely to place – they felt they also understood the limitations of secure accommodation: '… it's not a magic bullet'.

3.2.4 Personal and authority beliefs

Although no-one ruled it out completely, some respondents expressed their reluctance to use secure care because they thought it was 'wrong'. Sometimes this was a position that was shared across the authority. For others it was a personal position: 'I don't really

agree with it basically'. Some respondents perceived SCHs as prison-like environments and therefore unsuitable for children with complex needs and vulnerabilities.

> *Personally I don't think placing some of our most complex young people in the equivalent of Young Offender Institutions is the right way to address their needs.*
>
> *It's a punitive response to vulnerability.*

The fact that some SCHs also take children from the youth justice system was a concern for a number of those interviewed. They worried about:

- the effects of vulnerable children coming into contact with others who were there for criminal activity, particularly girls who had experienced sexual exploitation meeting gang-associated boys;
- the skill set of the staff, with some being more orientated towards offending behaviour work;
- the message to the children, who may see the placement as a punishment.

Others did not see this as a problem, because in their experience the children often had overlapping needs.

3.2.5 Tolerance of risk

All children's social care staff live with the prospect of being blamed if something happens to a child in their care, and there is pressure to take a risk-averse stance.

> *If they get shot in the street – people are going to say: 'You should have locked that child up'.*

Pressure could come from within, when social workers 'can't sleep at night', or from other agencies such as health, education or police. Where there were strong inter-agency working arrangements, such as the High-risk Strategy Meetings held in one authority, cases could be discussed and joint positions reached although it is ultimately the local authority's decision. This was more complicated if children were in out-of-authority placements and police in particular may put pressure on the home local authority because they want a troublesome or vulnerable child 'off their patch'. The stance of senior managers and councillors was particularly important in determining whether staff felt supported to manage risky situations or, conversely, became risk-averse.

3.2.6 Cost

This was not cited as a factor influencing decisions about secure placements although one respondent said that it had in the past. She felt the low use of secure care she inherited when taking up the post was driven by budgetary considerations rather than

children's interests, and she had reversed this stance. But more typically respondents said that, for this particular cohort of children, the predominant concern was keeping them safe. Given their complex needs, any placement would be equally costly. This also applied to children who were engaged in criminal behaviour. It has been suggested that authorities leave these to be detained through the criminal justice system in order to avoid the cost of placing them on welfare grounds (Centre for Social Justice, 2012; Mooney et al, 2012). This study found no evidence for this: several of the case examples involved high levels of criminality where a custodial sentence was likely, but the authority acted first with a welfare secure placement.

3.3 Children's profile

Information about the types of children where secure care was considered reflected the research literature. The managers described the typical circumstances of children where they were asked to authorise a secure placement, and provided specific examples. This was supplemented by 16 case studies across five authorities, with information obtained from practitioners, managers and case records.

3.3.1 Case studies

All of the 16 children studied were considered to have met s25 criteria and most had been placed in an SCH but, for three children, it had been decided that there were still other options to be tried. The children were at different stages of their care pathway, with some having made the transition back to the community and others either still in an SCH or the placement that was chosen to try to prevent their admission to secure accommodation. It is impossible to say at this stage whether diversion will be successful or whether these three children will be referred for a secure placement in the future. The small sample size and method of selection means that the profile of these children cannot be considered representative of all children who are considered for a secure placement. They do, however, help to illustrate the range of difficulties that pose the most challenges to local authorities in order to keep children safe. Six of the children were boys and 10 were girls. The range of risks that they presented included child sexual exploitation, self-harm, violence, substance misuse and association with risky adults. They all had a history of going missing from placements. Many of the children were also said to have mental health, emotional or developmental disorders. Vignettes from these children's stories are used throughout the remainder of the report to illustrate the findings.

3.3.2 Age and gender

Managers said that, although child sexual exploitation was nothing new, the recent level of public concern had increased the numbers of girls being considered. Nevertheless,

there were no clear patterns in terms of gender. Although boys and girls can present differently, or perhaps practitioners perceive the risks differently, both can cause equal levels of concern. Because of the expectation that other types of placement would be tried first, children were at least in their early teens before the possibility of secure care was raised.

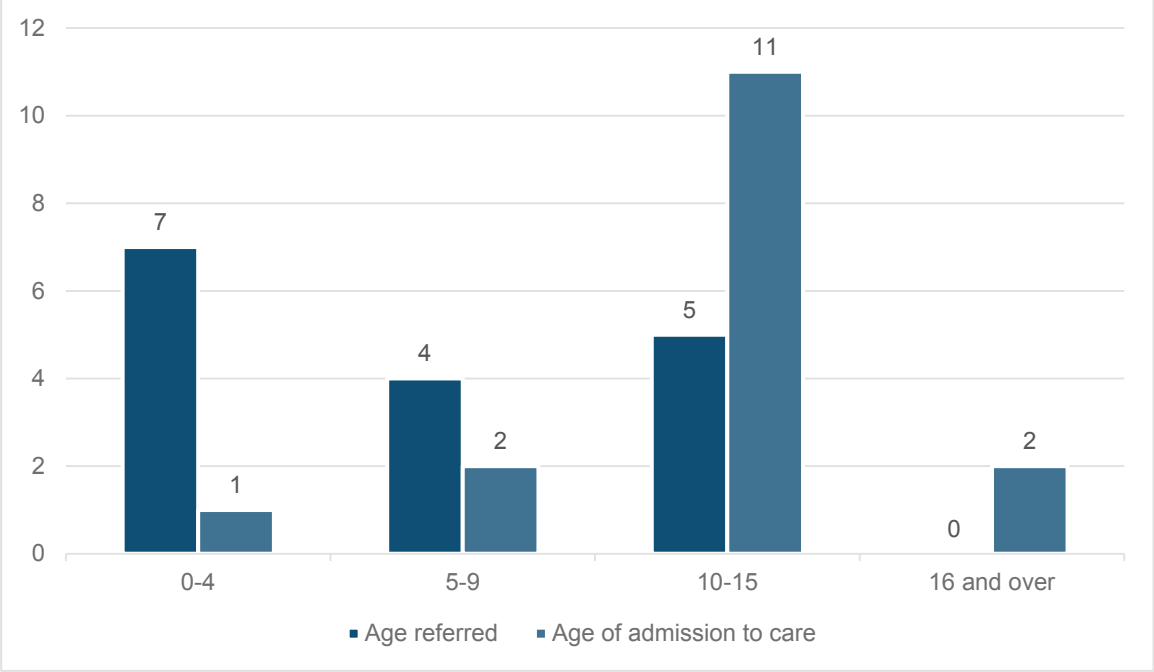
3.3.3 Social care history

Some managers had tracked back through children's records to see if there had been early indications of the child's difficulties.

> *We did an audit of children placed in secure – most we'd been involved with since birth or at least two or three years old: the boys had been persistently absent since primary school from age four and they'd all experienced neglect. Many were from criminal families and we'd not intervened until they hit secondary education. When we tracked back, I bet 70% had issues of educational attendance.*

This was not universal, however, with one manager who had undertaken a similar exercise saying they were not all cases with longstanding concerns, although they may have been 'on the edges of early help'. Other children were only referred in their teens.

Figure 2: Social care history of case study children



John-Paul was referred at the age of 15 because he was missing from home. He was said to be at risk from a family member and was reported to be using 'legal highs' and had smoked cannabis from the age of 11. His mother was suffering from a serious mental illness and John-Paul's grandfather, who had been an important life-line for him,

had recently died. John-Paul was arrested for hurting his mother while she slept and remanded to local authority care followed by a community sentence. He was then placed into secure care on welfare grounds.

The most common reason for the case study children being referred was abuse and neglect in early childhood but some children only became known later on because of their behavioural difficulties. When these difficulties were assessed, however, a picture usually emerged of parental rejection or significant loss. In only one case, of a girl who had been seriously sexually exploited, were the reasons for her vulnerability unclear.

Marie was referred as a very young child because of sexual abuse and severe neglect. She was removed and placed for adoption aged four with two younger siblings but went on to experience three adoption breakdowns. This was partly due to the children's sexualised behaviour but also events that couldn't have been predicted – including the death of two adoptive parents. She returned to the care system for the last time aged nine with a severe attachment disorder.

3.3.4 Entering the care system

Although the case study children had typically been known to services for some time, most were late entrants to the care system, reflecting both the research literature and managers' perceptions. The most common pattern was for children to become looked after in their early to mid-teens and then be unable to settle. The initial placement was often foster care but all of these placements broke down and were followed by a variety of residential provision, most very short-term. For those who went on to be placed in an SCH, most did so within six months of coming into care and during this time they had experienced several placements.

