Department for Education

Improving the outcomes of looked-after children and young people in complex situations with multiple needs, at risk or subject to a Deprivation of Liberty

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Introduction

This set of reports present findings from a research project undertaken by Research in Practice/National Children's Bureau (NCB) between November 2024 and March 2025. The research was commissioned by the Department for Education (DfE) under the title 'Improving outcomes for looked-after children and young people in complex situations with multiple needs, at risk or subject to a deprivation of liberty.' The requirement set out the following aims and objectives:

1. to bring together existing literature to build our understanding of the characteristics, needs, experiences and outcomes for children and young people who have been, or are at risk of, being deprived of their liberty. To identify examples of existing approaches to caring for these children and the possible barriers and facilitators to its implementation

   The aim was to build upon the groundbreaking research by the Nuffield Family Justice Observatory (NFJO) which made detailed analysis of the 208 applications submitted to the national Deprivation of Liberty Court during its first two months of operation in July and August 2022 (Roe & Ryan, 2023). This analysis identified three 'broadly distinct' groups of children subject to Deprivation of Liberty (DoL) orders: (i) children with learning and physical disabilities needing support/ supervision, (ii) children experiencing (or at risk of) sexual or criminal exploitation and (iii) children with multiple complex needs often recognised to be a response to complex and ongoing trauma. It was the latter group (which is also the biggest group) that was the intended focus of this research
2. to explore the journeys of a small sample of children and young people through analysis of their social work case files. Seeking to provide insight into their involvement with professional systems over time, the circumstances that led to the consideration of or an application for a DoL order, what support and interventions they may have received and their outcomes
3. to review three bespoke children's homes designed to meet the needs of this cohort of children to understand how local authorities and their partners have developed and delivered provision
4. to identify data gaps in knowledge and evidence which might be bridged in the future and that could provide insight for this cohort of children in terms of numbers, outcomes and costs.

The DfE outlined the following intentions in commissioning the project:

- to inform the next stages of policy development by building emerging evidence and understanding in relation to the increased use of DoL orders and the support and interventions being offered to those subject to these orders

- to build understanding of the issues faced by local authorities in relation to the needs and experiences of these children and young people such as any increase in the acuity of needs and any contextual factors contributing to any increase, including any evidence on the availability of any relevant service provision

- to develop evidence on residential provision, therapeutic care and joint workforce that might inform a typology of practice. To include consideration of how residential provision is set up and resourced and of system barriers and challenges to meeting the needs of these children and young people and strategies used to overcome these.

The project

The project was arranged into 4 strands of work, each of which are set out in the following chapters. The thematic summary draws out key messages from these 4 strands of work. It also includes references to research, grey literature, data and policy published since the completion of the evidence review.

Strand One

Systematic evidence review. Two systematic searches were conducted to identify literature (published from 2010 onwards) relevant to the areas identified at point 1 above and includes analysis of evidence in relation to the various legal routes by which deprivation of liberty is authorised in England.

Case law review. Provides an overview of the complex legal frameworks and issues in relation to the determination of a deprivation of liberty of children and young people.

In relation to DoL orders made under the inherent jurisdiction of the High Court, it is important to note that data and evidence in relation to the experiences of the children and young people deprived of their liberty via this legal route is emergent and limited. The main sources are Roe and Ryan's detailed analysis of the 208 applications submitted to the national Deprivation of Liberty Court during its first two months of operation in July and August 2022 (Roe & Ryan, 2023). Roe went on to lead the analysis of records for a subset of 113 of these 208 for an outcomes report (Roe et al., 2023). Work commissioned by the DfE from the Office of the Children's Commissioner (CCO) provides voice to 15 children and young people with experience of DoL orders (CCO, 2024a). Very little is known about longer-term outcomes for children and young people deprived of their liberty through a DoL order.

Strand Two

Case file review. A review of social care case files of 21 children and young people in 4 local authorities across north and south England was conducted between January and March 2025. Criteria for selecting case files for inclusion in the review were that the child or young person had multiple, complex safeguarding needs; that they were subject to, or being considered for DoL restrictions in any period between July 2022 and December 2024; and that they were aged 18 or under at the time of the application for/consideration of a DoL order.

In tracking the journeys of children and young people through these case files, the evidence demonstrates that an individual child or young person's liberty may be deprived in a variety of settings over time – in inpatient mental health settings, secure residential homes and DoL placements. As such, it is important to hold in mind that the legal route by which a child or young person's liberty is deprived does not define any specific cohort.

Strand Three

Case studies of existing provision. This online fieldwork with 3 case study residential homes took place between January and March 2025. Data were collected through semi-structured interviews/focus groups involving 25 participants in a range of roles and document analysis of a variety of material provided. Criteria for selection were that at least one site was funded through joint health and social care arrangements. At least one site was part of NHS England (NHSE) funded Vanguard activity and the Framework for Integrated Care. At least one site demonstrated innovative building design to enable flexibility in occupancy.

Key messages summary

This is a brief summary of evidence drawn from the work of this project – the thematic overview, the evidence review, case file analysis and case studies of 3 examples of residential provision (see introduction for further detail on the work of the project).

The evidence this project presents indicates that promising solutions lie in policy and service systems – in health and social care in particular - taking shared responsibility for reducing the complexity that lack of integration generates for these children and young people.

Escalating use of Deprivation of Liberty Orders. Over 2,500 children and young people were deprived of liberty in response to mental health, safeguarding and welfare concerns in 2023/24. The use of the High Court's inherent jurisdiction as the most common route for deprivation of liberty in this context reflects systemic issues that impede appropriate responses to children and young people's needs.

Insufficient early help and fragmented services: Key social determinants of health have all been moving in the wrong direction over the last 15 years, resulting in rising demand for health and social care from 'a society in distress' (Darzi, 2024, p. 2). Austerity policies have had radical impact on early help and youth services and have exacerbated disjointed CAMHS and social care provision (Ofsted 2022; ADCS 2025).

Case file analyses, both the work conduced for this project and work by Nuffield Family Justice Observatory (Roe and Ryan 2023) illustrate long histories of service involvement, repeated, short-term interventions but little evidence of sustained, targeted support. These issues contributing to the escalation of needs and risks in children and young people's lives.

Complexity of needs and adversity: The evidence review, and case file analysis build the evidence that children and young people deprived of their liberty often have multiple overlapping needs. The evidence review found a large body of literature that indicates developmental trauma and experiences of both intra, and extra familial harms contribute to significantly higher rates of adverse childhood experiences (ACEs) than the general population. Interviewees from the case studies outlined that many have unmet educational and speech and language needs and diagnosed and suspected neurodivergence (autism and ADHD).

Placement instability and market failures: The evidence review found issues of insufficient, appropriate placement options and specialist provision across residential children's homes, Tier 4 mental health, secure children's homes and specialist foster care. Case files demonstrate these children and young people often experience multiple placements across various settings, including Tier 4 Mental Health wards, secure accommodation settings and unregistered, unsuitable accommodation. The evidence review notes findings of the Office of the Children's Commissioner on the high costs and 'very high profits' being made by some providers on placements not registered to provide care and support to children and young people (CCO 2024b).Leaders of the development of all 3 case study homes were aiming to reduce spending on costly, unsuitable, out of area placements and to avoid subsequent costs as a result of achieving better outcomes.

The evidence review and case file analysis found that some children and young people who are the subjects of DoL applications may come into local authority care a relatively short time before the application is made, often at a point of crises. Interviews at case study sites and evidence in the review suggest that professional anxiety fuels crisis decision-making in which the deprivation of liberty appears the only means to keep a child or young person safe.

For others, repeated care placement breakdowns and delays exacerbate instability and behavioural issues. Case files and evidence reviewed foreground that access to appropriate mental health support, either when stepping down from, or when needs are deemed to fall just below Tier 4 mental health provision as a key issue.

Evidence reviewed demonstrates that that sufficiency issues lead to placements in unregistered settings, sometimes far from home (e.g. CCO 2024a). While immediate risks may be allayed, case file and evidence review illustrate the use of DoLOs in settings run by inexperienced staff without clinical supervision and insufficient planning for or access to for therapeutic input once stabilisation is achieved. These sources illustrate that the purpose of the DoL order is often unclear, particularly in relation to long-term recovery and that restrictions on liberty often remain unchanged or increase over time, with limited step-down planning.

Evidence on developing appropriate provision

Consistent themes may be drawn from the studies identified in this project's evidence review and in particular from 2 sets of evidence-informed principles designed to inform the development of provision to meet the needs of children and young people with complex needs who may be subject to deprivation of liberty. These are the NFJO principles of care for children with complex needs and circumstances (Bevington et al., 2023[1]); and the NHSE/Anna Freud Centre Framework for Integrated Care (Rogers et al., 2024.; see also Taylor et al., 2018[2]). Drawing on these two sources, and the evidence in our systematic review of literature, summary evidence-informed principles for improved provision:

Multi-disciplinary leadership and trauma-informed collaboration between health and social care leaders in particular. The evidence underlines that redesigning multi-disciplinary, cross-system responses requires 'bold and brave leadership to radically restructure how resource is allocated and organised' (Capacity, 2024) and a commitment to long term collaboration and cultural change.

The case study site interviews and document analysis show that Initiatives to develop specialist residential provision takes time. To agree governance and funding arrangements, to locate and develop suitable properties, to emerge from entrenched positions and build relationships that allow local leaders to work through the anxieties about risk that are so prevalent in the sector discourse. The 3 case study homes demonstrated the value of joint health and social care funding, though all 3 face challenges around sustaining funding arrangements.

[1] Five principles of care intended as a guiding framework to support changes to ways of working, services and provision to better meet the needs of children with complex needs and circumstances, including those subject to Deprivation of Liberty Orders.

[2] The NHSE-led response to the Long-Term Plan commitment to invest in services for children and young people with complex needs. Since 2021, 11 local areas have been funded as Vanguards for the Framework for Integrated Care (Rogers et al., 2024), The Framework provides a set of evidence-informed principles and practices intended to catalyse integration of services for children and young people in some of the most complex situations with versions for the secure estate (SECURE STAIRS) and for community settings.

Enabling stable, respectful relationships between children and young people and well supported and appropriately developed care home staff. The 3 local authority-led homes all appeared to demonstrate alignment with the principles of care for children with complex needs. For instance, a shared commitment to stabilisation, recovery, and keeping children local. The essential role of clinical expertise, both to children and young people themselves and to the support and professional development of the care home staff involved in day-to-day care was foregrounded. In one of the homes, data provided suggested that workforce development in relationship-based and trauma-informed care showed Improved child-staff relationships, reduced behavioural incidents and improved emotional climates in homes.

Holistic, psychologically informed care. The use of Formulation to produce co-owned narratives and tailored planning and intervention is particularly foregrounded. Formulation was described by one case study interviewee as 'the glue that holds everything together'. Interviews at all three sites noted that Formulation offered a positive vehicle for creating shared narratives with children and young people, families, and professionals that guides tailored care planning and the application of evidence-based therapeutic interventions.

As noted in the thematic overview, a range of local authority and local health partnerships have developed bespoke residential homes designed to offer therapeutic care in less restrictive environments, reduce reliance on out-of-area and unregistered placements and provide step-down pathways to family reunification or lower levels of care. Evidence reviewed and the principles of care (as above) underline that embedding new provision within the mixed economy of placement types rooted in local context is essential. The evidence review found international evidence that offered further examples of transitioning from large secure units to small-scale, integrated care, community-based facilities.

The Children's Wellbeing and Schools Bill (2025) aims to provide measure for regulation and oversight of the placement market, further support for regional commissioning of care and legislative changes to enable further development of specialist care and accommodation for children with complex needs. Ofsted's 2025 update to the Social Care Common Inspection Framework (SCCIF) is intended to encourage providers to accept children with high or multiple needs.

Context, caveats and limitations

Where do we understand complexity to lie?

In recent years, the conceptualisation of children and young people 'with complex needs' (Ofsted, 2024b) has been nuanced by descriptions such as 'children with complex needs and circumstances' with 'multiple, overlapping difficulties' (Bevington et al., 2023, p. 2) or 'in complex situations' 'with multiple needs' (Rogers et al., 2024). Children 'in complex

situations with multiple needs' is also the term used in the title of the DfE-led task and finish group focused on these issues.[3]

These phrases locate complexity, not as something situated within individual children and young people themselves, but in the fact that their needs and circumstances bring them into multiple and often poorly coordinated interactions with fragmented health, social care, education and justice systems and structures. To quote Bevington et al. in full:

> We use the phrase 'children with complex needs and circumstances' to refer to children with multiple, overlapping difficulties that are not being met by the services and systems collectively responsible for their care and safety. This includes the many children who are deprived of their liberty due to concerns about their well-being, and who are placed in unregulated settings because there is nowhere else for them to go. These children have multiple emotional and behavioural needs that are often associated with experiences of early and ongoing childhood adversity (such as abuse and neglect, but also poverty and racism) and complex trauma. There may have been repeated failures by children's services, mental health services and education services to provide them with effective help. The children's behaviour may cause significant risk to others (e.g. physical aggression) and to themselves (e.g. self-harm), which is very challenging to manage at home and in residential settings. They often have overlapping difficulties with mental health, emotion regulation, neurodevelopmental conditions (e.g. autism and ADHD), risk of exploitation, and missing education. It is often the combined impact of these multiple, intersecting (and mutually synergistic) needs – rather than the impact or 'severity' of any individual risk factor – that increases a child's vulnerability, and that systems struggle to effectively respond to. *Bevington et al., (2023, p. 2)*

The root causes of a situation in which systems under pressure are failing to meet the needs of children and young people, both before and when they escalate to this highest level of concern, are in themselves complex. Lord Darzi's independent investigation of the NHS in England foregrounds the fact that all key social determinants of health have been moving 'in the wrong direction over the last 15 years' resulting in 'rising demand for healthcare from a society in distress' (Darzi, 2024, p. 2). The evidence underlines that redesigning multi-disciplinary, cross-system responses cannot be solved by 'tinkering around the edges: it needs bold and brave leadership to radically restructure how resource is allocated and organised' (Capacity, 2024) and a commitment to long term collaboration and cultural change.

[3] https://www.gov.uk/government/groups/improving-cross-sector-support-for-children-in-complex-situations-with-multiple-needs-task-and-finish-group

Increases in acuity of needs

The evidence reviewed regarding the experiences of these children and young people describes multiple and overlapping social and emotional needs and underlying mental health and neurodevelopmental conditions. The evidence draws out associations between presenting behaviours in relation to developmental trauma resulting from maltreatment within the home, extrafamilial risk and harm, and the experience of poverty and discrimination. Growing up with some or all their needs unrecognised or unsuccessfully responded to, despite numerous interactions with universal, targeted and statutory services, means presenting behaviours escalate towards levels of risk or actual harm that are deemed to require the deprivation of liberty.

These factors are by no means unique to the lives of those subject to or at risk of a DoL order; these are common aspects of the lives of children and young people with statutory social work involvement and care experience. The impact of austerity policies on universal and targeted early help and prevention resources over recent decades has radically curtailed means to prevent such escalation of need, risk and harm (Research in Practice, 2022), while the simultaneous impact of austerity with the pandemic and its aftermath on children, young people and their parents (ADCS, 2025) increased the pressures on what is often described as a system in crisis. On children and young people's health needs, Darzi (2024) makes the overarching point that although they make up 24% of the population, children and young people account for only 11% of NHS expenditure. Darzi notes the deterioration in children and young peoples' mental health in recent years, the year-on-year increases in referral rates, and the great numbers of children and young people on long waiting lists for mental health services.

There is also evidence of longstanding fault lines which fragment and delay responses at earlier stages in children's involvement with services. One core example is the issue of access to child and adolescent mental health services (CAMHS) for children and young people with social work involvement in their lives (Mannes et al., 2024). National recommendations on increasing access to evidence-informed mental health provision for children in care (Hiller et al., 2025) offer clear guidance on improving access to mental health services and therapeutic support.

Regulation and registration of placements

The **Care Standards Act 2000** requires that all children's homes (including secure settings) are registered with Ofsted as the regulatory authority. Where children's homes provide health care that falls within the scope of activities regulated by the Care Quality

Commission (CQC), the requirement is that they are regulated and registered by both Ofsted and CQC.[4]

Since 2021, there have been changes in law and regulatory regimes in regard to placement options for children and young people. In the course of this project, literature published from 2010 onwards was reviewed and case file reviews and interviews conducted. Both the literature and the histories of many of the children and young people described in the case files go back beyond the changes in regulations that came into force in 2021 and 2023 and which are outlined here.

- **The Care Planning, Placement and Case Review (England) (Amendment) Regulations 2021 (SI 2021/161),** which came into force in September 2021, made it unlawful for local authorities to place children under the age of 16 in what were then known as 'unregulated' 'independent' or 'semi-independent' accommodation.[5] As a result, children in care aged 15 and under must always be placed by local authorities in settings where care is provided and are registered as such.

- **The Supported Accommodation (England) Regulations 2023 (SI 2023/416) introduced April 2023.** Supported accommodation is intended for 16- and 17-year-old looked-after young people 'who have relatively high or increasing levels of independence, who are ready to gain further skills in preparation for adult living, and who do not need or want the degree of care or type of environment provided in a children's home or foster care' (DfE, 2023a). These regulations made it mandatory (from October 2023) for those providing supported accommodation to young people aged 16 and above to be registered with Ofsted and to adhere to a set of Quality Standards.

The DfE's position is as follows: An establishment is a children's home 'if it provides care and accommodation wholly or mainly for children' (Care Standards Act 2000). All children's homes must be registered with Ofsted.[6] If a child is deprived of their liberty in a

[4] See the joint guidance Children's homes and health care: registration with Ofsted or CQC (Ofsted & CQC)

[5] The regulations set out a list of placement settings that were permitted for under 16-year-olds as 'other arrangements': a care home; a hospital; a residential family centre; a school providing accommodation that is not registered as a children's home; or an establishment that provides care and accommodation for children as a holiday scheme for disabled children.

[6] In mid-2025 Ofsted is dealing with an extremely high volume of applications, particularly for children's homes and supported accommodation. As a result, Ofsted is unlikely to meet usual timescales for many new applications. See Ofsted's updated (June 2025) guidance Children's social care: when and how to register with Ofsted.
Ofsted has a legal duty to decide whether to register or refuse an application to register. If Ofsted decides to refuse an application, Ofsted issues the provider with a notice of proposal to refuse. The provider can then appeal that decision, via written representations. If Ofsted does not uphold the appeal, Ofsted issues a notice of decision to refuse. It is at this point that people connected to the application are disqualified.

setting, they will very likely be receiving care and accommodation. This means that any setting where a child is deprived of liberty must register with Ofsted under the Children's Homes (England) Regulations 2015. This has been the case both before and since the Supported Accommodation regulations listed above came into force. It is for Ofsted to determine whether or not any placement/provider requires registration.

Across all strands of this project – interviewees, case file documents, case law and published research and policy documents – there are examples of the terms 'unregulated' and 'unregistered' being used somewhat interchangeably. There are a number of ways in which confusion arises in relation to these terms:

- some of the sources on which we report use these terms with reference to placements **that occurred before the changes in regulations** in what were previously known as 'unregulated' 'independent' or 'semi-independent' accommodation

- in some instances, interviewees and the social workers who wrote the case records we examined **may use these terms interchangeably and sometimes incorrectly**

- case law, case files and judgments include examples of children and young people on DoL orders being placed in 'unregistered' settings which:

    - may be provision that should be registered **as a children's home** and is not – for example, where an application for registration as a children's home has been made to Ofsted and a decision is pending. In such instances, it is possible that the provision might not meet the relevant requirements to be registerable as a children's home

    - may be provision for which no application to be registered as a children's home has been made, and the provider is choosing to operate as an illegal children's home rather than going through registration

    - may be a setting for which an application for registration **as supported accommodation** has been made to Ofsted and a decision is pending. In such an instance, this would be a placement setting 'other' than in a registered children's home. For young people aged 16 and 17 subject to a DoL order, a setting for which the provider seeks registration as supported accommodation will not be capable of meeting the care needs of that young person

After Ofsted has issued the notice of decision, a provider can appeal to the Third Tier Tribunal, where Ofsted's decision may be overturned, in which case they are no longer disqualified.

The evidence review and case law review below set out the evidence of the lack of available, suitable placement options in registered children's homes, secure accommodation and/or specialist mental health provision for children and young people for whom a deprivation of liberty is required. As Ofsted's National Director of Social Care has noted, local authorities often 'have to place children in unregistered homes because they cannot find a legal option that meets a child's specific needs. These children are usually placed alone, and the reason given is that they have complex needs. Many of these children are also the subject of deprivation of liberty orders' (Stanley, 2025b).

The High Court's powers under its inherent jurisdiction include the power to authorise the deprivation of liberty of children and young people. This power is one of four legal mechanisms for authorising under 18-year-olds' deprivation of liberty on welfare grounds. Legal mechanisms for secure accommodation on grounds relating to criminal justice are not included for the purposes of this research. The High Court's powers under its inherent jurisdiction only apply where the legislative powers for authorising a deprivation of liberty – SAOs (s.25 of the Children Act 1989); an order of the Court of Protection (Mental Capacity Act 2005); and detention in hospital (Mental Health Act 1983) – do not apply. The role of the High Court in relation to DoL applications is to exercise its inherent jurisdiction to ensure that any deprivation of liberty is not unlawful, whether as an unlawful detention under the common law, or a breach of Article 5 of the European Convention on Human Rights (ECHR).[7]

The evidence suggests that, for children and young people whose escalating needs have not been responded to effectively earlier in their lives, it is the lack of placement options that might be authorised by other legal routes which has driven the exponential rise in the number of applications to the High Court and to DoL orders being made in respect of placements not registered under relevant statutory regimes. Case law and judicial commentary tell the story of the judiciary grappling with the challenges this generates for local authorities seeking to protect children and young people in the absence of appropriate placement options.

Local authority procedural documents set out stringent procedures for staff to follow where there is no prospect of finding an appropriately registered placement in relation to a DoL order. These highlight the significant risks entailed for a child to be living in a placement outside of the safeguards of the relevant statutory regime.

In the context of these sufficiency issues, the use of 'stop gap' settings that would be unlikely to meet children's home registration requirements are evident in the literature. In such settings, case files reviewed for this project and the evidence review both cite examples of deprivation of liberty and use of restraint by inexperienced and

[7] President of the Family Division 2023. Revised Practice Guidance on the Court's approach to unregistered placements

underqualified staff (CCO, 2024a; Hindley, 2023; and this project's case file review). The Children and Young People's Commissioner for Scotland has raised concern about the experiences of children from England and Wales placed in residential care settings in Scotland while subject to a DoL order, including under conditions which have not fully respected their rights under the ECHR and the UN Convention on the Rights of the Child (UNCRC) (CYPCS, 2023). More generally, the evidence suggests a lack of clarity about the long-term purpose of restricting the liberty of children and young people with complex needs for welfare reasons, what is supposed to be achieved by secure placement and what, if any, focused intervention will address the presenting issues (Roe 2022; Roe et al., 2023; case study interviews for this project). In many cases, the inherent jurisdiction appears to be used as a last resort and at a point of crisis because placements that might better meet these children and young people's needs are not available (Roe & Ryan, 2023).

In summary:

- Any placement that comes within the definition of a children's home is 'regulated' even if it is not 'registered'. If a provider is not registered, rather than describe the provision as unregulated, it is actually operating on an unregistered basis.

- Since October 2023, a placement that does not come within the definition of a children's home (for instance, because it provides accommodation but not 'care') is required to be registered and is also therefore 'regulated' even if not (at a point in time) 'registered'.

- A provider who provides both care and accommodation wholly or mainly for children must register as a children's home. If a child or young person is not ready for supported accommodation at the point of referral, Ofsted would not expect a provider to accept the referral. As such, any provider registered with Ofsted as a supported accommodation provider but who then accepts the placement of a child who is deprived of their liberty is very likely to be operating as an unregistered children's home.[8] In the face of the sufficiency issues outlined, the question remains as to where children or young people should be placed when no appropriately registered provision is available.

Local, regional and national initiatives to address these issues

Significant initiatives and innovative developments in response to these challenges are being led at local and regional levels and by national bodies, and these are outlined

[8] Ofsted currently has the power to investigate unregistered provision, acquire evidence from the premises and prosecute where appropriate. Regulation is being strengthened through proposed new powers, set out in the Children's Wellbeing and School's Bill, to allow Ofsted to issue monetary penalties on children's social care providers, including to those found to be running unregistered children's homes.

below. There is a great deal to be learned from local and regional initiatives, which are unevenly spread across the country. Some, but not all, have associated funding for evaluative research. Mapping these activities would build the national picture and bringing stakeholders together to share experience and expertise will mitigate the risk that inequity of provision for these children and young people might increase as some local areas move forward at pace.

National Stakeholder Task and Finish Group. In 2023 a cross-sector Task and Finish Group (TFG)[9] was established, co-chaired by DfE and NHSE, with the aim of improving outcomes for children and young people who are 'in complex situations with multiple needs' and who are currently, or at risk of, being deprived of their liberty. The TFG 'vision' is set out in its terms of reference (DfE, 2023b):

> To improve how system partners work together to support and improve outcomes for children and young people who are currently (or at risk of) being deprived of their liberty and who are in the most complex situations, by ensuring that there is an aligned cross-government approach to design, commission and deliver the best possible model of integrated care (children's social care, health, education and youth justice), supported by key stakeholders. – *Department for Education (2023b)*

National Stakeholder Council. The purpose of the Stakeholder Council is to engage and communicate with stakeholders on the development of cross-sector approaches. The work undertaken on behalf of the Stakeholder Council was driven through a smaller cohort of members called the Active Stakeholder Council.

Peer Collaborative. Since August 2024, a peer collaborative has brought together 7 local areas, all of which are testing better ways to respond to children in complex circumstances. The collaborative's members have taken a variety of approaches, including local provider collaborative; social care, mental health and third sector joint commissioning; and initiatives within a Regional Care Cooperative pathfinder area. The group met 6 times between August 2024 and June 2025; its activities have included shared learning on developing relationship-based commissioning and joint funding arrangements; journey mapping for children and young people in complex circumstances; learning on common challenges, such as managing risk within current regulatory frameworks; developing a Case for Change.

Children's Homes Capital Funding

In 2021, the DfE introduced a £259 million capital funding programme to support local authorities to increase children's home capacity. In the 2024 autumn budget the department

[9] https://www.gov.uk/government/groups/improving-cross-sector-support-for-children-in-complex-situations-with-multiple-needs-task-and-finish-group

secured a further £90 million of capital funding for 2025-26 to continue and expand the programme. This enabled the launch of a further capital funding competition for the development of provision to meet the needs of the same group of children and young people (as defined in the NFJO analysis: Roe & Ryan, 2023, p. vi) that this research was commissioned to focus on: children with multiple complex needs often recognised to be a response to complex and ongoing trauma.

As the findings of this project demonstrate, these children and young people often experience multiple placements across various settings, including Tier 4 Mental Health wards, secure accommodation settings and unregistered, unsuitable accommodation at 'eye-watering'[10] costs.

Applications to the funding competition were submitted in February 2025, and in July 2025 the £53 million match funding investment from the government to create 200 new placements across 49 local authorities was announced.

Local and regional initiatives: The peer collaborative, the 49 successful applications for capital funding and the three case studies' sites described in this report are illustrative of a plethora of local and regional integrated health and social care initiatives aiming to develop provision to meet the needs of these children and young people. Examples of regional or sub-regional collaborative work to build the 'case for change' include work commissioned by the North West ADCS and partners (Capacity, 2024) and by the London Innovation and Improvement Alliance (LIIA).[11]

Given the significant health care needs of this cohort, these developments require that local health and social care systems work together on integrated care planning, joint funding arrangements and issues of building trust and sharing risk, informed by evidence on providing quality care and shared workforce development.

There is much to be learned from these initiatives; collation and sharing of examples of the high-quality scoping and business case development would be of value in building momentum for equitable provision across the country.

NHSE Vanguard initiatives: The NHSE-led response to the Long-Term Plan commitment to invest in services for children and young people with complex needs. Since 2021, 11 local areas have been funded as Vanguards for the Framework for Integrated Care (Rogers et al., 2024), The Framework provides a set of evidence-informed principles and practices intended to catalyse integration of services for children and young people in some of the most complex situations with versions for the secure estate (SECURE STAIRS) and for community settings.

[10] https://www.gov.uk/government/news/new-action-to-tackle-illegal-and-exploitative-childrens-homes
[11] Pan-London Secure Children's Home (SCH) and Pan-London Vehicle for Children's Complex Commissioning (PLV) programme https://www.liia.london/londons-secure-childrens-home-and-plv/

Legislative change: Provisions in the Children's Wellbeing and Schools Bill will provide a statutory framework to authorise the deprivation of liberty of children via s.25 of the Children Act 1989 in settings provided for the purpose of treatment and care, while also being capable of depriving liberty where needed to keep them safe. Specific requirements for these homes will be laid out in regulations in due course. In conjunction with capital funding and a range of other practical steps to support local authorities, this legislative change will increase placements of children in registered accommodation which meets their needs, under a statutory mechanism.

Thematic summary of the project findings

The current situation

Too many children are being deprived of their liberty because of our shared failure to meet their needs and keep them safe in the community

The case law review sets out the detail on the legal frameworks for the deprivation of liberty of children and young people under the age of 18. The evidence review drew data from a range of sources on each of these legal pathways to show that in the year 1 April 2023 to 31 March 2024:

- 963 children and young people were detained under the Mental Health Act 1983 (NHSE, 2024)
- 221 children and young people were subject to applications for a secure accommodation order under Section 25 of the Children Act 1989
- an unknown number of 16- to 17-year-olds were detained under the Mental Capacity Act 2005 (these data are not published in national statistics). In the previous year (2023), it was estimated that approximately 156 orders were made (CCO, 2024a)
- 1,259 children and young people were subject to applications for deprivation of liberty under the inherent jurisdiction of the High Court (MoJ, 2024).

As this 12-month picture and subsequent year's data (MoJ, 2025b; NFJO, 2025) demonstrate, deprivation of liberty under the inherent jurisdiction of the High Court, once seen as a last resort for children whose needs could not be met in any other secure setting, has become the most common legislative route for deprivation of liberty of under 18-year-olds in England. While children and young people deprived of their liberty in England 2023/24 across all these legal frameworks are a relatively small group (c. 2,500) when compared to the total number of children in the care of local authorities (c. 84,000 in 2023/24), the data set out above suggest that significantly more are now at risk of or

subject to restrictions on their liberty due to welfare and mental health concerns than was the case a decade ago.

This project's findings align with a range of other research which shows that both prior to and at the point at which a deprivation of liberty is considered, a lack of early intervention, early mental health and social care support is evident (Greatbatch & Tate, 2020; Ofsted, 2022a, 2024b; Roe, 2022; Roe & Ryan, 2023; Williams et al., 2020, 2024). Some of these children and young people come to the attention of children's social care and enter the care system a relatively short time before the DoL order application, at a point of serious crisis in relation to issues of exploitation, significant self-harm and trauma (ADCS, 2025). It is also true that for most of the children and young people described in the limited case file analyses that we have (Roe & Ryan, 2023; this project's case file analysis), there are long histories of service involvement in their lives and little evidence of sustained, targeted and effective intervention to respond to a range of presenting issues.

Most children and young people come into (or in and out of) care at increasing levels of crisis (Roe et al., 2023). In care, they have often experienced multiple placement breakdowns and delays in identifying suitable placements. Such disruption and instability exacerbates mental health and issues, and as needs escalate, availability of appropriate therapeutic interventions in suitable placements is insufficient. There is a growing body of strong evidence on the unmet mental health needs of children and young people with social work involvement in their lives; access to effective mental health support is frequently refused on the grounds that their needs are 'social' rather than mental health related (Morgan et al., 2025). There are also new and comprehensive recommendations on increasing access to evidence-informed mental health service provision for children and young people in care (Hiller et al., 2025).

It is in the face of what the Supreme Court recognised as a 'dangerous inadequacy' (Re T (A Child) [2021] UKSC 35)[12] of suitable provision for these children and young people that local authority applications to the High Court to authorise the deprivation of a child in care's liberty have risen exponentially. This insufficiency drives the use of bespoke placement in settings other than registered children's homes, often as a holding position in which children and young people may wait months for a suitable placement (Ofsted, 2024b).

Beyond immediate aims of providing safety from harm to self or others and aiming to 'stabilise' the child or young person, there is confusion about the purpose of deprivation of liberty under a DoL order and how and when to enact them.

[12] https://www.supremecourt.uk/cases/uksc-2019-0188#judgment-details

- some interviewees in this project's case study of children's homes fieldwork had found that a DoL order would authorise placement closer to home, be more age appropriate and less institutional environment than placement in a secure unit might offer
- when compared to other legal routes to deprivation of liberty, the 'permissive' nature of a DoL order was seen by some interviewees at the case study homes to allow the flexible use of deprivations of liberty in response to needs and behaviours, providing the potential to manage behaviours in the least restrictive way
- however, care that is genuinely applied at the least restrictive level viable was seen by the interviewees to require high levels of clinically informed support for staff and close, frequent oversight and management. These elements were seen as vital in order to keep the child or young person's needs in focus and adapt responsively to escalation or de-escalation of behaviours and risk. Where a DoL order was seen to have enabled a period of respite, safety and relative stability, supportive factors appear to be where the children or young people were cared for by trained staff who were consistent and available to form trusting and reliable relationships
- conversely, the evidence review suggests that restraint may be used more frequently to manage children and young people's behaviour in inappropriate settings or by inexperienced staff. In their report, the CCO highlights that for all the children they interviewed who had experienced restraint, this reduced significantly when they moved to a more appropriate placement and with the introduction of an experienced, child-centred care team (CCO, 2024a). A survey of staff in forensic child and adolescent mental health services (FCAMHS) highlighted concerns about the quality of care being provided to children in unregistered settings, in particular that there was over-reliance on the use of physical restraint as staff were inexperienced and underqualified in caring for children with complex needs (Hindley, 2023)

As noted in the introduction, initiatives are underway in regard to developing alternative community provision and a new statutory framework in order to move beyond the 'imperfect stop gap' (Re T (A Child) [2021] UKSC 35) that the DoL order legal route provides; the case studies chapter (chapter 4) describes 3 positive examples of improved provision, and there are many more examples around the country of such provision either in development or awaiting funding decisions.

It is important to note, as interviewees at all these 3 case study homes did, that such provision must be embedded in functional local and national systems of health and social care that identify and address needs much earlier in the course of children and young people's lives and provide 'step down' routes into other forms of care, including

supported return home to family where appropriate. Since many of these young people are close to legal adulthood, it is essential that account is taken of system requirements to meet their needs as they 'age out' of children's services support.

The reasons for lack of sufficient placement options are multiple and complex

Under s.22G of the Children Act 1989, local authorities in England have a duty to ensure, so far as reasonably practicable, that they are able to provide looked-after children with accommodation that meets their needs and is within the authority's area (so far as this is consistent with the child's welfare).

There are sufficiency issues across the range of placement options for children and young people in care (Ofsted, 2022b). Foster care households and carers have been decreasing for a number of years and while the numbers of approved family and friends foster carers are increasing, numbers of foster carers are at a ten-year low (Ofsted, 2024a). As a result, matching children to the right carers, close to home, becomes increasingly difficult, and instability, placement moves, and the compounded trauma contributes to escalating behavioural concerns.

While the number of children's homes of all types has increased over the last 10 years, provision has not kept pace with demand for placements for children and young people with increasingly complex needs (Revolution Consulting, 2023).

Sufficiency across the three types of secure provision

Children's homes: Residential care homes are unevenly distributed across the country. At 31 March 2024, private companies ran 83% of children's homes and provided 77% of places, while local authorities ran 13% of homes and provided 16% of places. In the past 5 years there has been a 70% increase in private-sector homes, a 10% increase in voluntary-run homes and a 7% increase in homes run by local authorities (Ofsted, 2024c).

As demand has increased, competition for placements has driven up costs well above rates of inflation, as the Competition and Markets Authority (CMA) highlighted in its market study (CMA, 2022). Local authority budgets, already under pressure, are further stretched in the face of 'the largest private providers of placements … making materially higher profits, and charging materially higher prices, than we would expect if this market were functioning effectively' (CMA, 2022). This hampers authorities' ability to fulfill sufficiency duties set out in the 1989 Children Act.

The CMA work fed into the independent review of children's social care (MacAlister, 2022), which recommended action. In 2024, the DfE launched the Market Interventions Advisory Group (MIAG). The Terms of Reference for the MIAG are to support DfE in their work to prevent profiteering in the children's social care placements market; to boost the

amount of placement provision available to provide more suitable placements for children in local authority care; to diversify the market to encourage greater involvement from local authorities, the voluntary sector and social investors and to stabilise the children's social care placements market and improve its resilience to market forces and possible shocks[13]).

In 2025, the current government has included measures in the Children's Wellbeing and Schools Bill to improve the regulation of the placement market, support regional commissioning of placements and to amend primary legislation in order to create a statutory framework to 'enable the system to deliver specialist care and accommodation for children who have complex needs' (DfE, 2024b).

Directors of children's services (ADCS, 2025) and children's home managers (Greatbatch & Tate, 2020; ICHA, 2019; Ofsted, 2024b) report provider concerns that accepting children with complex needs could negatively affect the home's Ofsted inspection judgement. When interviewed in 2024, directors of children's services made repeated reference to care providers giving 'immediate notice' when a child or young person's behavioural issues intensified, contributing to the perspective that the regulatory framework might be creating or exacerbating barriers to meeting the best interests of children and young people (ADCS, 2025). In April 2025 Ofsted updated the social care common inspection framework (SCCIF) with the intention to 'encourage more providers to look after children with high or multiple needs' (Stanley, 2025b).

An inquiry into the drivers of high-cost placements published since our evidence review was conducted (Coady & Karpf, 2025) noted that the recently introduced regulation of the supported accommodation sector may be leading to unintended consequences. Those interviewed for this research reflected that, in the context of the lack of suitable placements for children and young people with complex needs, registration may be leading to increased but misplaced commissioner confidence to accommodate young people with complex needs in supported accommodation. This is concerning in that (as set out above) supported accommodation for young people with complex needs may well be both unsuitable and potentially unlawful, in that these providers would be operating as unregistered children's homes.

Coady and Karpf (2025) looked in detail at the journeys of 7 children and young people into highest cost placements. The average annual placement cost was £901,501. These 7 shared complex profiles of needs and behaviour, such as self-harm, risk-taking, diagnosed and suspected neurodivergence (autism and ADHD), learning and mental health needs. All were in private sector provision, and 5 of these were not registered children's homes. The expectation expressed by professionals was that 6 of the 7 would

[13] https://www.gov.uk/government/groups/childrens-social-care-market-interventions-advisory-group

be long-term placements, despite the fact that 5 of them were made as emergency placements.

Placement costs of this magnitude mean that some local authorities are identifying the entirety of their overspend on children's social care as being on high-cost placements for children and young people with increasing complexity of need (Coady & Karpf, 2025).

Secure children's homes. The supply of approved places has decreased over recent years. At 31 March 2021 there were 17 homes and 311 approved places. At 31 March 2025 there are 14 homes and 235 approved places, of which 102 are contracted to the MoJ for youth justice placements.[14]

Demand for secure welfare beds significantly outstrips supply, and far more children and young people are referred for a place in a SCH than are placed. Analysis of data from the Secure Welfare Coordination Unit (SWCU) shows the proportion of children and young people successfully placed in SCHs has declined since 2019, and that just 1 in 2 children referred were found a place in 2020 (Downie & Twomey, 2021; see the evidence review chapter for detail). Factors cited by SCHs as reasons not to accept a referral included concerns about the capacity of the home to manage needs relating to violent behaviours, self-harm or suicidal intention, high drug use, mental health problems, offending, and/or frequent absconding (Williams et al., 2024).

Mental health inpatient provision. The overall number of NHS inpatient mental illness beds has declined at a rate of around 23% since 2010/11 in line with the policy ambition to move care out of hospitals and into the community (BMA, 2025). Reductions in children and young people's mental health inpatient bed numbers over the last 10 years have occurred alongside plans to develop inpatient services and community alternatives to Tier 4 beds. Work continues to enable care to be delivered close to home, in the least restrictive setting and to make best use of the resource to meet children and young people's needs.[15] Nevertheless, the pace and scale of these developments has not filled the gap generated by bed closures and the increased demand for mental health treatment for children and young people. This deficit contributes to the situation in which children's social care services are required to find and fund provision for children who might otherwise have been in mental health facilities (Ofsted, 2024b).

Finding suitable placements for children and young people with mental health difficulties that are deemed to be just below the Tier 4 threshold for mental health inpatient support, and for those discharged from an inpatient service, is particularly challenging (CCO, 2024a; Ofsted, 2024b; Roe & Ryan, 2023). A significant gap in provision occurs for

[14] https://explore-education-statistics.service.gov.uk/find-statistics/children-accommodated-in-secure-childrens-homes/2025
[15] NHS England – Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/

children and young people whose emotional difficulties and harming behaviours are judged to be the result of development trauma and/or attachment difficulties and not attributable to a diagnosable mental health disorder (Roe & Ryan, 2023). For those who have been in hospital due to mental health concerns, DoL orders may be sought in relation to a 'step down' placement (Roe & Ryan, 2023). Here again, sufficiency means that children and young people in hospital may spend many months awaiting discharge to a suitable community placement, despite no longer meeting the criteria for detention.

Characteristics and circumstances of children and young people with complex needs who are, or are at risk of being, deprived of their liberty

The summary information in this section draws from sources referenced in full in the evidence review and case file analysis chapters of this report.

Age

- Children and young people subject to DoL applications are mostly teenagers. MoJ latest data show 57.3% applications were for children and young people aged 13 to 15, 32.3% were for 16 to 18-year-olds, and 1 in 10 were in respect of children aged 12 or younger (MoJ, 2025a).

- This project's case file review shows broadly similar findings. All 21 children and young people[16] were aged between 13 and 17 when the DoL application was made (or considered), and most (i.e. 13 of the 19 whose precise age at application was clear from their records) were aged 14 or 15.

- This is broadly consistent with those deprived of their liberty through other routes. Three-quarters (74%) of those living in a SCH (for both welfare and justice reasons) on 31 March 2024 were between 15 and 17 years old (DfE, 2024a). Studies suggest that the majority of those referred for welfare reasons are aged 14 to 16 (Downie & Twomey, 2021; Williams et al., 2020).

- Official statistics show that 7 in 10 children and young people detained under the Mental Health Act between 1 April 2023 and 31 March 2024 were aged either 16 or 17 (NHSE, 2024).

Gender

- Roughly equal numbers of boys and girls are subject to DoL applications. The latest MoJ data (published since the evidence review was conducted) shows that

[16] In the case file review, 18 of the 21 children and young people had been subject to a DoL order; for the other 3, a DoL application had been strongly considered, but ultimately no application was made.

in 2024, 51.5% of DoL applications were in respect of girls, and 48.4% related to boys (MoJ, 2025a).

- Girls significantly outnumber boys (16 girls, 5 boys) in this project's review of 21 case files. This high proportion of girls in the sample may be an unintended consequence of the criteria applied in selecting the sample files.[17]

- MoJ data show a small number of children and young people who identify as 'other' than either female or male. In 2024, this was 0.2% (MoJ, 2024, 2025a), but in Roe and Ryan's (2023) analysis of applications over a 2-month period (July to August 2022), 7 of the 208 (3.4%) children and young people identified as transgender or non-binary. The Cass Review (2024) noted the heterogenous, complex needs of children and young people referred to the NHS Gender Identity Service and the need for 'greater integration to meet the wide-ranging needs of complex adolescents' (Cass, 2024, p. 230).

- From the evidence we have, reasons for DoL applications may differ for boys and girls. Concerns around sexual exploitation, self-harm and mental health appear to be more common in relation to girls; criminal exploitation, disability and behaviour deemed to be a risk to others are cited more often for boys. (Roe & Ryan, 2023).[18]

- Such differences reflect the gendered pattern of entry into the secure estate more generally. Many more boys than girls end up in the youth justice system (Hales et al., 2018; Roesch-Marsh, 2018), for example, while many girls in the welfare system present with challenging behaviours.

- The ratio of girls to boys referred for places in SCHs is broadly equal. As with DoL applications, some studies point to gender differences in the needs of children for whom secure accommodation orders are sought. Khan et al.'s (2021) analysis of SWCU data found that at the point of admission to a SCH, girls were more likely to have identified needs relating to self-harm (70.4% vs 27.6%) and sexual exploitation (87.6% vs 24.9%), for example. Differences in recorded need are likely to reflect, at least in part, gendered biases in how children and young people are perceived by services (Bartlett et al., 2021).

[17] In identifying cases for this review, local authorities were asked to focus on children and young people for whom consideration for a DoL application foregrounded complex behaviours relating to trauma, and not those for whom the reasons for application were related primarily to offending behaviour or disability-related support.

[18] Although Roe and Ryan's (2023) study is the only one to look at needs relating to children subject to DoL applications (most studies focus on children and young people in or referred to SCHs), it is a relatively small study (208 children and young people) which took place over a 2-month period. Findings should therefore be treated as illustrative rather than definitive.

- Girls detained under the Mental Health Act outnumber boys by around 2 to 1. Between April 2023 and March 2024, nearly two-thirds (63.3%) of the 883 children and young people detained under the Act were girls (NHSE, 2024).

Ethnicity

- The ethnicity of children and young people subject to DoL orders is not covered by national data, and action by both MoJ and DfE to collect and publish ethnicity data on children and young people subject to DoL applications and orders is needed. DfE are exploring adding a module on deprivation of liberty into the SSDA903 data collection (which is the main route through which statistics on looked-after children are collected and published). This data would only concern children who are looked after and deprived of their liberty by the local authority as the corporate parent.
- Roe and Ryan's (2023) analysis of the 208 applications to the national Deprivation of Liberty Court during its first 2 months of operation in 2022 suggest a possible overrepresentation of some ethnic groups.
- Of the 21 children and young people in this project's case file review (which cannot be considered a representative sample), 12 (57%) were from white backgrounds, and 9 (43%) were from Global Majority and multiple heritage backgrounds.

Official statistics also show overrepresentation of some ethnic groups elsewhere in the secure estate. Children and young people of Black and Mixed ethnicity are overrepresented among those referred to SCHs (Downie & Twomey, 2021; Roe, 2022; SWCU, 2024; Wood et al., 2024; Williams et al., 2020). In 2023, 60.4% referrals were for children of white British ethnicity (SWCU, 2024); the second most frequently recorded ethnicity was 'White and Black Caribbean' (9.56% respectively), with a further 15 ethnicity categories recorded in these data.

NHSE publish annual data about the ethnicity of children detained under the Mental Health Act. Data for 2023/24 show that children from Black, Mixed and Asian ethnic groups were overrepresented (66.8% of children were of white ethnicity, 11.2% Black, 9.3% Mixed, 7.1% Asian, and 5.5% Other) (NHSE, 2024).

Children and young people's previous involvement with services

Placements

Children and young people subject to DoL applications

Most of the children and young people subject to a DoL application in Roe and Ryan's study were living in a care placement at the time of the application. Nearly half of these

were in a residential children's home. Among the others: 21 (10.1%) were in hospital, usually on a general ward usually because of mental health concerns or self-harming behaviour; 35 (16.8%) were in an unregistered placement (i.e. a setting that was providing care but was not registered as a children's home); 18 (8.7%) were in supported accommodation;[19] and 12 (5.8%) were in secure accommodation (Roe & Ryan, 2023). When a DoL order was sought for a child or young person already in secure accommodation, this was usually because the child no longer met the criteria for secure accommodation (under s.25 of the Children Act 1989) or to support a transition into the community. In some cases, however, a SCH had given notice due to the child's behaviours (Roe & Ryan,2023).

Broadly similar findings emerged from this project's case file review, with 15 of the 21 children and young people (71.4%) living away from their family in a care placement at the time of the application, most often in a residential home.

Evidence suggests that, while children and young people at risk of being deprived of their liberty frequently have long histories of service involvement (of various kinds) in their lives, they may have come into the care system within a relatively short time before the application or have recently re-entered care after a period of not being looked after (Hart & La Valle, 2016; Williams et al., 2020, 2024). In their analysis of applications to the national Deprivation of Liberty Court in summer 2022, Roe and Ryan (2023) found that just under half (44.7%) had come into care within the previous 2 years, and 1 in 5 (19.2%) had come into care in the 6 months prior to the DoL application.

However, almost all children and young people deprived of their liberty have a long history of involvement with children's social care and other services. Their records commonly show long and frequently complex histories of service involvement, often marked by an increasing intensity in the run up to the DoL application.

Both case file studies (this project's case file review; Roe & Ryan, 2023) found evidence of insufficient early help and insufficient targeted and consistent multi-disciplinary support. Evidence highlights the need for more practitioners with the appropriate knowledge and skills to work with family or carers around the behaviours and emotional dysregulation common among these children and young people.

In particular, there is evidence of the disconnect between social care and mental health services both earlier and later in these children and young people's case file records. Aspects of this include disagreements around diagnoses and needs, including the eligibility for specialist mental health care.

[19] The authors do not provide an age breakdown of the children and young people placed in supported accommodation, so it is not known if any were under age 16 (which would be illegal) at the time of the DoL application.

Children and young people referred to or in other types of secure care

For children and young people referred to SCHs in 2023, the most common placement at point of referral (35.2% of referrals) was an 'unregulated or unregistered placement' (as defined by the referring local authority) described as bespoke (often single occupancy) placements created by the local authority for the child (SWCU, 2024), followed by a registered children's home (26.0%), and semi-independent accommodation (17.2%). Others were referred from a youth custody setting, mental health inpatient unit or were already in a SCH (SWCU, 2024).

A significant number of children and young people referred to SCHs have previous experience of a secure placement. A census of all children and young people living in secure care in England (welfare, youth justice and mental health settings) in September 2016 found that almost 1 in 5 (17%) had moved from another secure establishment to their present one (Hales et al., 2018). At the time of the survey, most of those entering secure care appeared to continue along the same 'legislative path'; most children and young people in youth justice settings (60%), secure hospitals (52%), and welfare placements (23%) had a previous secure placement under the same legislation (Hales et al., 2018).

Previous involvement with services

Children and young people subject to DoL applications

The evidence suggests the vast majority of children and young people who are subjects of a DoL application have a long history of involvement with services. Of the 208 case records examined by Roe and Ryan (2023), only 10 had first come to the attention of children's services fewer than 12 months before the application was sought. Despite long histories of involvement of services, these case records offered limited evidence of sustained intervention and support in the years preceding the DoL application.

For almost all (20 of 21) of the children and young people whose case files were reviewed for this project, their records showed long and frequently complex histories of fragmented service involvement with social care, youth justice and health services, with different professional disciplines working in fixed service pathways with different perspectives on need, risk and thresholds for care. There was an overall pattern of increasing intensity of intervention for most of the 21 children and young people in the run up to the DoL application.

The records point in particular to the difficulty these children experienced in accessing CAMHS or community healthcare at earlier points in their journeys, especially in the absence of an agreed diagnosis. Children had often cycled between different care arrangements, and there was often a lack of clarity around legal planning decisions and court proceedings.

While there is no single journey with or through support services, some common patterns were discernible from this project's case file review:

- Many children and young people in our sample of 21 had experienced abuse or exploitation from a young age, often both within and outside the family.
- As well as children's social care, children and young people were commonly involved with other agencies, including mental health, police and youth justice.
- Services may well have sought to safeguard and respond to concerns about risks in the child or young person's life. But unsuccessful, inadequate or ill-targeted professional responses contributed to escalating cycles of intervention.
- Case files showed multiple single assessments, early help plans, different targeted services, children in need and child protection plans, and then escalation through voluntary, interim and full care orders. Over time, the intensity of professional involvement tended to increase, but typically this was not a linear process. Where progress was made, it tended to be inconsistent and was often hindered by children's entrenched patterns of behaviour, periods of crisis or parental disengagement.
- Children and young people displayed behaviours and emotional dysregulation associated with experiences of complex trauma, according to social workers' perspectives captured in the case files. By the time of the DoL application, children's care needs had escalated beyond what parents, wider family, foster carers or even specialist carers and settings were able to provide. In some cases, residential homes were struggling to manage the types and level of behaviours.
- The recurring theme of disconnect between social care and mental health services was evident. Very few of these social work files recorded close working between the two. In some cases, this disconnect included disagreement over whether or not a child or young person was eligible for specialist mental healthcare. This led to DoL orders as a response to violence against the self or others, where no alternative was available in a secure setting or ward. Placements under the DoL order were subject to the same limitations, with difficulty securing appropriate accommodation and skilled, experienced staff.

Children and young people's needs and the reasons why restrictions on liberty are sought

There is a wealth of evidence of far higher rates of adversity and disadvantage for children and young people deprived of their liberty than in the general population. These experiences include exposure to abuse, neglect, family dysfunction, bereavement, loss, parental separation, poverty, discrimination, and exposure to domestic violence and

problematic substance use (Andow & Byrne, 2018; Barron & Mitchell, 2018; Gibson, 2021; Hart & La Valle, 2021; Khan et al., 2021; Pates et al., 2018; Roesch-Marsh, 2014; Williams et al., 2019).

The research and interpretation of adversity underpinning the ACEs body of evidence is not without critique (e.g. Asmussen et al., 2020), in particular in its limited attention to social determinants of health. Nevertheless, the ACEs analytical frame was used in a number of studies identified in our evidence review:

- Studies in England (Harris et al., 2021; Martin et al., 2022) and Scotland (Gibson, 2020, 2021, 2022) suggest that most children and young people living in a SCH have experienced at least four adverse childhood experiences (ACEs). For example, 74% of children in secure care settings in Scotland surveyed in 2019 had been exposed to four or more ACEs before entering secure care, rising to 86% among those living in relative poverty (Gibson, 2021). In the general UK population it is estimated that 9% have experienced 4+ ACEs (Bellis et al., 2014).

- Evidence about exposure to ACEs and trauma for children and young people detained under the Mental Health Act is limited, but a case file analysis of young people in one local area who entered secure care between 2010 and 2017 suggests their experiences may differ from their peers in other secure settings, as these young people were more likely to come from families where the parents were together, less likely to be eligible for free school meals, and less likely to have witnessed domestic abuse (Andow & Byrne, 2018).

- All 21 children and young people in this project's case file review had experienced excessive and persistent levels of trauma – and in many cases, their parents had experienced trauma also. Case records described multiple overlapping difficulties, including emotional and behavioural needs commonly associated with early adversity and complex trauma.

- Records from the case file review show there are multiple grounds for each DoL application – an average of 9 factors per child. Needs, behaviours and events commonly identified in children and young people's records include mental health needs, behaviour representing a threat to others or harm to self, going missing, sexual exploitation, criminal exploitation and substance use. The evidence suggests that presenting needs are similar for children and young people subject to DoL applications and those referred to SCHs.

- Beyond an immediate need to ensure a child's physical safety while the search for suitable longer-term options continues, a lack of clarity around the purpose of depriving a child or young person of their liberty for welfare reasons was apparent. This includes confusion about whether the primary purpose is to provide short-

term stabilisation and safety only, or to address the underlying needs and circumstances that led to deprivation of liberty being deemed necessary.

Children and young people's experiences

Experiences recorded in the files of the 21 children and young people whose records were considered in this project's case file review highlight ongoing safeguarding risks that services had often been trying to address for many months or even years. Those risks strongly reflected the concerns that were then identified as grounds for the DoL application. Files identified a range of safeguarding factors both within and without the family relating to actual, or risk of, significant harm. For example:

- **Intrafamilial risks:** for 17 of the 21 children and young people there was evidence of exposure to one or more factors, including: emotional abuse (11), domestic abuse (10), neglect (9), physical abuse (5), and parenting capacity compromised by poor parental mental health (7), past parental trauma (6) or parental substance use (5)

- **Extrafamilial risks:** 15 of the 21 case records showed one or more factors including: victim of child sexual exploitation (8), sexual assault (8) or physical assault (4), associating with peers who presented a risk of harm (8), criminal exploitation (5), and frequenting areas associated with exploitation (5)

(Neither of these lists is exhaustive.)

Why restrictions on liberty are sought through DoL applications and other routes

Multiple studies (most of which focus on those living in or referred to SCHs) have shown that children and young people at risk of being deprived of their liberty have high prevalence of a range of needs and high-risk behaviours (Roe, 2022). These include needs relating to mental health concerns (diagnosed and undiagnosed problems), self-harm, aggressive or violent behaviour, sexual exploitation, criminal exploitation, offending behaviours, substance use, gang affiliation, neurodiversity, and special educational needs and disabilities.

Both this project's case file review and Roe and Ryan's (2023) analysis of the 208 cases referred to the national Deprivation of Liberty Court during July and August 2022 describe children and young people with multiple overlapping difficulties, including emotional and behavioural needs commonly associated with early childhood adversity and complex trauma. All 21 children and young people in this project's case file review exhibited signs of emotional dysregulation, anxiety and self-harm.

The application for a DoL order often occurs at a point of crisis when children and young people face risk of harm to themselves and/or others, and professionals see deprivation

of liberty as their only means of keeping the young person safe (Roe & Ryan, 2023). Beyond this response to immediate risk of harm, the evidence suggests a lack of clarity in many cases around both short- and longer-term purpose. Roesch-Marsh's (2018) study of professional decision-making relating to secure accommodation in Scotland highlighted anxiety around risk as a key factor in professionals seeking to restrict a child's liberty. The combined issues of professional anxiety and lack of clarity about the purpose – beyond immediate physical safety while seeking appropriate longer-term placement – are key aspects of the crisis decision-making. While placed under DoL order restrictions, lack of access to education, mental health and specialist therapeutic care raise significant concerns (CCO, 2024a; Roe et al., 2023).

There is some consistency in the primary reasons for considering or making a DoL order in both Roe and Ryan's 2023 analysis and this project's case file review. Factors evident across both studies include behaviour considered a risk to others; self-harming behaviours; mental health concerns; issues of both sexual and criminal exploitation.

The lack of consistent and formalised assessment measures makes it difficult to compare identified needs and concerns for children and young people placed in different secure settings. Although studies rely on different methods of data collection and cover different time periods, findings do suggest that presenting needs for children who were referred to a place in a SCH and for a DoL order are similar (Bach-Mortensen et al., 2022; Roe & Ryan, 2023).

Approaches to care. Thematic overview

Where are children placed under a DoL order?

Analysis of the legal outcome of 113 DoL order cases found that in over half of these cases, children and young people were placed in at least one setting that was not a registered children's home;[20] a third of the 113 were in registered placements throughout the 6-month period of analysis; and information about registration status was not included in the orders in 14 cases (Roe et al., 2023). Registered placements tended to be further away from a child's home area, with more than a quarter (27.1%) of these in excess of 100 miles distant (compared to 9% of unregistered placements). This suggests that local authorities may be opting to place children and young people in bespoke unregistered provision in order to keep them closer to home.

Other settings included semi-independent accommodation, CQC-registered accommodation, hospital wards and temporary rented accommodation, including hotels or caravans. Placement in settings not registered as children's homes was particularly common for children for whom the DoL order was sought due to concerns about criminal

[20] Includes children placed in what was (at the time of the research) unregulated (supported) accommodation.

exploitation, emotional difficulties, risk to others and self-harm. Most of these 113 children and young people were moved at least once while subject to a DoL order, and 16 were moved 3 or more times (Roe et al., 2023).

The Children's Commissioner for England asked all local authorities in England for information about the children looked after placed in unregistered children's homes on 1 September 2024 (CCO, 2024b). Data showed that of 775 children and young people living in unregistered placements, almost a third (31%) were subject to a DoL order. Almost half of these were placements in an unregistered house (47%) followed by supported accommodation (40%), and around 5% in holiday rentals, holiday camps or activity centres. Most of these unregistered settings were out of the child or young person's local area. Of the 15 children and young people interviewed by CCO (2024a), all but 4 were living alone with adult staff while subject to a DoL order and reported struggling with isolation and loneliness. They spoke about their unhappiness at being placed out of area and their strong desire to be nearer their family.

Restrictions on children and young people's liberty

DoL orders can authorise a range of restrictions on a child or young person's liberty, which should be set out in the application to court. The final order made by the court is permissive and specifies that restrictions authorised should only be imposed when necessary for the child's welfare.[21] Roe et al. (2023) found that in general, courts authorised all restrictions requested, with an average of 6 different types of restriction per application. Almost all children and young people were subject to constant adult supervision – including nearly a third with 3 or more adults supervising them. Restraint was permitted in over two-thirds of cases. In subsequent orders, the type and severity of restrictions on a child or young person's liberty remained the same or increased in the overwhelming majority of cases, and an absence of step-down planning was noted. Most of the children and young people in this study remained subject to a DoL order for more than 6 months – and many for over a year – with restrictions rarely being relaxed (Roe et al., 2023).

The 15 children and young people interviewed by CCO were generally aware of the restrictions imposed on them and understood why those restrictions were in place, but they felt that the extent and duration of restrictions was unjustified. In particular, the lack of a clear plan about when and how restrictions would be reduced caused frustration.

[21] This means that while the court has authorised restrictions on liberty, those restrictions are permitted and not mandatory (unlike detention under the Mental Health Act, for example, whereby restrictions are required until the responsible clinician agrees they should end). When a DoL order is in place, the local authority should impose restrictions only when they are necessary for the child's welfare. The DoL order does not prevent restrictions being reduced and specifies that the restrictions authorised by the court should only be imposed when it is necessary for the child's welfare.

Nine of the 15 had experienced restraint. For 4 of them (all of whom had autism and/or a learning disability) this was a regular occurrence (CCO, 2024a).

Evidence suggests that restraint may be used more frequently in inappropriate settings and/or by inexperienced staff. CCO noted that children and young people's experiences of restraint reduced significantly after they moved to a more appropriate placement with a more experienced, child-centred care team (CCO, 2024a). A survey in forensic child and adolescent mental health services also highlighted concerns about over-reliance on the use of physical restraint by staff in unregistered settings who were inexperienced in caring for children with complex needs (Hindley, 2023).

There is a lack of data about the use of restraint with children and young people in SCHs for welfare reasons. In adolescent mental health inpatient settings, evidence suggests that restraint is used regularly, often as a reactive behaviour management strategy (Nielson et al., 2021).

Children's relationships with staff in the placement is consistently highlighted as a core factor in determining children's experiences of secure care (CCO, 2024a). Across the literature, consistency in children's care teams was seen as vital in supporting children to establish meaningful relationships, as well as having carers who took the time to get to know them, treated them as individuals, and had the skills and expertise required to recognise and meet their needs (CCO, 2024a; Jacob et al., 2024; NFJO, 2024). The development and support of this residential care workforce, including considerations of pay, qualifications and calibre, are crucial to the evidence-informed development of new provision under the proposed changes to s.25 of the Children Act 1989. The DfE committed to improve qualifications, standards and access to professional development for staff working in children's homes.

Transitions out of secure care

There is a lack of research on transitions from DoL orders, including an absence of data about where children and young people live once an order has expired. Children and young people interviewed by the CCO expressed uncertainty about their future, including where they would be living, their education, and when the conditions in their DoL order would come to an end (CCO, 2024a).

Interviewees in both the case study and case file sites for this project, and Ofsted's research and analysis (Ofsted, 2022b) all foreground local authorities' difficulties in finding suitable further placements for those who have been subject of a DoL order. This is also evident in research in relation to other children and young people with a history of secure care (Bach-Mortensen et al., 2022; Hart & La Valle, 2021; Roe, 2022; Williams et al., 2020, 2024). In consequence, children and young people may be placed in inappropriate accommodation or continue to be subject to restrictions on their liberty for

longer than may be necessary (Khan et al., 2021; Ofsted, 2022b; Williams et al., 2019). Such instability and uncertainty is associated with negative outcomes and feelings of rejection, abandonment and hopelessness, and can risk undoing any positive progress made while in secure care (CCO, 2024a; Williams et al., 2020). Deteriorations can in turn lead to further delays and children and young people becoming 'stuck' in the secure system (Khan et al., 2021; Williams et al., 2019). Conversely, the stark disconnect between children's and adults' legislation, policy and practice can mean that some young people lurch from being highly restricted as a result of their risks and harms to being left with little or no support. The noted fractured nature of services is very pronounced for those turning 18. (Cocker et al., 2024).

There is a lack of systematic research about children and young people's outcomes following detention in any setting.

Synthesis of principles to inform the development of community provision

Responding more effectively to the heterogeneity of children and young people's needs and their frequent experience of fragmented services requires provision that is flexible and adaptable to individual needs and circumstances. Nevertheless, consistent themes may be drawn from the studies identified in this project's systematic review, and from 2 sets of evidence-informed principles designed to inform the development of provision to meet the needs of children and young people with complex needs who may be subject to deprivation of liberty: principles of care for children with complex needs and circumstances (Bevington et al., 2023[22]); and the Framework for Integrated Care (Rogers et al., 2024.; see also Taylor et al., 2018[23]). Messages from these sources are summarised below.

Summary principles to inform the development of provision (drawn from the evidence review; Bevington et al., 2023; Rogers et al., 2024)

[22] Five principles of care intended as a guiding framework to support changes to ways of working, services and provision to better meet the needs of children with complex needs and circumstances, including those subject to Deprivation of Liberty Orders.

[23] The Framework for Integrated Care (SECURE STAIRS) is a national programme to develop integrated care for the children and young people secure estate in England implemented over the period 2016–2022 across the children and young people's secure estate (CYPSE) in under-18 young offender institutions, secure training centres and SCHs. The framework sets out a way of working in the CYPSE to provide more developmentally attuned, psychologically informed care, centred around the use of formulations to co-produce assessments of young people's needs. The NHSE-led response to the Long-Term Plan commitment to invest in services for children and young people with complex needs. Since 2021, 11 local areas have been funded as Vanguards for the Framework for Integrated Care (Rogers et al., 2024), The Framework provides a set of evidence-informed principles and practices intended to catalyse integration of services for children and young people in some of the most complex situations with versions for the secure estate (SECURE STAIRS) and for community settings.

Multi-disciplinary leadership and vision

Brave leadership with a commitment to the long-term collaboration and culture change is required. The development of cross-system, trauma-informed policies and practices in order to create the conditions for people to work in integrated and trauma-responsive ways requires a narrative of shared responsibility and strong governance. A core aspect of this is collaboration between local commissioners across health and social care in order to identify and address fractures between services. Drawing children and young people, families, staff and wider stakeholders into this collaborative development provides invaluable intelligence.

Enabling stable and respectful relationships of trust

All children and young people need the opportunity to build trusting relationships, none more so than those whose lives have been blighted by abuse, exploitation and long histories of fractured service involvement. Relationships of trust in residential care are enabled when staff providing day to day care are well trained and supported and communication is adapted to individual need.

Even – indeed especially – when their liberty is curtailed, children and young people need some agency in their lives. They should be able to express views about what happens to them and be listened to. In these circumstances, access to an independent advocate is particularly important.

Relational working with children and young people requires a parallel focus on relationship-based working between system leaders, agencies and professional disciplines.

Highly experienced multidisciplinary teams

Residential care for these children and young people requires the combined skills, knowledge and time of care staff and colleagues with specialist mental health and psychological competencies. Those working with children and young people day to day are key agents of change, having the opportunity to build trusting relationships that can enable stabilisation. To retain staff and allow them to remain attuned when working with what can be intensely challenging and distressing behaviours, reflective supervision, clinical advice and trauma-informed support to staff themselves is required, alongside appropriate therapeutic interventions with children and young people.

Community teams beyond those working within the residential setting can provide integrated support in the community for children with complex needs (see for instance the Positive Directions[24] project within the West Midlands Vanguard for integrated care).

[24] https://www.happyhealthylives.uk/staying-happy-and-healthy/keeping-yourself-happy-and-healthy/positive-directions/

These show potential both for preventing escalation of need and for appropriate tailored support out of a residential home and into another placement or return home. Direct work with families is an essential element of supporting these transitions between settings and of consistent long-term support.

Workforce development that offers cross-disciplinary, trauma-informed learning, clinical supervision and reflective practice is vital. This can build coherence and consistency of language and practice across different professional groups.

Holistic, psychologically informed formulation, intervention and support

In contrast to an assessment driven primarily by reaching diagnostic categorisations or describing presenting issues, formulation is a process derived from clinical psychology for building shared understanding of a person's 'narrative history' (or life story) and setting presenting behaviours in context.

For children and young people whose lives have involved multiple agencies and often fragmented professional perspectives, formulation aims to bring all of these professionals together with the child, carers and families to generate a shared understanding of the issues and how they came about (Rogers et al., 2024).

The primary objective is to ensure that each child or young person co-owns a coherent narrative concerning their needs and how these will be addressed. As such, the active involvement of the child or young person and the adults around them is essential. Where it is safe and appropriate for parents and other carers to be involved, preparation must ensure that financial, legal, language or other support are provided to facilitate this.

The plan for flexible and tailored support and intervention should be set out so that it is comprehensible to the child or young person, their family and those working with them. Where required, specialised mental health interventions are prioritised, along with access to expert neurodevelopmental services. A range of interventions address behavioural, emotional, psychosocial and educational needs holistically, including the provision of vocational or life skills. Day-to-day support includes a focus on strengths, interests, hobbies and hopes for the future.

All those working with the child have a joint responsibility to deliver the plan. The work set out should be reviewed regularly by a multidisciplinary team. Achievable, measurable goals evidence progress across the range of indicators agreed.

The reasons for any restrictions on a child's liberty should be set out clearly, with details of how and when this will be reviewed and a clear exit plan towards the restrictions no longer being required.

Summary evidence from the three case study sites

Summary analysis suggests that all 3 case study homes were working in ways congruent with many or most of these principles set out above.

Multi-disciplinary leadership and vision

Development was described by senior leaders as driven by interlinked issues: gaps in community services (CAMHS access being a particular area of concern), lack of pathways to support, and insufficient placement options at various levels (including experienced foster carers who are able to manage challenging behaviours). These issues were seen to compound one another and contribute to crisis-led decision-making and instability, with carers or providers giving notice on placements in response to escalating behaviours.

Professionals at all 3 sites expressed the aim to improve outcomes and reduce reliance on out-of-area and unregistered placements in the current climate of insufficiency, high costs and concerns about 'profiteering'. Interviewees (in these local authority-led homes) also expressed the view that local authority-led homes may be more likely to support 'their own' children through difficulties (rather than give notice on placements) and thereby reduce negative impacts on children's mental health and future placement prospects.

Securing joint health and social care funding requires shared recognition that children and young people are poorly served by current provision across both systems at high cost. Cost benefits and potential savings were assessed through audit of complex cases and financial mapping of long-term costs (such as admission to mental health hospitals). Different funding and partnership arrangements and varying degrees of long-term financial planning and integration have implications for long-term sustainability and replicability. Sustainability was in question across all 3 sites, particularly in relation to the clinical input into multi-disciplinary teams, due to changes in NHS structures and reductions in Integrated Care Board budgets.

Interviewees described the significant time investment over some years to build and strengthen leadership relationships and working arrangements between social care, health and education. As trust developed, collaboration improved, though working with virtual school heads was an area identified for further development. Early engagement with Ofsted to share the aims and reasoning behind approaches to managing risk and increasing stability was noted as an important enabling factor in developing the homes.

Considerable attention was paid in each site to adapting buildings to a high specification to create safe and calm environments. All 3 sites were designed to offer flexibility for single and small-group occupancy and adaptation to individual needs. All 3 comprised relatively few bed places, some of which may be occupied by one young person for

months or years. Not enough is understood about the extent to which these provisions can meet local requirement. The 3 areas all recognised the essential need for pathways and transitions for children and young people, and interviewees voiced concerns about the lack of registered providers willing to place children and young people leaving these homes. Maintaining education for the children and young people in their care was noted by interviewees as challenging.

Enabling stable and respectful relationships of trust

Enabling children and young people to develop trusted relationships with staff was a primary focus in all 3 homes, and interviewees at all 3 sites described the value of clinical advice, expertise and support for the staff providing everyday care. While involvement of children in formulations and care planning was discussed, none of the homes mentioned access to independent advocacy. Involvement of family and wider networks was discussed though not explored in detail. Interviewees described key aims of the care provided as:

Stabilisation: enabling children and young people to feel safe, wanted and secure in order to gain the stability needed to access intensive recovery support and engage with education, drug and alcohol and mental health interventions.

Intensive recovery support: interviewees at all 3 homes expressed aspirations beyond keeping children and young people safe. They described aims to move towards recovery, prevent placement breakdown, enable step down to a lower level of care provision and to seek ways for children and young people to thrive in relation to their health, education and future goals. For children and young people who are placed in the home on a DoL order, the aim is to reach the point of recovery where the order can be safely ended before they leave the home.

To keep children and young people local: near their schools and able to maintain relationships with family and friends. To work with families to enable reunification where appropriate, support them to manage their child's behaviour and prevent future mental health crisis.

Highly experienced multidisciplinary teams

All 3 homes placed high value on ensuring that the staff working day to day to build relationships with children and young people are well supported by clinical and multi-disciplinary staff. Ongoing therapeutic support and specialist training that recognises the challenges and impact of caring for children in acute and complex circumstances were seen as integral to the approach across the 3 homes and identified as key to staff retention, which in turn enables consistency and stability for children and young people.

Although the teams across the 3 homes were structured in different ways, interviewees reported that all benefit from the range of expertise, including clinical psychology, speech and language, occupational therapy and advanced social care practice. Interprofessional relationships and increased understanding of multi-agency roles were described as developing over time.

Workforce development: staff described being equipped with knowledge and strategies for understanding and responding to developmental trauma and presenting behaviours. This enables a focus on stability and recovery, rather than prioritising management of risk at the expense of children's liberty and opportunities to develop and thrive. Clinical psychologists build staff skills and understanding of issues such as neurodiversity.

It was evident that cultural, procedural and practical differences between health and social care working practices require ongoing attention – for example, in relation to the management of risk when a child or young person is supported to return home. Policies (e.g. on medication management) must be aligned and communicated to staff. Job roles need clear definition, and qualifications' requirements for staff in multi-disciplinary teams are not currently aligned. For instance, there is a requirement for social care staff working in children's homes to undertake a Level 3 Diploma in residential childcare, which is not an expectation for CAMHS staff.

Holistic, psychologically informed formulation, intervention and support

Multi-disciplinary joint ownership and involvement in formulation and planning was highlighted across all 3 sites as the most impactful element; one interviewee described it as 'the glue that holds everything together'. Ongoing management and discussion of risks was rooted in the context of understanding a child's background and story.

Interviewees described using formulations to enable staff to understand a child's story, the impact of trauma in their lives and reasons for their presenting behaviours. The involvement of children and young people in co-producing formulations warrants further development; the tailoring of long-term support to children's needs and preferences came through most strongly in interviews with one home. Less detail was gathered in the fieldwork about longer-term plans for transition.

Children and young people in the 3 homes

Across these 3 homes there were very few (n2) children or young people placed under a DoL order.[25] While the single occupancy provision in 2 of the homes was seen to offer an alternative to the use of a DoL order or placement in a secure setting, most often those interviewed described accommodating children and young people who had previously

[25] One of the 3 local authorities had been using the DoL order route very seldom. Another local authority had 12 children and young people placed on DoL orders in other settings (such as SCHs, unregistered placements and/or out of area placements) at the time of the research.

been detained under the Mental Health Act as a ‘step down’ from Tier 4 mental health provision.

Interviewees described confusion in the sector about the purpose of DoL orders and how and when to enact them. When compared to other legal routes to deprivation of liberty, the permissive nature of DoL orders was seen to offer potential to manage behaviours in the least restrictive ways. However, interviewees reflected that care applied at the least restrictive level viable requires clinically informed high support and close oversight and management in order that staff keep the young person’s needs in focus in managing and preventing escalation of behaviours.

Interviewees at the 3 sites described the children and young people in their care as having a range of intersecting needs which frequently crosscut the 3 cohorts described in Roe and Ryan’s (2023) analysis of characteristics and needs of children and young people subject to DoL order applications. The ‘complex presentations’ described had left local authorities struggling to match needs to appropriate placements. Histories included breakdowns of out of area and/or secure placements and unregistered single occupancy placements, children and young people having ‘bounced in and out’ of CAMHs services, with needs not deemed to reach Tier 4 threshold and others stepping down from Tier 4 mental health provision.

Interviewees described children and young people’s needs as ‘a multitude of complexities’. Challenging behaviours and emotional dysregulation were related to histories of trauma, including sexual/criminal exploitation. Many were described as having ‘some form of neurodivergence’, learning difficulties or disabilities and/or autism, which were often not identified previously despite long histories of involvement with services. A range of needs were identified as having been unmet for these children and young people over long histories of service involvement in their lives. This was particularly noted in relation to appropriate mental health provision, with children and young people experiencing cycling in and out of CAMHS involvement without sustained therapeutic input.

Evidence-based interventions and models of care for looked-after children with complex needs in secure care

Our rapid systematic review included evidence-based interventions or models of care delivered in secure settings, and others aimed at preventing admission to secure care delivered in residential, foster care or family settings. Of the research and evaluation studies that met the review criteria, many were based on small samples in single sites, and few evaluated longer-term outcomes. The examples identified were situated in various countries. While there is much to be learned from work in other jurisdictions, it is vital to bear in mind social and cultural contexts in translating models across different settings. Full descriptions and references are in the evidence review.

Workforce development. Several studies evaluated the implementation of workforce development programmes. In 3 of these, intensive training on relationship-based and trauma-informed care aimed to support staff understanding of, and ability to manage, children's behaviour. Results suggested improvements in child-staff relationships, better emotional climates within homes and reductions in behavioural incidents. High staff turnover and different organisational cultures across settings are highlighted as challenges in embedding workforce development. Staffing levels, stability in staffing arrangements and senior leadership support were key to successful implementation.

Models of care. Studies identified were of models primarily aimed at preventing admission or re-admission to secure care and tend to focus on children at risk of offending behaviours or children at risk of/being discharged from inpatient mental health care. These included evaluations of Multidimensional Treatment Foster Care and Intensive Alternative Family Treatment.

From the UK, the evaluation of the No Wrong Door 'edge of care' integrated service and framework (Lushey et al, 2017) was found to contribute to a reduction in the number of young people entering care and, for those already in care, less time spent in care and increased placement stability.

A supported discharge service at South London and Maudsley NHS Foundation Trust provides intensive community support to prevent re-admission for children admitted for psychiatric inpatient care. Hospital use at 6 months was lower than for the 'care as usual' comparison group. Though scores on mental health symptoms and functioning outcome measures did not differ between groups, children receiving the intervention were less likely to report multiple episodes of self-harm, more likely to achieve school reintegration, and spent fewer days out of mainstream school.

Residential care. Evaluation of a Swedish programme aiming to prevent young people with serious behavioural problems and at high risk of re-offending from being placed in a locked residential setting found reductions in such placements compared to those not receiving the intervention, with related cost benefits.

An Australian sub-acute residential service for young people aged 16 to 25 at risk of hospitalisation or transitioning out of hospital inpatient units provides residential care and a blend of clinical and psychosocial support services. Reported outcomes included improved resilience, better understanding of mental health, increased help-seeking behaviour and stronger connections to therapeutic services.

Evaluation of alternative educational facilities, which were intended to prevent school drop-out and placement in secure residential care in the Netherlands, found that 70% of adolescents were not placed in a secure residential facility up to 6 months after leaving the provision and positive changes in children's adaptive emotion regulation strategies.

Mental health interventions and therapeutic modalities. Several studies evaluate the use of evidence-based therapeutic approaches to improve outcomes for children in residential settings. Systematic reviews and meta-analyses highlight that evidence-based mental health interventions can be effective in improving the mental health of children with trauma-related psychopathology and those living in out-of-home care.

For children with complex needs living in residential settings, identified studies assessed a range of different modalities, including multi-systemic approaches; trauma-focused cognitive behavioural therapy (TF-CBT); Dialectical Behavioural Therapy (DBT); Adolescent Mentalisation-Based Integrative Therapy (AMBIT); and Acceptance and Commitment Therapy (ACT). Most studies reported promising findings and improvements in relation to children's mental health, externalising problems and substance misuse, although specific outcome measures differed across studies. Across all studies, the intensity of clinical provision is notable, including both in relation to contact with clinical services (e.g., multiple weekly sessions), and the length of interventions. For example, in Evolve Therapeutic Services (ETS), which provides a comprehensive assessment of the biological, psychological, social and cultural aspects of child and family and long-term attachment or trauma-focused therapies), children remained in treatment for 19.2 months on average. This highlights that long-term approaches are required.