Bethany had been known to children's services since infancy because of her mother's mental health problems. She experienced physical and racial abuse from her mother and step-father and sexual abuse by her brother. She became looked after aged 15 and was placed initially in foster care followed by five residential placements before her first secure placement only five months after entering care.

3.3.5 Risk behaviours

There was a high degree of consensus within the research literature and managers' interviews about the types of risky behaviour that prompt consideration of a secure placement, and this was confirmed by the case studies. Risky behaviour always included absconding and the risk of harm to self or others, in accordance with the legal criteria. It was evident that staff lived with a high level of anxiety about the possibility of the child being injured or even killed. Some of these behaviours were associated with criminality, although they were only considered in the context of a s25 application if associated with

a specific risk rather than as a substitute for the youth justice system. These risks were also associated with mental ill-health and disputes with NHS agencies about what constitutes a 'diagnosable' mental illness requiring a psychiatric placement. Attachment and conduct disorders, and emerging personality disorder are usually considered to be the province of social care services, who in turn feel ill-equipped to deal with them. Specific behaviours described included:

Self-harm and suicidal thoughts

This could take the form of cutting; pulling out clumps of hair; swallowing batteries or other objects; over-dosing; threatening or attempting to jump off bridges/under trains.

Child sexual exploitation

Child sexual exploitation could be a risk to boys as well as girls, and was usually associated with the child failing to recognise the extent of the exploitation. Although there is reported to be some stretching of the definition of sexual exploitation, the cases within the study were of children who were being groomed and passed around by groups of men for sex; multiply raped; given heroin, cocaine or alcohol to make them more compliant/wakeful.

Substance misuse

Children were abusing a wide range of substances, to the extent that their judgement was impaired.

Charlie was using mephadrone, cannabis, speed and alcohol and experiencing paranoia and hallucinations, thought to be drug-related. It was impossible to engage him because he was constantly impaired, could not 'think straight' and had no insight. He was having accidents through reckless behaviour and frequent attendances at A&E, where his behaviour required sedation before he could be treated. His needs could not be properly assessed because it was impossible to establish whether his violent and erratic behaviour was caused by substance misuse, mental illness, ADHD or emotional distress.

Association with 'risky' adults

Apart from the child sexual exploitation cases, some children were associating with adults who posed other types of risk to them. This was particularly the case with children involved in gang or criminal activity, such as low-level drug-dealing. Some of the children were described as naïve, or learning disabled, and keen to define themselves as being part of a gang or the criminal world without realising the risks if they stepped out of line or acquired drug debts.

Jack is a very immature 14 year old. He claims to have been in a 'crack house' where he was either forced to take drugs or, alternatively, that he stole them. Various men have

been phoning his placement asking to speak to him and he is anxious about strange cars pulling up outside. A knife has been found in his room.

Violence

Some children were violent to other staff or children in their placements, family members or frequently got involved in fights when they went out or absconded. This behaviour was often unpredictable and possibly associated with an underlying mental illness or disorder.

Marcus has a learning disability and an attachment disorder. He is unable to regulate his feelings or behaviour and is very violent. Prior to his secure admission, he had been arrested 90 times and had 11 pending criminal cases, including assault on his mother and a residential care worker who had required hospital treatment.

3.4 'Alternatives' to secure care

Previous reviews (Held, 2006; Deloitte, 2008) have mentioned 'alternatives' to secure care. Given that there is a belief that some authorities make less use of secure placements than others, this raises the question of what they do to keep very high-risk and absconding children safe. Are they using other types of placement as a direct alternative to an SCH? In fact, the findings of this study indicate the picture is more complicated than that.

> *There's no such thing as an alternative – that's a false premise.*

It is more useful to think of a continuum of services, with secure care at the end when other options have failed to reduce the risks. One authority described how they had learnt 'from and with our children' that they must avoid reaching the point where the only option to keep the child safe is secure care. The services that were usually tried to meet the needs of particularly vulnerable children within the care system may take the form of supportive interventions to engage the child and reduce risk, additional resources to support existing placements or moving the child to specialist fostering or residential provision. It must be remembered, however, that even if children are placed in secure care, they will come back out again and the same continuum of placements will then need to be deployed again. Children experience a whole range of interventions as well as placements during their journey through the care system, and each pathway will be different.

3.4.1 Relationship based approaches

Some of the study authorities described their attempts to improve the work undertaken with children and families by measures such as family or brief therapy, and relationship based approaches. One respondent described a request to approve secure

accommodation for a boy who had been missing for six months after two episodes in an SCH. These placements had destroyed the boy's trust in the authority, and he had survived during the intervening period without serious harm. The decision was taken to place him in open residential care, but with intensive efforts to rebuild his trust and generally 'get alongside him'. Another authority described staff taking a child (and family) away for a month to an outward-bound facility to get them away from the risk of sexual exploitation in the community. During this time, police tried to lessen the risk by serving child abduction notices on the perpetrators in the hope that the child would come back to a safer environment, with greater self-confidence and more trusting relationships with the staff who were trying to support her. In a similar case, a residential worker had taken a girl away for a 'pamper' weekend to raise her self-esteem and provide the opportunity for them to build a positive relationship.

3.4.2 Strengthening existing placements

Most children who were considered for secure care had a history of placement breakdown, which was likely to escalate their risk-taking behaviours. Some authorities felt this could be due to poor matching/placement planning by social workers with insufficient training and skills in this area of work.

> *Often the people who're placing the kids don't know enough about what a good placement/placement plan is and what the outcomes are. So invariably, if you put the kid in the wrong place, it will cycle down, it will collapse, and before you know it you've got this really difficult situation.*

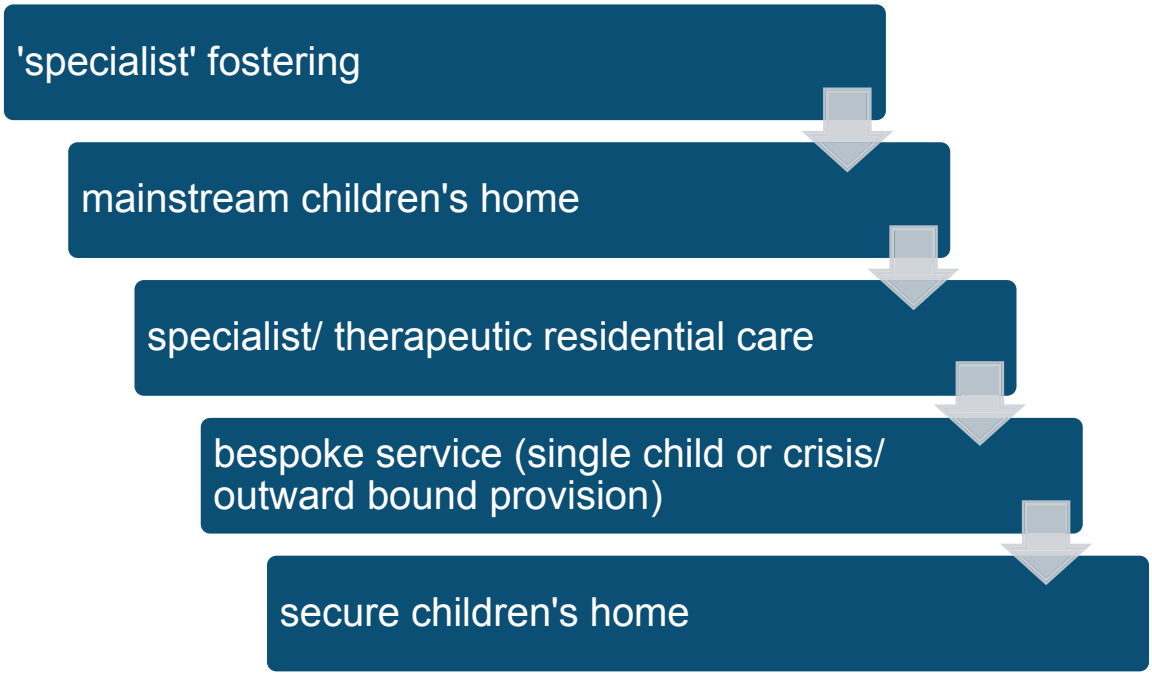
This authority was in the process of trying to improve placement planning by providing much more detail on placement request forms, including what the child liked and was good at as well as negatives, and specifying what outcomes they were hoping to achieve. In turn, they also specified what the authority would do to support the placement.

Other authorities described offering funding for additional staff or therapeutic support, and one had managed an extremely high-risk boy in a family placement with an intensive package of support to enable the carer to cope. They gave the boy a curfew and monitored this with frequent visits. Another family placement was supported by outreach work from residential staff. Other ideas were the use of respite placements to give carers a break and enable them to carry on. Some respondents felt that there was scope for further expansion, particularly with crisis support out-of-hours. It was thought that, if a child was in a placement they had 'bought into' this type of intensive support may be effective, but was less likely to work if the child was somewhere they did not want to be.