Emerging approaches. In the Netherlands, there has been a comprehensive effort in recent years to reduce the use of secure care, as part of a governmental proposal to end the use of SCHs by 2030 for children who have not caused harm to others. In place of large secure units, a model of integrated small-scale community facilities embedded in the community has been implemented, with intensive residential care available if required (in small-bedded units, with transitional independent living units available on the same site). A multidisciplinary integrated assessment and treatment approach encompasses a wide range of needs, including education, family counselling, therapy, mental health and psychology. The Netherlands has seen a reduction in the number of children placed in secure settings; for example, one region had no such admissions in 2023.

A concerted effort to reduce the number of children placed in secure settings on welfare or youth justice grounds is also taking place in Scotland. The Children and Young People's Centre for Justice report (CYCJ, 2024) presents a blueprint for secure care, which has been co-designed with children, young people, parents and professionals. It places focus on the provision of a rights-based, flexible continuum of care. There are 3 core components: community-based hubs providing a flexible, dynamic continuum of whole-family needs-led support and discrete accommodation to provide 'safe space' for children and their families in moments of crisis; multi-disciplinary teams around the family offering specialist, holistic support and enabling continuity and integration across services; and 'Flex Secure' providing intensive residential care for 2 to 4 children in

secure but home-like environments embedded in communities offering therapeutic and trauma-responsive care.

References: Thematic Summary

Andow, C., & Byrne, B. (2018). Family characteristics and experiences of children entering secure settings. In T. Bateman, P. Goodfellow, R. Little, & A. Wigzell (Eds), *Child-friendly youth justice?* (pp. 46-51). National Association for Youth Justice. https://thenayj.org.uk/wp-content/uploads/2019/02/NAYJ-Child-friendly-youth-justice-May-18.pdf#page=47

Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *Adverse childhood experiences: What we know, what we don't know, and what should happen next*. Early Intervention Foundation. https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Association of Directors of Children's Services (ADCS). (2025). *ADCS safeguarding pressures research – Phase 9*. https://www.adcs.org.uk/wp-content/uploads/2025/01/ADCS_Safeguarding_Pressures_Phase9_FINAL.pdf

Bach-Mortensen, A. M., Goodair, B., Briggs, E., & O'Higgins, A. (2022). *Commissioning secure children's homes placements in England*. What Works for Children's Social Care.

Barron, I., & Mitchell, D. (2018). Adolescents in secure accommodation in Scotland: Exposure and impact of traumatic events. *Journal of Aggression, Maltreatment & Trauma, 27*(7), 777–794. https://doi.org/10.1080/10926771.2017.1330294

Bartlett, A., Smith, J. G., Warner, L., & Hales, H. (2021). Young men and young women in secure care: Gender differences in the placement of those with mental health needs. *BMC Psychiatry*, *21*, 433. https://doi.org/10.1186/s12888-021-03440-7

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine*, *12*, 72. https://doi.org/10.1186/1741-7015-12-72

Bevington, D., Duschinsky, R., Hiller, R., Holmes, L., McCrory, E., Minnis, H., & Simon, A. (2023). *Principles of care for children with complex needs and circumstances*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/principles-of-care-for-children-with-complex-needs

British Medical Association (BMA). (2025, July 17 updated). *Mental health pressures in England*. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis

Capacity. (2024). *Building a case for change: Getting it right for children looked after who are living in complex situations with multiple needs*. https://thisiscapacity.co.uk/wp-content/uploads/2024/12/Final-Building-a-Case-for-Change.pdf

Cass, H. (2024). *The Cass Review: Independent review of gender identity services for children and young people*. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143642/https://cass.independent-review.uk/

Children and Young People's Centre for Justice (CYCJ). (2024). *Reimagining secure care: Final report: A vision for the reimagined/future world*. Children and Young People's Centre for Justice. https://www.cycj.org.uk/resource/reimagining-secure-care-a-vision-for-the-future/

Children and Young People's Commissioner for Scotland (CYPCS). (2023, June). Briefing: Children (Care and Justice) (Scotland) Bill. https://www.cypcs.org.uk/resources/ccj-bill-stage-1/

Children's Commissioner for England (CCO). (2024a). *Children with complex needs who are deprived of liberty: Interviews with children to understand their experiences of being deprived of their liberty*. https://assets.childrenscommissioner.gov.uk/wpuploads/2024/11/cc-deprivation-of-liberty.pdf

Children's Commissioner for England (CCO). (2024b). *Illegal children's homes*. https://www.childrenscommissioner.gov.uk/resource/illegal-childrens-homes/

Coady, C., & Karpf, B. (2025). *Costs and complexity in care: The real drivers of high-cost placements for children in care*. Local Government Association, & National Children's Bureau. https://www.local.gov.uk/sites/default/files/documents/73.6%20High%20cost%20childcare_FINALAA.pdf

Cocker, C., Holmes, D., & Cooper, A. (2024). *Transitional safeguarding*. Policy Press.

Competition and Markets Authority (CMA). (2022). *Children's social care market study. Final report.* www.gov.uk/government/publications/childrens-social-care-market-study-final-report/final-report

Darzi, A. (2024). *Independent investigation of the National Health Service in England*. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

Department for Education (DfE). (2023a). *Guide to the Supported Accommodation Regulations including Quality Standards*. https://assets.publishing.service.gov.uk/media/6514400088281e000db4e965/Guide_to_the_supported_accommodation_regulations_including_quality_standards.pdf

Department for Education (DfE). (2023b). *Improving cross sector support for children in complex situations with multiple needs. Task and finish group terms of reference*. https://assets.publishing.service.gov.uk/media/653bc19fd10f35000d9a6ae2/Children_with_Complex_Trauma_Task_and_Finish_Group_terms_of_reference.pdf

Department for Education (DfE). (2024a). *Children accommodated in secure children's homes*. National Statistics. Retrieved January 6, 2025, from https://explore-education-statistics.service.gov.uk/find-statistics/children-accommodated-in-secure-childrens-homes/2024

Department for Education (DfE). (2024b). *Keeping children safe, helping families thrive: Breaking down barriers to opportunity* (CP1200). www.gov.uk/government/publications/keeping-children-safe-helping-families-thrive

Downie, J., & Twomey, B. (2021). *Secure children's homes for welfare: 141 miles from home*. National Youth Advocacy Service. https://www.nyas.net/support-us/policy-and-research/nyas-research/secure-childrens-homes-for-welfare/

Gibson, R. (2020). *ACEs, places and status: Results from the 2018 Scottish secure care census*. Centre for Youth and Criminal Justice. https://www.cycj.org.uk/wp-content/uploads/2020/07/ACEs-Places-and-Status.pdf

Gibson, R. (2021). *ACEs, distance and sources of resilience*. Centre for Youth and Criminal Justice. https://www.cycj.org.uk/wp-content/uploads/2021/05/ACEs-Distance-and-Resilience.pdf

Gibson, R. (2022). *What do we know about children from England and Wales in secure care in Scotland?* Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/what-do-we-know-about-children-from-england-and-wales-in-secure-care-in-scotland

Greatbatch, D. & Tate, S. (2020). *Use of unregulated and unregistered provision for children in care*. Department for Education. https://www.gov.uk/government/publications/use-of-unregulated-and-unregistered-provision-for-children-in-care

Hales, H., Warner, L., Smith, J., & Bartlett, A. (2018). *Census of young people in secure settings on 14 September 2016: Characteristics, needs and pathways of care*. Central and North West London NHS Foundation Trust. https://www.england.nhs.uk/wp-

content/uploads/2018/10/secure-settings-for-young-people-a-national-scoping-exercise-paper-2-census-report.pdf

Harris, R., Stubbings, D., & De Claire, K. (2021). Factors predictive of behavioural and emotional dysfunction in adolescents in a secure children's home. *Journal of Child & Adolescent Trauma, 14*(3), 299–310. https://doi.org/10.1007/s40653-020-00329-7

Hart, D. & La Valle, I. (2016). *Local authority use of secure placements: Research report*. Department for Education. https://assets.publishing.service.gov.uk/media/5a8012a9ed915d74e622c4e6/Local-authority-use-of-secure-placements.pdf

Hart, D. & La Valle, I. (2021). *Secure children's homes: Placing welfare and justice children together. Research report*. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/983619/Secure_children_s_homes_placement_review_report.pdf

Hiller, R., Duschinsky, R., Fearon, P., Holmes, L., McGuire, R., Trickey, D., Wijedasa, D., & Woolgar, M. (2025). *Increasing access to evidence-informed mental health service provision for children in care in England: National recommendations for change.* UK Trauma Council. https://uktraumacouncil.link/documents/Hiller%20et%20al.%20National%20Recommendations%20MH%20Provision%20for%20CiC.pdf

Hindley, N. (2023). *The use of 'unregistered' placements to provide care for children and young people with the most complex emotional and behavioural needs: A national survey of regional forensic child and adolescent mental health teams (FCAMHS)*. National FCAMHS Network. https://www.rcpsych.ac.uk/docs/default-source/members/sigs/adolescent-forensic-psychiatry-afpsig/unregistered-placements-survey-final-april-2023.docx

Independent Children's Homes Association (ICHA). (2019). *ICHA 'state of the market' survey 5, February 2019*.

Jacob, J., D'Souza, S., Lane, R., Cracknell, L., Singleton, R., & Edbrooke-Childs, J. (2024). "I'm not just some criminal, I'm actually a person to them now": The importance of child-staff therapeutic relationships in the children and young people secure estate. *International Journal of Forensic Mental Health, 23*(1), 24–36. https://doi.org/10.1080/14999013.2023.2167893

Khan, L., Harris, A., & Sinclair, C. (2021). *Out of sight: Girls in the children and young people's secure estate*. Centre for Mental Health. https://www.centreformentalhealth.org.uk/publications/out-of-sight/

London Innovation and Improvement Alliance (LIIA). (2024). Pan-London Secure Children's Home (SCH) and Pal-London Vehicle for Children's Complex Commissioning (PLV). https://www.liia.london/londons-secure-childrens-home-and-plv/

Lushey, C., Hyde-Dryden, G., Holmes, L., & Blackmore, J. (2017). *Evaluation of the No Wrong Door innovation programme*. Department for Education. https://assets.publishing.service.gov.uk/media/5a82c2c540f0b6230269c8f5/Evaluation_of_the_No_Wrong_Door_Innovation_Programme.pdf

MacAlister, J. (2022). *The independent review of children's social care: Final report*. https://webarchive.nationalarchives.gov.uk/ukgwa/20230308122449/https://childrenssocialcare.independent-review.uk/final-report

Mannes, J., Coughlan, B., Yoon, Y., Morgan, T., Drayak, T., Crozier-Roche, F., Smith, J., Graham, D., Fraser, B., Hutchinson, D., Geoghegan, L., Hood, R., Woolgar, M., Broadbent, M., Chakravarti, P., & Duschinsky, R. (2024). *A call for change: Tackling inequalities in access to mental health support for children with social work involvement and those living in poverty*. University of Cambridge, & National Children's Bureau. https://www.ncb.org.uk/sites/default/files/uploads/files/240813%20A%20call%20for%20change%20-%20COACHES%20report.pdf

Martin, A., Nixon, C., Watt, K. L., Taylor, A., & Kennedy, P. J. (2022). Exploring the prevalence of adverse childhood experiences in secure children's home admissions. *Child & Youth Care Forum*, *51*, 921–935. https://doi.org/10.1007/s10566-021-09660-y

Ministry of Justice (MoJ). (2024). *Family Court Statistics Quarterly*. National Statistics. Retrieved January 6, 2025, from https://www.gov.uk/government/collections/family-court-statistics-quarterly

Ministry of Justice (MoJ). (2025a). *Family Court Statistics Quarterly: October to December 2024*. National Statistics. https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2024

Ministry of Justice (MoJ). (2025b). *Family Court Statistics Quarterly: January to March 2025*. National Statistics. https://www.gov.uk/government/statistics/family-court-statistics-quarterly-january-to-march-2025

Morgan, T., Crozier-Roche, F., Graham, D., Smith, J., Drayak, T., Mary, S., Cossar, J., Mannes, J., Pilimatalawwe, D., Parker, P., Coughlan, B., Hood, R., Hutchinson, D., Woolgar, M., & Duschinsky, R. (2025). The social must be stabilised: How are the social needs of young people with social work involvement characterized in their mental health case notes? *Social Science & Medicine, 374*, 118052. https://doi.org/10.1016/j.socscimed.2025.118052

NHS England (NHSE). (2024). *Mental Health Act statistics, annual figures, 2023–24*. National Statistics. Retrieved January 6, 2025, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures

Nuffield Family Justice Observatory (NFJO). (2024). *This is what we think: Perspectives on being cared for from older children and young people – including those on deprivation of liberty orders*. https://www.nuffieldfjo.org.uk/resource/this-is-what-we-think-perspectives-on-being-cared-for-from-older-children-and-young-people-including-those-on-deprivation-of-liberty-orders

Nuffield Family Justice Observatory (NFJO). (2025, June 26). *Data released by the Ministry of Justice shows 321 children subject to DoL applications January to March 2025* [Press release]. https://www.nuffieldfjo.org.uk/news/data-released-by-the-ministry-of-justice-shows-321-children-subject-to-dol-applications-january-to-march-2025

Nielson, S., Bray, L., Carter, B., & Kiernan, J. (2021). Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. *Journal of Child Health Care*, *25*(3), 342–367. https://doi.org/10.1177/1367493520937152

Ofsted. (2022a). *Children's social care 2022: recovering from the COVID-19 pandemic*. https://www.gov.uk/government/publications/childrens-social-care-2022-recovering-from-the-covid-19-pandemic/childrens-social-care-2022-recovering-from-the-covid-19-pandemic#the-immediate-impact-of-lockdowns-on-childrens-social-care

Ofsted. (2022b). *How local authorities plan for sufficiency of accommodation that meets the needs of children in care and care leavers*. https://www.gov.uk/government/publications/how-local-authorities-plan-for-sufficiency-children-in-care-and-care-leavers/how-local-authorities-plan-for-sufficiency-of-accommodation-that-meets-the-needs-of-children-in-care-and-care-leavers

Ofsted. (2024a). *Fostering in England 1 April to 31 March 2024*. https://www.gov.uk/government/statistics/fostering-in-england-1-april-2023-to-31-march-2024/fostering-in-england-1-april-2023-to-31-march-2024#main-findings

Ofsted. (2024b). *How local authorities and children's homes can achieve stability and permanence for children with complex needs*. https://www.gov.uk/government/publications/good-decisions-children-with-complex-needs-in-childrens-homes/how-local-authorities-and-childrens-homes-can-achieve-stability-and-permanence-for-children-with-complex-needs

Ofsted. (2024c). *Main findings: children's social care in England 2024*. https://www.gov.uk/government/statistics/childrens-social-care-in-england-2024/main-findings-childrens-social-care-in-england-2024

Pates, R. M., Davies, A., & Tiddy, D. (2018). A secure children's home in Wales: Care and educational provision from clinical, management, and educational perspectives. In D. Gallard, K. Evans & J. Millington (Eds.), *Children and their education in secure accommodation: Interdisciplinary perspectives of education, health and youth justice* (1st ed., pp. 146–161). Routledge.

Research in Practice. (2022). *What is early help? Concepts, policy directions and multi-agency perspectives. A scoping study on the purpose, provision and potential of early help for children and families in England*. Ofsted. https://www.gov.uk/government/publications/early-help-concepts-policy-directions-and-multi-agency-perspectives

Revolution Consulting. (2023). *CHA 'State of the sector' survey 9, Spring 2023*. https://www.revolution-consulting.org/wp-content/uploads/2023/04/CHA-Spring-2023-final.pdf

Roe, A. (2022). *What do we know about children and young people deprived of their liberty in England and Wales? An evidence review*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/children-and-young-people-deprived-of-their-liberty-england-and-wales

Roe, A. & Ryan, M. (2023). *Children deprived of their liberty: An analysis of the first two months of applications to the national deprivation of liberty court*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/children-deprived-of-their-liberty-an-analysis-of-the-first-two-months-of-applications-at-the-national-deprivation-of-liberty-court

Roe, A., Cusworth, L., & Alrouh, B. (2022). *Children subject to secure accommodation orders: A data review*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/children-subject-to-secure-accommodation-orders-a-data-review

Roe, A., Ryan, M, Saied-Tassier, A., & Edney, C. (2023). *Legal outcomes of cases at the national deprivation of liberty court*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/legal-outcomes-of-cases-at-the-national-deprivation-of-liberty-court

Roesch-Marsh, A. (2014). 'Out of control': Making sense of the behaviour of young people referred to secure accommodation. *British Journal of Social Work, 44*(2), 197–213. https://doi.org/10.1093/bjsw/bcs102

Roesch-Marsh, A. (2018). Professional relationships and decision making in social work: Lessons from a Scottish case study of secure accommodation decision making. *Qualitative Social Work: Research and Practice, 17*(3), 405–422. https://doi.org/10.1177/1473325016680285

Rogers, A., Fuggle, P., & Fonagy, P. (2024). *The Framework for Integrated Care: A catalyst for change to enhance services for children and young people at risk*. Anna Freud. Framework for Integrated Care: Supporting Service Integration | Anna Freud

Secure Welfare Coordination Unit (SWCU). (2024). *SWCU annual report England January 2023–December 2023: Data highlights*. https://www.securechildrenshomes.org.uk/wp-content/uploads/2024/04/SWCU_Annual_Report_2023.pdf

Stanley, Y. (2025a, March 18). Changes to our SCCIF guidance to improve stability for vulnerable children. *Ofsted*. https://socialcareinspection.blog.gov.uk/2025/03/18/changes-to-our-sccif-guidance-to-improve-stability-for-vulnerable-children/

Stanley, Y. (2025b, February 11). Setting up provision for children with the most complex needs – tips, reassurance and a new advice form. *Ofsted*. https://socialcareinspection.blog.gov.uk/2025/02/11/setting-up-provision-for-children-with-the-most-complex-needs-tips-reassurance-and-a-new-advice-form/

Taylor, J., Shostak, L., Rogers, A., & Mitchell, P. (2018). Rethinking mental health provision in the secure estate for children and young people: a framework for integrated care (SECURE STAIRS). *Safer Communities, 17*(4), 193–201. https://doi.org/10.1108/SC-07-2018-0019

Williams, A., Bayfield, H., Elliott, M., Lyttleton-Smith, J., Young, H., Evans, R., & Long, S. (2024). Secure futures? A mixed methods study on opportunities for helping young people referred to secure children's homes for welfare reasons. *Journal of Children's Services, 19*(1), 38–53. https://doi.org/10.1108/JCS-06-2022-0019

Williams, A., Bayfield, H., Elliott, M., Lyttleton-Smith, J., Evans, R., Young, H. and Long, S. (2019). *The experiences and outcomes of children and young people from Wales receiving secure accommodation orders. A report for Social Care Wales written by CASCADE, Cardiff University*. https://socialcare.wales/cms-assets/documents/The-experiences-and-outcomes-of-children-and-young-people-from-Wales-receiving-Secure-Accommodation-Orders.pdf

Williams, A., Wood, S., Warner, N., Cummings, A., Hodges, H., El-Banna, A., & Daher, S. (2020). *Unlocking the facts: Young people referred to secure children's homes*. What Works for Children's Social Care. https://foundations.org.uk/our-work/publications/unlocking-the-facts-young-people-referred-to-secure-childrens-homes/

Wood, S., Williams, A., Warner, N., Hodges, H. R., Cummings, A., & Forrester, D. (2024). Outcomes for high-risk young people referred to secure children's homes for welfare reasons: A population record linkage study in England. *Journal of Children's Services, 19*(2), 105–122. https://doi.org/10.1108/JCS-04-2023-0018

Chapter 2: Evidence Review

Introduction

The objective of this evidence review was to synthesise existing research to inform a better understanding of the needs, experiences, appropriate care requirements and outcomes for children and young people currently (or at risk of) being deprived of their liberty under the inherent jurisdiction in England and Wales.

The evidence review covers 2 broad areas: 1) identification of the characteristics, needs and experiences of the identified cohort; and 2) identification of literature on care and support, including evidence-based interventions or models of care for looked-after children with complex needs (subject to or at risk of being deprived of their liberty). The review aims to answer the following research questions:

1. How many children and young people are subject to deprivation of liberty (DoL) orders under the inherent jurisdiction in England and Wales, and how does this compare to children and young people deprived of their liberty for their welfare via other legislative routes in England and Wales?
2. What are the characteristics, needs and circumstances of children and young people deprived of their liberty?
3. What happens to children and young people while subject to restrictions on their liberty, including children and young people's experiences, where they are placed, and care and support received?
4. What are children and young people's short-, medium- and long-term outcomes after being deprived of their liberty?
5. What are the factors associated with positive outcomes for children and young people with complex needs subject to DoL orders?
6. What evidence-based interventions exist for looked-after children and young people with complex needs and/or complex trauma in secure care?

In this report, we use the definition of 'complex needs' put forward by the Nuffield Family Justice Observatory (NFJO, 2023c) and Ofsted (2024a): that children and young people experiencing 'complex needs' (and circumstances) are those with multiple, overlapping needs who require a collective response from multiple agencies. It is the combined and overlapping nature of their needs, rather than the severity of any single need, which is understood to increase the child or young person's vulnerability and risk. National Health Service England (NHSE) use the phrase 'children in complex situations with multiple needs' as a way to situate the complexity in the systems of care and support rather than within individual children and young people.

Methods

The full description of methods (inclusion criteria, search terms, information sources, search strategy etc.) is at Appendix 1. In brief, 2 systematic searches were conducted to identify literature (published from 2010 onwards) relevant to the 2 broad areas as identified above.

Search one

The first search aimed to identify research relevant to children currently or at risk of being deprived of their liberty. Given the limited evidence base on children subject to DoL orders under the inherent jurisdiction, searches were extended to include children deprived of their liberty in similar settings – namely, in a secure children's home (SCH) for welfare reasons (under s.25 of the Children Act 1989) or in a mental health inpatient setting (under the Mental Health Act 1983). Previous research has highlighted the similarity in needs and experiences for children deprived of their liberty in youth justice settings (see Roe, 2022 for a review); however, given the much larger body of evidence around custodial settings, studies focusing on children deprived of their liberty in custody (or on remand) were excluded from this review.

The focus for search one was on evidence from England and Wales. Relevant studies from Scotland were also included, given similarities in the secure accommodation system and the significant number of children from England and Wales who are placed in secure accommodation in Scotland (Gibson, 2022). International evidence was excluded due to differences in definitions and models of secure care internationally.

Search two

Search two aimed to identify evidence-based interventions or models of care aimed at addressing the identified ('complex') needs of children subject to or at risk of being deprived of their liberty. In the first instance, the search aimed to identify interventions delivered to children within welfare secure care (i.e. under a DoL order or in a SCH). Given the limited evidence base, searches were extended to include relevant interventions for looked-after children with complex needs. 'Complex needs' is an ill-defined term in the literature. Searches aimed to identify synonyms of 'complex needs' (e.g. 'high risk', 'multiple needs'), as well as particularly prominent needs or risk factors for the cohort of interest (e.g. 'self-harm', 'externalising problems', 'internalising problems'). Relevant interventions should target one or more of these problems and be designed for children at high risk (where other interventions or standard models of care have failed to address the child's needs).

For search two, geographical limitations were not imposed using search terms. During screening, priority was given to interventions evaluated in a UK context, followed by European countries, North America, New Zealand and Australia. These countries have

similar child welfare systems, and hence interventions delivered in these jurisdictions may have translational relevance to an English context.

Results of systematic searches

Search one

Search one returned a total of 435 results (following de-duplication) in academic databases. After abstract and full-text screening, a total of 33 studies were included in the review. Of these studies, none focused on the needs or characteristics of children subject to DoL applications under the inherent jurisdiction of the High Court. Eight studies were relevant to interventions and are considered in search two. Of the remaining 27 studies, 16 focused on children referred to or placed in SCHs, 8 on children in inpatient mental health settings, and 3 covered multiple settings. Eighteen had samples from England, 4 from Scotland and 1 from Wales. Four review articles were identified (all about inpatient settings).

Grey literature searches and reference/citation searching returned a further 36 articles.

Some of the studies identified used data from the same sample. Four studies were published by Hales and colleagues using data collected during a census of all children living in secure settings in England (mental health, welfare and youth justice settings) on 1 September 2016 (Bartlett et al., 2021; Hales et al., 2018, 2022; Smith et al., 2022). Three studies by Williams and colleagues (Williams et al., 2020, 2022; Wood et al., 2024) used a linked dataset of all referrals to SCHs made between 1 October 2016 and 31 March 2018, held by the Secure Welfare Coordination Unit (SWCU), linked to annual Children in Need and Children Looked After returns held by the DfE.

Findings from the included studies as relevant to the research questions set out above are narratively synthesised below.

Search two

Search two returned a total of 2,629 results (following de-duplication) in academic databases. After abstract and full-text screening, a total of 24 studies were included in the review. A further 15 studies were identified through other methods, including 6 identified via search 1 and deemed eligible for inclusion (see Figure 6 Chapter 2).

Eight reviews or meta-analyses were identified.

Of the studies included, none evaluated interventions to address the needs of children subject to or at risk of DoL applications under the inherent jurisdiction of the High Court, highlighting the lack of evidence-based practice for providing care and support to this cohort of children. Three were interventions delivered during or to prevent a stay in a

secure setting. Other interventions were delivered in residential settings or foster care for children with complex and multiple needs.

Children and young people with complex needs who are deprived of their liberty

How many children and young people are deprived of their liberty in England?

In England and Wales children and young people can be deprived of their liberty for their own welfare via multiple legislative routes. This includes:

- under s.25 of the Children Act 1989 (and s.119 of the Social Services and Well-being Act (Wales) 2014), which authorises the placement of a child (aged 10 to 17) in a SCH
- under the Mental Health Act 1983 for treatment of a mental disorder in a mental health hospital
- under the Mental Capacity Act 2005, which authorises the detention of children aged 16 and 17 who lack capacity to make decisions about their care arrangements (e.g. because of a learning disability) in any setting
- and under the inherent jurisdiction of the High Court, which authorises the deprivation of a child's liberty in an unregulated secure setting under a DoL order.

Information about the number of children and young people deprived of their liberty in different settings and via different legislative routes is collected and published by different government bodies, with varying levels of detail. This makes direct comparison of the numbers held in each setting and under different legislative routes difficult (Roe, 2022).

The evidence review drew data from a range of sources on each of these legal pathways to show that in the year 1 April 2023 to 31 March 2024:

- 963 children and young people were detained under the Mental Health Act 1983 (NHSE, 2024)
- 221 children and young people were subject to applications for a secure accommodation order under Section 25 of the Children Act 1989
- an unknown number of 16- to 17-year-olds were detained under the Mental Capacity Act 2005 (these data are not published in national statistics). In the previous year (2023), it was estimated that approximately 156 orders were made (CCO, 2024a)

- 1,259 children and young people were subject to applications for deprivation of liberty under the inherent jurisdiction of the High Court (MoJ, 2024).

Information about the number of 16- and 17-year-olds subject to applications under the Mental Capacity Act (MCA) 2005 is not published in national statistics and up-to-date data is not available (Roe, 2022; Waldegrave, 2020). The most recent published data found that between 1 April and 31 May 2023, a total of 32 applications were received by the Court of Protection for 16- and 17-year-olds (NFJO, 2023a). Extrapolating from this snapshot, the Nuffield Family Justice Observatory (NFJO) suggest that there has been an increase in applications from previously published figures in 2019/20 (59 applications). The Office of the Children's Commissioner for England (CCO) estimate that approximately 156 orders were made for 16- and 17-year-olds under the MCA in 2023, although it is not known how accurate these estimates are (CCO, 2024a).

It is possible (though not possible to ascertain from these data) that applications in regard to the same child might be made through more than one legislative route at different points within the time period. For instance, if due to the shortage of places in SCHs, an application did not result in a placement, the same child might then be the subject of a subsequent DoL application.

Nevertheless, the data demonstrate that applications for DoL orders vastly outnumber applications to place children in registered SCHs. Once seen as a last resort for those whose needs could not be met in any other secure setting (due to the complexity of their needs and/or insufficient secure placement options), the inherent jurisdiction has become the most common legislative route for depriving a child or young person of their liberty in England.

Changes in how children and young people have been deprived of their liberty over time

The size and capacity of the secure welfare estate and the availability of inpatient mental health provision have changed in the past 25 years.

Secure children's homes England and Wales

At 31 March 2025 there were 14 SCHs in England and Wales (13 in England and 1 in Wales). Of those in England, 6 provide welfare placements only, 2 provide justice placements only and 5 are mixed capacity.[26]

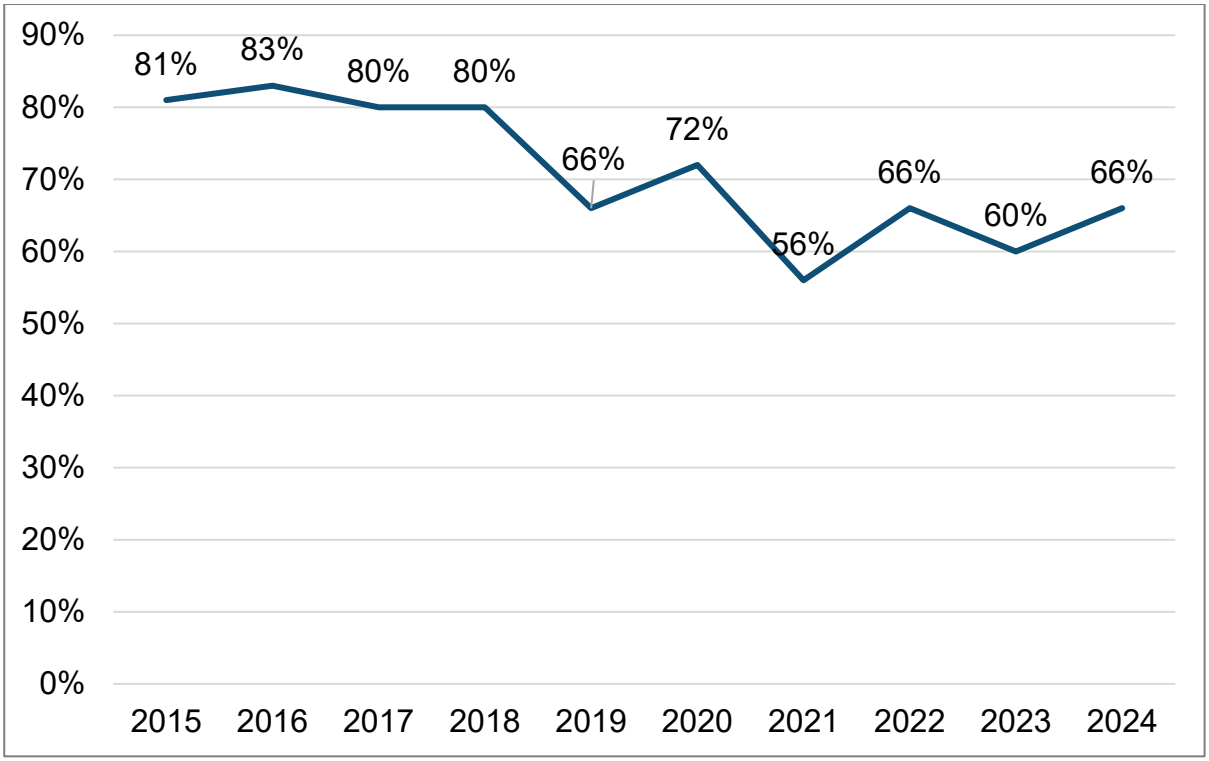
The number of SCHs and approved places within them have decreased. At 31 March 2010 there were 17 homes and 311 approved places; by 31 March 2025 there were 14

[26] https://explore-education-statistics.service.gov.uk/methodology/children-accommodated-in-secure-children-s-homes

homes and 235 approved places. The proportion of these contracted to the Ministry of Justice (MoJ) as justice placements has declined from 61% (n=191) in 2010 to 43% (n=102) in 2025.[27]

At 31 March 2015, the occupancy rate (the percentage of approved places occupied) was 81%. At 31 March 2024 it was 66% (see Figure 1). Research is limited, but SCH not operating at 'full' capacity is likely due to several factors, including staff shortages, the mix of children living in the home and their needs, and the built environment of SCHs (Andow, 2020; Bach-Mortensen et al., 2022b).

Figure 1 Occupancy rate (% of approved places occupied) of SCHs (welfare and youth justice placements) in England and Wales, 31 March 2015 to 31 March 2024



Source: DfE (2024)

Despite these reductions in size and capacity, demand for secure welfare beds remains high, and far more children and young people are referred for a place in a SCH than are ultimately placed. Analysis of data from the SWCU – the statutory unit responsible for managing referrals and the placement of children in SCHs – shows that the number of children successfully placed has declined in recent years. Data suggests that up until 2019, around 60% of children referred to SCHs on welfare grounds were offered a place (Downie & Twomey, 2021; Williams et al., 2022). But this declined to 51.0% in 2019 and 49.8% in 2020, suggesting just 1 in 2 children referred are found a place (Downie &

[27] https://explore-education-statistics.service.gov.uk/find-statistics/children-accommodated-in-secure-childrens-homes/2025

Twomey, 2021). More recent data is not available, although the SWCU state that in 2023 an average of 58 referrals were open daily (SWCU, 2024). We discuss the factors driving this below (see section 'Why are children and young people in complex situations with multiple needs deprived of their liberty?').

Mental health need and provision

Overall rates of mental illness in England have been rising for some years – at a faster rate for children and young people than among adults and at an accelerated rate since the COVID-19 pandemic. In 2023, about 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder. This was 20.3% of 8- to 16-year-olds, 23.3% of 17- to 19-year-olds and 21.7% of 20- to 25-year-olds (NHS England, 2023). There are around 3 times as many children and young people in contact with child and adolescent mental health services (CAMHS) at April 2025 than there were in April 2016.[28]

Overall, mental health bed numbers have reduced by 23% since 2010/11. This reflects policies to move care out of hospitals and into the community.[29] Reductions in children and young people's mental health (CYPMH) inpatient bed numbers over the past 10 years have occurred alongside plans to develop CYPMH inpatient services that can be commissioned safely and equitably across England. Work continues to transform the inpatient model of care to support care being delivered as close to home, in the least restrictive setting and to make best use of the resource to meet patient need.[30]

The number of children and young people detained under the Mental Health Act 1983 has remained relatively stable over the last 6 years, decreasing slightly from 1,177 in 2017/18 to 963 in 2023/24. There is no published data about the number of children who may be assessed under the MHA and not detained.

Inherent jurisdiction of the High Court (DoL orders)

The use of the inherent jurisdiction to deprive children of their liberty has increased exponentially over recent years. Until July 2023, data about the use of the inherent jurisdiction was not published in national administrative data. This makes comparison difficult as we must rely on different data sources that use different methods and/or cover different geographies.

Until 2022 the only available data came from Cafcass England, relating to applications made in England only (following data requests from the Children's Commissioner for England, NFJO and BBC). These data showed that, from 2017/18 to 2020/21, the

[28] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis
[29] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis
[30] NHS England » Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme

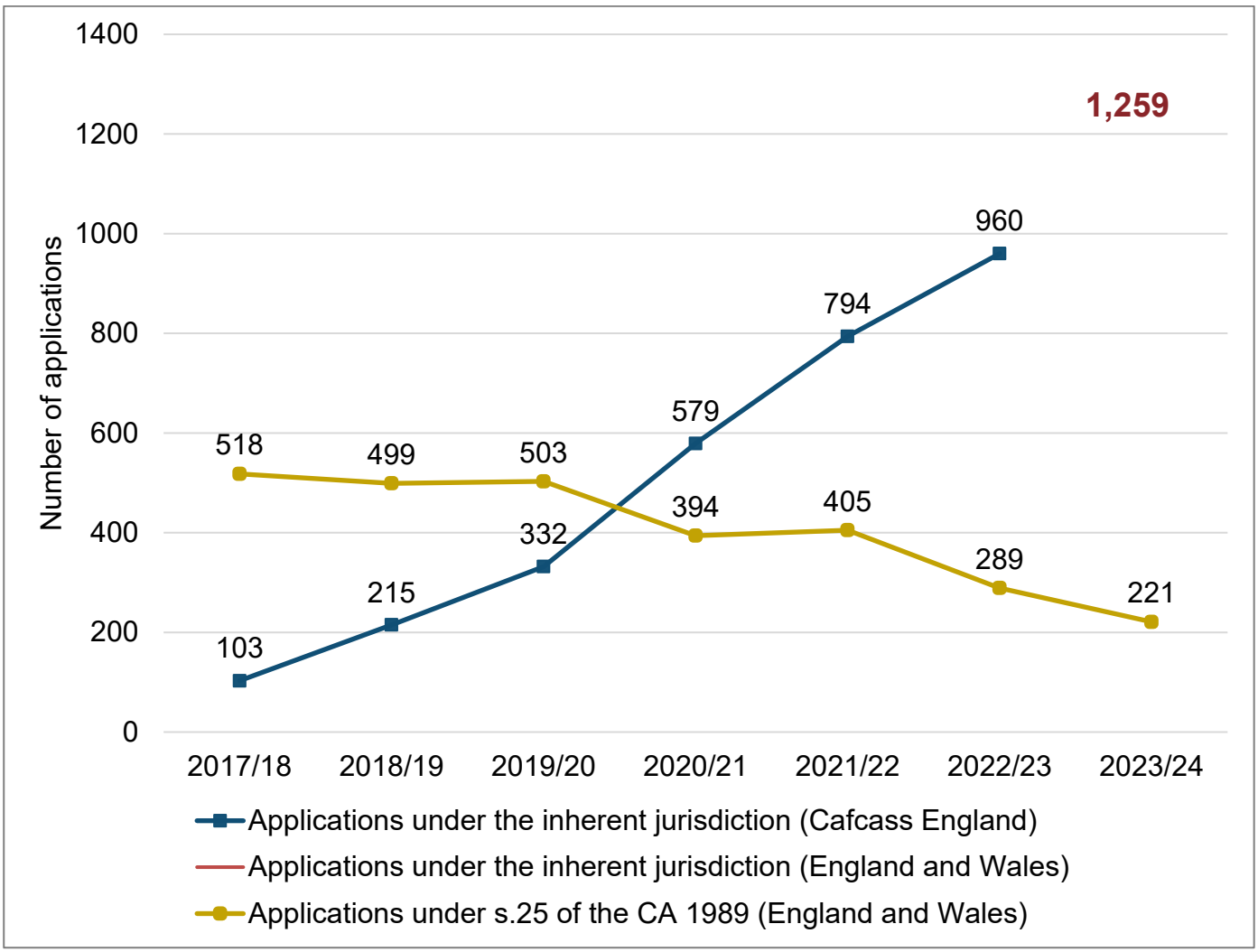
number of applications to deprive a child of their liberty under the inherent jurisdiction in England increased from 103 to 579 – a 462% increase (Roe, 2022). There are likely multiple reasons for this increase, including a reduction in capacity in other secure settings, as well as increased awareness among local authorities about when a child's care arrangements may constitute a deprivation of liberty (see Roe, 2023 for further discussion).

In July 2022, the NFJO began publishing data about the number of DoL applications in England *and* Wales, using data collected from the national DoL court from July 2022 to June 2023. There were 1,389 applications during this period. More recent data, published by the MoJ in Family Court Statistics Quarterly, suggests that the number of applications has remained broadly stable since 2022. The most recent data shows that there were 1,280 DoL applications in 2024 (MoJ, 2025).

Applications under the inherent jurisdiction now vastly outnumber applications for secure accommodation orders (SAOs) (see Figure 2). 2020/21 was the first year that there were more applications for DoL orders (579) than for SAOs (394).[31] This trend has continued, and in 2023/24 there were over 5 times as many applications for DoL orders compared to SAOs.

[31] Note that the figure for DoL applications covers England only.

Figure 2 Comparison of the number of applications made under s.25 Children Act 1989 and DoL orders under the inherent jurisdiction of the High Court, 2017/18 to 2023/24 (1 April–31 March)



Source: Cafcass England (see Roe, 2022), NFJO and MoJ. Note: Data comes from different sources and may not be directly comparable

The number of referrals to SCHs has also declined in recent years, from 492 referrals in 2019 to 366 during 2023 (SWCU, 2024).

Overall, data suggests that the number of children and young people subject to applications for DoL orders has increased exponentially over the past 7 years. At the same time, the number of applications for SAOs has decreased. Nonetheless, available data suggest that significantly more children are now at risk of restrictions on their liberty due to concerns about their welfare than a decade ago.

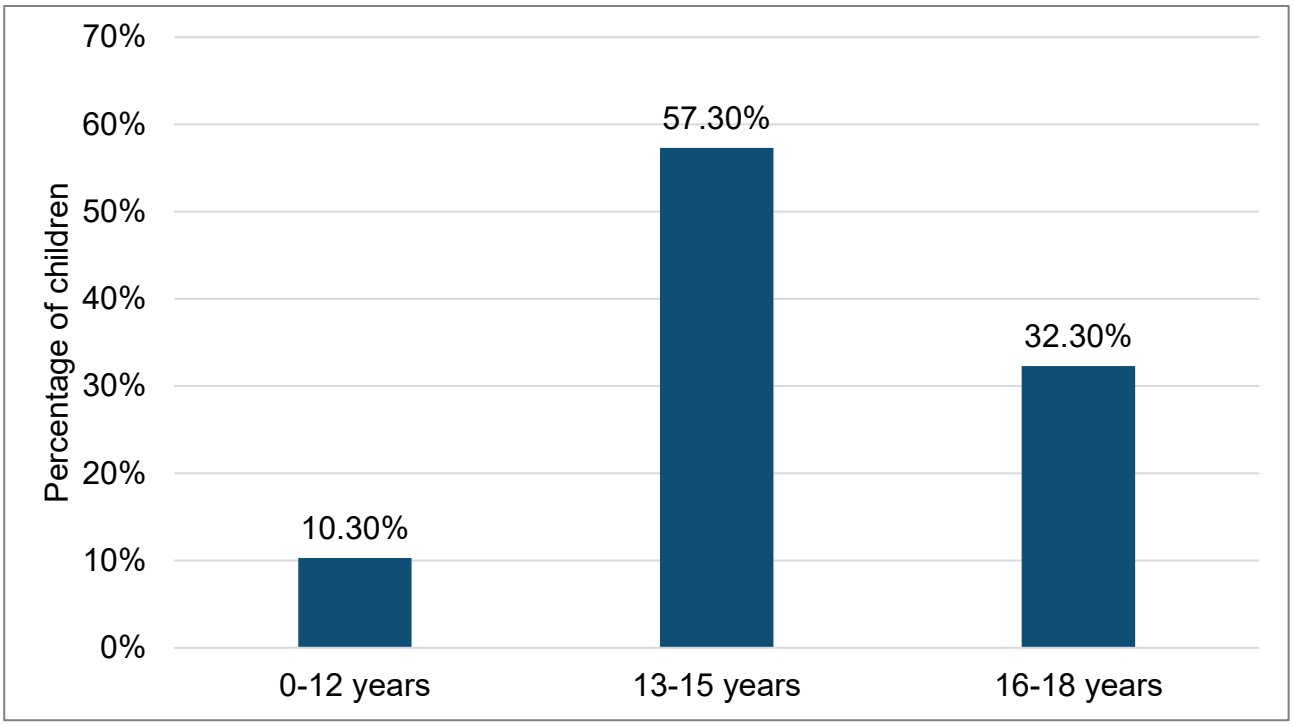
Who are the children and young people?

Age

DoL applications

Data from MoJ shows that most children and young people subject to DoL applications are aged 13 and above, with a small number of applications for children under 13 (see Figure 3).

Figure 3 Age of children and young people subject to DoL applications, 2024



Source: Ministry of Justice (2025)

Secure children's homes

Three-quarters (74%) of children and young people accommodated in SCHs (for both welfare and justice reasons) are aged 15 and above (DfE, 2024). Among those referred for welfare reasons only, studies suggest that the majority are aged 14 to 16 (Downie & Twomey, 2021 – SWCU referral data, 2018-2020; Williams et al., 2020 – SWCU referral data from 1 October 2016 to 31 March 2018).

Mental Health Act

Children and young people detained under the Mental Health Act 1983 also tend to be older. In 2023/24, 71.5% were aged 16 or 17 (NHS England, 2024).

Gender

DoL applications

Approximately equal numbers of boys and girls are subject to DoL applications (NFJO, 2023b – national data from July 2022 to June 2023; MoJ, 2024). In addition, a small minority of children (2.8% in 2023) identified as 'other' than either male or female (MoJ, 2024), although issues with data and the mis-gendering of children on court applications may underrepresent this (Roe & Ryan, 2023). There is a dearth of research on the gender identity and sexuality of children in the secure estate generally (Khan et al., 2021; Roe, 2022). More research would be needed to understand how gender identity and/or gender dysphoria may affect the presentation of children and young people at risk of being deprived of their liberty.

Secure children's homes

An approximately equal number of boys and girls are referred for a place in a SCH (Downie & Twomey, 2021 – SWCU referral data, 2018-2020; Williams et al., 2020 – SWCU referral data October 2016-March 2018; SWCU, 2024).

As reported above, we know that not all children referred for a place in a SCH will ultimately be found a place. One study, analysing referrals made to the SWCU between October 2016 and March 2018, found that being female was associated with significantly higher likelihood of being placed in a SCH (Odds Ratio = 2.26) compared to being male (Wood et al., 2024). More recent data from the SWCU suggests that this gap may have narrowed – in 2023, girls made up 55% of referrals and 54% of those offered a place (SWCU, 2024).

Research has also shown that the gender balance of children and young people subject to SAOs has changed in the last decade. Analysis of Cafcass and Cafcass Cymru data found that in 2011/12, far more girls than boys were the subject of applications for a SAO (69%) – but by 2019/20 the number was equal (Roe et al., 2022).

Mental Health Act

Girls are much more likely than boys to be detained under the Mental Health Act 1983. Of the 883 children detained under the Act in 2023/24, 63.3% were girls (NHS England, 2024).

Ethnicity

DoL applications

There is a lack of data on the ethnicity of children and young people subject to DoL orders, and information about children's ethnicity is not included in national administrative data.

Available data, based on an analysis of 208 applications for DoL orders made in July and August 2022, suggests that most children and young people subject to applications in that period were White British (69.9%) (Roe & Ryan, 2023); 13.3% were from Mixed ethnic groups, 7.1% were of 'White Other' ethnicity, 6.2% were Black and 3.5% were of Asian ethnicity (Roe & Ryan, 2023). The data suggests that children from Mixed and Black ethnic groups were overrepresented compared to their proportion in the general population (~5% according to the 2021 census).

Children and young people from Mixed ethnic backgrounds were also overrepresented compared to the general children in care population, which suggests that looked-after children of Mixed ethnicity may be more likely to be deprived of their liberty than other children in care (Roe & Ryan, 2023). It is important to note, however, that these data are a snapshot in time of DoL applications made over a 2-month period in 2022, and data on ethnicity was missing in almost half of the 208 applications. As such, these data should not be considered representative.

Secure children's homes

Children and young people of Black and Mixed ethnicity are overrepresented among those referred to SCHs (Downie & Twomey, 2021; Roe, 2022; SWCU, 2024; Wood et al., 2024; Williams et al., 2020). According to the SWCU, 60.4% of referrals in 2023 were for children of White British ethnicity (SWCU, 2024). The second most frequently recorded ethnicity in 2023 was 'White and Black Caribbean' (9.6%), with a further 15 ethnicity categories recorded in these data.

These data also suggest that there may be gender differences in the ethnicity of children and young people referred. In 2023, 59% of White British referrals were female, and 41% were male. Of the combined further ethnicity referrals received in 2023, 49% were female and 51% male (SWCU 2024).

Mental Health Act

Data about the ethnicity of children and young people detained under the Mental Health Act is published by NHS England annually. The most recent data, for 2023/24, shows that children from Black, Mixed and Asian ethnic groups are overrepresented (66.8% of

children were of White ethnicity, 11.2% Black, 9.3% Mixed, 7.1% Asian, and 5.5% Other) (NHS England, 2024).

What do we know about children and young people's experiences prior to being placed in secure care?

Care histories

Most children and young people deprived of their liberty under a DoL order or in a SCH are in care at the time of the application to court (Roe & Ryan, 2023; Williams et al., 2020).

The case file analysis of 208 cases where a DoL order had been sought (during July and August 2022) found that at the time of the application, most children were in care under a care order (61.7%) or interim care order (15.5%) (Roe & Ryan, 2023). A fifth of children (19.4%) were also in care under voluntary arrangements (s.20 Children Act 1989 or s.76 Social Services and Well-Being (Wales) Act 2014). A small number (3.4%) were not in care at the time of the DoL application; these children were living at home with their parents.

Evidence suggests that children and young people at risk of being deprived of their liberty have often come into care relatively recently (i.e. not long before the application is made) or may have recently re-entered care after a period of not being looked after (Hart & La Valle, 2016; Williams et al., 2020, 2024). Among the children and young people subject to DoL applications in the 2022 case file analysis, just under half (44.7%) had come into care within the previous 2 years, with almost a fifth (19.2%) coming into care in the 6 months prior to the DoL application being made (Roe & Ryan, 2023).

Nevertheless, these children and young people are not unknown to services and often have significant histories of involvement with children's services (Williams et al., 2019, 2020). In the study of 208 children subject to DoL applications, just 10 had only recently (i.e. within the last 12 months) come to the attention of children's services (Roe & Ryan, 2023).

The most comprehensive study of children's prior social care involvement by Williams et al. (2020, 2024) linked child in need and child looked after returns, routinely collected by the DfE, with SWCU data on referral to a SCH between 1 October 2016 and 31 March 2018. This highlights a lot of activity within children's services in the 3 years before referral to a SCH, including new referrals, new assessments and new child protection plans. The majority of the children (59.8%) received one or more new referrals to children's services during this time period. This may have been their first referral, or a new referral for children who had previously been on a child in need plan that had

subsequently ceased. Of these children, 27.5% received more than 1 referral and 10.5% received 3 or more.

While almost all of these children and young people referred to SCHs (94.9%) were looked after at some point in the 3 years prior to referral, only 1 in 4 (27.1%) were in care continuously in this period (Williams et al., 2020, 2024). This suggests that many children and young people experienced going in and out of care in the years prior to referral to a SCH. Indeed, around 1 in 4 (23.9%) had more than one episode of being looked after in the 3 years prior to referral, with one child experiencing 5 episodes.

The study also compared children's services' involvement in the 3 years prior to referral for children who were placed in a SCH and those placed in alternative accommodation, finding no significant differences in social care histories between the 2 groups (Williams et al., 2024).

There is a lack of comparable data about the patterns of involvement with children's services for teenagers whose experiences do not lead to deprivation of liberty, which may highlight differences – and therefore aid early identification of children at risk of secure care – between groups. Nonetheless, the evidence suggests that risk factors may include entering care late and being subject to repeat referrals to children's services. While Williams' et al. (2020, 2024) study shows that children are well known to children's services in the years leading up to entering secure care, information about what support was actually provided to children, young people and their families is non-existent. Roe and Ryan's (2023) analysis of 208 DoL cases highlights the limited evidence (according to the information included in the application to court) of sustained intervention and support provided to children and families in the years leading up to a DoL application. Earlier intervention may prevent needs escalating to the point where a deprivation of liberty is sought.

Data about the number of children and young people in care who are detained under the Mental Health Act is not published by NHS England or DfE. A freedom of information request by Article 39 to NHS England in September 2020 found that in 2018/19, 293 looked-after children were admitted under the Act to specialised mental health inpatient services (24.1% of the total number of children admitted) (Article 39, 2021). A case file analysis of adolescents detained under s.136 of the Mental Health Act in an inpatient mental health unit in London between January 2007 and December 2010 similarly found that just under a quarter (23.5%) of patients were looked-after children (Patil et al., 2013).

Placement histories

There is clear evidence that, while in care, these children and young people experience a high number of placement moves and instability in their living arrangements (Gibson, 2022; Hart & La Valle, 2016; Roe & Ryan, 2023; Smith et al., 2022; Williams et al., 2020).

Across all placement types and all children in care, rates of multiple placement moves are highest for children and young people whose first placement is in secure/specialist residential placements (25.5%) or children's homes (16.7%) (CCO, 2020a).

Williams et al. (2020) found that in the 3 years prior to referral to a SCH, children experienced on average 5.5 different placements (using linked SWCU/DfE national data). Over half (55.5%) of the 208 children in the case file analysis who were subject to an application for a DoL order had experienced multiple changes in where they were living in the months and years prior to the DoL application, with some children experiencing 10 or more moves (Roe & Ryan, 2023).

In most cases, placements broke down due to residential or foster carers finding it difficult to manage the child's behaviours (Hart & La Valle, 2016; Roe & Ryan, 2023; Williams et al., 2024). Placements would often break down with short notice, often following a crisis moment in the child's life (e.g. self-harm incident, physical aggression toward a carer or causing damage to property), with providers giving immediate or very little notice that they could no longer accommodate the child (Hart & La Valle, 2016; Roe & Ryan, 2023; Williams et al., 2024).

There is some evidence that multiple placement moves and the repeated failure of placements to meet children's needs may exacerbate children's challenging or risky behaviours – and, in turn, increase difficulties in finding appropriate care placements (Williams et al., 2024). One study (Hiller & St. Clair, 2018) found a relationship between the number of placements looked-after children experienced and significantly worse emotional, peer, conduct and hyperactivity problems, compared to other children in care over a 5-year period. While the relationship between placement instability and children's behaviour may well be cyclical, placement instability appears to be a significant risk factor for entering secure care, and points to a lack of placements that can support these children and young people's needs.

Placement at the time of the application

The evidence summarised in this section shows that most children are living in out-of-home care immediately prior to being deprived of their liberty (under a DoL order or in a SCH).

In England, Ofsted is responsible for registering and inspecting children's homes. The Care Standards Act 2000 says that 'an establishment is a children's home... if it provides care and accommodation wholly or mainly for children'.

Supported accommodation is distinct from children's home provision, and is suitable for older children, aged 16 and 17, who are ready for a degree of independence. From October 2023 it became mandatory for supported accommodation providers (previously known as independent or semi-independent accommodation providers) to be registered

with Ofsted and to adhere to a set of Quality Standards (DfE, 2023). The level of care and supervision that children with complex needs require means that supported accommodation is unlikely to be appropriate (DfE, 2023). As such, if a child is subject to restrictions on their liberty in a placement that purports to be supported accommodation, that accommodation will therefore be an unregistered children's home.

Case file analysis of 208 children subject to DoL applications between July and August 2022 took place prior to the mandatory registration of supported accommodation. This found that just under half (46.6%) were living in a children's home at the time of the application (Roe & Ryan, 2023). A significant number were living in what was at that time an unregistered placement (16.8%) (i.e. a setting providing care but not registered as a children's home) or supported accommodation (8.7%).[32] One in 10 (10.1%) were in a hospital at the time of the DoL application, most often (6.7%) in a general hospital ward.

For children referred to SCHs, evidence suggests that increasing numbers of children were being placed in what was, at the time of the study, unregistered accommodation prior to referral. Earlier studies (Hales et al., 2018; Williams et al., 2020) suggested that the majority (~80%) of children referred to or living in a SCH came from a registered residential children's home. However, the latest data from the SWCU for 2023 shows that the most common placement at the point of referral was an 'unregulated or unregistered placement' (as defined by the referring local authority), for over a third of children (35.2%) (SWCU, 2024).[33] This was followed by placement in a registered children's home (26.0%), and semi-independent accommodation (17.2%). The SWCU first reported this pattern, where more children were being referred from what were then unregulated or unregistered placements, in 2022.

Previous secure placements

Evidence also suggests that many children and young people referred to SCHs or subject to applications for a DoL order have already experienced a secure placement. Among children subject to DoL applications in July and August 2022, 5.8% were in secure accommodation (on welfare or youth justice grounds) at the time of the application (Roe & Ryan, 2023). In most of these cases, the DoL was sought because the child no longer met criteria (under s.25 of the Children Act 1989) for secure accommodation and/or to support a planned transition back into the community, with a DoL requested for a 'stepdown' placement. In some cases, however, the SCH had given notice due to the child's behaviours. More than 1 in 10 (11.1%; 23 children) had spent

[32] The authors do not provide an age breakdown of the children placed in supported accommodation so it is not clear if or how many, if any, children under 16 were living in supported accommodation at the time of the DoL application, which would be illegal.
[33] Unregistered placements were bespoke placements created by the local authority for the child or young person.

time in secure accommodation at some point prior to the DoL application, and over a third (37.3%; 75 children) had been subject to previous DoL orders.

Similarly, in 2023, 4.4% of children referred to secure accommodation were living in youth custody at the time of referral, 3.0% were already placed in a SCH, and 3.0% were in a mental health inpatient unit (SWCU, 2024).

Hales et al.'s (2018) census of all children living in secure care (welfare, youth justice and mental health settings) in England on 14 September 2016 reported that almost a fifth (17%) of young people had moved from another secure establishment to their present one. They also suggest that once they are in the system, children and young people tend to continue along the same 'legislative path', with the majority of young people in secure hospitals (52%) or YJS placements (60%), and a quarter (23%) of those on welfare placements, having had a previous secure placement under the same legislation (Hales et al., 2018).

Williams et al. (2020) found that previous placement in a SCH was associated with increased likelihood of being successfully placed following referral in a SCH at a later date, while previous placement in a YOI or an establishment providing medical care was associated with reduced likelihood of being placed.

Children and young people placed in hospital settings

Roe and Ryan (2023) found that a small but significant number of the 208 children and young people (6.7%) were in a general hospital ward at the time of the DoL application, usually because of mental health concerns or self-harming behaviour. Although there is limited research about the experiences of these children, a recent national cohort study suggested that this may be a growing national issue. Ward et al. (2025) found that between 2012 and 2022, there was a 65% increase in the number of children (aged 5 to 18) being admitted to general acute medical wards in hospitals in England because of a mental health concern. Over half (53.4%) of admissions for mental health concerns were due to self-harm, with particularly stark increases seen for females aged 11 to 15 (112.8% increase in admissions).

While admission of children and young people to acute general wards in response to self-harm, eating disorders or other mental health concerns may sometimes be appropriate, evidence suggests that there are significant challenges in providing safe, high-quality care to children in these settings, with growing concern that children may become 'stuck' on hospital wards because there is nowhere else for them to go (see for example Lever et al., 2024; Ward et al., 2025). Ward et al (2025) conclude that innovative health policy initiatives are required to provide integrated care for these individuals when admission is needed, to increase the capacity of mental health services to enable shorter lengths of stay and to improve co-working across acute, mental health and social care.

Exposure to trauma and adversity in childhood

A large body of evidence indicates that the early lives of many children who are deprived of their liberty are characterised by adversity and trauma, including exposure to abuse, neglect, family dysfunction, bereavement, loss, parental separation, poverty, discrimination, and exposure to domestic violence and problematic substance use (Andow & Byrne, 2018; Barron & Mitchell, 2018; Gibson, 2021; Hart & La Valle, 2021; Khan et al., 2021; Pates et al., 2018; Roesch-Marsh, 2014; Williams et al., 2019).

One common approach in the literature has been to explore the prevalence of adverse childhood experiences (ACEs) among children in secure accommodation. ACEs refer to a defined list of highly stressful and potentially traumatic experiences that may occur throughout childhood and which have been strongly linked with poorer mental health, behaviour and other outcomes in childhood and adulthood (see Gibson, 2020). The research and interpretation underpinning the ACEs body of evidence is not without critique (for example, see Asmussen et al., 2020), particularly in relation to its sometimes limited attention to social determinants of health. Nevertheless, studies in England (Harris et al., 2021; Martin et al., 2022) and Scotland (Gibson, 2020, 2021, 2022) suggest that the majority of children living in SCHs have experienced 4 or more ACEs – far higher exposure than in the general population. For example, 74% of children in secure care settings in Scotland surveyed in 2019 had been exposed to 4 or more ACEs prior to entering secure care, this rising to 86% among those who lived in relative poverty prior to entering secure care (Gibson, 2021). This compares to 9% of the UK population who have experienced 4+ ACEs (Bellis et al., 2014). The most common ACEs include emotional neglect, parental separation, physical neglect and emotional abuse.

Gibson (2021, 2022) highlight that children placed in Scottish SCHs by English or Welsh local authorities tend to have experienced more ACEs across their lifetime than both Scottish children in SCHs, and children in SCHs in England and Wales. This suggests that some of the most vulnerable children may be being sent to SCHs in Scotland. Over 70% of these children had experienced emotional neglect, parental separation, physical neglect, emotional abuse, physical abuse, parental mental ill-health, parental substance abuse or exposure to domestic violence at some point in their lives (Gibson, 2022). In the year prior to admission, over 50% had experienced emotional neglect and abuse, exposure to parental substance misuse and parental mental ill-health (Gibson, 2022).

Evidence about exposure to ACEs or other potentially traumatic experiences among children detained under the Mental Health Act 1983 is limited. Andow and Byrne's (2018) case file analysis of children living in Surrey who entered secure care between 2010 and 2017 highlights possible differences in the early life experiences of children who are placed in secure care for welfare or youth justice reasons, and those detained under the Mental Health Act. Compared to their peers in other settings, children detained under the Mental Health Act were more likely to come from families where the parents were still

together, were less likely to be eligible for free school meals and were less likely to have witnessed domestic abuse.

There is a large body of international evidence that shows that exposure to ongoing complex trauma, adversity and deprivation in childhood can have a significant impact on children's development and mental and physical health; this includes increased risk of mental health problems, more severe mental health problems that are harder to treat, and difficulties with emotion regulation and trusting others (J. G. Green et al., 2010; Hein & Monk, 2017; Koenen & Widom, 2009; McCrory et al., 2017, 2022; van IJzendoorn et al., 2020). Research has highlighted that for many children at risk of being deprived of their liberty, exposure to these experiences – and crucially, a lack of supportive early intervention – may contribute to their presenting needs and behaviours (CCO, 2024a; Khan et al., 2021; Roe, 2022; Roe & Ryan, 2023). There is a lack of evidence about exposure to which types or severity of trauma is most harmful, and why other children who experience similar trauma and adversity are not at risk of being deprived of their liberty (likely due to stability in living arrangements and relationships).

Children and young people's needs

Multiple studies have shown that children at risk of being deprived of their liberty have high prevalence of a range of needs and high-risk behaviours, including mental health concerns (relating to both diagnosed and undiagnosed problems), self-harm, aggressive or violent behaviours, sexual and criminal exploitation, offending behaviours, substance use, 'gang' affiliation, neurodiversity, and special educational needs and disabilities (Andow, 2024; Bartlett et al., 2021; Barron & Mitchell, 2018; Bryan et al., 2015; Gibson, 2022; Hales et al., 2018, 2022; Harris et al., 2021; Hart & La Valle, 2021; Kennedy et al., 2019; Khan et al., 2021; Roe & Ryan, 2023; Williams et al., 2019, 2020, 2024 – see Roe 2022 for a review of the evidence). All but one of these studies have focused on children living in or referred to SCHs; the exception is Roe and Ryan (2023), whose study explored the needs of children and young people subject to DoL applications over a 2-month period.

In particular, these studies found that emotion dysregulation – often linked to experiences of complex trauma – was strongly associated with self-harming behaviours, suicide attempts, alcohol and drug misuse, and challenging behaviours or responding with violence, which made managing needs and risks at home or in community (open) placements challenging (CCO, 2024a; Khan et al., 2021; Roe & Ryan, 2023).

There is some evidence that children deprived of their liberty (in a SCH or DoL order) may have undiagnosed or unidentified needs, including for potentially treatable or manageable mental health conditions. For example, Downie and Twomey (2021) report that in 2020, 35% of children placed in a SCH had a formal mental health diagnosis, while a further 44% had a suspected but undiagnosed mental health condition. Bartlett et

al. (2021) suggest that, of all children living in the secure estate in England on 14 September 2016, children detained in the welfare system were the least likely to have a formal mental health diagnosis (including neurodevelopmental conditions) compared to those in the youth justice and mental health secure estate.

A study in Scotland found that 65% of young people living in a SCH had clinically significant levels of post-traumatic stress and depression symptoms (Barron & Mitchell, 2018). Other studies have also suggested that autism spectrum disorder (ASD) (Kennedy et al., 2019), ADHD (Roe & Ryan, 2023), and speech and language difficulties (Bryan et al., 2015) may be undiagnosed in these children and young people. Hales et al. (2022) highlight that existing community identification and support for children with neurodevelopmental disorders is insufficient and may result in children developing a level of challenging behaviour that requires secure provision. Variable access to comprehensive formulation and assessment of children's mental health needs may also mean that treatable mental health needs go undiagnosed, exacerbating the difficulties children experience (NFJO, 2023c).

Some studies have pointed to gender differences in children's needs (Bartlett et al., 2021; Roesch-Marsh, 2014). Khan et al. (2021) highlighted that at the point of admission to a SCH, girls were more likely to have identified needs relating to self-harm (70.4% of girls vs 27.6% of boys) and sexual exploitation (87.6% vs 24.9%) compared to boys. A similar pattern emerges among children subject to DoL applications. Roe and Ryan (2023) found that more girls were likely to be subject to a DoL application primarily because of concerns related to sexual exploitation (100% vs 0%), self-harm (94.3% vs 5.7%), and mental health problems (73.1% vs 26.9%), while more boys had primary concerns related to criminal exploitation (100% vs 0%), disability (67.4% vs 32.6%) and behaviours that were considered a risk to others (66% vs 34%). This reflects the gendered pattern of entry into the secure estate, with many more boys ending up in the youth justice system than girls (Hales et al., 2018, Roesch-Marsh, 2018). However, research has also shown that many boys who end up in the youth justice system have high prevalence of mental health problems, and many girls in the welfare system present with challenging behaviours – differences in recorded needs likely reflect biases in how children are seen by services and decision-making processes, rather than substantial differences in children's needs (Bartlett et al., 2021).

Evidence also highlights that children often experience multiple needs. Roe and Ryan (2023) found that more than one risk factor was present for almost all children (95.2%) subject to DoL applications over a 2-month period, with an average of 4.2 risk factors present in each case (range: 1 to 8). Similarly, Williams et al. (2020) found that each child referred to a SCH between 1 October 2016 and 31 March 2018 had an average of 5.7 risk factors recorded on the referral form (range: 2 to 11). It is often the combined impact

of these multiple, intersecting needs that increases a child's vulnerability – and that systems struggle to respond to effectively (NFJO, 2023c).

The lack of consistent and formalised assessment measures makes comparison of the needs of children who end up in different settings difficult. Table 1 shows a comparison of identified needs for children who were referred for a place in a SCH in 2020, reported in Bach-Mortensen et al. (2022b) (based on referral data collected by the SWCU), and those subject to DoL applications between July and August 2023, reported in Roe and Ryan (2023). Different methods of data collection and different time periods make direct comparison difficult, but, overall, the 2 studies suggest that the most common presenting needs across the 2 groups are similar.

Table 1 Most common identified needs among children and young people referred to SCHs and subject to DoL applications

Need/risk factor	Children and young people referred to SCHs in 2020 (n=420; Bach-Mortensen et al., 2022b)	Children and young people subject to DoL applications, July and August 2022 (n=208; Roe & Ryan (2023)
Going missing (absconding)	97%	46.6%
Challenging behaviours	98%	69.2%
Substance misuse	83%	21.2%
Self-harm	33%	52.4%
Sexual exploitation	44%	21.2%
Mental health concerns	32%	59.1%

Sources: Bach-Mortensen et al. (2022b); Roe and Ryan (2023). Note: data comes from different sources and covers different time periods and may not be directly comparable.[34]

Limitations to the evidence

There are several limitations to the evidence on children's needs, which limits a full understanding of the complexity and multiplicity of needs that children experience.

[34] History of absconding is a criterion for use of s.25 of the Children Act 1989, which may explain why this is more frequently mentioned in referrals compared to in DoL applications. In the SWCU data, 'substance misuse' relates to any mention of alcohol, tobacco or drug use. Analysis of DfE data by Williams et al. (2020) found that 46% of children referred to SCHs over an 18-month period had an identified drug or alcohol problem and may be a more comparable figure.

Firstly, most studies have used a case file analysis approach, based on information included in applications for a DoL order or referrals for a place in a SCH. Available data therefore reflects information included in these sources only and may not provide a holistic picture of the child's needs.

Second, most studies have focused on quantifying the most common needs or risk factors present within the study cohort, and there is a lack of evidence about severity of need, how needs may overlap, cluster or co-occur, and when needs first present. A more in-depth understanding of children's needs may facilitate the identification of different cohorts of children with different needs.

There have been attempts to do this, including studies highlighting gender differences in children's needs (Bartlett et al., 2021; Khan et al., 2021; Roe & Ryan, 2023; Roesch-Marsh, 2014). In their analysis of 208 cases, Roe and Ryan (2023) attempted to group children subject to DoL applications according to different need profiles, based on information included in the application to court. They identified 3 'broadly distinct' cohorts:

- children who were considered at high-risk of harm from multiple, overlapping needs (mental health concerns, self-harming behaviours, and behaviours that were a risk to others)
- children for whom a DoL was sought due to concerns relating to a disability, and
- children for whom a DoL was sought primarily due to concerns relating to criminal or sexual exploitation

However, the study is based on a small sample using qualitative methods, and the authors stress that all children were experiencing a high level of intersecting needs that services were often struggling to manage. This multiplicity of need and the complexity it generates for services – including the prevalence of neurodiversity among children subject to DoL orders (CCO, 2024a) – must be considered when assessing children's needs. Data driven approaches to identify clustering of needs may be more fruitful.

One promising approach sought to use administrative data to identify households in the North West of England who might have children with 'complex needs' in order to support the design of integrated, whole-family services (Piroddi et al., 2024; note that the study has not yet been peer-reviewed). Households were identified as having children with complex needs if they included adults that had a combination of mental and physical health problems and at least one child with a known health or social care problem, a range of indicators of social vulnerability (e.g. homelessness, living in the 20% most deprived areas, lone parent, child in care), and high cost-weighted health and social care utilisation. They found that 8% of all households in the Cheshire and Merseyside region were identified as having children with complex needs. Such risk identification methods may be useful in providing targeted support to children and families.

There is also a lack of evidence about *when* needs first occur. Roe and Ryan (2023) suggest that, in many cases, the issues that led to the DoL application being made had been present for several years. In some of these case files, there was evidence of a rapid escalation in risk in the months leading up to the application – often linked to external factors, including placement moves, relationship breakdown or bereavement – and in a handful of cases the issues had only recently come to the attention of services. Many behavioural or mental health concerns were established by early adolescence, in line with developmental studies that highlight early adolescence as a key period for the development of mental health problems (Blakemore, 2019; McGorry et al., 2024). Further work in this area may highlight crucial periods where earlier intervention might be particularly beneficial.

Overall, there is a need for further research to facilitate a more in-depth understanding of the intersecting nature of children's needs and trajectories, which may help inform more targeted prevention and intervention efforts. The use of data driven approaches may be fruitful, although the lack of consistent assessment measures and data availability, particularly for children subject to DoL orders, remains a significant barrier.

Support received by children, young people and their families prior to a deprivation of liberty

There is also a lack of data about the support children receive to address identified needs prior to depriving them of their liberty. It is well-documented that many children and young people have experienced disrupted educations or spent significant time out of education, particularly in the months immediately prior to being deprived of their liberty (Andow, 2020, 2024; CCO, 2024a; Pates et al., 2018; Roe & Ryan, 2023; Williams et al., 2019, 2020).

In a mixed methods study of 43 children in Wales subject to SAOs between April 2016 and March 2018, Williams et al. (2019, 2024) found little evidence of sustained mental health support prior to the application for a secure order. In interviews, social workers attributed this to a range of factors, the most common being that the young people did not qualify for CAMHS as their behaviours were categorised as 'behavioural and emotional problems' rather than a diagnosable mental health disorder. For those that did qualify for treatment, services were inflexible, with treatment only being offered to those who quickly engaged or were in a stable environment. One young person was discharged after missing a single appointment. Children and young people also experienced long waiting lists, exacerbated by being placed at the bottom of waiting lists if they moved to a new placement that was in a different local health board boundary. Another study interviewing 15 children subject to DoL orders found that they struggled to access timely mental health support due to long waiting times, lack of an appropriate service, or feeling that the service provided was not right for them (CCO, 2024a). Hales

et al. (2018) report that 65% of those on welfare orders had contact with CAMHS prior to detention, although it is not clear what support was provided.

The difficulties that all children in care experience in accessing consistent and appropriate mental health support has been documented elsewhere (see for example Mannes et al., 2024; McGuire et al., 2022, 2025). For example, an analysis of over 71,000 records from a large NHS Trust showed that, despite their high levels of need, children with a social worker faced unequal access to CAMHS (Mannes et al., 2024). Even after accounting for other sociodemographic and referral characteristics, the study found that compared to other children and young people, those on child protection plans were around 2 times more likely to be rejected from CAMHS following referral, and those with other general social work involvement over 3 times more likely to be rejected.

Given the nature of their needs, children at risk of being deprived of their liberty and their families or carers require a joined-up approach in which multiple sectors, including health, social care, education and youth justice, work together to provide seamless support and care. While there is limited research about how sectors work together – and the factors that enable or prevent effective joint working – it is clear that this remains a significant challenge characterised by disagreements over care and funding responsibilities, fragmented services, limited resources and siloed working (CCO, 2024a; NFJO, 2023c; Ofsted, 2024a).

Summary and discussion

Evidence indicates that children and young people who are deprived of their liberty experience a range of complex, intersecting needs that services struggle to respond to effectively. In most cases, the evidence shows that needs have been evident for many years and children and their families are well known to services, indicating potential missed opportunities to intervene and provide effective support before needs escalate. The fact that evidence shows that children often experience repeat referrals to children's services, come in and out of care, and experience significant placement instability and disruption once in care, suggests that this early intervention is not being provided and their needs are not being met by the right services.

More research is needed to facilitate a more nuanced understanding of the intersecting needs of children at risk of being deprived of their liberty – particularly those subject to DoL orders – and to identify particular risk factors that may signal the need for intensive earlier support. Poor data availability and the lack of consistent assessment measures makes this research difficult (e.g. through data linkage or data driven studies). Similarly, research exploring alternative trajectories for children with similar experiences and needs who do not end up deprived of their liberty may be worthwhile.

Why children and young people in complex situations with multiple needs are deprived of their liberty

Research on the characteristics and needs of children and young people at risk of being deprived of their liberty suggests that they have a range of complex needs that are not being met. At the point of a DoL application being made, children face severe and immediate risk of harm to themselves (e.g. through self-harming or suicidal behaviours, or risks from others) and/or others (e.g. through dysregulated and violent behaviours) (Roe & Ryan, 2023).

There is a lack of research about decision-making prior to restricting a child's liberty, but an application is often made because professionals feel there is no other option to keep the child safe (Roe & Ryan, 2023). Research has highlighted significant professional anxiety around risk as a key component in deciding to restrict a child's liberty (Roesch-Marsh, 2018), although there is need for more research to understand how professionals can effectively manage risk without depriving a child of their liberty.

A lack of available placements for children with complex needs, and for older children in the care system in general, is a key contributing factor in the increase in children subject to DoL orders (Ofsted, 2022a, 2024a; Greatbatch & Tate, 2020; Parker & Tunnard, 2021; Roe, 2022; Roe & Ryan, 2023; Williams et al., 2020, 2024). The vast majority (91%) of local authorities surveyed by Ofsted in 2023 said they frequently have difficulty in finding suitable homes for children and young people with complex needs, particularly those with complex behavioural or mental health needs (Ofsted, 2024a).

The reasons for this are multiple and complex. Local authorities report that children's homes are often reluctant to accept referrals for children with complex needs. This might be because homes do not have the ability to meet specialist care needs, or the perceived risks of caring for a child with high levels of need. According to Ofsted, only 22% of children's homes in England say they can support children's mental health needs – and of these homes, just 5% were based in London, compared with 21% in the North West of England (Ofsted, 2022c). Children with complex needs also require more staff to care for them, which presents challenges in recruiting and retaining staff (Ofsted, 2024a).

In some cases, concerns about how children with high needs or certain risks may impact the dynamic within the home and the lives of other children living there lead to referrals being rejected (Ofsted, 2024a; Hart & La Valle, 2021). Some managers also report concerns that accepting children and young people with complex needs could negatively affect the home's Ofsted inspection judgement, as it can be more challenging to achieve or evidence good outcomes for these children (Greatbatch & Tate, 2020; Ofsted, 2024a; ICHA, 2019). Lack of joined-up working with other services – in particular, difficulty in getting support for children from mental health services – is also an issue (Bach-Mortensen et al., 2022b; Ofsted, 2024a).

The children's residential market has also not kept up with demand. In 2018/19, Ofsted reported that the children's residential system saw only a 6% increase in homes and a 1% increase in beds (cited in CCO, 2020b). Competition for placements is driving up costs. Around half of local authorities reported 'often' (41%) or 'always' (10%) struggling to find homes for children because the placement costs are too high (Ofsted, 2024a). Most residential children's homes in England – 79% in March 2022 – are operated by for-profit companies (Ofsted, 2024b), and concerns have been raised about the impact of this on local authorities' power in commissioning arrangements, sufficiency planning and being able to find high-quality residential homes in suitable locations that can meet children's needs (Bach-Mortensen et al., 2022a; Ofsted, 2022b).

Placement sufficiency is complex and multi-faceted and is beyond the scope of this review to consider fully. Nonetheless, it has obvious consequences for children with complex needs. Lack of choice means local authorities are having to resort to using placements that are unsuitable, including unregistered accommodation (Ofsted, 2024a; Greatbatch & Tate, 2020; CCO, 2020b). According to Ofsted, children can wait months – or in the worst cases, years – for a stable home, while in the meantime ending up in sometimes inappropriate placements with carers who lack the skills to look after them (Ofsted, 2024a). Difficulty finding suitable placements can drive thinking around applying for a DoL order, when it is often seen as the only way to keep a child safe (Ofsted, 2024a; Parker & Tunnard, 2021). The lack of sufficient and suitable places in SCHs and appropriate mental health provision is also contributing to this.

Lack of capacity in SCHs

Demand for places in SCHs far outstrips the number of places available, with many children referred not found a place – around 1 in 2 in 2020 (Downie & Twomey, 2021). A study by Wiliams et al. (2022), which analysed welfare referrals made to SCHs between October 2016 and March 2018, provides some evidence about why children may not be offered a place in a SCH and who is least likely to be offered a place. Of the 527 children and young people referred during the study timeframe, 40% were not allocated a place. In many cases, the application process was time-consuming. Of those successfully found a place, it took on average 3 applications to SCHs across England and Wales – and up to 6 in one case (Williams et al., 2022).

The factors associated with successful placement included being female, being younger, having had a previous placement in a SCH, and being at risk of sexual exploitation (Williams et al., 2022; Wood et al., 2024). Children not placed were significantly more likely to be older, to be male, and have a history of challenging, offending or sexually harmful behaviour. A history of challenging behaviour prior to referral reduced the odds of placement by 66% (Wood et al., 2024). Single factors that were cited by SCHs as a reason not to accept a referral included concerns about the capacity of the home to

manage needs relating to violent behaviours, self-harm or suicidal intention, high drug use, mental health problems, offending, and/or frequent absconding, as well as concerns that the child's needs together with those of other residents would exceed staff capacity (Williams et al., 2024). More recent descriptive data from 2021 (Bach-Mortensen et al., 2022b) suggests that the behaviours associated with the lowest placement success in a SCH include sexually harming behaviour, fire setting, self-harm, adoption breakdown, and mental health needs (35%). Children experiencing risks from sexual exploitation, criminal exploitation and sexualised behaviour were most likely to be accommodated.