3.4.3 Specialist placements

Even with support, there may come a point where children cannot be kept safe in a foster or kinship placement. There was a high level of consensus amongst respondents about the continuum of placements that may be tried for children with increasingly risky behaviour and all authorities used them on occasion if they thought the child would benefit – and tried to make them work. This placement pathway is described below.

Figure 3: Placement pathway for children with risky behaviours



Where differences arose was in judgements about their respective merits, and at what point it was judged that options other than secure care had been exhausted. Some authorities described positive experiences with specialist placements, whilst others were worried about the quality of what is available, particularly the validity of claims to offer 'therapeutic' services.

> *I have tried things like (company) – they take kids out on barges – and I've tried – to my shame – one kid placements but I've never been easy about it. I've never been impressed – they say they've got therapeutic input and they say they've got all this skill-base but they pay their staff the lowest possible wage.*

A particular source of unease is the extent to which specialist placements restrict children's liberty without the safeguards that would accompany a secure placement. The units are often in rural locations, and have high staff to children ratios. There was a clear division of opinion here: managers who were positive about what a secure placement could offer, for example seeing it as 'part of their toolbox to help young people' were

uncomfortable with the idea of 'having three people following you around' in a setting that was not ostensibly secure. They felt it was preferable to be behind locked doors. Others took the exact opposite view:

> *I wouldn't deny those places also restrict young people's freedom but there's enough of a difference from being in an SCH, where you're locked in, to make a difference for the young people – it's not as punitive.*

There were examples given of children who'd been placed at *more* risk by a rural or distant placement. When they did run away, their attempts to find their way home meant accepting lifts or money from strangers, or committing crimes to raise the fare. There were graphic descriptions of police helicopters searching a mountainside for one girl who had absconded from an outward-bound project.

3.5 Key points

- There is a lack of accurate data on individual local authority use of secure care, although it seems that some are more positive about its benefits than others and are therefore more likely to use it.
- The factors that influenced decision-making were:
  - The likely effect of a secure placement on the child's outcomes;
  - Perceptions about the 'right' threshold for using secure care;
  - Whether there is a local SCH;
  - Personal and authority beliefs about the restriction of liberty;
  - Tolerance of risk.
- The children considered for secure care reflect those described in other studies of secure accommodation. They display a range of risky behaviours, including self-harm, violence to others, having been sexually exploited or associating with dangerous adults. There are no clear gender patterns, with boys and girls both vulnerable to this range of risks.
- Children were likely to have been known to social care services for some time but late entrants to the care system. There were a minority of children, however, where problems only became evident in adolescence. Parental abuse, neglect and rejection were common and bereavement seemed to be a factor for some.
- The concept of an 'alternative' to secure care is not straightforward. In one sense, there is no alternative because no other placement is authorised to restrict children's liberty. Neither are there two separate models of service delivery for authorities depending on their attitudes to secure care. The same continuum of placements is available to all local authorities: the difference lies in judgements

about when it is appropriate to use them. Efforts to prevent children's needs from escalating to the point when secure care is needed include:

- Additional and creative ways to engage children in order to reduce their risk taking behaviours;
- Support services to prevent existing placements from breaking down;
- Specialist placements, including small residential units with therapeutic services or bespoke placements commissioned specifically for individual children.

4. Purpose and outcomes of secure care

In this chapter, we first explore views on the purpose of secure accommodation. Drawing on examples described during the interviews and our case studies we then analyse:

- children's experiences of secure care and their progress at the point of leaving;
- the arrangements made to support their transition out of secure care;
- their subsequent life experiences and longer-term outcomes.

In the final part of the chapter we consider how the evidence base on outcomes from a stay in secure accommodation could be improved.

4.1 Purpose of secure care

Although the local authorities differed in their attitudes towards secure placements, all acknowledged that there were occasions, however rare, when they would use them. As described in Chapter 3, there was a consensus that it would be a misuse of the provision to use SCHs just for containment, even in exceptionally challenging circumstances. There must be a clear sense about what a secure placement will achieve for any child placed there, and how it will contribute to their care plan.

4.1.1 Keeping the child safe

Given that a secure placement can only be made if the child is posing a risk to themselves or others, it is not surprising that keeping them safe – and to a lesser extent other people safe – was mentioned by all respondents as a key purpose. The level of risk needed to be high:

> *… that child's going to die otherwise or end up seriously injured so no other service can pick them up.*

The risk of death was mentioned in relation to a number of cases: at their own hand through extreme substance misuse or suicide, or at the hands of criminal or abusive adults. Because secure placements are authorised to restrict children's liberty, they can prevent children from absconding or associating with dangerous adults and ensure they do not have access to drugs and alcohol. For those with self-harming or violent behaviour, there is an expectation that staff will stop the children – and others – from coming to any harm.

Prior to his admission to an SCH at the age of 14, **Jamie** was abusing crack cocaine and alcohol, funded through having sex with adult men, and had created a false identity on Facebook as a gay man ten years older than his real age. He was reported missing 111

times, had been hospitalised with suicidal thoughts, contracted a sexually transmitted disease and committed five assaults, but did not take on board the risks and dangers he posed to himself and others.

4.1.2 Stabilisation and engagement

There are a number of aspects to this. Some respondents referred to the need to 're-establish routines'. For children who had been leading chaotic lives, absconding, out all night and not going to school, simply having the opportunity to develop a pattern of getting up in the morning, going to education and eating regularly were seen to be beneficial. This was linked to the existence of 'clear and consistent boundaries'. Some respondents described children who had been so out of control that they needed to re-learn that their behaviour had consequences.

Charlie was misusing drugs and becoming increasingly involved in criminality. He was an intelligent boy and established a position as 'top dog' in the open residential units he'd been placed in. He began to see himself as 'invincible' and took no responsibility for the hurt he was causing to himself and others. The local authority hoped that secure care would help him to 'climb back down the mountain'.

Patterns of family abuse or rejection, and placement disruption, meant that most children had become disengaged from adults who wanted to help them. Secure care provided the opportunity to 'hold' them so that this engagement work could begin.

> *If you can give them stability but also actual love: 'We do like you, we want to support you', and that continued praise … that's all you'd aim for the first couple of weeks – get them the belief they're safe, and they're liked, then you can start on the other bits.*

4.1.3 Assessment and planning

As described in Chapter 3, children may have been recent entrants to the care system, if not contact with social care services, and had not settled long enough or engaged sufficiently for staff to build up a comprehensive picture of their needs. Several respondents described a secure admission as providing an opportunity to undertake a thorough assessment in order to plan for the future.

> *You'd do health checks, some form of psychological testing, get them back into education in the unit: begin to set up some baselines. Often we don't know where they are in terms of education; we don't know what health problems they've got.*

Some children's lives had been so chaotic that the origins of their risky behaviour were poorly understood, and more assessment was needed. This need for a thorough

assessment was particularly the case for several children with psychiatric symptoms that could be a sign of emerging mental illness, or the temporary effects of drug or alcohol abuse.

Ayesha was increasingly violent to peers and staff in her placement, but had also started to be aggressive to members of the public. She was having what were thought to be 'pseudo seizures'. She showed very little empathy for others and seemed to be stuck in terms of her social and cognitive development, presenting as very child-like. Ayesha didn't seem to understand the consequences of her behaviour and could become very aggressive quite suddenly. The possible causes of these problems were suggested as ADHD, trauma as a result of sexual abuse, or attachment disorder following rejection by her family. Attempts to undertake mental health assessments in previous placements had been unsuccessful because she would not co-operate.

Thorough assessment could then form the basis of planning, both for the work to be done during the placement and subsequently, and where the child should move on to. The child was also seen as an important participant in the plan and some respondents talked about the importance of secure care identifying strengths as well as difficulties, including finding what children enjoy and are good at, so they can see a pathway towards a more positive future.

> *It's an opportunity to turbo charge their education, turbo charge their aspirations: give them a sense there's a different life out there.*

4.1.4 Reduce future risk

The Northern Ireland study reviewed in Chapter 2 (Sinclair and Geraghty, 2008) described the, perhaps unrealistic, expectation that a secure placement would reduce a child's risks not just while they were placed, but into the future. This would require either the causes of the children's troubling behaviour to be tackled, and/or children to develop both a desire and ability for self-regulation. Mixed opinions were expressed by the participants within this study: some thought that the children's difficulties were so entrenched that a short placement in a protected environment was unlikely to bring about any lasting change.