While Williams et al. (2022) highlight that in some cases non-acceptance was related to a range of legal, organisational and individual factors, it is nonetheless concerning that there appear to be a group of children who are viewed as 'too difficult' to place in SCHs. Andow's (2020, 2024) ethnographic study in one SCH in England has suggested that staff perceive that the complexity of needs of children in SCHs has increased, with homes struggling to manage this complexity (see also Bach-Mortensen et al., 2022b). These struggles are related to staffing issues and outdated physical facilities (i.e. homes were considered too large for the variable needs of the current cohort of children), as well as issues with siloed commissioning practices and a lack of national oversight to manage demand (Andow, 2020; Bach-Mortensen et al., 2022b; Hart & La Valle, 2016). Stakeholders have called into question the ability of SCHs to meet their purpose – to keep the most vulnerable children safe (Bach-Mortensen et al., 2022b).

The evidence from these studies highlights the need for further research and review to understand why SCHs are unable to meet the needs of so many children referred to them, and what improvements or changes to the current regulated secure accommodation estate and commissioning practices may be required to enable them to better meet these needs.

Children and young people who do not meet criteria for detention under the Mental Health Act

Local authorities also report difficulty in finding suitable placements for children with mental health difficulties who fall just below the threshold for children and young people's mental health (CYPMH) inpatient services (the threshold for sectioning under the Mental Health Act), or for children who have just been discharged from a CYPMH inpatient treatment admission (CCO, 2024a; Ofsted, 2024a; Roe & Ryan, 2023). These are children who may display often extreme dysregulated behaviours, including self-harm that can cause serious injuries, and suicidal thoughts and behaviours (Roe & Ryan, 2023). While mental health inpatient treatment services may not always be the most appropriate service response to these children and young people's needs, Ofsted report that 'children's social care services are now finding and funding provision for children who might otherwise have been in mental health or secure facilities' (Ofsted, 2024a).

There is a lack of published data about the number of children who are assessed as not meeting criteria for detention under the Mental Health Act.

Roe and Ryan's (2023) analysis of the applications for a DoL order in 208 cases highlights that, despite the prevalence of severe emotional difficulties and self-harming behaviours in the study sample, very few children and young people met the criteria for inpatient mental health treatment. In all, 39 were recorded as being assessed for treatment under the Mental Health Act 1983. Of these children, a quarter (10 children) had met criteria for detention under the Act at some point, but the overwhelming majority did not. In these cases, presenting behaviours were judged to be the result of ongoing trauma, attachment difficulties and/or other behavioural issues, and not attributable to a diagnosable or acute mental health disorder.

Another study by the CCO involved interviews with 15 children (aged 13 to 17) who had been subject to a DoL order (CCO, 2024a). For around half (7) of the children interviewed, mental health problems, and increased risk of harm to themselves or others, were the main reason a DoL order had been sought. Five children had been admitted to hospital with mental health difficulties and self-harm prior to discharge into the community under a DoL order, 4 of whom were admitted under the Mental Health Act.

These 2 studies have suggested that local authorities experience particular difficulties finding suitable community placements for children with severe emotional or mental health difficulties. Around 10% of DoL applications are made for children who are in hospital (at the time of the application) due to mental health concerns (Roe & Ryan, 2023). All 5 of the children interviewed by the CCO who had spent time in hospital prior to a DoL order, had spent many months awaiting discharge to a suitable community placement, despite no longer meeting the criteria for detention and being medically fit for discharge. Another study by Lever et al. (2024), which summarises the experiences of 2 looked-after children (who are co-authors of the study) during an inpatient stay, similarly highlighted that children can become 'stuck' in hospital wards. One of the children, Amy, was initially admitted for a 72-hour crisis admission but ended up spending around 12 months on the ward because there was nowhere else for her to go.

What is the purpose of depriving a child or young person of their liberty?

There is a lack of research about what professionals and providers deem the *purpose* of depriving a child of their liberty. A recent evidence review (Roe, 2022) highlighted a lack of clarity around the purpose of depriving a child of their liberty for welfare reasons and what is supposed to be achieved by a secure placement, with some confusion about whether the primary purpose of secure placements is to provide short-term stabilisation and safety (i.e. to 'hold' children; Hart & La Valle, 2016), or to address the child's underlying needs and circumstances that led to the deprivation of liberty.

There is no evidence about what professionals consider the purpose and aims of a DoL order, although research has highlighted that DoL orders are often sought during a 'crisis' where there is no other available placement that can keep the child safe and is unlikely to be planned (Roe & Ryan, 2023).

What happens to children and young people with complex needs who are deprived of their liberty

Legal outcomes of a deprivation of liberty application

Data suggests that most applications for a DoL order under the inherent jurisdiction of the High Court are granted. Most recent data from the MoJ shows that of the 960 applications made between January and September 2024, a DoL order was made in 830 cases (86.5%) (MoJ, 2024). There is no information about what happened in the 130 cases where an order was not made.

A case file analysis of legal outcomes in 113 cases reported that in the 9 cases (8.0%) where a DoL order was not made, the application was withdrawn at or before the first hearing (Roe et al., 2023). This was mainly because a DoL order was no longer deemed necessary, but in some cases the local authority was directed to apply to the court of protection due to the child's age, or a SAO was made to place the child in a SCH (Roe et al., 2023).

Where are children and young people placed under a DoL order?

A child subject to a DoL order can be placed in any setting, but there is limited evidence about where children are living while subject to DoL orders, and data is not routinely collected or published.

The only national data comes from an analysis of the legal outcome of 113 DoL cases which were tracked over a 6-month period (Roe et al., 2023). In over half of cases (53.8%), children were placed in at least one setting that was (at the time of the research) an unregistered placement.[35] A third of children (32.7%) were in registered placements throughout, and information about registration status was not included in orders in 14 cases (13.4%). Unregistered settings ranged from semi-independent accommodation, Care Quality Commission (CQC)-registered accommodation, hospital wards, and temporary rented accommodation, including hotels or caravans.

Placement in what was (at the time of the research) an unregistered setting was particularly common for children for whom the DoL order was sought mainly due to

[35] Includes children and young people placed in what was (at the time of the research) unregulated (supported) accommodation as care was being provided.

concerns about criminal exploitation, emotional difficulties, risk to others and self-harm (>70% placed in at least one unregistered placement during the study period) (Roe et al., 2023). The authors suggest that this indicates a particular lack of suitable registered provision for children experiencing such risks.

The use of unregistered provision to accommodate children subject to DoL orders was also identified in a recent report by the Children's Commissioner for England (CCO, 2024b), who asked all local authorities in England for information about the looked-after children who they had placed in unregistered children's homes. Data showed that on 1 September 2024, 775 looked-after children were living in unregistered placements in England, of whom almost a third (31%) were subject to a DoL order. The most common type of placement was an unregistered house (47% of children), followed by supported accommodation (40%), holiday rentals (3%) and holiday camps or activity centres (2%).

The CCO found high costs and 'very high profits' being made by some providers. Notably, the mean cost of placements for children on DoL orders in unregistered accommodation was higher than other placements, at £2,140 per day compared to £1,321 per day (CCO, 2024b).

The lack of routinely published national data about how many children subject to DoL orders are living in unregistered settings is a key gap in the evidence. While local authorities should notify Ofsted when they place a child in an unregistered setting, changes to Practice Directions issued by the President of the Family Division in 2023 (Courts and Tribunals Judiciary, 2023) and concerns about the court's ability to monitor the use of unregistered accommodation (Roe et al., 2023) suggest this is unlikely to be happening consistently. There is a need to improve data collection on a national scale.

There is also a lack of data about who children are living with while subject to a DoL order, with one qualitative study raising concern about the number of children living in solo placements (CCO, 2024a).

Evidence also suggests that children and young people continue to experience placement instability while subject to a DoL order. A case file analysis of the legal outcomes in 113 DoL cases over a 6-month period found that most children and young people moved at least once while subject to a DoL order, and 16 moved 3 or more times (Roe & Ryan, 2023).

Distance from home

The Children Act 1989 (s.22C) and accompanying guidance requires children to be placed as near to their home as possible, unless this would be contrary to their welfare. Despite this, evidence suggests that children deprived of their liberty are often placed out of their home area, more so than other children in care.

In their analysis of the legal outcomes in 113 DoL cases, Roe et al. found that children subject to DoL orders were placed at a mean distance of 56.3 miles away from home (range: 1 to 390) (Roe et al., 2023). The authors found that registered placements tended to be further away: 27.1% of registered placements were more than 100 miles from the child's home area, compared to 9.0% of unregistered placements, suggesting that local authorities may be opting to place children in unregistered provision that is closer to home. However, this is not borne out by data collected by the Children's Commissioner for England, which showed that most children living in unregistered provision in England on 1 September 2024 while subject to a DoL order were placed out of area (CCO, 2024b).

Children subject to DoL orders have spoken about their unhappiness at being placed out of area and their strong desire to be nearer their family (CCOa, 2024).

Children and young people in SCHs tend to be living further from home – between 2018 and 2020, those living in SCHs were, on average, 141 miles from home (Downie & Twomey, 2021). Smith et al. (2022; see also Hales et al., 2018) found that, of all children living in the secure estate in England on 14 September 2016, children in welfare placements were more likely to be living out of area than those detained under justice or mental health legislation. Three-quarters (73.8%) of those in welfare placements were living more than 100 miles from home, compared to just one quarter (26.4%) across the whole secure estate (Smith et al., 2022). There are no SCHs in London or the West Midlands, and just one in Wales, meaning it is highly likely that children will be living some distance from home (Warner et al., 2018).

Children and young people placed in Scotland

There is also evidence that a small but significant number of children from England or Wales are deprived of their liberty in Scotland, under a DoL or SAO.

One study has shown that in a sample of 113 children and young people subject to DoL orders, 6 were placed in Scotland (in a registered children's home) (Roe et al., 2023). There is no routinely published data about the number of children placed in Scotland under DoL orders. The Scottish Government recently confirmed that they received 8 notifications regarding children placed into residential care in Scotland from England on a DoL order in the previous 12 months (December 2023 to December 2024) (Scottish Government, 2025). As of the end of January 2025, 2 further notifications had been received. The Children and Young People's Commissioner for Scotland (2023) has raised concern about the experiences of children from England and Wales placed in residential care settings in Scotland while subject to a DoL order, including under conditions that have not fully respected their rights under the European Convention on Human Rights and the UN Convention on the Rights of the Child (particularly in relation to their rights to education and health).

Gibson (2020, 2021) found that, of all children living in secure accommodation in Scotland on one day in 2018 and 2019, over two-thirds (37% in 2018; 36% in 2019) were placed there by English or Welsh local authorities. Further analysis of these cases suggests that children placed in Scotland have more complex needs than those in SCHs in England (Gibson, 2022). Williams et al. (2020) also found that some children (12%) who were refused a place in an English SCH went on to be accommodated in secure accommodation in Scotland. It is not clear why Scottish SCHs were able to accommodate these children while English SCHs were not.

Scottish Government statistics show that the number of English and Welsh children placed in SCHs has declined in recent years.[36] The latest data for 2022/23 shows that, on average, there were 22 children (down 33% from 2021/22) from outside Scotland living in Scottish SCHs at any point during the year; those 22 children comprised more than a third (37.3%) of the total number accommodated (Scottish Government, 2024).

Unsurprisingly, children deprived of their liberty in Scotland are further away from home than those placed in England and Wales – on average, children on DoL orders in Scotland were 254 miles away from their homes (Roe et al., 2023) and children in SCHs 353 miles away (Gibson, 2022).

Restrictions on children and young people's liberty

DoL orders can authorise a range of restrictions on a child's liberty, and the applicant should set out the restrictions sought in the application to court. The final order made by the court is permissive. This means that while the court has authorised restrictions on liberty, those restrictions are permitted and not mandatory (unlike detention under the Mental Health Act, for example, whereby restrictions are required until the responsible clinician agrees they should end). When a DoL order is in place, the local authority should impose restrictions only when they are necessary for the child's welfare. The DoL order does not prevent restrictions being reduced and specifies that the restrictions authorised by the court should only be imposed when it is necessary for the child's welfare.

There is no routinely published data about restrictions authorised by DoL orders. Analysis of the legal orders made in 113 DoL cases highlighted the severe restrictions that children subject to DoL orders are placed under (Roe et al., 2023). Each child or young person was subject to an average of 6 different types of restriction (range 1 to 12), with almost all (99.0%) subject to constant adult supervision – including 31.6% of children who had 3 or more adults supervising them. Restraint was permitted in over two-thirds (69.4%) of cases. In three-quarters (77.6%) of cases, doors and windows were locked to

[36] Note that as part of the recommendations made following the Scottish Independent Care Review ('The Promise'), Scottish SCHs should only accept children from local authorities in Scotland.

prevent the child from leaving the placement, and restrictions on mobile phone and internet use were enforced in 62.2% and 55.1% cases respectively. Other restrictions included the removal of items from the home that might cause harm, searches of the child's belongings and/or self, use of secure transport, and restricted access to money.

In general, the court authorised all the restrictions requested by the local authority (or other applicant) and the authors of the report raised concern about the lack of step-down planning or clear processes for removing restrictions on children's liberty (Roe et al., 2023). Indeed, the study found that in subsequent orders, the type and severity of restrictions on the child's liberty either remained the same or was increased in the overwhelming majority of cases (90.7%).

In interviews with the CCO, children and young people expressed dissatisfaction and uncomfortableness of being under constant supervision and feeling like they had a complete lack of control over their lives (CCO, 2024a). While children generally were aware of the restrictions imposed on them and understood why they were in place, they felt that the extent and duration of restrictions was unfair and unjustified. In particular, the lack of a clear plan about when and how restrictions would be reduced caused frustration. While some thought that staff were flexible, other children and young people felt they did not have the opportunity to demonstrate that restrictions were no longer necessary (CCO, 2024a).

The frequent authorisation of restraint in DoL orders is a concern, as reflected in data showing that most orders authorise restraint and by children's experiences highlighted in the CCO's report (Roe et al., 2023; CCO 2024a). There is no data about how often children experience restraint. But while DoL orders are permissive, qualitative evidence suggests it is used on a regular basis for some children (CCO, 2024a). In interviews with 15 children and young people who had experience of a DoL order, the CCO found that most (9) had experienced restraint: for 4 (who had autism and/or a learning disability) this was a regular occurrence, and 5 experienced occasional restraint (CCO, 2024a).

There is some evidence that restraint may be used more frequently to manage children's behaviour in inappropriate settings or by inexperienced staff. In their report, the CCO highlight that for all children who had experienced restraint, its use reduced significantly after they moved to a more appropriate placement and with the introduction of an experienced child-centred care team (CCO, 2024a). In a survey carried out in 2023, staff in forensic child and adolescent mental health services (FCAMHS) highlighted concerns about the quality of care being provided to children and young people in unregistered settings – in particular, an over-reliance on the use of physical restraint because staff were unexperienced and underqualified in caring for children with complex needs (Hindley, 2023).

With regard to children living in SCHs for welfare reasons, there is a lack of data about the use of restraint and restrictive practices. Data from the Youth Justice Board (YJB) shows frequent use of restraint and separation for children placed in SCHs on youth justice grounds (YJB, 2024); however, equivalent data for welfare children does not exist. In her ethnographic study in a children's home in England, Andow (2020) reports that restraint was often used in response to children's self-harming behaviours, and children themselves report experiences of restraint while in secure care as petrifying and highly traumatising (Khan et al., 2021).

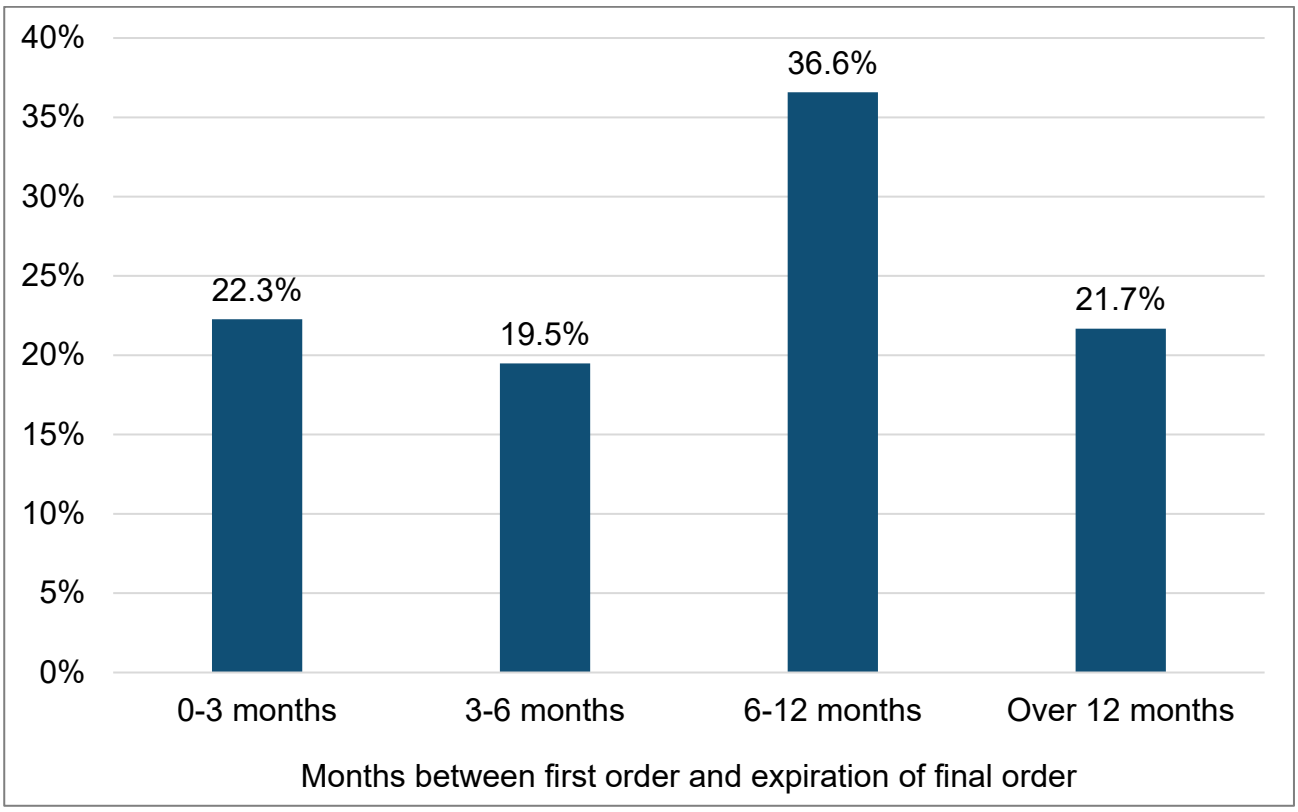
In adolescent mental health inpatient settings, evidence suggests that restraint is used regularly, often as a reactive behaviour management strategy (Nielson et al., 2021). Doyle et al. (2024) aimed to explore whether demographic and clinical characteristics were associated with the use and type of restrictive interventions in an adolescent inpatient unit in the North West of England, using routinely collected NHS data over a 2-year period from 2021 to 2022. Of the 122 children admitted, 46 (38%) experienced restrictive intervention. Being a looked-after child (7% of those admitted) was associated with increased use of restrictive interventions, particularly physical and chemical interventions.

How long are children and young people subject to restrictions on their liberty?

There is limited evidence about the length of time children remain subject to DoL orders. The MoJ began collecting data about DoL orders under the inherent jurisdiction in July 2023 and, as of September 2024, have begun publishing information about the length of time between the first order and the expiration of the final order for cases where a final order has been made.

Of the 651 cases started between July 2023 (when data was first available) and December 2023, 503 had had a final order made by September 2024. In over one-fifth (21.7%) of these cases, children were still subject to a DoL order 12 months after the first order was made (see Figure 4). Over one-third (36.5%) were subject to a DoL order for more than 6 months, over one-fifth (22.3%) for less than 3 months, and just under one-fifth (19.4%) for between 3 and 6 months.

Figure 4 Length of time between first DoL order and expiration of final order (% of cases started between July and December 2023 with a final order at September 2024) (MoJ, 2024)



Source: Ministry of Justice (2024)

Data shows children are subject to DoL orders for significant lengths of time, which suggests these are not short-term measures. In the CCO's qualitative study, one child interviewed had been subject to a DoL order for just under 3 years (CCO, 2024a).

Children placed in SCHs appear to be subject to restrictions on their liberty for less time. Although data published by the DfE does not differentiate between children placed under welfare and justice legislation, it shows that in 2024 most children were accommodated for either 1 to 3 months (28%) or 3 to 6 months (26%) (DfE, 2024). Earlier evidence has suggested that just a third (29%) of all children placed on welfare grounds who were discharged between 2018 and 2020 had stayed longer than 6 months (Downie & Twomey, 2021; see also Khan et al., 2021). This is likely due to the nature of SAOs: once the child no longer meets criteria under s.25 of the Children Act 1989, the order must be discharged. Although there has been some suggestion that the relatively short nature of secure accommodation placements can restrict children's progress and cause unnecessary instability (Williams et al., 2019), it does mean that children under SAOs are subject to restrictions on their liberty for significantly less time than those on DoL orders.

Children and young people's experiences of being deprived of their liberty

There is a lack of research on children's experiences of being deprived of their liberty, under both DoL orders and SAOs. There have been a handful of ethnographic studies, where researchers have spent an intensive of period of time in one SCH (Andow, 2020, 2024; Ellis, 2018), and some studies have interviewed children directly about their experiences of living in a SCH (Williams et al., 2019; Khan et al., 2021; Roesch-Marsh, 2014) or on a DoL order (CCO, 2024a; NFJO, 2024).

The most substantial study in relation to DoL orders was conducted by the CCO in 2024 (CCO, 2024a). The study, which was commissioned by DfE to inform planning and joint work to improve care, involved interviews with 15 children and young people (aged 13 to 17) who were currently subject to, or had previous experience of, a DoL order. While the study provides crucial insight into children and young people's experiences of a DoL order, it is based on a small sample that is unlikely to be representative of all those subject to an order. In particular, as the authors acknowledge, most children were recruited to the study via contact with local authorities, and those who choose to speak to researchers may have had a more positive experience than those who are not in a position to share their experiences. There is a need for further research in this area.

Just one study was identified that explored the experiences of looked-after children admitted to mental health inpatient units; that study summarised the experiences of 2 care-experienced young people (Lever et al., 2024).

Communication and involvement in decision-making

A key theme to emerge from the literature is that children and young people are frustrated by a lack of communication and limited opportunities to be involved in decision-making about their care both before and during a deprivation of liberty (CCO, 2024a; Khan et al., 2021; Lever et al., 2024; NFJO, 2024; Roesch-Marsh, 2014; Williams et al., 2019). This caused anger, frustration and potential disengagement.

One-third of children interviewed by the CCO (2024a) were not told anything about the DoL order until after it had been made – an experienced shared by several young people involved in a study by the NFJO (2024). It took one child 6 months to find out they were subject to a DoL order.

Children expressed the view that a failure to properly involve them in assessments or care planning meant professionals had an incomplete picture of their lives, which in turn meant that they were less likely to receive the support they needed (CCO, 2024a). One child reported feeling like they were only allowed to be involved in decision-making when they were considered 'low risk'; when their behaviour escalated, they were not involved (NFJO, 2024).

Analysis of court applications suggests that children and young people have limited formal opportunities to be involved in DoL hearings (Roe et al., 2023). In their analysis of applications to the national DoL court, Roe et al. (2023) found that 1 in 10 children (9.6%) attended at least one hearing in their case. Five children spoke to the judge directly before the hearing, and 6 children had written to the judge to share their views. Among the 15 children interviewed by the CCO, 7 had an independent advocate and 8 did not (CCO, 2024a).

Experiences prior to the DoL order

A key theme that emerged in the Children's Commissioner's report was that although the 15 children interviewed all had a unique set of circumstances and experiences prior to the DoL order, a lack of early intervention was evident in all cases (CCO, 2024a). Children and young people wanted more support for their families, including intensive packages of support and better coordination between children's, health, education and/or youth justice services. Several children felt that if this support had been provided, it might have prevented issues escalating and enabled them to remain at home. Some also felt that their parents were unnecessarily and unhelpfully blamed by children's services for the situation, at the expense of focusing on their needs and circumstances (e.g. poor mental health and/or risks from extra-familial harm). For several children and young people who were subject to a DoL order because of their mental health, there was little evidence of sustained mental health support prior to the DoL order. Some felt that the crisis point which ultimately triggered implementation of the DoL order could potentially have been avoided if more timely and appropriate mental health support had been provided earlier on.

Children and young people have also spoken about the impact of instability in their living arrangements, high staff turnover and living in placements that did not meet their needs on their mental health, their behaviour and their ability to form trusting relationships (CCO, 2024a; Williams et al., 2019). In one study, which involved care experienced children from Somerset being interviewed by a peer researcher (5 of whom had experience of a DoL order), children described feeling as if building relationships was 'pointless' as they knew they would be moved again (NFJO, 2024). In one study involving children referred to secure accommodation in Scotland (Roesch-Marsh, 2014), children pinpointed their move from the family home into residential care as a crucial turning point; they saw this as directly related to why they ended up in secure accommodation. They described feeling hopeless and unsettled, and this coincided with a decline in their behaviour or starting to run away from the home in an attempt to communicate their unhappiness with their placement and situation – a finding that is echoed in the CCO's report (CCO, 2024a).

Experiences of living under a DoL or in a SCH

In general, children report negative experiences of being subject to restrictions on their liberty. Children and young people subject to DoL orders have described the severe impact that restrictions had on their mental health and wellbeing, expressing a sense of hopelessness, frustration, boredom, anger and loneliness at living under a DoL (CCO, 2024a).

Several studies have highlighted that girls entering SCHs felt as though they were being punished, and – particularly for children who were placed in secure care due to concerns about sexual or criminal exploitation – confusion and a sense of injustice about why they had been locked up when their perpetrators were not (Ellis, 2016; Khan et al., 2021; Williams et al., 2019). Other studies have reported positive experiences, with children feeling safe once settled in the SCH (Andow, 2020; Ellis & Curtis, 2021; Pates et al., 2021).

In terms of the home environment, studies in SCHs have highlighted that children and young people commonly experience the environment as institutionalised and oppressive (Ellis, 2018; Ellis & Curtis, 2021). Settings varied for children subject to DoL orders interviewed by the CCO, but children generally reported that they were clean and well furnished, with some evidence of personalisation (CCO, 2024a). Of the 15 children interviewed, 3 were living in ‘bespoke’ placements – i.e. in a house rented or bought by the local authority for the child. The authors report that while visiting children and young people in their placements, these homes appeared to be of good quality and suitable for the children, although interviewees spoke about previous poor experiences of bespoke arrangements, particularly emergency placements.

There is little information about children’s daily routines in secure care. The CCO found that most children interviewed had a weekly timetable and opportunities to engage in leisure activities and trips (CCO, 2024a). Several children were following structured programmes or plans to increase their independence in skills such as cooking and cleaning. However, children also spoke about experiencing boredom and having a lot of unstructured free time – this was significantly worse for those who had spent time in unregistered placements or on hospital wards. Parents and professionals also expressed concern about the lack of sensory stimulation and activities provided for 2 children with autism. In general, children reported good access to physical healthcare when they needed it and spoke positively about the food provision in their current placement. However, some had had poor experiences in the past with (mostly unregistered) placements that provided ready meals or junk food. The study makes clear that there is significant variation in children’s day-to-day experiences while subject to a DoL order, and more research is needed to understand day-to-day life for children in unregistered settings in particular.

Ethnographic studies in SCHs have highlighted homes' attempts to deliver an extra-curricular programme of activities for children, including painting, colouring, baking and drama (Andow, 2020; Ellis, 2018). However, activities had to be carefully chosen and supervised due to the prevalence of self-harming behaviours among residents, and children reported that they sometimes found the activities patronising rather than enjoyable (Ellis, 2018).

Children's relationships with staff in the placement is consistently highlighted as a crucial factor in determining children's experiences of secure care. The CCO report that all children had some positive things to say about their current care team (CCO, 2024a). Eight of the 15 children and young people reported particularly positive relationships with staff in their current placement, including that they were involved in day-to-day decisions about their care. However, they also reported that the quality of staff could be variable; many spoke about less positive experiences in previous placements, particularly in emergency or unregistered placements or when being cared for by agency carers. Experiences of poor treatment included feeling that staff did not care about them or did not have adequate training to meet their needs – particularly needs relating to neurodiversity and/or disabilities.

Across the literature, consistency in children's care teams was seen as vital in supporting children and young people to establish meaningful relationships, as was having carers who took the time to get to know them, treated them as individuals, and had the skills and expertise required to recognise and meet their needs (CCO, 2024a; Jacob et al., 2024; NFJO, 2024).

Contact with friends and families

Children's ability to maintain connections with friends and family while in secure care has received little attention in the literature, despite the importance of this for maintaining relationships and supporting transitions back into the community (Roe, 2022).

Of the 15 children and young people interviewed by the CCO, all but 4 were living alone with their carers while subject to a DoL order, and they reported struggling with isolation and loneliness (CCO, 2024a). One child described how she had lost contact with a lot of her friends while subject to a DoL order. Parents and professionals also expressed concern about the impact of solo placements on the children's social development and their ability to form relationships with peers later in life.

The report does highlight some positive examples where placement providers had sought to provide children with opportunities to socialise with other young people, despite the risks that might be associated with peer interaction (CCO, 2024a). This included one child who was supported by carers to attend weekly activities including mountain biking, kayaking and climbing.

Children also wanted to have more contact with their family. Contact with family members varied according to a range of factors, including whether children had unsupervised access to a mobile phone, restrictions imposed on family contact by the DoL order and/or care order, and geographical distance and travel costs for family members. Nine children spoke about missing their family and the impact this had on their mental health and wellbeing (CCO, 2024a).

Access to interventions and care provided while subject to a DoL order

Judges, children's guardians and parents and carers have raised concerns about children's access to education, mental health and therapeutic interventions while under DoL orders (Roe et al., 2023), although there is a lack of evidence about the quality and type of care that is provided to children.

Again, the only evidence for children subject to DoL orders comes from the study by the CCO who interviewed 15 children about their experiences while subject to a DoL order (CCO, 2024a). This study raises significant concerns about children and young people's access to specialist care, education and mental health support while subject to a DoL order.

Education

All 15 children interviewed by the CCO had access to some form of education while subject to the DoL order, but the quantity and quality of provision varied significantly. Five children attended an external education provision with restrictions in place. Another child had the option of attending college in person but chose to access provision online. All other children received 1:1 tuition in their placement (CCO, 2024a).

All but 2 children received far fewer hours of education provision while on a DoL order than is typical for their peers living in the community without restrictions, whether in a mainstream school or a specialist setting; this includes one child who received just 2 hours a week of face-to-face tuition (CCO, 2024a). Children expressed frustration at the limited courses and subjects available to them as these did not match their interests or aspirations. The CCO's report raises significant concern about children's rights to access education while under a DoL order and the support they need to reach their educational potential, including to study for and achieve GCSE qualifications.

Mental health support

Children and young people interviewed by the CCO described receiving a variety of mental health interventions while subject to the DoL order, depending on their individual needs and situation (CCO, 2024a). This included the involvement of a psychiatrist, talking therapies provided by CAMHS or other specialist therapeutic support from other services, including from within their education provision for some children. Six children

and young people had therapy in their setting, which could be regular sessions from a visiting psychotherapist, art or music therapy, or support provided by staff through therapeutic activities.

Children's satisfaction with mental health provision varied. Some spoke positively about the interventions they had had, while others felt the provision was inadequate or inappropriate for their needs.

It is worth noting that most children and young people in the CCO's study were in registered, stable placements (CCO, 2024a), and other children on DoL orders may experience much more variability in access to mental health interventions. A study analysing the legal orders made in 113 DoL cases highlighted that issues around children's access to therapeutic services were often raised in court (Roe et al., 2023); these includes issues relating to waiting lists, disruption to services caused by children frequently moving placement, and delays in appointing psychologists to carry out assessments. Data suggests that 60% of children living in unregistered accommodation while subject to a DoL order on 1 September 2024 were in receipt of CAMHS services – almost twice as many as those in unregistered accommodation not on a DoL order (33%) – although it is not clear what services children were receiving (CCO, 2024b).

Children themselves report that, while subject to a DoL order, they did not receive sufficient help or support to address their underlying needs, with professionals tending to focus on risks rather than needs (CCO, 2024a; NFJO, 2024). Despite being medically fit for discharge, one child had spent a month in a general hospital ward because the local authority could not find anywhere else for her to go. She talked about professionals 'constantly fighting fires, rather than planning how to stop the fire altogether' (NFJO, 2024).

Secure children's homes and mental health inpatient settings

Concern has also been raised about the ability of SCHs to meet children's mental health and behavioural needs through the provision of therapeutic, integrated and trauma-informed services (Andow, 2020; Hart & La Valle, 2016; Khan et al., 2021; Williams et al., 2024). In a Welsh study, social workers reported that children's mental health needs were not met during placements in a SCH (Williams et al., 2024). They reported concerns about the nature and quality of the therapy being offered, suggesting that a 'sticking plaster' approach was common, which failed to address the child's underlying needs.

Reviews have also highlighted the significant variation in the types of treatment models used and interventions offered in SCHs and general adolescent mental health inpatient units. Warner et al. (2018) surveyed all secure care providers in England (across welfare, justice and mental health) in 2016, finding that most – but not all – hospitals (89%) and SCHs (71%) had an overarching theoretical treatment model. They report wide variability

in the types of models used: in hospitals, the most common overarching theoretical framework was a selection of 'non-specific/multi-therapeutic' models, which grouped models such as the recovery model and bio-psycho-social model; in welfare SCHs, frameworks tended to be more focused on social theories, such as systemic frameworks. International evidence reviews (Hayes et al., 2019; Schutte et al., 2023) have also highlighted significant variety in the type of interventions offered in adolescent inpatient units and inconsistent evidence about the effectiveness of approaches used, which makes it difficult to decipher a 'gold standard model of care' for adolescent inpatient units. Other studies have highlighted barriers in the implementation of evidence-based interventions within adolescent inpatient units, including reduced length of admission, lack of early intervention, high levels of self-harm and high rates of readmission (Doyle et al., 2024).

One study, which reported on the experiences of two care-experienced children during an inpatient admission, highlights that both felt unstable, confused and insecure during the hospital stay (Lever et al., 2024). The two young people, Amy and Diego (who are also co-authors of the study), ended up staying on the ward for longer than initially planned. They highlight that this made them feel 'unwanted' and 'hopeless', with a sense that their needs were too difficult for others to support them. Amy and Diego also report being acutely aware that they were at the centre of disagreements between services, particularly mental health and social care – with heated discussions about who was responsible for their care taking place in front of them. This led to them feeling belittled and as though they were a burden. They also highlight that their sense of hopelessness was 'mirrored' by the systems supporting them, with everyone involved becoming 'caught in a narrative of helplessness'.

Transitions from secure care to the community

Research has consistently highlighted effective planned transitions from secure accommodation as key to supporting children's outcomes (Bach-Mortensen et al., 2022b; Hart & La Valle, 2021; Williams et al., 2020, 2024; Roe, 2022). However, transitions are frequently highlighted as being poorly managed, with children's needs often not being adequately met following discharge from secure accommodation. Several barriers to effective transition planning have been identified, including difficulty finding suitable placements for children, providers refusing to accept children with a history of secure care, poor communication between services, and a lack of advanced planning (Bach-Mortensen et al., 2022b; Hart & La Valle, 2021; Roe, 2022; Williams et al., 2020, 2024). Poor transition planning is associated with negative outcomes for children, with feelings of rejection, abandonment and hopelessness, and can risk undoing any positive progress made while in secure care (CCO, 2024a; Williams et al., 2020).

Williams et al. (2019, 2024) investigated outcomes for 24 children and young people who had spent time in secure accommodation in Wales. Just over a third (37.5%) experienced positive, timely transition planning, including opportunities to visit their new home prior to moving, and placements that met children's needs and were close to family. A quarter (25%) of children experienced mixed transition planning, resulting in some placement instability and a decline in children's mental health and behaviour. The remaining 37.5% experienced negative transitions, including being placed in unsuitable placements which led to placement breakdowns and further instability, increased mental health difficulties and absconding. Many (66%) of the children went on to receive further SAOs. In 2016, one study found that 72% of children under SAOs did not have a placement address ready for their move back into the community (Hales et al., 2018).

Particular issues have been raised in relation to finding suitable 'step-down' placements to facilitate children's transition from secure to open accommodation (Bach-Mortensen et al., 2022b; Hart & La Valle, 2021; Williams et al., 2020, 2024). Evidence shows that children transitioning from secure care are likely to still require a high level of intensive and specialist support, and the lack of such placements can mean that children with complex needs are placed in inappropriate accommodation or continue to be subject to restrictions on their liberty for longer than may be necessary or in their best interests. Three children in Williams et al.'s (2019) study had their discharge from a SCH delayed because a suitable placement could not be found, and 3 young people were placed under DoL orders because no appropriate step-down accommodation could be found. Girls interviewed by Khan et al. (2021) described being placed in caravans, holiday cottages or in hotel chains once they had left a SCH. This ongoing instability and uncertainty can cause further trauma and disruption for children, resulting in deteriorations in their progress, which in turn leads to further delays in finding suitable accommodation and can lead to them becoming 'stuck' in the secure system (Khan et al., 2021; Williams et al., 2019).

There is a lack of research on transitions from DoL orders, including any data about where children live once an order has expired. Children and young people interviewed by the CCO expressed uncertainty about their future, including where they would be living, their education, and when the conditions in their DoL order would come to an end (CCO, 2024a). Many children and young people with complex needs subject to DoL orders will have needs that require ongoing support from adult services, and there is a need for effective multi-agency planning to support this transition. Moreover, the fractured nature of services is often very pronounced for those turning 18 (Cocker et al., 2024). The disconnect between legislation, policy and practice governing children's and adults' services means that some young people can lurch from being highly restricted to being left with little or no support from adults' services.

Children and young people's outcomes

This review did not identify any quantitative evidence on the short-, medium- or long-term outcomes for children and young people subject to DoL orders. There is a lack of systematic research about children's outcomes following detention in any setting. The evidence available does not allow conclusions to be drawn about the impact of a deprivation of liberty on a child or young person's outcomes, and this remains a significant gap in the literature (Roe, 2022). Pates et al. (2021) highlight the lack of consistent, standardised intake and outcome measures in secure settings as a key problem, which makes systematic evaluation of even short-term outcomes impossible.

DoL orders

Following interviews with 15 children and young people who had experienced a DoL order, the CCO concluded that although DoL orders might keep them safe in the short term, orders generally fail to address children's long-term needs, which often stem from ongoing trauma and instability (CCO, 2024a). For many of the children and young people interviewed, the experience of separation from family and friends, changes in caregivers, isolation, restrictions and restraints experienced under the DoL order were traumatising events in themselves and had a severe impact on children and young people's health and development. One child spoke about the severe impact that living under a DoL had on their social skills and reported that they had got PTSD from the experience. While most children acknowledged that they needed support, they felt that this could have been provided in a different way. Data (MoJ, 2024) and evidence (Roe et al., 2023) that most children remain subject to DoL orders for more than 6 months (and many for over a year) with restrictions rarely being relaxed, also suggest that DoL orders are not successful in reducing the risks that children experience.

The CCO also highlights some concerning examples where the deprivation of liberty did not even appear able to keep the child safe (CCO, 2024a). This was the case with children who had profound mental health difficulties, self-harm and dysregulated behaviour. These children had been subject to DoL orders for 2 years or longer. For some who were placed on a DoL order due to concerns around exploitation, there was concern that time under a DoL had not led to increased insight by the child or young person of the risks or harm they had been exposed to, nor had it provided them with the tools and support to keep themselves safe in the future.

There were some exceptional cases where the DoL order had led to a period of stabilisation and stability for the child. In all these cases, it was notable that the DoL order was combined with the right care and support, including a consistent and skilled care team around the child, and clear plans around how and when restrictions would be relaxed or removed. In one case in particular, the positive implementation of the DoL order, according to both the child and professionals, was attributed to the social worker's

longstanding relationship with the child, good joint working and communication between all involved parties, and a joint understanding of what the DoL was supposed to achieve and how this would happen (CCO, 2024a). Another study, which explored the circumstances and characteristics of older children (aged 10 to 17) subject to care proceedings in 4 local authorities in England and Wales in 2019/20, highlighted that in some cases DoL orders could provide opportunities for children and young people to engage with interventions and education services, and bring about positive change (Parker & Tunnard, 2021). Crucially, positive change appeared more likely when the deprivation of liberty was made in a planned way as part of a clear strategy for a child, rather than in an emergency or crisis (Parker & Tunnard, 2021).

The limited evidence available suggests that DoL orders by themselves are unlikely to result in improved outcomes for children and young people. Indeed, DoL orders may make things worse – unless combined with the right support and with a clear rationale about the purpose of the order. This support will look different for each child, based on their individual needs and circumstances; but consistent, caring relationships from staff skilled and qualified to support children with complex need is foundational, according to the evidence summarised above.

Other settings

Evidence about the short-term impact of SCHs on children's mental health, education and behaviour is mixed. Some qualitative (Andow, 2020; Williams et al., 2019) and quantitative (Pates & Hooper, 2017) studies highlight improvements in educational outcomes, with children often re-engaging with education during their time in a SCH. A review by Justice Studio (2014) of outcome data collected by each SCH, and interviews with staff and children, also highlights some positive outcomes. Of the 5 SCHs that measured wellbeing outcomes, 4 demonstrated noticeable improvements in children's wellbeing from admission to discharge.

While children may experience some improvements following secure care – including a period of stabilisation and engagement in some support – most benefits appear short-term (Hart & La Valle, 2016). In their investigation of outcomes for 24 children who had spent time in secure accommodation in Wales, Williams et al. (2019, 2024) report mixed outcomes. Between 3 and 18 months after leaving the SCH, 15 of the 24 children had poor outcomes. Although some experienced a period of stabilisation while in the SCH, harmful and risky behaviours quickly re-emerged and intensified after discharge, resulting in successive placement moves. For children with high levels of mental difficulties before admission, these concerns persisted throughout and after their stay in a SCH, with social workers attributing this to the absence of mental health therapy or support. For the 9 children who were doing well, this was considered to be the result of their environment post-secure care, with all these young people living with carers able to meet their needs,

form long-term relationships and facilitate change. However, in only 3 of these cases did social workers believe that adequate psychological support was being provided.

The only quantitative evidence of short- and medium-term outcomes of secure accommodation identified by this review comes from Wood et al. (2024), who linked referral data held by the SWCU for the 547 young people referred to a SCH between October 2016 and March 2018 to children in need and children looked after data returns held by the DfE for the 3 years prior to referral and the year after referral. They compared outcomes between children who were 'successfully' placed in a SCH (60%) and those who were not found a place and ended up in alternative accommodation (40%) on 4 outcome measures collected in DfE administrative data – placement moves, substance misuse, convictions and mental health. Information about where children in alternative accommodation were placed and whether they were subject to a DoL order was not available. Overall, the study suggests that in the year after referral there was little difference across all outcomes between children placed in a SCH and those in alternative accommodation. In the year after referral, the average number of placement moves was 3, with no difference between those placed in a SCH or alternative accommodation. However, 37% of those placed in alternative accommodation were re-referred to a SCH in the following year, compared to 30.1% of those placed in a SCH.

Overall, 46.2% of the young people referred to a SCH had a recorded substance misuse problem. Placement in a SCH instead of alternative accommodation did not significantly change the odds of having a substance misuse problem in the year after referral to a SCH, even when controlling for historical substance misuse problems. In the year after referral, 37.9% of children in SCH had a recorded substance misuse problem, compared to 30.4% of those in alternative accommodation.

Over the 5-year observation period (2013 to 2018), 53.5% of the total number of young people referred to a SCH had a recorded conviction, with more young people receiving a conviction by the end of the year they were referred, than in the years before and after referral. In the year after referral, there were no significant differences between children placed in SCHs (30.6%) and those in alternative accommodation (37.8%).

Mental health outcomes were measured by scores on the Strength and Difficulties Questionnaire (SDQ) – a common measure of internalising and externalising difficulties used in children and adolescents. During the year of referral to a SCH, the mean SDQ score for the whole sample was 18.2 (not reported separately for children placed in a SCH or alternative accommodation). In the year after referral, the mean SDQ score was 17.2 (a score above 17 is considered 'abnormal'). Those placed in alternative accommodation had a slightly higher score than those placed in a SCH (18.2 vs 16.7), suggesting poorer mental health for young people who had been in alternative accommodation.

Wood et al. (2024) provide some quantitative evidence that, in the year after referral to a SCH, many children and young people continue to experience placement instability, substance misuse problems, and mental health difficulties, and are at risk of receiving a conviction. The study shows the potential of using linked data to explore children's outcomes and, if DoL orders were recorded in linkable national datasets, a similar approach could be used for children subject to DoL orders. However, the study is also limited by the outcome measures assessed in children in need and children looked after data returns, which provide limited binary information about substance misuse and convictions and a relatively limited measure of mental health. More detailed assessment measures of children's behaviours, wellbeing, mental health, education, health and relationships would enable better assessment of outcomes. Tracking children's outcomes for a longer time period is also required.

Evidence about outcomes following mental health inpatient admission also report mixed findings. Two international systematic reviews found that most children show improvements in at least one area of their symptomatology from admission to discharge (Hayes et al., 2018; Hsu et al., 2024). However, some have questioned whether this evidence is adequate, given the high cost and high stakes of inpatient care (Doyle et al., 2024). Improvements are often not maintained in the long term, with many children being readmitted within a few years (Schutte et al., 2023). One study (James et al., 2010) found that, among adolescents admitted to an inpatient mental health unit between 1998 and 2004, death rates in the year following discharge were significantly higher than those found in the general population of equivalent age. Schutte et al. (2023) conclude that significant questions remain about the effectiveness, efficiency and timeliness of adolescent inpatient care.

Evidence-based interventions or models of care that exist for looked-after children and young people in complex situations with multiple needs in secure care

The second systematic search aimed to identify evidence-based interventions or models of care to improve the mental health and behavioural outcomes for children and young people with complex needs in, or at risk of, secure care (see Methods section for further details).

Identified studies included interventions delivered in secure settings, as well as those aimed at preventing admission to secure care, which were delivered in residential, foster care or family settings. No interventions specifically targeted children with complex needs subject to, or at risk, of being deprived of their liberty in unregistered secure accommodation (DoL order). Interventions covered a range of approaches, which can broadly be split into 3 different core approaches:

- workforce development for staff caring for children with complex needs
- models of care delivered across multiple settings and/or professional bodies
- therapeutic approaches within a particular setting.

In this section, we consider international evidence, including studies from North America, Australia and Northern Europe. While approaches to residential care and, in particular, the make-up of the residential workforce differ substantially in different countries, these studies may provide insight into approaches that could be translated into a UK or English context, given the limited evidence base in the UK.

Overall, there is a lack of literature evaluating interventions or models of care for responding to the needs of children and young people with complex needs, particularly in relation to children at risk of being deprived of their liberty in un-registered settings. Given the recent increase in the use of DoL orders, this is perhaps not surprising. But it points to an urgent need to develop and evaluate approaches to caring for children with complex needs in England. Many studies were based on small samples in single sites (i.e. one residential home), with multi-site studies highlighting the difficulties in translating models across different settings (Edbrooke-Childs et al., 2022; van Gink et al., 2018). Some of the studies identified were not randomised control trials (RCT), the gold standard for evaluating effectiveness in which the target intervention is compared to a similar control group; while there are difficulties in using RCTs in complicated multi-site interventions within children's social care, limitations in study design nonetheless make it difficult to isolate the effect of the target intervention on children's outcomes. In addition, there was significant variation in outcome measures used, including limited use of child-focused outcomes, which makes comparison between studies difficult, and few studies evaluated longer-term outcomes.

Given the complexity of children's needs and experiences, and the need for multi-agency responses, no single model of care will be able to meet the needs of all children and young people. However, these studies may highlight common principles and approaches that may be fruitful. We summarise these key themes at the end of this section.

Workforce development with residential care staff

Several studies evaluated the implementation of workforce development programmes to staff caring for children with complex needs in residential settings, including in secure care. In 3 of these studies – in England (Edbrooke-Childs et al., 2022), the United States (Izzo et al., 2016, 2022) and Portugal (Santos et al., 2023) – residential or care staff were given intensive training on relationship-based and trauma-informed care. This was intended to support their understanding of and ability to manage children's behaviour, and to strengthen relationships between staff and children. Results suggest that such approaches can lead to improvements in child-staff relationships, better emotional climates within homes, and a reduction in the number of behavioural incidents within the home (Edbrooke-Childs et al., 2022; Izzo et al., 2016, 2022; Santos et al., 2023). In one study in the Netherlands (van Gink et al., 2018), staff working in psychiatric and secure residential units were trained in Non-Violent Resistance, a method for supporting professionals to manage aggressive behaviour. However, the study did not find any substantial evidence of change in incident prevalence or culture of the living environment. High staff turnover and different organisational cultures across settings were highlighted as a major challenge (van Gink et al., 2018).

The SECURE STAIRS Framework for Integrated Care (England)

This holistic framework includes a focus on workforce development for developmentally attuned, psychologically informed care. The framework has a central focus on formulation as a means to develop comprehensive, co-produced assessments of need. In England, SECURE STAIRS was implemented across the children and young people's secure estate – in young offender institutions (YOIs), secure training centres (STCs) and SCHs (Edbrooke-Childs et al., 2022). A 2-year mixed-method evaluation in 18 sites across England between August 2018 and December 2020 (Addy et al., 2023; Edbrooke-Childs et al., 2022; Farooq et al., 2021; McKeown et al., 2023a, 2023b) found that SECURE STAIRS led to significant improvements in staff knowledge, understanding and confidence, and staff reported feeling more equipped to work in trauma and attachment-informed ways (Edbrooke-Childs et al., 2022). Feedback from children highlighted some improvements in staff-child relationships and their involvement in decision-making – and there was some evidence of reductions in the use of restraint and improvements in transition planning. The 2-year study did not provide evaluation of long-term outcomes. The evaluation highlighted challenges in implementing culture change within the secure estate, particularly in YOIs and STCs: staffing levels and stability in staffing

arrangements, along with senior leadership support, were key to determining the success of implementation.

Models of care

Other approaches aimed to implement alternative models or systems of care (i.e. across multiple settings) for children and young people with complex needs. In most cases, the identified models were primarily aimed at preventing admission or re-admission to secure care, rather than addressing the needs of children currently deprived of their liberty (i.e. with the most complex needs). Approaches tended to focus on those at risk of offending behaviours (e.g. Treatment Foster Care, MultifunC) or at risk of/being discharged from inpatient mental health care (e.g. Intensive Alternative Family Treatment, Youth Prevention and Recovery, Supported Discharge Service).

Treatment Foster Care (international)

The most substantial evidence base relates to Treatment Foster Care Oregon (TFCO) (also called Multidimensional Treatment Foster Care – MTFC), an intensive model of foster care. TFCO was primarily developed for teenagers (aged 12 to 17) in foster or residential placements at high risk of offending and/or disruptive behaviours, although other versions have been developed for younger children. Foster carers are provided with specialist training and routine support to help them manage challenging behaviours and have insight into the needs of children in their care. Support includes daily contact with a multi-disciplinary team (MDT) around the family. The MDT includes case managers, mental health professionals, educational specialists and social workers (Turner & Macdonald, 2011). Children and their birth families also have direct support from a range of services, including mental health support. TFCO aims to prevent multiple placements and to provide an alternative to restrictive institutional placements. Originating in the US, TFCO has now been implemented internationally, and there have been multiple systematic reviews evaluating its effectiveness.

In the United States, TFCO was originally focused on reducing offending behaviours in adolescents, and the most convincing evidence for improved outcomes relates to this domain (Turner & Macdonald, 2011). A recent meta-analysis (Åström et al., 2020) of studies with a control group examining the effect of TFCO on adolescents (aged 12 to 17) highlighted moderate certainty of evidence that TFCO reduced future criminality. However, evidence of TFCOs effect on other outcomes is more mixed. Lower certainty of evidence was found in relation to mental health, risky peer associations, drug and alcohol use, and school attendance. An earlier systematic review (Turner & Macdonald, 2011) also found some evidence that TFCO resulted in a reduction in children's offending behaviours, but overall the picture was mixed and there were no consistent effects across studies.

Some studies have highlighted the challenges in adapting the TFCO to a UK context (Waterman, 2021), and a randomised control evaluation of MTFC for adolescents (MTFC-A) in 23 local authorities in England between 2004 and 2007 found no evidence that MTFC-A resulted in better outcomes for children than usual care (although there have been some criticisms of the study design) (Green et al., 2014). Waterman (2021) reports some promising outcomes for children that completed TFCO in the UK, including improvements in children's problem behaviours and foster carers' stress ratings. In 2021, as reported by Waterman, just one UK TFCO site remained.

With regard to cost, one study in England found that TFCO showed a reduction in costs during the foster placement (Holmes et al., 2012), and a recent meta-analysis suggested that TFCO was seen as likely to be cost saving compared to residential care (Åström et al., 2020).

Intensive Alternative Family Treatment (IAFT) – USA

Lanier et al. (2022) implemented a similar model of enhanced therapeutic foster care to prevent admission to psychiatric residential units in the US (Intensive Alternative Family Treatment – IAFT). IAFT involves rigorous training for foster parents, one child per home, weekly engagement with the child's family, and high levels of support, including daily contact, weekly supervision, 24/7 crisis support, and respite care. The evaluation found that children who received the IAFT intervention had a significantly lower risk of first-time entry to psychiatric care compared to a (non-randomised) treatment as usual control group. This suggests that such intensive community-based support packages may be effective in preventing the escalation of severe mental health needs (Lanier et al., 2022).

No Wrong Door – England

No Wrong Door[37] is an integrated service and framework to support adolescents, aged 12 to 25, who are in or on the edge of care (Bellonci et al., 2019). At the heart of the model is a residential hub, which provides short-term placements and outreach (Edge of Care) support. Each hub has an embedded multidisciplinary team consisting of a manager, 2 deputy managers (one responsible for the residential element of the hub and the other for the outreach service), NWD hub workers, a communications support worker (who is a speech and language therapist), a life coach (who is a clinical psychologist) and a police liaison officer. Core to the approach is providing a flexible, proactive service that can build relationships with the child and provide support that 'wraps around the child' when they need it the most. An independent evaluation of NWD (Lushey et al., 2017, cited in Bellonci et al., 2019) showed that the service contributed to a reduction in the number of young people entering care, and, for those already in care, less time spent in care and increased placement stability. At the point of referral to NWD, children were identified as having complex needs and were considered to be prone to risk-taking

[37] No Wrong Door

behaviours, such as criminal offending, drug and alcohol misuse, running away from placements and non-attendance at school; these are similar issues to those identified above for children subject to DoL applications. The evaluation identified improvements across all outcome domains. A key theme in the evaluation was the centrality of relationships between the young person and their key worker.

MultifunC – Sweden

In Sweden, the Multifunctional Treatment in Residential and Community Settings (MultifunC) programme aimed to prevent children and young people aged 15 to 17 with serious behavioural problems and at high risk of re-offending from being placed in a locked residential setting (Löfholm et al., 2020). The treatment includes a short stay in a small (i.e. a maximum of 8 children) therapeutic residential care setting with ongoing support provided to families following discharge (aftercare). The MultifunC unit is staffed by 4 teams: the assessment team, the school team, the family/aftercare team and the milieu team. The assessment team, which includes a psychologist and 2 therapists, assesses each child to formulate a treatment plan, with ongoing follow-up assessments throughout the treatment. The school team (made-up of 2 to 3 teachers) provides pedagogical support, including feedback on children's behaviour in the school setting. The family/aftercare team, which provides parents with training in parenting skills and support in aftercare, comprises 3 therapists with a background (bachelor degree) in social work and trained in family therapy. Daily therapeutic work and the delivery of relevant interventions are delivered by the milieu team (a team of 10 'treatment assistants'). Across all teams, the level of staff training is high, with a minimum requirement of a bachelor's degree in social work. Total length of treatment varied between 10 and 12 months of which 4 to 5 months are spent in compulsory 'aftercare' when the child has returned home.

Results indicate that after 24 months, children and young people participating in MultifunC had a reduced need for residential care in a locked setting and out-of-home placement, compared to those not receiving the MultifunC intervention (treatment as usual) (Löfholm et al., 2020). Economic analysis also found MultifunC to be a cost-effective alternative because of the reduced need for residential care in locked settings. There were no significant effects on reoffending or the need for psychiatric care. MultifunC has also been implemented in Norway. Implementation studies in Sweden and Norway showed that it was possible to implement the model within regular residential care settings; however, it took about 2 years for the units to achieve satisfactory implementation levels (i.e. all areas of the programme implemented).

Youth Prevention and Recovery Care (Y-PARC) – Australia

In Australia, Green et al. (2019) evaluated a sub-acute residential service for young people (aged 16 to 25) at risk of hospitalisation or transitioning out of hospital inpatient

units (Youth Prevention and Recovery Care – Y-PARC). Young people are provided with up to 4 weeks of residential care, which involves a blend of clinical and psychosocial support services (e.g. CBT, DBT, mindfulness, peer support, family therapy, support with education, social skills training). The team consists of both psychologists and social workers. Reported outcomes included improved resilience, better understanding of mental health, increased help-seeking behaviour, and stronger connections to therapeutic services (Green et al., 2019). The authors suggest that the service fills a gap between community services and acute inpatient wards.

School2Care – Netherlands

In the Netherlands, the School2Care programme, delivered in alternative educational facilities, aimed to prevent school drop-out and placement in secure residential care for children with behavioural and emotional problems, problematic family functioning, and problems in social contexts (e.g. offending) (Pronk et al., 2023). Children attend a school-based programme from 8a.m. to 8p.m., which includes academic classes, individual and group skills training, and mental health therapies. Programme staff work as 'coaches' providing both teaching and counselling. Parents and families are also provided with therapeutic and practical support. School2Care focuses on facilitating a range of important therapeutic factors, including fostering a positive therapeutic alliance, building a structured and nurturing environment, positive behavioural interventions and the use of a cognitive behavioural approach. All children complete a functional behavioural assessment. Results of the evaluation showed that 70% of adolescents were not placed in a secure residential facility up to 6 months after leaving School2Care. Positive changes in adaptive emotion regulation strategies and empowerment were also reported.

Supported Discharge Service – England

In England, the Supported Discharge Service (SDS) has been implemented in South London and Maudsley NHS Foundation Trust to provide intensive community support to children admitted for psychiatric inpatient care to prevent re-admission (Ougrin et al., 2018). Children are supported by a SDS team, which includes 1 consultant child and adolescent psychiatrist, 2 to 4 CAMHS practitioners with nursing backgrounds, 2 to 4 clinical support workers, and an administrator. The nature of the work includes intensive case management, community (including home) treatment, day care in hospital, or any combination of these approaches, with intensity scaled up or down (up to a maximum of daily contact) according to need. Staff tasks included assisting young people with creating customised care plans, providing psychiatric care and psychological interventions, helping with school reintegration, and optimising physical health care and social support. An efficacy RCT (Ougrin et al., 2018) found that hospital use at 6 months was lower in the SDS than in the usual care group (median 34 days compared to 50 days), although this did not remain statistically significant after controlling for pre-randomisation differences in hospital use between groups. Scores on mental health

symptom and functioning outcome measures did not differ between groups. Children in the SDS group were less likely to report multiple episodes of self-harm, more likely to achieve school reintegration, and they spent fewer days out of mainstream school than those in the usual care group. The authors suggest that the intervention may be cost-effective due to its effectiveness in reducing inpatient care.

Mental health interventions and therapeutic modalities

Several studies aimed to evaluate the use of evidence-based therapeutic approaches to improve outcomes for children in residential settings.

Systematic reviews and meta-analyses highlight that the provision of evidence-based mental health interventions (such as CBT) can be effective in improving the mental health of children with trauma-related psychopathology and those living in out-of-home care (Daş et al., 2024; Leenarts et al., 2013; Ramos Miguel et al., 2024; Trubey et al., 2024). Although Trubey et al. (2024) highlight that benefits may not always be sustained in the long term, and issues with study design make meta-analyses in this area difficult, this is nonetheless an important finding given the difficulties that children and young people in care experience in accessing evidence-based mental health care.

For children with complex needs living in residential settings, identified studies assessed a range of different modalities, including multi-systemic approaches (Rovers et al., 2019; Rowe, 2010), trauma-focused cognitive behavioural therapy (TF-CBT) (Joiner & Buttell, 2018), Dialectical Behavioural Therapy (DBT) (Simpson et al., 2024; Waitz et al., 2021), Adolescent Mentalisation-Based Integrative Therapy (AMBIT) (Fuggle et al., 2024), and Acceptance and Commitment Therapy (ACT) (Livheim et al., 2020). Most studies reported promising findings and improvements in children's mental health, externalising problems and substance misuse, although specific outcome measures differed across studies.

One promising approach (ThuisBest) tested in the Netherlands combined a short stay in a secure residential unit (6 to 8 weeks) with longer-term multi-systemic therapy over several months to reduce the amount of time children spend in secure settings (Rovers et al., 2019). Children are supported by a mentor (a group worker in the residential setting) and a psychologist (who takes on a coordinating role). Results showed that the intervention led to a significant reduction in children's externalising behaviours and in parent-reported stress. Most children went on to live at home, and 83% had no new police contact.

In the United States, Simpson et al. (2024) conducted a large-scale evaluation of DBT adapted for adolescent girls living in long-term residential care with borderline personality disorder, struggles with interpersonal relationships, self-harm, depression, trauma, suicidal ideation, severe emotional dysregulation and problems with identity

development. The comprehensive intensive intervention programme included individual therapy, group skills sessions, family therapy, group skills training for parents, 24/7 coaching and a consultation team, with companion therapies also provided alongside DBT as needed for each child (e.g. art therapy; eye movement desensitisation and reprocessing – EMDR). The evaluation found significant improvements in children's emotion regulation skills, functioning and depression symptoms and a reduction in self-harm. Participants were followed for up to 2 years post-discharge, and while rates of self-harm and symptoms did increase, they remained below intake levels, indicating that treatment benefits may be maintained long-term. Similarly, a systematic review of DBT for adolescents in inpatient and residential psychiatric treatment settings highlighted promising improvements in emotion regulation and depression symptoms and a reduction in challenging behaviours (Waitz et al., 2021).

Mental health services in Queensland, Australia have developed a specialist service for children in out-of-home care with complex and extreme behavioural and mental health problems (i.e. a chronic trauma history, extreme behavioural problems across multiple settings, at risk of harming self/others and multiple placement breakdowns) (Klag et al., 2016). Evolve Therapeutic Services (ETS) provides a comprehensive assessment of the biological/psychological/social/cultural aspects of the child or young person and family, with the provision of long-term (i.e. 12+ months) attachment- and/or trauma-focused therapies. The teams are situated in mental health services and are made up of psychologists and allied health professionals, including social workers, nurses and occupational therapists. An evaluation of ETS revealed significant improvements across a range of areas, including general functioning and adjustment, disruptive behaviours, non-accidental self-injury, emotional symptoms, peer and family relationships, and school attendance (Klag et al., 2016).

Across all studies, the intensity of clinical provision is notable, including both in relation to contact with clinical services (e.g. multiple weekly sessions), and the length of interventions (e.g. in ETS, children remained in treatment for 19.2 months on average), highlighting that long-term approaches are required.

Emerging approaches

In addition, there are several emerging approaches to supporting children with complex needs that are yet to undergo comprehensive evaluation or implementation (see Crowe, 2024 and Gibson & Whitelaw, 2024 for reviews). These approaches share many common themes with the frameworks highlighted above, as well as with the NFJO's 'Principles of Care', which set out 5 core principles for interventions or models of care for children at risk of being deprived of liberty (NFJO, 2023c) and align with the Principles of Care in the Framework for Integrated Care (Rogers et al., 2024) – see Table 2.

Table 2 Comparison of NHSE and NFJO principles of care for children and young people with complex needs

NHSE Principles of Care	NFJO Principles of Care
Principle 1: Every Interaction Matters: Trusting Relationships as Intervention	1. Stable valued, trusted relationships
Principle 2: Trauma-informed, not Trauma-organised	
Principle 3: Integrating Perspectives: Collaboration & Co-Production	2. Holistic assessment, formulation and tailored plan of intervention 4. Highly experienced multidisciplinary teams 5. Agency and respect
Principle 4: Frontline practitioners as key facilitators of change	4. Highly experienced multidisciplinary teams 3. Long-term support
Principle 5: Understanding Behaviours in Context - Shared Understanding and Formulating 'their story'.	2. Holistic assessment, formulation and tailored plan of intervention 5. Agency and respect
Principle 6: The Rule of 167: Positively influencing day-to-day care	3. Long-term support 1. Stable valued, trusted relationships

Source: NFJO (2023c) and Rogers et al. (2024)

In the Netherlands, there has been a comprehensive effort in recent years to reduce the use of secure care, as part of a governmental proposal to end the use of SCHs by 2030 for children who have not caused harm to others (Crowe, 2024; Gibson & Whitelaw, 2024). Legislative changes which brought responsibility for the care of children from state to a local level have been cited as key to the pace of change (Crowe, 2024; Gibson & Whitelaw, 2024). In place of large secure units, they have adopted a model of integrated, small-scale community facilities which are embedded in the community and aim to promote relational security (Gibson & Whitelaw, 2024). The approach includes a scaled model with intensive residential care available if required (in small-bedded units, with transitional independent living units available on the same site). The service adopts a multidisciplinary integrated assessment and treatment approach, with interventions encompassing a wide range of needs, including education, family counselling, therapy, mental health and psychology (Gibson & Whitelaw, 2024). While the Netherlands has seen a reduction in the number of children placed in secure settings – for example, one

region in the north of the country had no closed admissions in 2023 (Crowe, 2024) – there is a lack of systematic research on children's outcomes and funding arrangements.

A concerted effort to reduce the number of children placed in secure settings on welfare or youth justice grounds is also taking place in Scotland. The Children and Young People's Centre for Justice (CYCJ) was commissioned by the Scottish Government to 'reimagine' a future for secure care and alternatives to secure care in Scotland. In their recent report, the CYCJ present a blueprint for a new model of secure care, co-designed with children, young people, parents and professionals (CYCJ, 2024). The new model focuses on the provision of a continuum of care that is flexible, responsive to individual children's needs and rights based.

There are 3 core components of the model: community-based hubs, multi-disciplinary teams (MDTs) and 'Flex Secure'.

1. Community-based hubs are intended to provide flexible, dynamic spaces that can offer a continuum of whole-family support tailored to local needs. Support provided would be needs-led, including education, training, and psycho-social, health, well-being and leisure activities and interventions offered to children and families on a universal basis. Community hubs are also intended to provide discrete accommodation, that could provide a 'safe space' for children and their families in moments of crisis.

2. The teams around the family would be supported by a MDT providing specialised, holistic support to children and their families, ensuring continuity and integration across services. The MDTs can offer both a consultative role and direct intervention with the child and family, depending on what is required to meet needs.

3. Flex Secure would provide adaptive, intensive 24/7 care for 2 to 4 children in home-like environments that are embedded in communities. These offer supportive, relational-based care in spaces that are nurturing, therapeutic, and trauma-responsive. These environments have adaptable security tailored to the needs of the child, keeping them and others safe while upholding their rights.

While the CYCJ highlight several potential challenges in implementing the whole-scale system change required to make their vision for secure care a reality, monitoring their progress may provide important learning to implement new models of care in an English context.

Common themes and principles

While each intervention or approach we identified operates slightly differently, with different target populations and intended outcomes, there are several common

components across these models that may be useful in establishing alternative approaches to caring for children with complex needs. These include:

- the proactive identification of children at risk of poor outcomes
- a central focus on building trusting and reliable relationships with key people in the child's life
- a skilled multidisciplinary team working around the child
- sufficiently trained, experienced and valued carers providing day-to-day care
- a model of care that enables the same team to stick with the child across multiple settings and to support transitions across settings
- personalised and holistic assessment to identify the child's needs, co-produced with the child and their family
- the provision of long-term support
- provision of intensive therapeutic support to the team around the child, as well as, where deemed appropriate, direct therapeutic interventions with the child
- support which can be scaled up and down according to the child's needs, including 24/7 support when required
- integrated care that can meet children's needs without children and families being passed between different services or agencies
- short stays in secure care and the use of quasi-secure accommodation that could be adapted to provide short-term restrictions on children's liberty where this was deemed necessary as part of a child's longer-term care plan
- the provision of a range of interventions to address children's behavioural, emotional, psychosocial and educational needs holistically, including the provision of vocational or life skills with a future focus
- whole family support, including the provision of therapy and practical support to parents and family members.

Studies also highlighted challenges in implementing alternative models of care, including time needed to embed changes, the importance of leadership, staff stability, and challenges with the recruitment of staff with a range of skills. Most interventions were developed for specific communities, localities or residential settings, and it is not clear how services could be scaled up to enable widespread system change. In addition, the approaches we identified tended to be delivered either in a social care or mental health settings, and there is limited evidence of effective multi-agency working to support children with complex needs.

Conclusion

Overview of the literature

This evidence review aimed to identify and summarise existing research to inform a better understanding of the needs, experiences, care requirements and outcomes for children and young people currently (or at risk of) being deprived of their liberty under the inherent jurisdiction in England and Wales. It has highlighted a limited evidence base regarding children and young people subject to DoL orders, and those at risk of entering secure care more generally. A review published in 2022 by the NFJO (Roe, 2022) highlighted the lack of data and research on this topic.

While there have been some efforts to fill this evidence gap since then – including research carried out by NFJO using data collected at the national DoL court from July 2022 to June 2023 (NFJO, 2023b; Roe & Ryan, 2023; Roe et al., 2023), a report from the Children's Commissioner for England highlighting the experiences of 15 children subject to DoL orders (CCO, 2024a), and the publication of data about DoL applications and orders in the MoJ Family Court Statistics Quarterly (from July 2023) – there remain significant gaps in the evidence. These gaps and priority areas for further research are highlighted below.

Overall, the research is of mixed quality and often relies on small sample sizes and case file analysis methodologies. The body of evidence published by Williams and colleagues (Williams et al., 2020, 2022; Wood et al., 2024), using linked data from DfE and the SWCU from 2016 to 2018, is the most comprehensive quantitative research to date, detailing children and young people's experiences and involvement with children's services prior to entering secure care, the factors associated with placement in a SCH, and outcomes in the 12 months after referral for children and young people placed in a SCH and those placed in alternative accommodation (i.e. referred but not found a place). However, given the substantial increase in the use of unregulated secure accommodation in recent years, the study's findings may no longer be up to date. Nonetheless, Williams and colleagues show the potential of using linked data to answer pressing questions about the needs and outcomes of children deprived of their liberty.

To date, research (and therefore also the search terms used in this review) has grouped children and young people according to the setting in which they are placed and/or the legislation used to deprive them of their liberty. While this is understandable, given the difficulties in accessing data and the lack of a shared definition about children and young people with 'complex needs' across sectors, it may limit a fuller understanding of the needs and experiences of this cohort of children and young people. Moving beyond legislative, setting and service siloes across research and policy is an important next step.

Key findings

Too many children and young people are being deprived of their liberty because of failures to meet their needs and keep them safe in the community

A shortage of suitable residential placements for teenagers in care, a lack of sustained and effective early intervention, and a lack of mental health support for children and young people in care are contributing to the rising number of children being deprived of their liberty.

Children and young people with complex needs do not appear overnight. While most enter care late, they are known to children's services for many years and often experience repeat referrals and/or periods of coming into and out of care. Better identification and provision of sustained support to children and their families in early adolescence may prevent issues escalating.

Once in care, children and young people often experience multiple placement breakdowns, and local authorities experience prolonged difficulties in identifying suitable placements for those with complex needs. This disruption and instability can re-traumatise children and young people and exacerbate existing mental health and behavioural issues. This in turn increases the difficulties in finding alternative placements and increases the likelihood that children and young people will be placed in unsuitable homes and/or subject to restrictions on their liberty. There is a critical need for more high-quality registered children's homes, supported by multi-agency and multidisciplinary teams of skilled staff, to keep children and young people safe and to provide therapeutic support that can address their core needs.

There is a lack of clarity about the purpose of a DoL order

Evidence suggests a lack of clarity around the long-term purpose of restricting the liberty of children and young people with complex needs. Instead, the inherent jurisdiction appears to be used in many cases as a last resort and at a point of crisis because other placements that can meet children's needs without restricting their liberty are not available. While it may be the case that, in some instances, a planned DoL order in a suitable placement may be appropriate, the limited evidence available suggests that this is not how DoL orders are being used in many cases.

While evidence is limited, concern has been raised about children and young people's access to mental health support, education and other care while subject to DoL orders. A DoL order by itself does not guarantee that children and young people will receive any therapeutic support, and changes to legislative and statutory frameworks should be considered to enable greater scrutiny of how DoL orders are used, where children are placed and what support they are entitled to.

There is limited research on children and young people's outcomes following a DoL order

The limited evidence available suggests that DoL orders by themselves are unlikely to result in improved outcomes for children and young people. Indeed, unless orders are combined with the right support and a clear rationale about the purpose of the DoL, they may make things worse. The right support will look different for individual children and young people, based on their individual needs and circumstances, but consistent caring relationships with staff skilled and qualified to support children with complex needs is foundational.

The secure welfare estate is not meeting children and young people's needs

Secure children's homes and s.25 of the Children Act 1989 are designed to provide care and safeguard children and young people for whom a deprivation of liberty may be necessary to keep them safe. That more children and young people are now subject to DoL orders under the inherent jurisdiction suggests that the secure welfare estate is unable to fulfil its purpose in keeping the most vulnerable children and young people safe.

There is a need to review existing secure welfare provision to understand why it is not able to meet the needs of this cohort of children and young people and to identify necessary changes to the design, commissioning or purpose of SCHs to support this. Promising approaches in other countries (e.g. Scotland, Netherlands) may provide a framework for the reform of secure care. Such changes may have the potential to reduce the number of children subject to DoL orders in unregistered secure accommodation.

Children and young people in complex situations with multiple needs are not receiving appropriate support with their mental health

This evidence review has highlighted multiple difficulties experienced by children and young people in care in accessing mental health support, both before and during a deprivation of liberty. There is a need to improve access to timely person-centred mental health support for all looked-after children and young people.

Too many children and young people are falling between the gap between social care and mental health services. In several instances, those with complex needs are assessed as not meeting criteria for inpatient detention under the Mental Health Act 1983 due to their difficulties being associated with 'behavioural and emotional problems' rather than a diagnosable mental health disorder. While inpatient mental health provision is unlikely to be suitable for many children and young people with complex needs, a better understanding of the assessment criteria and purpose of inpatient mental health provision would be helpful. There is a need to develop alternative community placements for these children and young people, co-run with children's services and mental health

services, to keep children and young people safe and provide therapeutic and trauma-informed care.

There is a need for better assessment of children and young people's needs to better understand complexity, comorbidity and children and young people's trajectories

To date, most research has focused on understanding how common certain needs or risk factors are among children and young people in or at risk of secure care, instead of understanding comorbidities or co-occurring needs. This is mostly due to limitations in the data that is available to researchers and a lack of common assessment or outcome measures. Data-driven approaches that can facilitate a better understanding of the co-occurrence of children and young people's needs and trajectories of behaviours, risk factors and service use may be fruitful, but significant advances in data collection, assessment and data linkage are necessary to enable this.

Promising approaches do exist, but there is no one-size-fits-all model

While there is limited evidence regarding best-practice alternative approaches to managing risk and supporting children and young people with complex needs, promising approaches and frameworks do exist. Given the complexity of children's needs and experiences, and the need for multi-agency responses, there will be no single model of care that can meet the needs of all children and young people. These studies, however, can highlight common principles and approaches that may be fruitful; these are summarised earlier under 'Common themes and principles'.

Areas for further research and improved data collection

- Information about children and young people subject to DoL orders should be included in annual DfE data returns. Opportunities for data linkage have the potential to increase our understanding of the trajectories and experiences of children and young people at risk of or subject to DoL orders. This should include monitoring the types of placements they are living in while subject to DoL orders. DfE are working on including DoL orders as a module in the Children Looked After returns.

- The MoJ should collect and publish data relating to the number of 16- and 17-year-olds that are subject to Deprivation of Liberty Orders under the Mental Capacity Act in the Court of Protection. Currently, this data is not disaggregated by age, and this cohort of children and young people remain invisible in national data.

- Information about the ethnicity of children and young people subject to DoL applications and orders should be collected and published by the MoJ and DfE. Existing data has suggested an overrepresentation of those from Black and Mixed ethnic backgrounds among children and young people deprived of their liberty. There

is a need for further research to understand how children and young people's experiences may differ according to their ethnicity.

- There is a need for further research to understand children and young people's experiences of a DoL order, particularly for those placed in unregistered settings. This should include national monitoring of who is caring for children and young people under DoL orders, use of restraint, access to education and other services, and children and young people's own views about their care.

- Information about children and young people's short-, medium- and long-term outcomes remains a significant evidence gap. While improved national data collection and data linkage offer some opportunity to fill this gap, there is also a need to develop consistent national assessment and outcome measures to be used with children and young people who are deprived of their liberty to track and compare outcomes.

- This evidence review highlighted children and young people's transitions as an important area for further research – including transitions from secure to non-secure placements, as well as longer-term transitions from children's services to adult services.

- Research to explore the alternative trajectories of children and young people who may enter care at similar times and/or experience similar risk factors to those who are deprived of their liberty may support the identification of factors that support better outcomes and how they can be achieved.

- It was beyond the scope of this review to consider children and young people who are deprived of their liberty in custodial settings, but previous research has highlighted similarities in the needs and experiences of children and young people in welfare and youth justice secure settings, and there is clear crossover between the 2 populations. Further research to understand the role of youth justice services in the care of children and young people subject to DoL orders – including those who transition from custodial settings to DoL orders – will be important.

References: Evidence Review

Addy, C., Appiah, A., Martin, A., & Farooq, R. (2023). Working with a reflective system within the SECURE STAIRS framework for integrated care: An evaluation of reflective practice sessions within the children & young people secure estate. *Clinical Psychology Forum*, *364*, 10. https://doi.org/10.53841/bpscpf.2023.1.364.10

Andow, C. (2020). The institutional shaping of children's educational experiences in secure custody: A case study of a secure children's home in England. *International Journal of Educational Development*, *77*. https://doi.org/10.1016/j.ijedudev.2020.102217

Andow, C. (2024). 'Am I supposed to be in a prison or a mental hospital?' The nature and purpose of secure children's homes. *Children & Society*, *38*(5), 1622–1636. https://doi.org/10.1111/chso.12828

Andow, C., & Byrne, B. (2018). Family characteristics and experiences of children entering secure settings. In T. Bateman, P. Goodfellow, R. Little, & A. Wigzell (Eds), *Child-friendly youth justice?* (pp. 46-51). National Association for Youth Justice. https://thenayj.org.uk/wp-content/uploads/2019/02/NAYJ-Child-friendly-youth-justice-May-18.pdf

Article 39. (2021). *Statistics briefing: Children in hospital (mental health)*. https://article39.org.uk/wp-content/uploads/2021/02/Child-mental-health-inpatients-statistics-briefing-01-02-21-Final.pdf

Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *Adverse childhood experiences: What we know, what we don't know, and what should happen next*. Early Intervention Foundation. https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Åström, T., Bergström, M., Håkansson, K., Jonsson, A. K., Munthe, C., Wirtberg, I., Wiss, J., & Sundell, K. (2020). Treatment Foster Care Oregon for delinquent adolescents: A systematic review and meta-analysis. *Research on Social Work Practice*, *30*(4), 355–367. https://doi.org/10.1177/1049731519890394

Bach-Mortensen, A. M., Goodair, B., & Barlow, J. (2022a). Outsourcing and children's social care: A longitudinal analysis of inspection outcomes among English children's homes and local authorities. *Social Science & Medicine*, *313*, 115323. https://doi.org/10.1016/j.socscimed.2022.115323

Bach-Mortensen, A.M., Goodair, B., Briggs, E., & O'Higgins, A. (2022b). *Commissioning secure children's homes placements in England*. What Works for Children's Social Care.