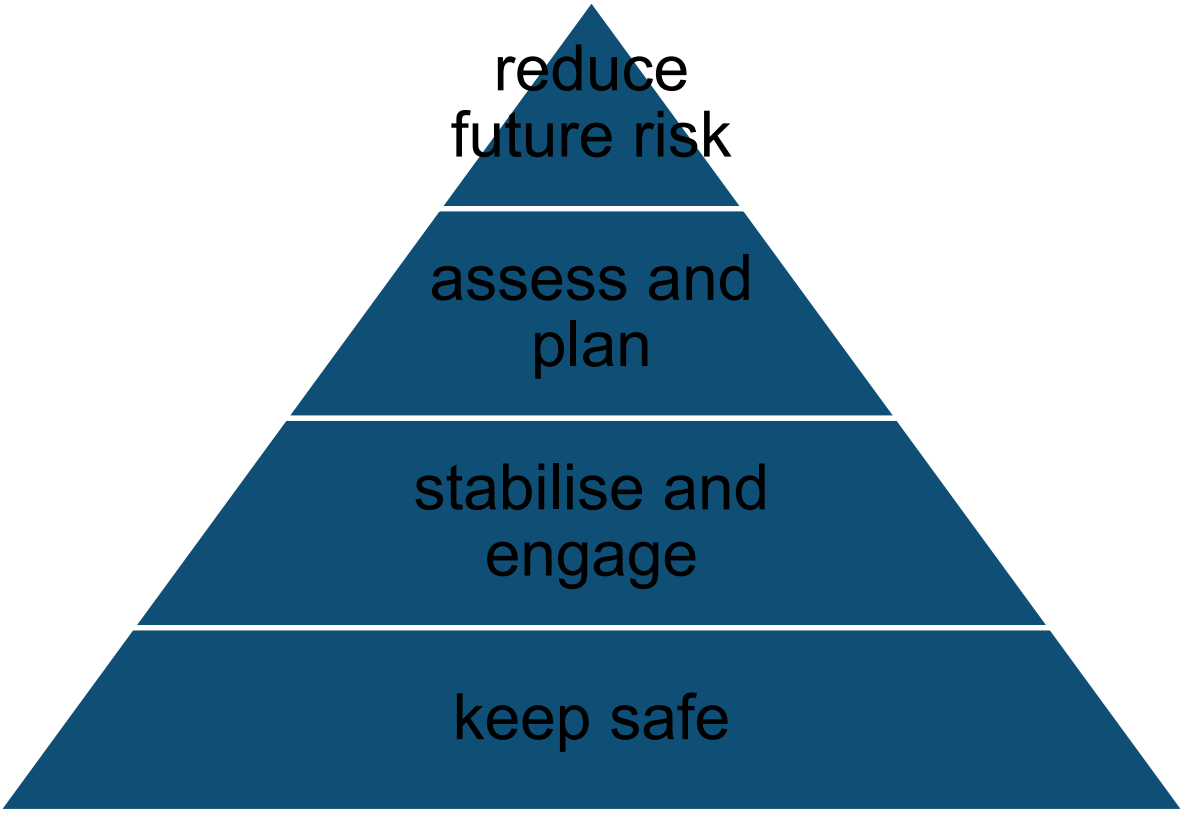
> *The danger is you'll spend three to six months restricting their liberty, effectively sticking them in prison, and they'll come out exactly as they were.*

The question of whether it was feasible, or desirable, to embark on therapy with no guarantee the work could continue after the child returned to the community was acknowledged. This was particularly the case for attachment disorders, or trauma. It was considered more feasible to tackle substance misuse, or some of the risks associated with exposure to risky adults. No-one expected a spell in secure care to be

transformative in itself: it was more about motivating the child towards wanting a more 'normal' life, identifying the support needed and finding high quality services that could provide it continuing into the future. The effectiveness of a secure placement can therefore be assessed, not in terms of whether it has eliminated the risk completely but whether the child and their professional network are equipped to start down that road.

Figure 4 summarises the hierarchy of expectations that the managers in the study had for secure care.

Figure 4: Hierarchy of expectations from secure care



4.2 Life in secure care: short-term outcomes

How far were these expectations fulfilled? In line with the literature (Sinclair and Geraghty, 2008) children's experiences of, and short-term outcomes from (i.e. at the point of leaving), secure accommodation were typically reported to be positive. The progress children were said to have made whilst in secure accommodation does broadly reflect respondents' expectations as described above.

4.2.1 Keeping the child safe

First and foremost, respondents believed that secure accommodation had kept children – and others – safe in the short-term. There was little doubt in respondents' minds that by the time children had been placed in secure accommodation they were 'out of control', and without a secure admission they would have gone on to commit serious offences, become embroiled in the sex industry and/or may have suffered severe injuries and even death. Some children also began to see their SCH as a place of safety.

For **Grace** secure accommodation was the only place where she had felt safe for a long time and, on one occasion when she absconded from an open placement, she ran back to the SCH.

The contained environment and high staffing levels were effective at managing the risks that had led to the child's admission, although some behaviours were an ongoing challenge for staff. Grace, described above, continued to cut herself with anything available, displayed grooming behaviour towards other children, started a fire and persuaded other children to hand over their medication, which she then used to spike drinks on the unit.

4.2.2 Stabilisation and engagement

Respondents said that children were kept safe in secure care not only through the external controls provided by a high level of supervision and locked doors. At their best, secure settings can also enable children to begin to regulate their own behaviour through providing them with boundaries and stability within a loving and nurturing environment.

This process of stabilisation can be partly a result of the structured environment, with clear rules, but a number of respondents talked about secure care as offering a 'breathing space' where children could calm down and reflect on how they wanted to go forward with their lives. The fact that they could not run away also provided the opportunity for staff to begin to form relationships with the children, most of whom had failed to settle in previous placements. There were descriptions within the case studies of children 'beginning to talk' or disclosing abuse for the first time. They also engaged with health and education services, and one boy began to enjoy sport in spite of having disliked it previously.

Kathy engaged really well with all the support that was provided. Reports on her education and the CSE group work indicated some clear improvements and she even engaged in activities she was not 100% comfortable with, such as reading aloud and expressing her opinion in a group. While in secure care, Kathy did well in her academic work and, by the time she left, had obtained a number of certificates which were the

equivalent of a C grade in GCSE: for her that meant the earth because she had been out of education for so long.

4.2.3 Assessment and planning

As children became more stable, assessments were carried out to determine what interventions children required while in the secure placement and beyond. For children who arrived in secure accommodation with poor health, this provided an opportunity to identify and treat health conditions which had been neglected, such as poor dental care or sexually transmitted diseases. Children were typically disengaged from education and SCHs had the facilities to assess any special educational needs, including children's academic strengths and weaknesses, and to provide a programme of work and continuous assessment that enabled the children to work at their own pace.

Although arrangements differ, SCHs have access to a range of psychological assessment services. Some children received the kind of forensic mental health assessments they badly needed but which had not been possible in the very chaotic period that preceded the secure placement.

Marcus was facing criminal charges, including a number for violence. He also had a learning disability and attachment disorder and could not regulate his behaviour. Given his age (17) he was likely to be sentenced to custody in a young offender institution. The secure placement enabled him to be thoroughly assessed: it was accepted that he was unfit to plead and would need to transfer to a specialist facility for adults with challenging behaviour associated with learning disability.

4.2.4 Reduce future risk

Respondents were hoping that a period in secure care would achieve some lasting change so that children did not resume their risk-taking behaviours when they returned to the community. This could be through tackling the underlying causes of the behaviour, or building the child's resilience so that they could better regulate their own behaviour or resist pressure from others.

Children did seem to engage well with the support typically provided by SCHs: not necessarily immediately but once they realised that they were safe and had established a trusting relationship with at least some staff. This was a considerable achievement as it had proved impossible to engage some of these children with any form of support in previous placements. It was hoped that this engagement would encourage children to take advantage of help offered to them in the future.

Children who had not had any education for a long time were said to have made good progress and to be proud of their achievements. One senior manager, who regularly visited the local SCH, observed:

> *I see their smiling faces, I go and see their work and there is this kid that was marauding round the city with knives and gangs and he's there showing me all his basic maths and English and beaming with pride.*

The opportunity to engage in a range of recreational activities, sports and hobbies was also seen as beneficial, because it kept children occupied with positive activities and helped them to build confidence and self-esteem. For children who had been trapped in a cycle of failure and rejection, this was a significant change.

Kathy's self-esteem improved. By the time she left her hair and her nails were done, she felt good about herself and proud of what she had achieved. She was always keen to let her auntie know what she had done and her auntie responded by saying how proud she was of her. Kathy knew she was worth more than the way she had been treated in the past and by the time she left she had a real 'can do' attitude.

In SCHs some children were said to benefit from the therapeutic psychological and/or psychiatric input provided to meet their specific needs identified from the assessment, and others disclosed traumatic experiences that had not emerged before. Children were also kept away from drugs and alcohol, and intensive work on their substance misuse was carried out. Work on these issues had typically been very difficult, if not impossible, in the period preceding the secure placement, because of high instability due to placement changes, children's absconding behaviour and children's reluctance or inability to engage. Having introduced these services, the intention was usually to continue them in subsequent care plans although there could be practical problems associated with lack of availability, or changes in provider.

Reconnecting with family

Respondents talked about the importance of engaging families in the work, regardless of whether the child was returning home. Many of the case study children had experienced parental rejection, compounded by the problems caused by their behaviour prior to the secure admission, but the families needed to be 'on board' if the next placement stood any chance of working: 'I say to them: "Your child deserves better than this!"' SCHs were reported to have helped to strengthen relationships with families: relationships which may have been very fragile or have broken down completely. Family therapy was provided by some units, as well as support to keep the family engaged e.g. encouraging visits, providing regular feedback to parents. One unit organised 'Come Dine with Me' evenings when children cooked for their parents. Another provided a family room for overnight stays for families who had to travel a long distance to visit.

4.2.5 Children's views

Children themselves were said to have recognised benefits, as the social workers below reported when asked what the children would have said of their time in secure care:

> *She did not like it because she was away from [home town] but she recognised that the time in secure taught her that there are consequences of behaviour.*
>
> *She resented being placed in secure initially, but she now recognises that it was right for her and the progress she was able to make while in there.*
>
> *I was taken aback by how well the boy did and he enjoyed his time in secure.*

While these positive views were reported by social workers and not children themselves, they are in line with previous research presented in Chapter 2, which was based on data collected directly from children.

4.3 Transition planning

The assessments and the progress children made in secure care informed decisions about the timing of their move and where they would go next. On leaving, some of the children went into residential care. At least initially, they would typically be placed in settings that provided a high level of supervision and specialist support. Some children were placed directly from SCHs into adolescent or adult mental health units. It seemed unusual for children to go into foster care or to live with their families, although some did. Bespoke packages involving single child placements with a high level of supervision (e.g. 1:1 or 2:1) and a multi-agency support package (e.g. education, Child and Adolescent Mental Health Service [CAMHS], Youth Offending Service) were set up for some children when they left a secure setting.

Bespoke placements could be chosen for a range of reasons:

- Some of these children were approaching the time when they could live (semi) independently and a single-child placement could provide an initial first step towards this move.
- They were seen as providing the kind of stepdown, gradual and highly supervised return to 'freedom' a child needs after a period in a secure environment.
- Some children had not done well in group provision and attempting this immediately after a period in a secure environment could destabilise them.
- Given the level of placement instability and 'placement rejection' these children had experienced, a single-child placement may also represent an attempt to provide some stability and protect children from further 'failures' and 'rejections'.

Due to **John-Paul**'s age (17 when he left secure care) and his behaviour, it was decided that he would not manage well living with other people and therefore planned for him to have his own property with wraparound support. He had an Education Healthcare Plan, a training placement and support from the Youth Offending Team, CAMHS, the housing provider and a drugs worker. SCH staff were also initially involved to provide follow-up support.

As indicated by senior managers, work on the child's exit plan was expected to start from day one but there was a particular focus on the more practical and immediate arrangements needed to support children to make the transition towards the end of the secure placement. The two key aims of the transition plans were to test out how well children would be able to manage risks with the level of 'freedom' they would have in the new placement; and, to give a child the opportunity to familiarise themselves with the new placement and education setting. Transition arrangements had to be tailored to the child's needs and the kind of placement chosen for them.

The SCHs regarded by respondents as effective provided a period of mobility in the last six to eight weeks when children were allowed to go outside, typically with SCH staff, their social worker, the new setting staff and/or their family. If children were moving to semi-independent accommodation the level of mobility would be higher than usual. Similarly, a girl who was due to move back with her family was allowed to attend education for two weeks in the community while she was still living in the secure unit.

During the transition period there were visits to the new placement with the length of the visits gradually increased and including overnight stays. 'Transition visits' were also arranged for the girl who was moving back home, with SCH staff making random checks to ensure she was there. When children were moving to semi-independent accommodation SCH staff would, if possible, help to decorate and personalise the new flats. Staff from the new residential placement were meant to visit and keep in touch with a child in preparation for their move, although the extent to which this happened varied, particularly if the new placement was far away. When appropriate and feasible, families were encouraged to be involved with visits to the new placement.

The level of mobility described above was not believed to be universal practice, and there was a concern that what were seen as less effective SCHs were not sufficiently flexible to provide the level and type of mobility a child needed in preparation for the next placement. For example, one authority in the study went to court because the SCH would not allow a child to test an overnight stay in the post-secure placement where the child was due to go after leaving the unit.

SCH staff sometimes provided outreach support for some time (typically a few weeks) after children left secure accommodation, particularly if children were not going into another residential placement. For example, one SCH continued to provide support to the

girl who returned to her family. Outreach support for John-Paul in his semi-independent accommodation included going around in the morning to have breakfast with him. This was dependent, of course, on the location of subsequent placements. It was acknowledged to be an important factor in providing continuity for children, but difficult to achieve given the fact that both SCH and other specialist placements are so scarce.

4.4 Life after secure care: longer-term outcomes

While securing children's safety in a moment of crisis was hugely important, it was believed that the real test of effectiveness was whether they could sustain the progress they had made at the point of leaving once back in the community.

The case studies provided evidence of a relatively short post-secure period (mainly in the first year) but, even within this short time-scale, it was clear that longer-term outcomes were more mixed than outcomes at the point of leaving:

- A short settled period following secure care seemed common, although not universal. For a few weeks, children had much reduced levels of risky behaviour compared with the pre-secure period; modest or even good engagement with services provided, with families involved in some cases. However, some then quickly reverted to the destructive patterns of behaviour that had characterised the pre-secure period, requiring intensive supervision and specialist support, and in some cases another period in secure accommodation, in a mental health setting or a youth justice placement.
- For other children, the settled period seemed more sustained, albeit in the relatively brief period we considered. Children continued to engage with support services (e.g. counselling), education and training and, for some, relationships with the family seemed to stabilise. While there were still some ongoing 'issues' and concerns, they were nowhere near the level of intensity and risk they had reached in the period immediately before secure accommodation.

Beyond the features of the secure unit discussed below, it was not possible within the scope of this small scale study to explore other factors that contributed to sustain or undermine progress over time. Given the complexities of children's lives and the range of services provided, social workers themselves struggled to pin down what could have made a difference and why these children's trajectories could change considerably (for better or worse), as the example below illustrates.

> After 8 months **Jamie** left the SCH: he seemed to have settled down and was doing well. He was placed in a therapeutic setting where he did well for six weeks, but then his behaviour deteriorated fast – he went missing 15 times, was associating with known sex workers, admitted to having sex with older men for drugs and money, and

he was reported to have been raped. As he was approaching the age of 16, he was accommodated in a single-child placement with 1:1 staffing and a multi-agency support package. He had ups and downs but recently he enrolled in college full-time doing performing arts and loves it. This seems to have been a turning point for Jamie, and he is the most settled he has ever been as far as all professionals who work with him can remember.

4.5 Factors associated with a successful placement

It could be difficult for respondents to disentangle the effects of the secure placement versus other influences on children's trajectories. However, as far as respondents were able to make these links, the factors more strongly associated with success or failure of a placement were, predictably: whether secure care had been the right option for the child as opposed to a mental health admission, whether the SCH the child was placed in matched his/her specific needs, and the quality of the placement.

4.5.1 Secure or psychiatric care?

A number of children were placed in a mental health setting immediately or shortly after secure care. In some cases, it may have not been possible to predict this outcome earlier on, but respondents described cases when social work and SCH staff felt that, whilst a secure placement had kept these children safe, they would have been more appropriately placed in psychiatric provision to begin with.

The most extreme case we found was that of **Marie**, now aged 24. She had 63 placements during her time in care, including 12 secure admissions, and was eventually diagnosed as having a severe mental health condition (personality disorder and/or schizophrenia). While from her mid-teens she had had a number psychiatric admissions interspersed with open and secure children's placements, with hindsight it was concluded she would have benefitted from earlier and more consistent treatment in a Tier 4 mental health setting.