Barron, I., & Mitchell, D. (2018). Adolescents in secure accommodation in Scotland: Exposure and impact of traumatic events. *Journal of Aggression, Maltreatment & Trauma, 27*(7), 777–794. https://doi.org/10.1080/10926771.2017.1330294

Bartlett, A., Smith, J. G., Warner, L., & Hales, H. (2021). Young men and young women in secure care: Gender differences in the placement of those with mental health needs. *BMC Psychiatry*, *21*, 433. https://doi.org/10.1186/s12888-021-03440-7

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine*, *12*, 72. https://doi.org/10.1186/1741-7015-12-72

Bellonci, C., Holmes, L., & Whittaker, J. (2019). Re-thinking therapeutic residential care (TRC) as a preventive service: Examining developments in the US and England. *Residential Treatment for Children & Youth*, *36*(1), 35–53. https://doi.org/10.1080/0886571X.2018.1536495

Blakemore, S.-J. (2019). Adolescence and mental health. *The Lancet*, *393*(10185), 2030–2031. https://doi.org/10.1016/S0140-6736(19)31013-X

British Medical Association (BMA). (2025). *Mental health pressures in England*. Retrieved 27 February, 2025, from https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis

Bryan, K., Garvani, G., Gregory, J., & Kilner, K. (2015). Language difficulties and criminal justice: The need for earlier identification. *International Journal of Language and Communication Disorders*, *50*(6), 763–775. https://doi.org/10.1111/1460-6984.12183

Children and Young People's Centre for Justice (CYCJ). (2024). *Reimagining secure care: Final report: A vision for the reimagined/future world*. Children and Young People's Centre for Justice. https://www.cycj.org.uk/resource/reimagining-secure-care-a-vision-for-the-future/

Children and Young People's Commissioner for Scotland (2023, June). *Briefing: Children (Care and Justice) (Scotland) Bill*. https://www.cypcs.org.uk/resources/ccj-bill-stage-1/

Children's Commissioner for England (CCO). (2020a). *Stability index 2020*. https://www.childrenscommissioner.gov.uk/resource/stability-index-2020/

Children's Commissioner for England (CCO). (2020b). *Unregulated: children in care living in semi-independent accommodation*. www.childrenscommissioner.gov.uk/wp-content/uploads/2020/09/cco-unregulated-children-in-care-living-in-semi-independent-accommodation.pdf

Children's Commissioner for England (CCO). (2024a). *Children with complex needs who are deprived of liberty: Interviews with children to understand their experiences of being deprived of their liberty*. https://assets.childrenscommissioner.gov.uk/wpuploads/2024/11/cc-deprivation-of-liberty.pdf

Children's Commissioner for England (CCO). (2024b). *Illegal children's homes*. https://www.childrenscommissioner.gov.uk/resource/illegal-childrens-homes/

Cocker, C., Holmes, D., & Cooper, A. (2024). *Transitional safeguarding*. Policy Press.

Courts and Tribunals Judiciary (2023, October 11). *Revised practice guidance on the court's approach to unregistered placements*. https://www.judiciary.uk/guidance-and-resources/revised-practice-guidance-on-the-courts-approach-to-unregistered-placements/#:~:text=If%20it%20is%20unregistered%20it,child%20in%20an%20unregistered%20placement

Crowe, K. (2024). Community-based alternatives to secure care for seriously at-risk children and young people: Learning from Scotland, The Netherlands, Canada and Hawaii. *Youth*, *4*(3), 1168–1186. https://doi.org/10.3390/youth4030073

Daş, H., Kurnaz, M. F., & Koçtürk, N. (2024). The effectiveness of cognitive behavioral therapy in mental health problems of children and adolescents in child protection system: A meta-analysis. *Journal of Behavioral and Cognitive Therapy*, *34*(4), 100509. https://doi.org/10.1016/j.jbct.2024.100509

Department for Education (DfE). (2023). *Guide to the Supported Accommodation Regulations including Quality Standards*. https://assets.publishing.service.gov.uk/media/6514400088281e000db4e965/Guide_to_the_supported_accommodation_regulations_including_quality_standards.pdf

Department for Education (DfE). (2024). *Children accommodated in secure children's homes* (National Statistics). Retrieved January 6, 2025, from https://explore-education-statistics.service.gov.uk/find-statistics/children-accommodated-in-secure-childrens-homes#

Downie, J., & Twomey, B. (2021). *Secure children's homes for welfare: 141 miles from home*. National Youth Advocacy Service. https://www.nyas.net/support-us/policy-and-research/nyas-research/secure-childrens-homes-for-welfare/

Doyle, L., Hochard, K. D., Wadsworth, R., Pender, F., Watkin, A., & Jaydeokar, S. (2024). Demographic and clinical characteristics impact the use of restrictive interventions in an adolescent inpatient unit. *Evidence-Based Practice in Child and Adolescent Mental Health, 10*(1), 46–55. https://doi.org/10.1080/23794925.2024.2344474

Edbrooke-Childs, J., Jacob, J., Labno, A., Costa da Silva, L., Merrick, H., Singleton, R., Cracknell, L., Lane, R., D'Souza, S., Deighton, J., Fonagy, P., Fuggle, P., Bevington, D., Riches, W., Ullman, R., Jin, L., & Law, D. (2022). *Independent evaluation of the Framework for Integrated Care (SECURE STAIRS)*. Anna Freud.

https://www.annafreud.org/research/past-research-projects/the-framework-for-integrated-care-secure-stairs/

Ellis, K. H. (2016). 'He's got some nasty impression of me he has': Listening to children in the secure estate. *British Journal of Social Work, 46*(6), 1553–1567. https://doi.org/10.1093/bjsw/bcv114

Ellis, K. (2018). Contested vulnerability: A case study of girls in secure care. *Children and Youth Services Review, 88*, 156–163. https://doi.org/10.1016/j.childyouth.2018.02.047

Ellis, K., & Curtis, P. (2021). Care(ful) relationships: Supporting children in secure care. *Child & Family Social Work*, *26*(3), 329–337. https://doi.org/10.1111/cfs.12812

Farooq, R., Martin, A., Addy, C., Burgess, K., & Kennedy, P. (2021). Understanding psychological theories within the SECURE STAIRS Framework for Integrated Care: An evaluation of training on attachment and developmental trauma within a secure children's home. *Clinical Psychology Forum*, *341*, 10. https://doi.org/10.53841/bpscpf.2021.1.341.10

Fuggle, P., Fairbairn, J., & Fonagy, P. (2024). Outcomes for adaptive mentalization based integrative treatment informed care for adolescents using a deployment-based approach. *Psychology and Psychotherapy*, *97 Suppl 1*, 91–104. https://doi.org/10.1111/papt.12496

Gibson, R. (2020). *ACEs, places and status: Results from the 2018 Scottish secure care census*. Centre for Youth and Criminal Justice. https://www.cycj.org.uk/wp-content/uploads/2020/07/ACEs-Places-and-Status.pdf

Gibson, R. (2021). *ACEs, distance and sources of resilience*. Centre for Youth and Criminal Justice. https://www.cycj.org.uk/wp-content/uploads/2021/05/ACEs-Distance-and-Resilience.pdf

Gibson, R. (2022). *What do we know about children from England and Wales in secure care in Scotland?* Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/what-do-we-know-about-children-from-england-and-wales-in-secure-care-in-scotland

Gibson, R., & Whitelaw, R. (2024). *Reimaging secure care: Literature review*. Children and Young People's Centre for Justice. https://www.cycj.org.uk/wp-content/uploads/2024/10/Reimagining-Secure-Care-2-Lit-Review.pdf

Greatbatch, D. & Tate, S. (2020). *Use of unregulated and unregistered provision for children in care*. Department for Education.

https://www.gov.uk/government/publications/use-of-unregulated-and-unregistered-provision-for-children-in-care

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2010). Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: Associations with first onset of DSM-IV disorders. *Archives of General Psychiatry*, *67*(2), 113–123. https://doi.org/10.1001/archgenpsychiatry.2009.186

Green, J. M., Biehal, N., Roberts, C., Dixon, J., Kay, C., Parry, E., Rothwell, J., Roby, A., Kapadia, D., Scott, S., & Sinclair, I. (2014). Multidimensional Treatment Foster Care for adolescents in English care: Randomised trial and observational cohort evaluation. *The British Journal of Psychiatry*, *204*(3), 214–221. https://doi.org/10.1192/bjp.bp.113.131466

Green, R., Mitchell, P. F., Lee, K., Svensson, E., Toh, J. W., Barentsen, C., Copeland, M., Newton, J. R., Hawke, K. C., & Brophy, L. (2019). Key features of an innovative sub-acute residential service for young people experiencing mental ill health. *BMC Psychiatry*, *19*, 311. https://doi.org/10.1186/s12888-019-2303-4

Hales, H., Warner, L., Smith, J., & Bartlett, A. (2018). *Census of young people in secure settings on 14 September 2016: Characteristics, needs and pathways of care*. Central and North West London NHS Foundation Trust. https://www.england.nhs.uk/wp-content/uploads/2018/10/secure-settings-for-young-people-a-national-scoping-exercise-paper-2-census-report.pdf

Hales, H., Warner, L., Smith, J. G., & Bartlett, A. (2022). Primary neurodevelopmental disorders in detained adolescents: Point prevalence and patterns of care. *Journal of Forensic Psychiatry & Psychology*, *33*(3), 354–370. https://doi.org/10.1080/14789949.2022.2069587

Harris, R., Stubbings, D., & De Claire, K. (2021). Factors predictive of behavioural and emotional dysfunction in adolescents in a secure children's home. *Journal of Child & Adolescent Trauma, 14*(3), 299–310. https://doi.org/10.1007/s40653-020-00329-7

Hart, D. & La Valle, I. (2016). *Local authority use of secure placements: Research report*. Department for Education. https://assets.publishing.service.gov.uk/media/5a8012a9ed915d74e622c4e6/Local-authority-use-of-secure-placements.pdf

Hart, D. & La Valle, I. (2021). *Secure children's homes: Placing welfare and justice children together. Research report*. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/983619/Secure_children_s_homes_placement_review_report.pdf

Hayes, C., Palmer, V., Hamilton, B., Simons, C., & Hopwood, M. (2019). What nonpharmacological therapeutic interventions are provided to adolescents admitted to general mental health inpatient units? A descriptive review. *International Journal of Mental Health Nursing*, *28*(3), 671–686. https://doi.org/10.1111/inm.12575

Hayes, C., Simmons, M., Simons, C., & Hopwood, M. (2018). Evaluating effectiveness in adolescent mental health inpatient units: A systematic review. *International Journal of Mental Health Nursing*, *27*(2), 498–513. https://doi.org/10.1111/inm.12418

Hein, T. C., & Monk, C. S. (2017). Research review: Neural response to threat in children, adolescents, and adults after child maltreatment – a quantitative meta-analysis. *Journal of Child Psychology and Psychiatry*, *58*(3), 222–230. https://doi.org/10.1111/jcpp.12651

Hiller, R. M., & St. Clair, M. C. (2018). The emotional and behavioural symptom trajectories of children in long-term out-of-home care in an English local authority. *Child Abuse & Neglect*, *81*, 106–117. https://doi.org/10.1016/j.chiabu.2018.04.017

Hindley, N. (2023). *The use of 'unregistered' placements to provide care for children and young people with the most complex emotional and behavioural needs: A national survey of regional forensic child and adolescent mental health teams (FCAMHS)*. National FCAMHS Network. https://www.rcpsych.ac.uk/docs/default-source/members/sigs/adolescent-forensic-psychiatry-afpsig/unregistered-placements-survey-final-april-2023.docx

Holmes, L., Ward, H., & McDermid, S. (2012). Calculating and comparing the costs of multidimensional treatment foster care in English local authorities. *Children and Youth Services Review*, *34*(11), 2141–2146. https://doi.org/10.1016/j.childyouth.2012.07.010

Hsu, C., Ayres, A., & Payne, L. (2024). Evaluating outcomes following adolescent and youth mental health inpatient admissions: A systematic review. *Early Intervention in Psychiatry*, *18*(7), 481–501. https://doi.org/10.1111/eip.13499

Independent Children's Homes Association (ICHA). (2019). *ICHA 'state of the market' survey 5, February 2019*.

Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the setting level to prevent behavioral incidents in residential child care: Efficacy of the CARE program model. *Prevention Science, 17*(5), 554–564. https://doi.org/10.1007/s11121-016-0649-0

Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A. (2022). Promoting a relational approach to residential child care through an organizational program model:

Impacts of CARE implementation on staff outcomes. *Children and Youth Services Review, 132*. https://doi.org/10.1016/j.childyouth.2021.106330

Jacob, J., D'Souza, S., Lane, R., Cracknell, L., Singleton, R., & Edbrooke-Childs, J. (2024). "I'm not just some criminal, I'm actually a person to them now": The importance of child-staff therapeutic relationships in the children and young people secure estate. International Journal of Forensic Mental Health, 23(1), 24–36. https://doi.org/10.1080/14999013.2023.2167893

James, A., Clacey, J., Seagroatt, V., & Goldacre, M. (2010). Adolescent inpatient psychiatric admission rates and subsequent one-year mortality in England: 1998–2004. *Journal of Child Psychology and Psychiatry, 51*(12), 1395–1404. https://doi.org/10.1111/j.1469-7610.2010.02293.x

Joiner, V. C., & Buttell, F. P. (2018). Investigating the usefulness of trauma-focused cognitive behavioral therapy in adolescent residential care. *Journal of Evidence-Informed Social Work*, *15*(4), 457–472. https://doi.org/10.1080/23761407.2018.1474155

Justice Studio. (2014). *They helped me, they supported me: Achieving outcomes and value for money in secure children's homes*. Justice Studio.

Kennedy, P., Sinfield, P., Tweedlie, L., Nixon, C., Martin, A., & Edwards, K. (2019). Brief Report: Using the Social Communication Questionnaire to identify young people residing in secure children's homes with symptom complexes compatible with autistic spectrum disorder. *Journal of Autism and Developmental Disorders*, *49*, 391–396. https://doi.org/10.1007/s10803-018-3684-9

Khan, L., Harris, A., & Sinclair, C. (2021). *Out of sight: Girls in the children and young people's secure estate*. Centre for Mental Health. https://www.centreformentalhealth.org.uk/publications/out-of-sight/

Klag, S., Fox, T., Martin, G., Eadie, K., Bergh, W., Keegan, F., Turner, D., & Raeburn, N. (2016). Evolve Therapeutic Services: A 5-year outcome study of children and young people in out-of-home care with complex and extreme behavioural and mental health problems. *Children and Youth Services Review*, *69*, 268–274. https://doi.org/10.1016/j.childyouth.2016.08.017

Koenen, K. C., & Widom, C. S. (2009). A prospective study of sex differences in the lifetime risk of posttraumatic stress disorder among abused and neglected children grown up. *Journal of Traumatic Stress*, *22*(6), 566–574. https://doi.org/10.1002/jts.20478

Lanier, P., Chung, G., & Rose, R. (2022). A quasi-experimental study of Intensive Alternative Family Treatment to prevent entry of youth to psychiatric residential treatment. *Child & Adolescent Social Work Journal*, *39*(3), 303–311. https://doi.org/10.1007/s10560-021-00758-9

Leenarts, L. E. W., Diehle, J., Doreleijers, T. A. H., Jansma, E. P., & Lindauer, R. J. L. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry*, *22*(5), 269–283. https://doi.org/10.1007/s00787-012-0367-5

Lever, L., Shaw, D. M., & Jackson, A. (2024). 'Caught in the gaps': Experiences of young people in care accessing mental health support on a general adolescent unit. *The Child & Family Clinical Psychology Review*, 9, 18–25. https://doi.org/10.53841/bpscypf.2024.9.1.18

Livheim, F., Tengström, A., Andersson, G., Dahl, J., Björck, C., & Rosendahl, I. (2020). A quasi-experimental, multicenter study of acceptance and commitment therapy for antisocial youth in residential car. *Journal of Contextual Behavioral Science 16*, 119–127. https://doi.org/10.1016/j.jcbs.2020.03.008

Löfholm, C. A., Olsson, T. M., & Sundell, K. (2020). Effectiveness and costs of a therapeutic residential care program for adolescents with a serious behavior problem (MultifunC). Short-term results of a non-randomized controlled trial. *Residential Treatment for Children & Youth*, *37*(3), 226–243. https://doi.org/10.1080/0886571X.2019.1619500

Mannes, J., Coughlan, B., Yoon, Y., Morgan, T., Drayak, T., Crozier-Roche, F., Smith, J., Graham, D., Fraser, B., Hutchinson, D., Geoghegan, L., Hood, R., Woolgar, M., Broadbent, M., Chakravarti, P., & Duschinsky, R. (2024). *A call for change: Tackling inequalities in access to mental health support for children with social work involvement and those living in poverty*. University of Cambridge, & National Children's Bureau. https://www.ncb.org.uk/sites/default/files/uploads/files/240813%20A%20call%20for%20change%20-%20COACHES%20report.pdf

Martin, A., Nixon, C., Watt, K. L., Taylor, A., & Kennedy, P. J. (2022). Exploring the prevalence of adverse childhood experiences in secure children's home admissions. *Child & Youth Care Forum*, *51*, 921–935. https://doi.org/10.1007/s10566-021-09660-y

McCrory, E., Foulkes, L., & Viding, E. (2022). Social thinning and stress generation after childhood maltreatment: A neurocognitive social transactional model of psychiatric vulnerability. *The Lancet Psychiatry*, *9*(10), 828–837. https://doi.org/10.1016/S2215-0366(22)00202-4

McCrory, E. J., Gerin, M. I., & Viding, E. (2017). Annual Research Review: Childhood maltreatment, latent vulnerability and the shift to preventative psychiatry – the contribution of functional brain imaging. *Journal of Child Psychology and Psychiatry*, *58*(4), 338–357. https://doi.org/10.1111/jcpp.12713

McGorry, P. D., Mei, C., Dalal, N., Alvarez-Jimenez, M., Blakemore, S.-J., Browne, V., Dooley, B., Hickie, I. B., Jones, P. B., McDaid, D., Mihalopoulos, C., Wood, S. J., El Azzouzi, F. A., Fazio, J., Gow, E., Hanjabam, S., Hayes, A., Morris, A., Pang, E., … Killackey, E. (2024). The *Lancet Psychiatry* Commission on youth mental health. *The Lancet Psychiatry*, *11*(9), 731–774. https://doi.org/10.1016/S2215-0366(24)00163-9

McGuire, R., Halligan, S. L., Meiser-Stedman, R., Durbin, L., & Hiller, R. M. (2022). Differences in the diagnosis and treatment decisions for children in care compared to their peers: An experimental study on post-traumatic stress disorder. *British Journal of Clinical Psychology*, *61*(4), 1075–1088. https://doi.org/10.1111/bjc.12379

McGuire, R., Meiser-Stedman, R., Smith, P., Schmidt, D., Bjornstad, G., Bosworth, R., Clarke, T., Coombes, J., Simpson, E. G., Hudson, K., Oliveira, P., Macleod, J., McGovern, R., Stallard, P., Wood, K., & Hiller, R.M. (2025). Access to best-evidenced mental health support for care-experienced young people: Learnings from the implementation of cognitive therapy for PTSD. *British Journal of Clinical Psychology, 64*(1), 63–85 https://doi.org/10.1111/bjc.12471

McKeown, A., Martin, A., Farooq, R., Wilson, A., Addy, C., & Kennedy, P. (2023a). The SECURE STAIRS framework: Preliminary evaluation of formulation developments in the Children and Young People's Secure Estate. *Mental Health Review Journal*, *28*(1), 73–81. https://doi.org/10.1108/MHRJ-02-2022-0005

McKeown, A., Ramshaw, G., Smith, A., Atkinson, S., & Kennedy, P. (2023b). The SECURE STAIRS framework: Preliminary evaluation of the impact on therapeutic climate in a secure children's home (SCH). *Safer Communities 22*(1), 1–14. https://doi.org/10.1108/SC-11-2021-0044

Ministry of Justice (MoJ). (2024). *Family Court Statistics Quarterly*. National Statistics. Retrieved January 6, 2025, from https://www.gov.uk/government/collections/family-court-statistics-quarterly

Ministry of Justice (MoJ). (2025). *Family Court Statistics Quarterly: October to December 2024*. National Statistics. https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2024

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

NHS England. (2023). *Mental health of children and young people in England, 2023 – wave 4 follow up to the 2017 survey*. National Statistics. Retrieved May 14, 2025, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up/data-sets

NHS England. (2024). *Mental Health Act statistics, annual figures, 2023–24*. National Statistics. Retrieved January 6, 2025, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures

Nielson, S., Bray, L., Carter, B., & Kiernan, J. (2021). Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. *Journal of Child Health Care*, *25*(3), 342–367. https://doi.org/10.1177/1367493520937152

Nuffield Family Justice Observatory (NFJO). (2023a). *Focus on the deprivation of liberty of 16 and 17 year-olds: Comparison of data from the national Deprivation of Liberty court and the Court of Protection in April and May 2023*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/news/focus-on-the-deprivation-of-liberty-of-16-and-17-year-olds-comparison-of-data-from-the-national-deprivation-of-liberty-court-and-the-court-of-protection-in-april-and-may-2023

Nuffield Family Justice Observatory (NFJO). (2023b). *National deprivation of liberty court: Latest data trends – June 2023*. https://www.nuffieldfjo.org.uk/resource/national-deprivation-of-liberty-court-latest-data-trends-june-2023

Nuffield Family Justice Observatory (NFJO). (2023c). *Principles of care for children with complex needs and circumstances*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/principles-of-care-for-children-with-complex-needs

Nuffield Family Justice Observatory (NFJO). (2024). *This is what we think: Perspectives on being cared for from older children and young people – including those on deprivation of liberty orders*. https://www.nuffieldfjo.org.uk/resource/this-is-what-we-think-perspectives-on-being-cared-for-from-older-children-and-young-people-including-those-on-deprivation-of-liberty-orders

Ofsted. (2022a). *Children's social care 2022: Recovering from the COVID-19 pandemic.* https://www.gov.uk/government/publications/childrens-social-care-2022-recovering-from-the-covid-19-pandemic/childrens-social-care-2022-recovering-from-the-covid-19-pandemic#the-immediate-impact-of-lockdowns-on-childrens-social-care

Ofsted. (2022b). *How local authorities plan for sufficiency of accommodation that meets the needs of children in care and care leavers.* https://www.gov.uk/government/publications/how-local-authorities-plan-for-sufficiency-

children-in-care-and-care-leavers/how-local-authorities-plan-for-sufficiency-of-accommodation-that-meets-the-needs-of-children-in-care-and-care-leavers

Ofsted. (2022c). *What types of needs do children's homes offer care for?* https://www.gov.uk/government/publications/what-types-of-needs-do-childrens-homes-offer-care-for/what-types-of-needs-do-childrens-homes-offer-care-for

Ofsted. (2024a). *How local authorities and children's homes can achieve stability and permanence for children with complex needs*. https://www.gov.uk/government/publications/good-decisions-children-with-complex-needs-in-childrens-homes/how-local-authorities-and-childrens-homes-can-achieve-stability-and-permanence-for-children-with-complex-needs

Ofsted. (2024b). *Largest national providers of private and voluntary social care (March 2022)*. https://www.gov.uk/government/publications/inspection-outcomes-of-the-largest-childrens-social-care-providers/largest-national-providers-of-private-and-voluntary-social-care-march-2022#:~:text=from%20Companies%20House.-,Children's%20homes,are%20not%20a%20

Ougrin, D., Corrigall, R., Poole, J., Zundel, T., Sarhane, M., Slater, V., Stahl, D., Reavey, P., Byford, S., Heslin, M., Ivens, J., Crommelin, M., Abdulla, Z., Hayes, D., Middleton, K., Nnadi, B., & Taylor, E. (2018). Comparison of effectiveness and cost-effectiveness of an intensive community supported discharge service versus treatment as usual for adolescents with psychiatric emergencies: A randomised controlled trial. *Lancet Psychiatry*, *5*(6), 477–485. https://doi.org/10.1016/S2215-0366(18)30129-9

Pates, R. M., & Hooper, K. (2017). Drug use and mental health in a secure children's home. *Advances in Dual Diagnosis, 10*(2), 71–82. https://doi.org/10.1108/ADD-09-2016-0016

Pates, R. M., Davies, A., & Tiddy, D. (2018). A secure children's home in Wales: Care and educational provision from clinical, management, and educational perspectives. In D. Gallard, K. Evans & J. Millington (Eds.), *Children and their education in secure accommodation: Interdisciplinary perspectives of education, health and youth justice* (1st ed., pp. 146–161). Routledge.

Pates, R. M., Harris, R. H., Lewis, M., Al-Kouraishi, S., & Tiddy, D. (2021). Secure children's homes – How do we know if they work? *Journal of Children's Services*, *16*(1), 13–23. https://doi.org/10.1108/JCS-04-2019-0027

Patil, P., Mezey, G. C., and White, S. (2013). Characteristics of adolescents placed under section 136 Mental Health Act 1983. *Journal of Forensic Psychiatry & Psychology, 24*(5), 610-620. https://doi.org/10.1080/14789949.2013.829518

Parker, J., & Tunnard, C. (2021). *Why are older children in care proceedings? A themed audit in four local authorities.* Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/older-children-in-care-proceedings-themed-audit

Piroddi, R., Astbury, A., Baker, W., Daras, K., Rafferty, J., Buchan, I., & Barr, B. (2024). Identifying households with children who have complex needs: A segmentation model for integrated care systems. https://doi.org/10.21203/rs.3.rs-5573233/v1

Pronk, S., van den Berg, G., Mulder, E. A., Kuiper, C., Stams, G. J. J. M., & Popma, A. (2023). The development of adolescents in a non-residential alternative educational facility, including the prevention of secure residential placement. *Children and Youth Services Review, 145*, 106809. https://doi.org/10.1016/j.childyouth.2023.106809

Ramos Miguel, R., Santos, L., do Céu Salvador, M., Nobre Lima, L., & Rijo, D. (2024). Effectiveness of mental-health interventions for children and adolescents placed in residential care by the welfare services: A systematic review. *Children and Youth Services Review, 166*, 107929. https://doi.org/10.1016/j.childyouth.2024.107929

Roe, A. (2022). *What do we know about children and young people deprived of their liberty in England and Wales? An evidence review.* Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/children-and-young-people-deprived-of-their-liberty-england-and-wales

Roe, A. (2023). *Children subject to deprivation of liberty orders: Key findings from 12 months of research at the national deprivation of liberty court*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/wp-content/uploads/2023/09/CHILDR1.1.pdf

Roe, A. & Ryan, M. (2023). *Children deprived of their liberty: An analysis of the first two months of applications to the national deprivation of liberty court*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/children-deprived-of-their-liberty-an-analysis-of-the-first-two-months-of-applications-at-the-national-deprivation-of-liberty-court

Roe, A., Cusworth, L., & Alrouh, B. (2022). *Children subject to secure accommodation orders: A data review*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/children-subject-to-secure-accommodation-orders-a-data-review

Roe, A., Ryan, M, Saied-Tassier, A., & Edney, C. (2023). *Legal outcomes of cases at the national deprivation of liberty court*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/legal-outcomes-of-cases-at-the-national-deprivation-of-liberty-court

Roesch-Marsh, A. (2014). ‘Out of control’: Making sense of the behaviour of young people referred to secure accommodation. *British Journal of Social Work, 44*(2), 197–213. https://doi.org/10.1093/bjsw/bcs102

Roesch-Marsh, A. (2018). Professional relationships and decision making in social work: Lessons from a Scottish case study of secure accommodation decision making. *Qualitative Social Work: Research and Practice, 17*(3), 405–422. https://doi.org/10.1177/1473325016680285

Rogers, A., Fuggle, P., & Fonagy, P. (2024). *The Framework for Integrated Care: A catalyst for change to enhance services for children and young people at risk*. Anna Freud. https://www.annafreud.org/services/services-for-professionals/the-framework-for-integrated-care-a-catalyst-for-change/

Rovers, A., Blankestein, A., van der Rijken, R., Scholte, R., & Lange, A. (2019). Treatment outcomes of a shortened secure residential stay combined with multisystemic therapy: A pilot study. *International Journal of Offender Therapy and Comparative Criminology, 63*(15–16), 2654–2671. https://doi.org/10.1177/0306624X19856521

Rowe, C. L. (2010). Multidimensional Family Therapy: Addressing co-occurring substance abuse and other problems among adolescents with comprehensive family-based treatment. *Child and Adolescent Psychiatric Clinics of North America, 19*(3), 563–576. https://doi.org/10.1016/j.chc.2010.03.008

Santos, L., do Rosário Pinheira, M., & Rijo, D. (2023). Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers. *Child Abuse & Neglect, 139*, 106122. https://doi.org/10.1016/j.chiabu.2023.106122

Schutte, V., Danseco, E., Lucente, G., & Sundar, P. (2023). Mental health treatment programs for children and young people in secure settings: A systematic review. *International Journal of Mental Health Systems, 17*, 30. https://doi.org/10.1186/s13033-023-00599-2

Scottish Government. (2025, January 29). *Deprivation of Liberty Order data: FOI release.* https://www.gov.scot/publications/foi-202400445455/

Scottish Government. (2024). *Children’s social work statistics 2022–23 – secure care*. Retrieved January 8, 2025, from https://www.gov.scot/publications/childrens-social-work-statistics-2022-23-secure-care/

Secure Welfare Coordination Unit (SWCU). (2024). *SWCU annual report England January 2023–December 2023: Data highlights*. https://www.securechildrenshomes.org.uk/wp-content/uploads/2024/04/SWCU_Annual_Report_2023.pdf

Simpson, B., Beatty, D., & Broadbent, C. (2024). Associations between symptoms and participation in a DBT-A-focused long-term residential treatment program: Outcomes at discharge and 2-years post-discharge. *Evidence-Based Practice in Child and Adolescent Mental Health,* 1–18. https://doi.org/10.1080/23794925.2024.2358483

Smith, J. G., Bartlett, A., & Hales, H. (2022). Exploration of adverse patterns of placement of young people in secure care: The unwanted child? *Criminal Behaviour and Mental Health, 32*(3), 212–226. https://doi.org/10.1002/cbm.2233

Trubey, R., Evans, R., McDonald, S., Noyes, J., Robling, M., Willis, S., Boffey, M., Wooders, C., Vinnicombe, S., & Melendez-Torres, G. J. (2024). Effectiveness of mental health and wellbeing interventions for children and young people in foster, kinship, and residential care: Systematic review and meta-analysis. *Trauma, Violence, & Abuse, 25*(4), 2829–2844. https://doi.org/10.1177/15248380241227987

Turner, W., & Macdonald, G. (2011). Treatment Foster Care for improving outcomes in children and young People: A systematic review. *Research on Social Work Practice,* 21(5), 501–527. https://doi.org/10.1177/1049731511400434

van Gink, K., Vermeiren, R., Goddard, N., van Domburgh, L., van der Stegen, B., Twisk, J., Popma, A., & Jansen, L. (2018). The influence of non-violent resistance on work climate, living group climate and aggression in child and adolescent residential care. Children and Youth Services Review, 94, 456–465. https://doi.org/10.1016/j.childyouth.2018.08.009

van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Coughlan, B., & Reijman, S. (2020). Annual Research Review: Umbrella synthesis of meta-analyses on child maltreatment antecedents and interventions: differential susceptibility perspective on risk and resilience. Journal of Child Psychology and Psychiatry, 61(3), 272–290. https://doi.org/10.1111/jcpp.13147

Waitz, C., Tebbett-Mock, A., D'Angelo, E., & Reynolds, E. K. (2021). Dialectical Behavior Therapy in inpatient and residential settings for adolescents: A systematic review. Evidence-Based Practice in Child and Adolescent Mental Health, 6(4), 497–515. https://doi.org/10.1080/23794925.2021.1970052

Waldegrave, H. (2020), Who are they? Where are they? 2020: Children locked up. Children's Commissioner for England. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/11/cco-who-are-they-where-are-they-2020.pdf

Ward, J. L., Vázquez-Vázquez, A., Phillips, K., Settle, K., Pilvar, H., Cornaglia, F., Gibson, F., Nicholls, D., Roland, D., Mathews, G., Roberts, H., Viner, R. M., & Hudson, L. D. (2025). Admission to acute medical wards for mental health concerns among children

and young people in England from 2012 to 2022: A cohort study. The Lancet Child & Adolescent Health, 9(2), 112–120. https://doi.org/10.1016/S2352-4642(24)00333-X

Warner, L., Hales, H., Smith, J., & Bartlett, A. (2018). Secure settings for young people: A national scoping exercise. Central and North West London NHS Foundation Trust. https://www.england.nhs.uk/wp-content/uploads/2018/10/secure-settings-for-young-people-a-national-scoping-exercise-paper-1-scoping-analysis.pdf

Waterman, C. (2021). Evidence-supported interventions for children in care: Does Treatment Foster Care Oregon (TFCO) fit within the UK context? Journal of Family Therapy, 43(3), 392–413. https://doi.org/10.1111/1467-6427.12349

Williams, A., Bayfield, H., Elliott, M., Lyttleton-Smith, J., Evans, R., Young, H. and Long, S. (2019). The experiences and outcomes of children and young people from Wales receiving secure accommodation orders. A report for Social Care Wales written by CASCADE, Cardiff University. https://socialcare.wales/cms-assets/documents/The-experiences-and-outcomes-of-children-and-young-people-from-Wales-receiving-Secure-Accommodation-Orders.pdf

Williams, A., Bayfield, H., Elliott, M., Lyttleton-Smith, J., Young, H., Evans, R., & Long, S. (2024). Secure futures? A mixed methods study on opportunities for helping young people referred to secure children's homes for welfare reasons. Journal of Children's Services, 19(1), 38–53. https://doi.org/10.1108/JCS-06-2022-0019

Williams, A., Cummings, A., Forrester, D., Hodges, H., Warner, N., & Wood, S. (2022). Even secure children's homes won't take me. Children placed in alternative accommodation. Residential Treatment for Children & Youth, 39(4), 370–386. https://doi.org/10.1080/0886571X.2022.2044431

Williams, A., Wood, S., Warner, N., Cummings, A., Hodges, H., El-Banna, A., & Daher, S. (2020). Unlocking the facts: Young people referred to secure children's homes. What Works for Children's Social Care. https://foundations.org.uk/our-work/publications/unlocking-the-facts-young-people-referred-to-secure-childrens-homes/

Wood, S., Williams, A., Warner, N., Hodges, H. R., Cummings, A., & Forrester, D. (2024). Outcomes for high-risk young people referred to secure children's homes for welfare reasons: A population record linkage study in England. Journal of Children's Services, 19(2), 105–122. https://doi.org/10.1108/JCS-04-2023-0018

Youth Justice Board (YJB). (2024). Youth Justice Statistics: 2022 to 2023. National Statistics. Retrieved January 8, 2025, from https://www.gov.uk/government/statistics/youth-justice-statistics-2022-to-2023/youth-justice-statistics-2022-to-2023-accessible-version#behaviour-management-in-the-youth-secure-estate

Appendix 1: Methods Evidence Review

Search one

The first search aimed to identify research relevant to children currently or at risk of being deprived of their liberty. Given the limited evidence base on children subject to Deprivation of Liberty Orders under the inherent jurisdiction, searches were extended to include children deprived of their liberty in similar settings – namely, in a secure children's home for welfare reasons (under s.25 of the Children Act 1989) or in a mental health inpatient setting (under the Mental Health Act 1983). Previous research has highlighted the similarity in needs and experiences for children deprived of their liberty in youth justice settings (see Roe, 2022 for a review); however, given the much larger body of evidence around custodial settings, studies focusing on children deprived of their liberty in custody (or on remand) were excluded from this review.

The focus for search one was on evidence from England and Wales. Relevant studies from Scotland were also included, given similarities in the secure accommodation system and the significant number of children from England and Wales who are placed in secure accommodation in Scotland (Gibson, 2022). International evidence was excluded due to differences in definitions and models of secure care internationally.

The following inclusion criteria were used:

a) population of the sample are older children (c. age 10-18) who are (or are at risk of being) deprived of their liberty for welfare reasons, i.e. subject to a deprivation of liberty order, in a secure children's home under a secure accommodation order, or in an inpatient mental health unit under the Mental Health Act
b) study is a review article or empirical research (quantitative, qualitative or mixed methods)
c) study addresses the experiences and/or needs of children prior, during or post-secure care
d) the sample is from a UK population
e) study is in the English language
f) study was published from January 2010 onwards
g) study is peer reviewed

Information sources

In December 2024, 6 electronic databases were searched: Scopus, Sociological Abstracts via ProQuest, Social Services Abstracts via ProQuest, Applied Social Sciences Index & Abstracts (ASSIA) via ProQuest, PsycINFO via EBSCOhost, and Web of Science. Relevant grey literature was identified by searching publications of relevant organisations and the reference lists of key studies or reports.

Search strategy

1. The following search terms were used.
2. "child*" OR "youth" OR "teen*" OR "adolesc*”
3. "depriv*" n3 "liberty" OR "detain*" OR "detention"
4. "secure" n3 ("care" OR "children's home*" OR "accommod*" OR "placement*" OR "setting*" OR "facilit*" OR "residential")
5. ("mental" OR "psychiatric") n3 ("inpatient*" OR "ward*" OR "unit*")
6. "Engl*" OR "Wales" OR "Welsh" OR "UK" OR “United Kingdom” OR “Scotland” OR “Scottish”
7. S1 AND (S3 OR S4 OR S5) AND S6

The screening and data extraction process was informed by PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Moher et al., 2009), an evidence-based guideline that presents the minimum set of items used for reporting in systematic reviews.

Identified citations were imported into Endnote and duplicates removed. Titles and abstracts were imported into Rayyan (https://www.rayyan.ai) for screening. Screening was completed by 3 reviewers using the inclusion criteria above. An overview of the search and selection process is shown in Figure 5.

Search two

Search two aimed to identify evidence-based interventions or models of care aimed at addressing the identified (‘complex’) needs of children subject to or at risk of being deprived of their liberty. In the first instance, the search aimed to identify interventions delivered to children within welfare secure care (i.e. under a deprivation of liberty order or in a secure children’s home). Given the limited evidence base, searches were extended to include relevant interventions for looked-after children with complex needs. ‘Complex needs’ is an ill-defined term in the literature. Searches aimed to identify synonyms of ‘complex needs’ (e.g. ‘high risk’, ‘multiple needs’), as well as particularly prominent needs or risk factors for the cohort of interest (e.g. ‘self-harm’, ‘externalising problems’, ‘internalising problems’). Relevant interventions should target one or more of these problems and be designed for children at high-risk (where other interventions or standard models of care have failed to address the child’s needs).

For search two, geographical limitations were not imposed using search terms. During screening, priority was given to interventions evaluated in a UK context, followed by European countries, North America, New Zealand and Australia. These countries have similar child welfare systems, and hence interventions delivered in these jurisdictions may have translational relevance to an English context.

The following inclusion criteria were used:

a) study is an evaluation of an intervention aimed at addressing at least one of the following identified needs:
    - complex trauma
    - self-harm or self-injurious behaviours
    - externalizing problems including challenging behaviours
    - internalizing problems including emotion dysregulation, affective disorders, attachment difficulties
b) population of the sample are older children (c.10-18) in residential care, or at high risk of entering residential care
c) study measures at least one child-focused quantitative outcome measure addressing one or more of the needs described above. Priority will be given to randomised control trials (RCTs).
d) or study is a review of interventions
e) the sample is from a UK, Western Europe, North America, Australia or New Zealand population
f) study is in the English language
g) study was published from January 2010 onwards
h) study is peer reviewed.

Search strategy

The search and data extraction process were similar to search one, using the above inclusion criteria. Given the rapid nature of the evidence review and the large volume of articles returned (2,995), more stringent criteria were applied during full-text screening. Priority was given to systematic reviews or meta-analyses where available, to interventions carried out in secure welfare settings or in residential settings, and high-quality studies (i.e. fully powered, feasibility or efficacy RCT or quasi-RCT design).

An overview of the search and selection process is shown in Figure 6.

The following search terms were used.