Jane was in secure accommodation on three occasions over a period of just over two years. In between secure placements she was placed in very specialised open placements which broke down very quickly as her behaviour was escalating. At the end of her third period in secure care, Jane transferred directly into a psychiatric unit. The mental health treatment seemed to have been effective and Jane would have probably benefitted from being treated in a mental health setting at an earlier stage. The need for specialised mental health treatment had been raised at an early stage by SCH and social work staff but there were delays in CAMHS undertaking the mental health assessment, suspected to be because there were no mental health beds available.

4.5.2 Which unit and how long the child stayed

When it was believed that it was in a child's best interests to be in a secure placement, scarcity of provision could limit the options available. However, when social workers were able to place children in a placement that met his/her specific needs, positive longer-term outcomes were more likely to be reported. Where placements were within close geographical proximity to the home authority, this could facilitate family contact, maintain links with the community services the child needed and allow SCH staff to offer after-care support. Finding a placement that ticked these boxes could be very challenging, as we will discuss later.

Length of placement was also associated with longer-term outcomes. In some cases, it was felt that children had not remained in secure care long enough to sustain the initial improvements they had made. Given the legal requirement to release children from secure accommodation as soon as it is safe to do so, it was felt that SCHs do not always have the opportunity to undertake the work needed to bring about sustainable change. In those cases where decisions had been taken to extend the secure placement, respondents felt this had enabled children to consolidate the initial progress made. However, the line between keeping children long enough to provide a solid foundation but not keeping them so long that they would become de-motivated and institutionalised could be a very fine one.

4.5.3 Quality of secure provision

There were features of (some) SCHs that were also believed to contribute to sustainable positive outcomes. The experience, dedication and motivation of the staff was seen as fundamental. Examples were given of children who had done well because they had key workers who never gave up on them, who advocated for them and really 'fought their corner'. The range of in-house services and multi-disciplinary teams some SCHs had meant that they could provide comprehensive and high quality assessments, and a tailored, flexible, joined-up package of support that may be difficult to find elsewhere.

While good placement matching and high quality secure provision were seen as key to ensuring positive long-term outcomes for children, they were not, on their own, seen as sufficient.

Long-term benefits were also seen to be crucially dependent on the quality of social work input and support services such as mental health, during as well as after secure care, and the suitability of the post-secure arrangements. As we will see in the next chapter, it was not always possible to commission post-secure arrangements that were considered to be in the child's best interests.

4.6 Strengthening the evidence on secure care

We were asked to consider if there was a need for more evidence on the costs, benefits and outcomes of secure accommodation and how this could be collected. Assessing these would require comparing outcomes for two comparable cohorts of children, some of whom are placed in secure accommodation while others are placed in an 'alternative' placement, to explore any differences in outcomes, while controlling for any other factors (e.g. social care history, presenting issues) that may explain differences in these outcomes. As we have seen above, longer-term outcomes are required to establish if a secure placement has 'worked', and these would require the collection of data several years after a child left secure care or an 'alternative' placement, and, again, one would have to control for the impact of placement and support arrangements during these months to attribute any differences in outcomes to the period in secure rather than what happened afterwards. Even if all these methodological challenges were resolved, it may prove difficult to detect any differences, because the period in secure care is typically short and the sample size would be very small. We have outlined elsewhere (Hart and La Valle, 2015) our suggestions for designing a longitudinal study of children in care to explore outcomes for children with different care pathways. We believe that such a study would provide the most robust and cost-effective way of gathering evidence on this group of children and attempting to assess if, for whom and under what circumstances secure accommodation might be beneficial.

There is, however, scope to commission smaller scale research to fill some of the evidence gaps on children who are considered for and/or placed in secure accommodation, highlighted earlier in the report. Study participants felt that this would support their decision-making.

DfE collects a wealth of data from local authorities on looked after children. However, at the moment, this data is not provided separately for children in welfare secure placements on either a national or local basis. The new co-ordination arrangements for welfare placements will provide an opportunity to collect evidence specifically on the demographic profile of children placed in secure care on welfare grounds and their risk factors. It will also allow an exploration of trends in the use of welfare secure care, both in terms of absolute numbers of the places required and as a proportion of the looked after children population, and variations between local authorities. In order to inform longer-term planning, however, it will also be important to find a way of collecting information about outcomes, including measures such as whether they are in suitable accommodation and their employment status after the age of 18.

It may be worth considering research to provide reliable statistical estimates on some of the patterns that have emerged from this and other studies, namely:

1) the age children considered for secure accommodation enter the care system;

2) their social care history prior to coming into care;
3) placement stability and placement arrangements before and after a period in secure accommodation.

Reliable data on these patterns would be a first step towards understanding the reasons behind children's pathways, identifying 'missed opportunities' to prevent admission to secure accommodation and supporting positive outcomes when children spend a period in secure accommodation. Most of this data is available from local authority case files and could therefore be collected without placing too much of a burden on local authorities, although systematic collection of these data using a purposively developed framework would require considerable research resources.

The variable quality of both secure and open residential placements was also a recurring issue (discussed further in Chapter 5). It may be worth exploring how existing data could be used to understand this perceived variability. For example, by combining Ofsted ratings with Department for Education child level data, data from authorities' case files, and social workers' and children's views on placement quality. Research on quality could also focus on the quality of exit plans from secure care and how they are implemented as these are key to supporting long-term positive outcomes. Case studies could be carried out to explore in-depth the implementation of these plans i.e. do all the planned services materialise and are inputs well co-ordinated?

4.7 Key points

- The participants in this study agreed that the purpose of secure care was to:
    - keep children safe;
    - restore some stability to their lives;
    - assess their needs and identify the supports needed in the future.
- There was less agreement about the extent to which SCHs could tackle the underlying causes of children's risk-taking behaviours and bring about sustainable change.
- Based on respondents' experience and the case studies, secure care appeared to be effective in meeting the short-term objectives of keeping children safe and providing them with stability, identifying some of the underlying causes of their risky behaviour, and engaging them in support.
- The evidence on longer-term outcomes was more mixed and children did not always manage to sustain progress after they left secure care. It could be difficult for respondents to disentangle the effects of secure care versus other influences on children's trajectories after they left a SCH. However, the factors more strongly associated with better longer-term outcomes were:

    - Whether secure care had been the right option for the child as opposed to mental health provision.
    - The location, duration and quality of the placement and whether it matched the child's needs.

- Long-term benefits were also seen to be dependent on the quality of ongoing care-planning and social work input and the suitability of the arrangements following a secure placement.
- The qualitative information from this study has helped to map the expectations and outcomes from secure care but there is a need for robust evidence. We have outlined options for collecting statistical information on an ongoing basis in order to support future practice improvement.

5. Challenges

In this chapter we consider the contextual challenges in meeting the needs of children with very risky behaviours. These include the need to operate within the current legal framework governing the restriction of liberty, and the difficulties in procuring the service thought to be in each child's best interests. These services include both secure and other types of placement, and mental health provision.

Figure 5: Challenges facing local authorities

5.1 Legislative and policy framework

Some respondents reported challenges in operating within the current regulatory framework. Placements are either registered as secure – or not (Department for Education, 2015d). This does not allow for a kind of semi-secure option for children who could benefit from some restrictions to their liberty but do not need the level of security provided by SCHs. In Chapter 2, the model in Finland was described whereby open children's homes have some authority to prevent children from going out for a short period. In England, residential staff are acutely aware that they must not limit a child's freedom other than to address immediate risk and worry about exceeding their authority. A number of respondents felt that a more flexible approach might work for some children, provided there were safeguards. They were also uneasy about how far single-child, or

very remote, placements restricted liberty by default without any clear recognition of this within regulations.

If there were scope for a more flexible approach towards security, it could also allow the development of better 'step-down' arrangements. At the moment, the transition from a secure, locked, environment to an open placement can be abrupt. This is extremely challenging for children who have difficulty in regulating their behaviour and there were many examples within the study of children who had returned to old patterns of behaviour. If their return to the community could be phased in some way through a gradual reduction in restrictions, both the findings of previous studies (Walker et al, 2005) and participants in this study suggest that outcomes are likely to be better. Authorities try to achieve this as best they can, but struggle with the legality of the arrangements.

Because of the wish not to lock children up unless absolutely necessary, the legislation states that children must be released if the s25 criteria are no longer met, even if the order has not expired. The maximum term for an initial order is three months, although subsequent extensions of up to six months can be made. This can make it difficult to plan. SCHs cannot be certain at the outset exactly how long the child will be there, and the timescale is driven by a reduction in risk, not the child's needs.

> *The most frustrating bit is when the young person isn't meeting the secure criteria any more but we haven't got a clear placement…*

This also means that more fundamental – and lengthy – work on the underlying causes of the child's difficulties cannot be undertaken. Again, some respondents would welcome more flexibility. They gave examples of children who had moved on to an open placement too soon, and needed to return for a second or third time. Sometimes children were 'saying all the right things' – and possibly meaning them – but change was still superficial.

Duane was placed in secure care because of his violence, drug misuse and absconding. In the short-term, the placement really worked for him: he could not run away and therefore engaged, and it gave him some stability, boundaries and rules he hadn't had for a long time. Duane started to believe in himself. His social worker thought that, because he was doing so well, he should have remained longer but – precisely because he was doing well – the order was not renewed after three months. Duane is now reported to be back to square one after serving a custodial sentence.

Some authorities also mentioned the legal challenges posed by older children. Statutory guidance states that children over 16 cannot be made subject to a s25 secure order if they are voluntarily accommodated under s20 of the Children Act 1989 (Department for Education, 2014a: p.42). This means that authorities have to initiate either care or Wardship proceedings, both of which can be cumbersome and costly.

5.2 Finding the right placement

To support children with the most complex needs and whose behaviour is putting them or others at risk, local authorities are reliant on the market to provide: secure placements, in the rare cases when these are considered necessary, and open placements that could provide the kind of high level specialist support these children require. Specialist open placements are required both to keep vulnerable children safe without depriving them of their liberty, and as stepdown placements after a period in secure accommodation.

5.2.1 Secure placements

Availability

At the point this study was undertaken, senior managers reported problems in the availability of suitable welfare secure placements. As an Assistant Director said when asked if she had ever been in a position when a child needed a secure placement and none were available: 'More times than I care to remember'. This had occasionally meant local authorities being left to manage the risk of holding a child in a placement they knew to be unsuitable. Even local authorities with their own SCH did not necessarily find it easier to obtain a place because of the financial pressure to have the beds occupied.

Location and quality

There were also concerns about the suitability of secure placements linked to the SCH's location and quality of provision. It was not unusual for children to be placed in faraway secure settings as these were the only ones available. Sending children away meant disrupting their (often fragile) connections with family and other support networks, and with local services. This could add to the stress of what was already an extremely stressful experience for a child, and could make transition back into the community more difficult.

Reflecting the findings from the literature discussed in Chapter 2, it was also believed that the quality of secure accommodation was variable and some respondents talked about a 'two tier' system.

- Some SCHs were seen as having 'modernised', as being flexible and prepared to go the extra mile to accommodate needs. They were reported to have the skill-set and multi-disciplinary team required to provide high quality assessments and a therapeutic environment to start the healing process, while stabilising children and keeping them safe. They are also willing to operate flexibly to support stepdown arrangements. Respondents reported some very good outcomes from these units for children with severe emotional and mental health issues. However, capacity in these SCHs was said to be very limited.

- Other SCHs were said to be 'stuck in the past', and were described as being rigid and run more 'like prisons' with little, if any, therapeutic input and support with transition.

5.2.2 Specialist open placements

Respondents described difficulties in identifying suitable placements to meet the needs of very high-risk children. As discussed in Chapter 3, these children had typically had a number of placements (including residential ones) in a short space of time. From the case studies, it seems considerable resources were invested in identifying suitable open placements, with dedicated placement staff working alongside social workers. However, the difficulties were considerable:

- Following the introduction of a new Ofsted quality framework, some providers were said to have become risk-averse and more likely to turn down children who are not only a risk to themselves or others, but also – in their perception – to the home's Ofsted rating. In a supply-led market providers can be 'choosy', and not only reject referrals of highly problematic children, but also terminate the placement if children become difficult to manage. Children who have been in secure accommodation and/or those with multiple previous residential placements were believed to be particularly likely to be rejected.
- Even very specialist providers claiming to cater for children with complex needs, and reflected in very high costs, did not always seem equipped to fulfil these claims. As one respondent said: 'The glossier the brochure, the worse the service'.
- There seem to be a very small number of open residential settings that are highly regarded for their ability to provide good quality and tailored support to the most vulnerable children, and these homes rarely have vacancies.
- It was felt that there were gaps in provision possibly because of the small number of children involved (e.g. sexually abused boys, transgender or gay children) and because the needs of some children were very specific and niche.

The evidence from this study therefore confirms previous studies (Deloitte, 2008; Mooney et al, 2012) that the market is not working for some of the most vulnerable children in the care system. Supply, and especially supply of high quality, was not sufficient to meet demand and to allow sufficient choice in the type of provision that would meet each child's needs.

5.2.3 Local solutions

A number of authorities were developing their own provision to meet children's needs more effectively. For example, one was setting up centres for short-term respite care and assessment. Primarily developed to provide intensive family support and cater for

children on the edge of care, they were also seen as potentially contributing to a package of support to keep children out of secure accommodation.

Another authority had made the strategic decision to rely largely on in-house residential resources. This approach was said to provide greater flexibility so that provision could be adapted to match changing needs. Yet another authority was reviewing its approach to out-of-area placements, prompted partly by the escalating costs of this provision, but also concerns about quality.

Specialist foster care was also mentioned as suitable for some high-risk children. Availability was patchy although one authority was involved with a Department for Education Innovation Programme that was developing specialist child sexual exploitation foster care. Another respondent said they had previously used specialist fostering, but that costs had escalated whilst expectations about what would be delivered were unclear. As with secure care, she felt that specialist fostering would benefit from a strategic rather than a market-led approach.

5.2.4 National responses

Even in authorities that wanted to rely primarily on their own residential resources, it was recognised that some very specialist needs could not be met in-house and they, like other authorities, faced challenges in commissioning places from that niche part of the market catering for the most challenging children. There was agreement among respondents that the problem required a national strategy with central co-ordination of the expected level, type and location of need and possibly regional delivery arrangements.

5.3 Mental health services

As we have seen, significant mental health problems are common among children who are considered for and/or placed in secure accommodation. This requires authorities to work closely with CAMHS to decide when mental health issues require a psychiatric admission, as well as to get mental health assessments and services for children in both open and secure placements. Respondents reported considerable challenges in securing the mental health input these children required, partly as a result of a shortage of provision but also disagreements about thresholds between mental health and behavioural disorders.

CAMHS services were said to be stretched, resulting in long waiting lists for mental health assessments and treatment. Furthermore, CAMHS services do not operate flexibly to work around the needs of children who lead very chaotic lives. For example, if children missed a CAMHS appointment, they sometimes had to re-join the waiting list and wait

weeks before another was offered. CAMHS staff were not always prepared to deliver their services within the child's placement, making it even harder to assess these children's needs and engage them with mental health support. Some SCHs commission their own mental health service, which can ensure a speedier response, but these practitioners still have to liaise with the child's local NHS to access services. This may also lead to some discontinuity for the child.

As highlighted by previous research discussed in Chapter 2, there were disagreements with CAMHS on what constitutes a disorder requiring a psychiatric admission or treatment. A number of children were placed in a mental health setting immediately or shortly after secure care. While it was not always possible to predict this outcome, respondents reported cases when social work and SCH staff felt that a child would have been better served by admission to a Tier 4 bed. These disputes sometimes arose because CAMHS said their assessment had not identified a diagnosable mental illness and that the problem was 'behavioural'. It was argued that some of these diagnoses were 'supply-led' i.e. a child was not assessed to require a mental health bed because there were none available.

> *We've had two girls who were clearly mentally ill. The psychiatrist said 'I agree with you but we haven't got a bed so I'm not going to say it'. I charged them for the bed in the SCH – and they paid. They both went into forensic[6] beds eventually and one's still there.*

These difficulties have been recognised by both the Department for Education and the Department of Health, and they are working together to ensure additional funding and resources are made available.

There is still a debate to be had about how best to help children who have experienced abuse or neglect. This can lead to symptoms of post-traumatic stress disorder, severe attachment disorders, conduct disorder or emerging personality disorder and there is no consensus about the appropriate response to these difficulties. CAMHS may say they are 'social or emotional' rather 'mental health' problems, but respondents felt there was a gap in provision. Whilst secure unit staff may be able to keep children safe and begin the healing process, they are not mental health professionals and cannot be expected to provide treatment. Interestingly, one SCH had considered the possibility of applying for dual registration as both a children's home and mental health unit. This is not just an issue for secure care: some non-secure units describe themselves as 'therapeutic' but there is no agreed definition as to what this means, and a degree of mistrust across local authorities as to the validity of the claims.

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[6] Forensic psychiatry assesses and treats mentally disordered offenders.

5.4 Key points

- The legal and policy framework for secure care is considered to be somewhat inflexible, both in the rigid de-lineation between secure and open placements, and the requirement that children cannot remain in secure care if the criteria are no longer met. This limits the capacity for SCHs to embark on longer-term interventions for children who may benefit from these.
- Local authorities require a range of secure and specialist placements to support children with the most complex needs and whose behaviour is posing a risk to themselves and/or others. Our findings indicate that the current market-led system for providing such placements is not working effectively. There are problems with both supply and quality.
- Some authorities are placing an increasing emphasis on in-house resources, both to engage children and meet their needs, and to ensure more control over the quality and quantity of placements.
- However, there was agreement that a national strategy is required for secure and specialist provision with central co-ordination around the expected level, type and location of need, and possibly regional delivery arrangements.
- Problems related to the way the social care residential market works were compounded by difficulties in securing adequate NHS mental health services, particularly for children not considered to have a diagnosable mental illness but who need treatment for conditions such as attachment or conduct disorders, post-traumatic stress or emerging personality disorder.

6. Conclusions

This small-scale study was designed to increase our understanding about local authority use of welfare secure placements and the children most likely to benefit from them. The findings indicate that there are no simple answers but it is hoped that the study will contribute to improved practice.

6.1 When is secure care used and for whom?

Local authorities in our sample agreed that, for a small number of children, there is no substitute for a secure placement. They also agreed that it is a 'draconian' step that should be averted wherever possible. Where opinions did diverge was about the level of risk that makes it ethically justifiable to restrict a child's liberty, the extent to which it is effective in improving children's outcomes in the longer-term, and the threshold when other types of placement can no longer be considered viable.

Although precise data is not available, the use of secure care varies. Some local authorities certainly see secure accommodation as a positive intervention, believing that it can break the downward spiral of risk-taking behaviour for the most vulnerable children and even start the 'healing' process as children engage with support services. Others see it in a more negative light and are sceptical that it will achieve anything more than keeping children safe in a moment of crisis. These perspectives also reflect different beliefs about the right balance between children's right to freedom and the need to protect them from harm. In trying too hard to keep a child out of secure care, is it possible to do more harm than good? Or is it always right to try yet another open placement until there are no options left?

Our findings show that the children who are considered for a welfare secure placement present high levels of risk, primarily to themselves but also to others. One of the biggest challenges is that these behaviours can make children inaccessible to the practitioners and services that want to help them. Children may be physically absent or emotionally chaotic, sometimes compounded by substance misuse or emerging mental illness, or so suspicious because previous services have let them down, that they are unable to engage. Although the threshold for deciding when an open placement can no longer keep a child safe is decided on a case by case basis, the bar is high. We found no evidence to suggest that welfare secure placements are used unless the criteria are met *and* professional judgement is that the child will benefit. In fact, our findings suggest that more children are likely to technically meet s25 criteria than are ever placed. A more useful question might be whether anything could have been done to prevent the child's distress from escalating to the point where secure care was needed.

Children considered for a secure placement present a variety of risk-taking behaviours and, for most, the origins of this behaviour lie in their early childhood experiences. It is not surprising that many have been abused or neglected, or have lived with parents with significant problems of their own. More unusually, there is research evidence to suggest that they are much more likely than their peers to have experienced the death of someone significant in their lives. This was confirmed within this study, where most children had experienced bereavement or parental rejection. This warrants further investigation, particularly to establish whether the children had received help to make sense of their loss through specialist counselling.

6.2 Is there an alternative?

The evidence from our study suggests that there is no direct alternative to secure care either in legislation or in practice. Rather it makes sense to consider it as being at the end of a continuum of increasingly specialist provision, from fostering/residential/therapeutic/ to crisis or single child placements. All authorities in the sample use this placement continuum, although there may be differences in the point at which each option is considered to have been exhausted. In line with previous research, we found that it is common for children placed in secure care to be late entrants to the care system although they are likely to have been known to social care services since early childhood. Typically, they will have experienced several placement breakdowns in a short period of time. The fact that some children were the subject of a s25 application within six months of coming into care raises questions about the effectiveness of both the matching process and quality of previous placements. Whilst the children were undoubtedly challenging to care for, the impact of a placement serving notice that they no longer wished to care for a child is likely to compound previous rejections. It could also lead to children realising that they can bring about a placement move through their behaviour, and will reduce the likelihood of engagement.

It is important, however, that children's care experience is not considered solely in terms of placements. The role of the local authority is to be their corporate parent, undertaking the range of tasks that any good parent would. Having a warm and nurturing home environment is part of the story but effective care planning requires much more. A range of services must be provided, based on the child's unique needs, and these need to be well co-ordinated and monitored in partnership with the child to ensure they are effective. When we consider the question of 'alternatives' to secure care, we need to consider not just other types of placement, but other ways of making sure that children are getting what they need before their problems escalate. Troubling behaviour can be a way of telling us that we aren't getting that right.

6.3 What contribution does secure care make?

Evidence from previous studies suggests that expectations about what secure accommodation can achieve are high – possibly unrealistically so. Children display a range of internalising and externalising problematic behaviours: some have complex and deep-seated emotional disorders and may have emerging mental illnesses. SCHs are expected to take them all. If the purpose of a secure placement is primarily to contain, then this makes sense: if it is to address the underlying causes of the children's behaviour, then it is a major task requiring a wide range of skills and interventions, and a timescale based on the child's needs rather than the risks they pose. This question about the fundamental purpose of a welfare secure placement needs to be clarified before effective decisions can be made about the future of SCHs.

The advantage that secure placements were seen to have over other settings is that they can 'hold' the child to restore some stability in their lives and begin to engage them. They are usually seen as effective in achieving this: children appear to become calmer and leave in better shape than when they arrived. Social care staff have had some respite from the crisis-driven work that often characterises these cases and have a clearer picture of the child's needs. In theory, children should move on to a suitable placement, and with a tailored support package that will enable them to maintain their progress. The reality is more mixed: some children do well but others 'go back to square one'.

Some would argue that it is unrealistic to expect SCHs to bring about sustainable change. For many children, the origins of their risk-taking behaviour are the deep-rooted consequences of abuse, neglect and rejection. These require long-term and intensive interventions and are not what SCHs are set up to do. Nevertheless, some children did seem to maintain at least some of the progress they had made. It is impossible in such a small study to establish the reasons for this, although there are some clues. For example, where children did not have serious mental health problems, had been in high-quality provision, with an element of after-care support from SCH staff and the placement had been judged to be for the right duration, outcomes seemed more likely to be positive.

6.4 What further evidence is needed?

There are major gaps in the evidence base on the impact of both secure and other types of placement on children's well-being, particularly in relation to longer-term outcomes. We suggest the type of research that could begin to answer some of the questions about effectiveness. It is important that any study takes a holistic view of children's social care history, both prior to and since becoming looked after. For some children, more effective early intervention might have prevented their problems from escalating so that they could remain at home, or become looked after at a younger age when the prospects of achieving permanency are more positive. For others, better placement planning (or better

quality placements) when they first became looked after might have prevented the need for secure care. Finally, for those who did require secure care, their ability to sustain any benefits might have been improved if there had been somewhere more suitable to move on to and better support services.

6.5 How can the challenges be overcome?

Those responsible for meeting the needs of this cohort of troubled and troublesome children face many challenges, including problems in the supply of both secure and other specialist placements. Our evidence confirms that the residential care market is not working for these children, with reported concerns about the availability, cost and quality of provision. It is hoped that the proposed new commissioning system for SCHs and the Children's Residential Care Review will resolve this problem. Respondents welcomed these initiatives and are keen to be involved.

These problems are compounded by the gap in provision for children with attachment, conduct, emerging personality or post-traumatic stress disorders. In line with previous studies, our research participants reported that whilst the NHS may be willing to assess these children, there are weaknesses in the model of subsequent intervention. In-patient beds are reserved for those with diagnosable mental illnesses, and the well-intentioned reluctance to pathologise children while they are still developmentally immature means that many do not meet this threshold. Even where it is accepted that a child needs an NHS resource, there may not be one available. Yet local authorities feel ill-equipped to meet some of the complex mental health needs that children present. Further debate is needed about how best to help them, possibly through the development of a new type of provision that provides treatment but in a care setting. If this were to take place within the context of SCHs, the current model whereby the length of stay is determined by the level of risk rather than the child's needs would need to be revised.

This brings us to the legal and regulatory framework governing welfare secure provision. Our findings suggest that it would be helpful for this to be reviewed. Respondents indicated that the rigidity of the current arrangements, and the lack of clarity about the parameters of 'restrictions of liberty' are limiting opportunities to help children in a tailored and flexible way. If the possibility of 'semi-secure' provision were to be explored, this might prevent the need for some children to be subject to a secure order, or would allow for a more phased transition back to the community.

Although numbers of children eligible for secure care are small, the stakes are high. The level of disturbance amongst the children we came across during this study was striking, as was the commitment of practitioners in trying to help them. They deserve to be supported by better evidence and further consideration of ways in which the current model of service provision could be improved.

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