1. "child*" OR "youth" OR "teen*" OR "adolesc*"
2. “looked after” OR “looked-after” OR “out-of-home care” OR “out of home care” OR “foster care*” OR “foster parent*" OR “foster famil*” OR “foster placement*” OR “children’s home*” OR “children’s residential home*” OR “residential care” OR “residential place*” OR “residential unit” OR “alternative care”
3. “intervention*” OR “treatment*” OR “therap*” OR “trial” OR “program*”
4. “complex needs” OR “complex trauma” OR “multiple needs” OR “high risk”
5. “self harm” OR “self-harm” OR “self-injurious” OR “self injurious” OR “suicid*”

6. (“behavior” OR “behaviour”) NEAR/3 (“challeng*” OR “aggress*” OR “problem*” OR “criminal” OR “antisocial” OR "anti-social" OR “disorder”)
7. “mental health” OR “mental disorder*” OR “mental illness*” OR “psychiatric disorder*” OR “conduct disorder*” OR “oppositional defiant disorder*” OR “ODD” OR “PTSD” OR “post-traumatic stress disorder*” OR “internalizing” OR “internalising” OR “externalizing” OR “externalising” OR “depress*” OR “affective disorder*” OR “anxiety” OR “fear” OR “attachment problem*” OR “attachment disorder*”
8. (“emotion*” OR “mood”) NEAR/3 (“dysregulat*” OR “problem*”)
9. 1 AND 2 AND 3 AND (4 OR 5 OR 6 OR 7 OR 8)

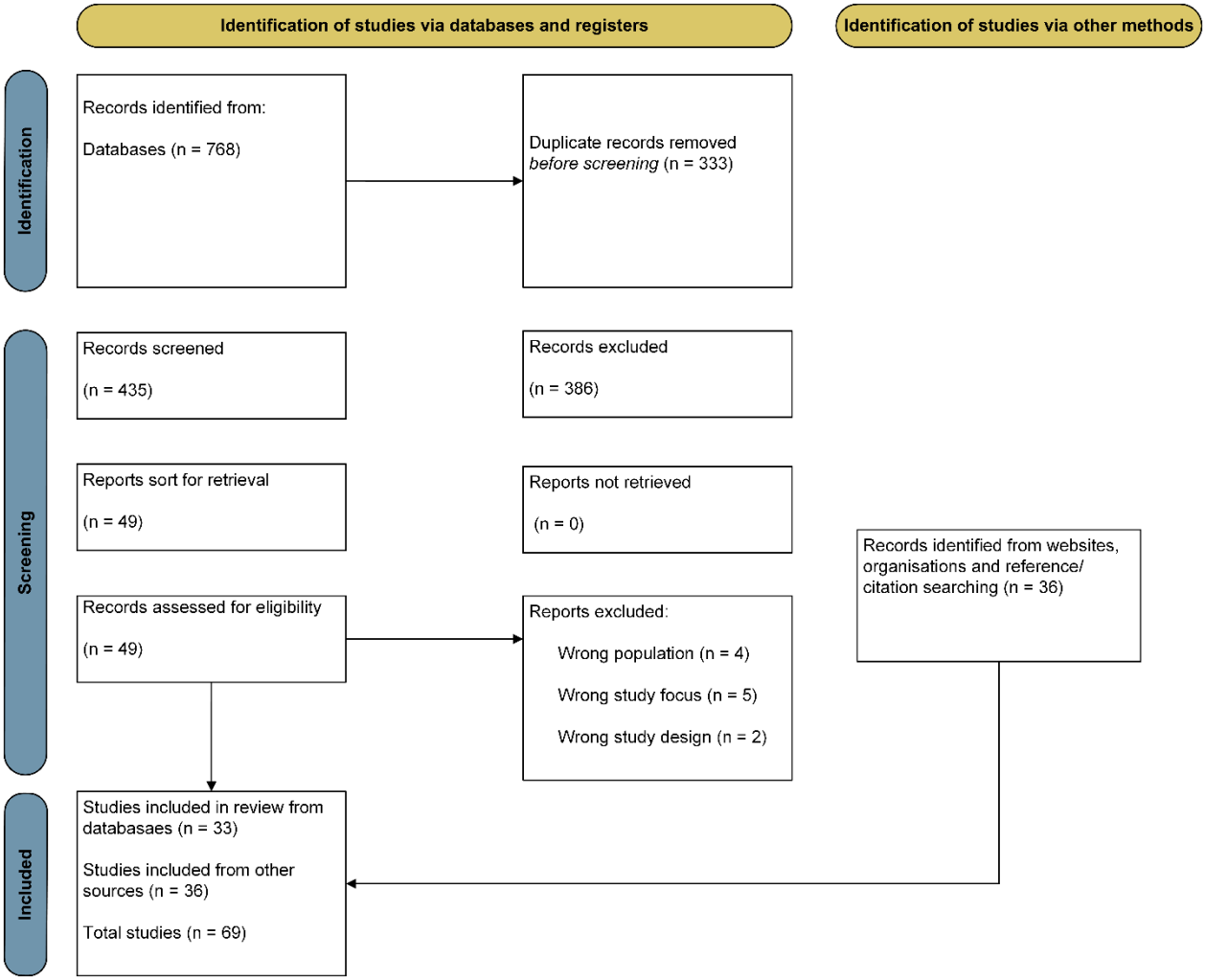
Results of systematic searches

Search one

Search one returned a total of 435 results (following de-duplication) in academic databases. After abstract and full-text screening, a total of 33 studies were included in the review. Of these studies, none focused on the needs or characteristics of children subject to DoL applications under the inherent jurisdiction of the High Court. Eight studies were relevant to interventions and are considered in section 2. Of the remaining 27 studies, 16 focused on children referred to or placed in SCHs, 8 on children in inpatient mental health settings, and 3 covered multiple settings. Eighteen had samples from England, 4 from Scotland and a from Wales. Four review articles were identified (all about inpatient settings).

Grey literature searches and reference/citation searching returned a further 36 articles.

Figure 5 PRISMA diagram for search one.



Some of the studies identified used data from the same sample. Four studies were published by Hales and colleagues using data collected during a census of all children living in secure settings in England (mental health, welfare and youth justice settings) on 1 September 2016 (Bartlett et al., 2021; Hales et al., 2018, 2022; Smith et al., 2022). Three studies by Williams and colleagues (Williams et al., 2020, 2022; Wood et al., 2024) used a linked dataset of all referrals to SCHs made between 1 October 2016 and 31 March 2018, held by the Secure Welfare Coordination Unit (SWCU), linked to annual Children in Need and Children Looked After returns held by the DfE.

Findings from the included studies as relevant to the research questions set out above are narratively synthesised below.

Search two

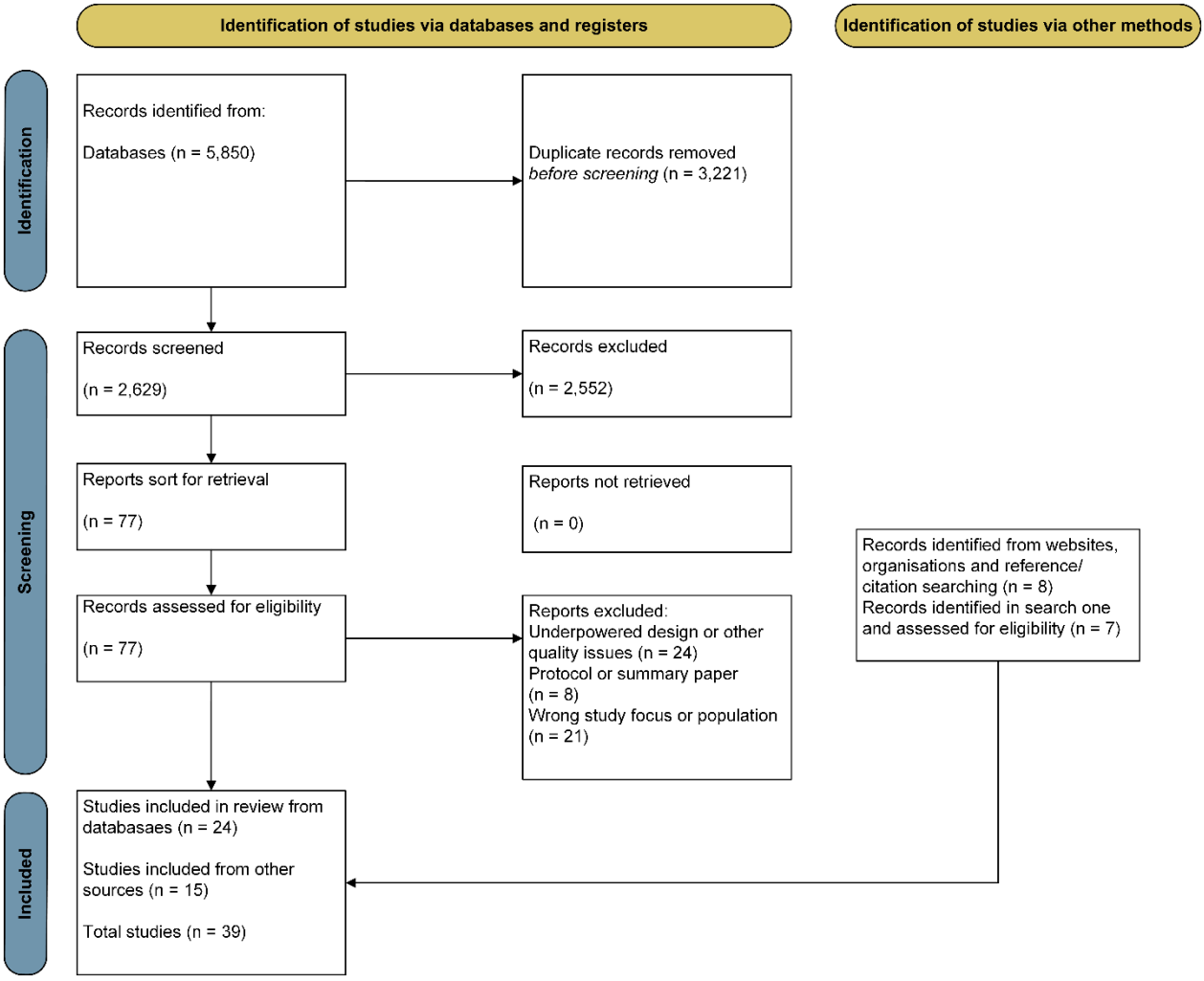
Search two returned a total of 2,629 results (following de-duplication) in academic databases. After abstract and full-text screening, a total of 24 studies were included in

the review. A further 15 studies were identified through other methods, including 6 identified via search one and deemed eligible for inclusion (see Figure 6).

Eight review or meta-analyses were identified.

Of the studies included, none evaluated interventions to address the needs of children subject to or at risk of DoL applications under the inherent jurisdiction of the High Court, highlighting the lack of evidence-based practice for providing care and support to this cohort of children. Three were interventions delivered during or to prevent a stay in a secure setting. Other interventions were delivered in residential settings or foster care for children with complex and multiple needs.

Figure 6 PRISMA diagram for search two.



Chapter 3: Case File Review

About the case file review

Chapter 3 describes findings from a review of 21 children's and young people social care case files in 4 local authorities in early 2025. Research in Practice and National Children's Bureau worked with the Department for Education (DfE) to identify local authority sites for the case file review. The purpose was to explore the characteristics, needs, experiences and outcomes for children and young people who have been – or were at risk of being – deprived of their liberty. Given the involvements with health, education, criminal and family justice that we know are often aspects of the lives of children and young people deprived of their liberty (see Evidence Review Chapter 2) the social care case files offer one lens on these journeys through multiple, complex systems. Nevertheless, the files enable further insights into the circumstances that lead to a Deprivation of Liberty Order (DoLO) being made.

Fieldwork sites with which DfE had engaged in scoping the specification of the research commission were prioritised. These local authorities were known to have a range of experience with DoLOs, had expressed interest in the research and outcomes, and had capacity to work with the research team to identify and access the case information required.

From these contacts, the research team worked with the DfE to select 4 local authorities across north and south England. Each local authority identified suitable cases for inclusion in the review based on criteria and guidance from the team. The criteria were children and young people who:

- had multiple, complex safeguarding needs
- were subject to – or at risk of having – DoLO restrictions in any period between July 2022 and December 2024
- were aged 18 and under at time of the application for/consideration of a DoLO

NFJO research (Roe 2023) generated a typology of 3 broad groups of children subject to a DoLO:

- children with learning and physical disabilities needing support/supervision
- children experiencing (or at risk of) sexual or criminal exploitation and
- children with multiple complex needs often recognised to be a response to complex and ongoing trauma

It was the last of these (which was the largest of these groupings in the NFJO study) on which DfE aimed to focus on this research and on which the local authorities selected

case files for inclusion in the review. The analysis of 21 cases across these 4 sites found that most of the children and young people whose files were selected had experienced abuse, neglect, loss and other adverse life experiences. Many had multiple, overlapping difficulties, including multiple emotional and behavioural needs that are often associated with experiences of early childhood adversity and complex trauma. While the NFJO typology is a helpful frame for analysis, in most of the case files selected for this review the DoLOs were sought primarily to protect children and young people from risks associated with exploitation and complex behaviours relating to mental health issues or emotional distress. Their experiences and needs crossed the 3 typologies.

All of these children and young people had experienced excessive and persistent levels of trauma, arising from within their own families and earlier life experiences. For some there was evidence in the case files of abusive and traumatic circumstances evident through social care involvement in their parent/s life pre-birth and continuing throughout very early life. This included examples of familial sexual abuse, physical abuse, domestic violence, harmful impacts of parental drug and alcohol misuse, and parental mental ill health. Parents' own experience of trauma compromised their own parenting resilience and resourcefulness.

The methodology and tools were reviewed for ethical approval by the Department of Education. The research team accessed the selected case files of children and young people, extracting anonymised information and summarising the case history in a bespoke data collection template. All the data was accessed and extracted in January and February 2025. In total, data was extracted from 21 case files as set out in Table 3 below. The research team conducted semi-structured interviews with 8 professionals to provide additional depth, with reflections on their decision making and practice. Analysis of this data and themes from the qualitative descriptions are presented in the findings section.

Table 3 Count of cases included in the review, by Local Authority

Local Authority	Count
A	5
B	7
C	4
D	5
Total	**21**

Data source: Case files

This fieldwork was a small, selective sampling of both organisations and case files. As such, it was not possible to create the robust population framework and random selection process needed for a representative sample of all instances of DoLOs. Therefore, the journeys and characteristics described in this report may be considered as illustrative of children and young people experiencing restrictions on their liberty; but certainly cannot be treated as representative of all children and young people subject to a DoLO.

Social care case files do not typically include detailed clinical information nor full health records. Case files and case management systems are not designed for research purposes, and the researchers found the data extraction for the review challenging. Events, processes, decisions and dates were not recorded in structured ways that would enable straightforward data exported.

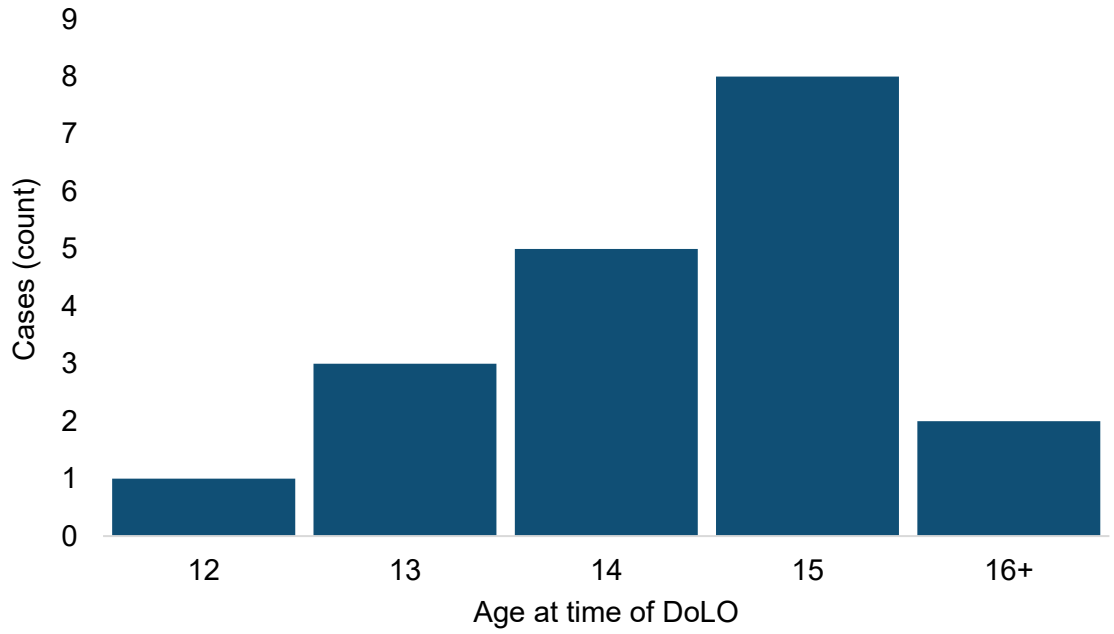
Much of the data on which these findings are based was collected from the narrative contained within documents and open text in the case files about children and young people. The emphasis on documents and open text narratives limited the researchers' ability to extract consistent data for this review, and this difficulty accessing evidence could present a barrier in future research. The lack of a consistent, structured dataset will limit whether court or social care data about the DoLOs can be linked to key outcome data from education or health.

The quality of the open text and documentation in files varied. There were examples of well-structured files with strong evidence of planning, assessment, and care. Good practice included clear notes and recording of decisions; with the language, tone and level of description directed towards the young person; should they choose to access their file in future. In other cases, the sequence of events and decisions was less clear or key dates and data missing. This limited the review's ability to explore placements, multi-agency approaches, and legal decisions in full.

Findings

Ages: At the time a DoLO was applied for these children and young people were aged between 13 and 17 years, with an average age of 14. Two of the 21 are not included in the chart below because it was not sufficiently clear from their records at what age making an application for a DoLO had been considered.

Figure 7 The age of children and young people when the DoLO application was made (or considered)



Data source: Information recorded from case files in the data extraction tool

Genders: 16 of the children and young people in the review were recorded in their case files as female, and 5 as male. One young person identified differently from how they were assigned at birth, and they have been included in line with their self-identified gender.

The high number of girls and young women in this case file review contrasts with findings from the Nuffield Family Justice Observatory; where the number of girls and boys subject to DoLO applications was almost equal (NFJO 2023), or greater for boys and young men (Roe 2022). It is likely this is an unintended consequence of the criteria and selection process for the review. Local Authorities were asked to focus their selection of files on children and young people with complex behaviours relating to trauma, rather than those in which the reasons for the DoLO related primarily to disability-related support needs or addressing offending behaviours. It may be that behaviours related to complex trauma were more readily identified, or presented differently, among girls and led to this selection.

Ethnicities and nationalities: Twelve of the children and young people were from white backgrounds; 9 were from Global Majority and multiple heritage backgrounds. Nineteen held British nationality, and 2 held other nationalities.

Siblings: Seventeen of the children and young people had siblings or half siblings, either living together or elsewhere.

Recorded health issues. All 21 children and young people showed signs of emotional dysregulation, anxiety and self-harm. Eleven were recorded as having a mental health condition or needs. Generally, these mental health needs were observed and recorded by social workers who linked these in case file narrative to earlier trauma. Seven of the 11 had diagnosed mental health conditions and involvement of mental health clinical teams.

A small number of children and young people had either a physical health condition, physical disability, or a learning disability that affected their social care support needs. Five children and young people were recorded as neurodiverse; this included autistic people, those with ADHD, and other neurodiversity. For those for whom ADHD was noted in the files, this was not identified as relating to the grounds for a DoLO application.

Resilience factors

These children and young people had a range of strengths which had helped them survive adversity and might support their recovery. Relationships were an incredibly important element of this, and different case files highlighted strong bonds with a parent, grandparent, sibling, teacher, support worker or foster carer. There were examples of parents or wider family who were engaged and supportive, including attempting to disrupt activities linked to criminal or sexual exploitation.

Children and young people were seen to have personal characteristics that supported their resilience. Notes in case files showed social workers' appreciation of the young people's strength, passions and positive qualities such as 'bright, strong willed and humorous', highly motivated in education or extra-curricular hobbies, drawing on faith and cultural connections, or with strong plans and aspirations for the future.

Some of the children and young people showed insight and understanding into their own behaviours and 'triggers', the risks they faced through exploitation, or their parents' situations and abilities. Other strengths highlighted when working with professionals were a willingness to ask for help, accepting input from therapeutic or clinical mental health teams, and the trust needed to share experiences with their social worker.

Safeguarding factors

Researchers extracted the main reasons that an application for a DoLO was made or considered in each case file. Multiple grounds for a DoLO were identified for each child or young person in the review. The number of factors identified ranged from 4 to 15, with an average of 9 factors. Given the selection criteria for this review, the presence of many different factors leading to deprivation of liberty was to be expected and is illustrative, not representative.

Closely reflecting the selection criteria for the case file review, the principal reasons for the DoLO applications for all 21 children and young people were needs and behaviours that were symptomatic of trauma, familial abuse and/or extra-familial harm or exploitation. The reviewers categorised these based on the case file evidence. The most common grounds were factors relating to mental health and emotional difficulties (17 children and young people, see table 9); self-harm, going missing and placement breakdowns (each were identified for 13 children and young people, see tables 10, 11 and 7); and exploitation (12 children and young people, see table 5).

The review of the case files revealed that a DoLO was frequently sought to protect young people from the risks associated with Child Sexual Exploitation; concerns around coercion, grooming, direct exploitation or going missing were central to the decision-making process. Common risks were exploitation through peer networks and online, relationships linked to substance misuse or gangs, and unsuitable or frequent changes to care placements increasing vulnerability.

Tables 4-12 below provide the breakdown of the grounds for application by category. These categories are overlapping and mutually reinforcing. The grounds for use or consideration of a DoLO were multi-faceted in all 21 case files and no category or single item within the table should be taken as the sole reason for a DoLO.

Table 4 Grounds for application: Risk to others

Risk to others. Nine of the 21 children and young people's files showed one or more of the following factors.	**Count**
Physical aggression	7
Serious assault	3
Verbal aggression	3
Damage to property	2
Criminal charges	1
Offending behaviours	1
Inappropriate sexual behaviours	1
Setting fires	1

Data source: Categories recorded from case files in the data extraction tool

Table 5 Grounds for application (continued): Exploitation

Exploitation. Twelve of the 21 children and young people's files showed one or more of the following factors.	**Count**
Child sexual exploitation	9
Criminal exploitation	5
Exploitation (unspecified)	3
Gang affiliation	1

Data source: Categories recorded from case files in the data extraction tool

Table 6 Grounds for application (continued): Education

Education. Ten of the 21 children and young people's files showed one or more of the following factors.	**Count**
Out of education	10
School exclusion	1

Data source: Categories recorded from case files in the data extraction tool

Table 7 Grounds for application (continued): Placement breakdown

Placement breakdown. Thirteen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Multiple	12
Single	1

Data source: Categories recorded from case files in the data extraction tool

Table 8 Grounds for application (continued): Disability needs

Needs or behaviours as a result of a severe learning disability, a physical disability and/or autism. Four of the 21 children and young people's files showed one or more of the following factors.	**Count**
Autism	3
Neuro-developmental disability (other)	1
Physical Disability	1
Learning disability	1

Data source: Categories recorded from case files in the data extraction tool

Table 9 Grounds for application (continued): Mental health

Mental health and emotional difficulties. Seventeen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Mental health (without diagnosis)	9
Emotion dysregulation	9
Trauma	9
Mental health (diagnosed condition)	6
Anxiety	5
Attachment difficulties	5
Low self-esteem	3
Rejection	2
PTSD	2
Eating disorders	2

Data source: Categories recorded from case files in the data extraction tool

Table 10 Grounds for application (continued): Self-harm

Self-harm. Thirteen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Self-harm	10
Suicidal ideation	8
Previous hospital admission	6
Current hospital admission	6
A&E or outpatient presentations	5

Data source: Categories recorded from case files in the data extraction tool

Table 11 Grounds for application (continued): Missing

Missing. Thirteen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Repeatedly missing (multiple days or events)	8
Going missing (single day/event)	5

Data source: Categories recorded from case files in the data extraction tool

Table 12 Grounds for application (continued): Other

Other grounds. Ten of the 21 children and young people's files showed one or more of the following factors.	**Count**
Misuse of drugs and/or alcohol	8
Other	2

Data source: Categories recorded from case files in the data extraction tool

Safeguarding risks identified in the files strongly reflected similar concerns to the grounds for the DoLOs. However, there were also additional 'inter-familial' areas of concern highlighted which related to signs of abuse, neglect, and limited parenting capacity.

The young people's experiences highlighted long-term, on-going safeguarding risks. Although the risks were not new, and often services had been working to try to address them for many months or years, there were 2 common features leading up to the use of a DoLO. These were that either:

- there was a significant incident or clear signs of escalation. Incidents leading up to the DoLO included acts of self-harm, violence against others, extensive or very high-risk missing periods, and being a victim of violence or exploitation.
- the children's and young people's living situation (whether with parents or in a care placement) has broken down or was considered highly likely to break down unless additional restrictions were put in place. Living situation break downs were attributed to a range of different circumstances. Carers – whether family, foster carers, or residential care staff – were facing extremely serious behaviours and emotional dysregulation which in many instances went beyond the skills, capacity and support of carers, making placements and living arrangements unsustainable and unsafe.

The files suggest an absence of multi-disciplinary, specialist support and intervention from professionals with the necessary skills and expertise to work with family or carers around the symptomatic behaviours and emotional dysregulation of trauma. There was

limited evidence of work with other professionals in these areas from the case files from when concerns first emerged through to the crisis points when a DoLO was used, although there were examples for some young people of input from mental health and exploitation teams. Other work may have taken place, which was not clear in the case files, or may not have been known to the social work teams. However, supervision and meeting notes in the case files indicate this absence was also sometimes due to a lack of available or appropriate services.

Sometimes social workers took the decision to move a young person because carers were not safe and suitable or were not coping. Sometimes the move took place at the request of the carer because they felt unable to keep the child or young person safe and manage their behaviour. Sometimes children and young people spent short periods in emergency placements and moved again once more suitable arrangements could be made.

Table 13 Safeguarding risks: Inter-familial harm

Inter-familial actual or risk of future significant harm. Seventeen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Emotional abuse including very poor parenting skills	11
Domestic abuse	10
Neglect including very poor parenting skills	9
Child missing from home	8
Parenting capacity limited by mental ill health	7
Child's emotional and/or behavioural problems	7
Parenting capacity limited by past trauma	6
Poor/fractured relationships with parents/family	6
Physical abuse	5
Parenting capacity limited by substance misuse	5
Parent or parents absent	5
Severity of child's behaviour puts child beyond parental control	5
Violence against parent(s) or family member	5
Sexual abuse (familial)	4
Family members in prison or involved in criminal activity	3

Data source: Risks recorded from case files in the data extraction tool

Table 14 Safeguarding risks (continued): Extra-familial harm

Extra-familial actual or risk of future significant harm. Fifteen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Child using Class B drugs	9
Victim of sexual assault	8
Child sexual exploitation	8
Association with peers who present risk of harm	8
Increased and/or secretive mobile phone use by child	6
Offending behaviour	6
Criminal exploitation including gangs/county lines	5
Child frequenting areas associated with exploitation	5
Victim of physical assault	4
Child using Class A drugs	4
Child acquiring items or money	4
Child using alcohol	3
Human trafficking	3
Child is violent/aggressive towards others	2
Frequent changes of phone, or multiple phones/numbers	1
Modern slavery	1

Data source: Risks recorded from case files in the data extraction tool

Table 15 Safeguarding risks (continued): Schools and welfare concerns

Schools and further welfare concerns. Seventeen of the 21 children and young people's files showed one or more of the following factors	**Count**
Not attending school	12
Unresolved trauma including bereavement	5
Significant change to emotional well-being	3
Going missing from school	2
Significant decline in school performance	2
Target of bullying	2
Referred/attending a Pupil Referral Unit	1
Permanent exclusion from school	1
Association with peers who present risk of harm	1
Sexually transmitted infections	1
Pregnancy	1
Weight loss	1
Signs of exhaustion	1
Short-term exclusion from school	0
Isolation from peers	0
Perpetrator of bullying	0

Data source: Risks recorded from case files in the data extraction tool

Table 16 Safeguarding risks (continued): Mental and emotional health

Mental and emotional health. Sixteen of the 21 children and young people's files showed one or more of the following factors.	**Count**
Acts or ideation of suicide or self-harm	12
Treatment under CAMHS	9
Undiagnosed signs of illness, crisis, distress	7
In-patient mental health treatment	6
Mental health conditions (diagnosed)	4
Treatment under other mental health team (e.g. community mental health)	4
Treatment under other health service (e.g. GP)	0

Data source: Risks recorded from case files in the data extraction tool

Prior support and interventions

All but one of these children and young people had contact with children's services prior to consideration of a DoLO; many had very extensive histories of involvement from social care, youth justice and health services. Most were child protection and/or care-experienced including a range of different statuses either prior to (see table 17 below) or at the point of the DoLO: including with Child in Need status, an Interim Care Order, or Child Protection Plan.

For many, the grounds that led to the application for a DoLO were not new. Trauma, exploitation and abuse/neglect had been on-going or recurring in cycles; sometimes for years with corresponding signs of emotional distress and challenging behaviours. From case records, and across such extensive histories, it is not possible to fully assess the quality of this care they had received over time.

Positive practice. Reviewers did note some strong examples of in-depth, personalised and child-focused care planning and supervision; professional network meetings and multi-disciplinary reviews; attempts to support stability either in a placement or with family; regular contact with social worker and guardians; involvement of therapeutic and exploitation support; and a joint commitment to safeguarding the children and young people in collaboration with the court.

Practice challenges. Where the researchers identified areas for improvement, acknowledging that this is a retrospective case file review so that these are reflection made with hindsight, these tended to focus around:

- difficulty accessing CAMHS and community mental healthcare, due to services capacity and threshold criteria (especially where there was not an assessed/agreed mental health diagnosis)
- repeated patterns taking place long-term and without improvement, such as placement break downs and cycling between different care arrangements
- a paucity of either earlier care planning or needs assessment, particularly for the few who had not been involved with children's social care teams for long before the application for a DoLO was made
- legal planning decisions and court proceedings not being clear in case files.

Table 17: Involvement with services prior to the application for a DoLO

Previous involvement with services	Count
Child in Need	13
Interim Care Order	13
Child Protection Plan	12
Voluntary care (Section 20 or Section 76)	10
Care Order	8
Referral and assessment followed by NFA	6
Referrals at information/information sharing level	5
Referral, assessment and referral to another agency	5
Psychiatric in-patient under the Mental Health Act	5
CAMHS patient	4
Not known to services prior to matters leading to a DoLO application	1
Youth Justice involved	1
Other level of involvement	1
On-going care proceedings (without interim order)	0

Data source: Information recorded from case files in the data extraction tool

The case files showed long, and often very complex, histories of service involvements. Types of support and care status varied, but an overall pattern of increasing intensity of intervention was clear for most children and young people. Typically, by the point the local authority made an application for a DoLO, there was evidence of professional responses progressively intensifying but not being sufficient to address escalating risk of harms. Decisions to use a DoLO at this point were recorded as being due to a lack of suitable therapeutic placements or support resources at the level required.

> The homes [were] unable to give her what she needed – *reflections from a social worker about a young person who was subject to DoLO due to needs relating to their traumatic experiences, and who was considered to be at high risk of death from self-harm or suicide.*

There is no single 'journey' with support services for these children and young people, but there were some common patterns. The children and young people had frequently experienced abuse or exploitation from a young age; often from both within and outside the family. Services aimed to stabilise and keep the young person safe, but the on-going nature of the risks often led to cycles of different interventions. Case records showed multiple single assessments, early help plans, different targeted services, Child in Need leading to a Child Protection plans, stepping up to applications for voluntary, interim and full care orders. Alongside the response from social care, children and young people were also assessed by (or working with) a variety of other agencies including mental health, police, and youth justice. A small number of children and young people were assessed or receiving support for needs relating to autism and learning disabilities; including 1 child who was referred to, but not accepted by, a residential school for special educational needs.

Over time the intensity of intervention by professionals stepped up but this was typically not a linear process. Various agencies provided support; although where progress was made this was inconsistent, often being hindered by children's and young people's entrenched patterns of behaviour, periods of crisis or parental disengagement. For example, after emergency foster placements there were attempts to support the young people to return to their family, a kinship arrangement, or to try again with different foster carers. There were also periods of relative stability, which included children and young people engaging with therapeutic support in residential placements, CAMHS and other mental health offers, and with work around child criminal or sexual exploitation.

The children and young people were displaying behaviours and emotional dysregulation aligned with persistent, on-going trauma including self-harm, absconding, violence, arson and property damage. By the point a DoLO was considered, their parenting and care needs were exceeding what parents, wider family, foster carers and even specialist carers and settings were providing.

There was a recurring theme of disconnect between social and mental health services in some instances, with disagreement around whether these children and young people had assessed mental illness needing specialist mental healthcare (either at Tier 3 or Tier 4) or whether instead they required therapeutic parenting outside a clinical setting. This led to a DoLO being used as a response to extreme violence against the self and others, as there was an absence of an available care plan alternatives in secure settings or wards. Placements and support provided under the DoLOs were subject to the same limitations however, with difficulty securing appropriate accommodations and skilled, experienced staff. As a result, the focus of the placements made under some of the DoLOs became security and surveillance, with limited therapeutic and relational approaches supporting children and young people's recovery.

Case files illustrated long-standing evidence that young people were beyond parental control and that different care arrangements were not succeeding in keeping these children and young people safe, with very strong evidence by the time applications for the DoLOs were pursued. For instance, there were examples of residential homes struggling to manage the types and level of presenting behaviour. On one occasion 7 police officers attended a child's placement, in addition to 3 agency care staff present; prompting the social workers to ask, if the child was 'constantly being taken into custody - How can [they] repair and get better?' Both in case files and interviews professionals considered a DoLO at the point all other options were felt to have been exhausted.

For 1 child, it took over 7 years for a decision to be made that their parents were unable to care for them, after multiple attempts with different care arrangements. For another young person, at the time a legal planning meeting was held to discuss a DoLO, there had been tens of missing episodes just in their most recent placement. Recognising these dynamics sooner could have provided an opportunity to implement more robust protective measures, potentially mitigating the adverse effects on the child's wellbeing and stability.

Deprivation of Liberty Orders

Eligibility for the case file review focused on the high-level, complex needs. Children and young people could be selected for inclusion if they had been subject to a DoLO by the court, restrictions to liberty under any other arrangement, or if application for a DoLO had been strongly considered and decided against by the local authority.

In the case files selected for the review, 18 children and young people had been subject to a DoLO granted by the court. For 3 children and young people the use of a DoLO had been strongly considered, without leading to an application.

For some children and young people, their orders were still open at the time of the review. For others, while it was clear an order had been made or completed, the precise

dates were not recorded in the case file. Meetings to review the legal considerations were often recorded but the content and decisions taken in these meetings – and later in court – were not always clear. There were 13 case files where a DoLO had been granted by the court for which it was possible to extract both start and end dates from the case files. The length of these orders varied considerably, and extensions were granted to initial periods. The overall time spent subject to the DoLO, and subsequent extensions ranged from 1 month to over 3 years; the median length was 92 days.

About the orders

We did not find records that indicated the court had refused an application for a DoLO for any of the children and young people included in this review; however, for 3 of these, some of the restrictions to liberty requested were not approved. This included restricted mobile phone usage, which the courts deemed to be within the local authorities' existing scope of corporate parental responsibility. One young person appears to have been subject to high levels of supervision prior to an application for a DoLO.

Most of the children and young people subject to a DoLO were recorded as being able to participate in education, whether fully (5) or with limitations to the timetable/setting (6). 3 children and young people were not able to participate in education during the order. For the remaining 7 children and young people access to education was not clearly determined from the review of case files.

Contact agreements during the DoLO were recorded for 7 children and young people, and these arrangements returned to court for subsequent review for 2 people. Almost all the children and young people who were living separately to their siblings during the DoLOs had also been living separately prior to the order; 1 young person was separated from siblings due to their order and the placement made to support it.

Most (13) of the children and young people subject to a DoLO were also subject of further care and legal proceedings during the same period, including Care Orders and further DoLOs. Generally, the initial application for a DoLO was for a relatively short duration (as little as 30 days), but often the local authority had returned to court for periods of extension. This meant some of the DoLOs were in place for long periods, with 1 of the young people subject to a DoLO for 3 years. In some instances, the DoLOs seemed to be extended as a result of lack of suitable trauma-informed support and placement options.

Other legal routes to deprivation of liberty

The High Court's powers under its inherent jurisdiction to authorise a DoLO is 1 of 4 legal mechanisms for authorising under 18-year-olds' deprivation of liberty. It only applies where the legislative powers for authorising a deprivation of liberty do not apply (secure accommodation orders (section 25 of the Children Act 1989); an order of the Court of

Protection (Mental Capacity Act 2005) and detention in hospital (Mental Health Act 1983).

Four of the 21 children and young people's case files showed that a Secure Accommodation Order had been considered as an alternative to the DoLO. In 2 of the instances, the reason a Secure Accommodation Order had not been used was attributed to a lack of secure children's home placements available were such an order to be granted. In 1 instance, the young person was not considered to meet the thresholds set for secure placements. One application had been made to the Court of Protection. In interview, 1 social worker described why they had considered a DoLO first, instead of a secure placement or ward: their perspective was that a DoLO would help give a setting closer to the type of life the child wanted, could be more age-appropriate, and in a less institutional environment than a secure unit.

Mental health concerns were the most common grounds in the reviewed files for the use of a DoLO. It is important to note that the review was of social care case files, which do not typically include detailed clinical information nor full health records. It is of note that very few case files indicated close working with CAMHS, though for 1 person advocacy from CAMHS team was seen as crucial in securing them a secure mental health bed in an out of area hospital. Referrals were made but, due to the short-term nature of many of the placements, assessments were not always completed, and therapeutic relationships were broken when children and young people moved. For some, the use of a DoLO appeared to be in part because no suitable alternative was identified and/or because needs or presentation were not aligned with available mental health provision and thresholds. Two young people were subject to a DoLO after being discharged from secure mental health care.

In one instance, both social care and mental health professionals recommended a Tier 4 secure mental health bed, but this request was rejected and a 'highly restrictive' DoLO was applied for as what the social worker described as 'the only way to keep [the young person] safe'. For another child, a placement with a residential school for special educational needs was refused because, despite several assessments, there was not agreement on a formal diagnosis of their learning difficulties.

The social work team for 1 young person strongly considered applying for a DoLO to manage risks and harms associated with trafficking and child sexual exploitation. In an interview, the social worker reflected on the importance of the relationship with a crisis support worker as the young person strongly resisted input from other services and support. This was an adult who 'did not give up' and provided a point of consistency, was persistent about wanting to get to know the young person, showed up in times of crisis, and was prepared to support them to take age-appropriate risks. Prior interventions by social care, carers and the police had attempted to keep the young person safe but went against their wishes. In this instance a DoLO was not pursued as it was considered that

the restrictions would further build resistance; instead, the social work team prioritised the voice of the young person and worked to build a relationship with carers that the young person had connected with in their community.

Placements

The Care Standards Act 2000 requires that all children's homes are registered with Ofsted as the regulatory authority. Children in care aged 15 and under must always be placed in settings where they receive care and are registered as such.

Supported accommodation is intended for 16–17-year-olds transitioning to independence. The Supported Accommodation (England) Regulations 2023 made it mandatory (from October 2023) for those providing supported accommodation to be registered with Ofsted and to adhere to a set of quality standards. If a child is deprived of their liberty, their needs will require care. As such, any setting where a child is deprived of liberty must register with Ofsted under the Children's Homes (England) Regulations 2015. A setting registered with Ofsted as a supported accommodation provider but offering a placement to a young person with a DoLO is operating as an unregistered children's home.

The DoLO applications in the case files for which the researchers found clear dates, were made across the period March 2021 to September 2024. Eight of these occurred prior to the introduction of the Supported Accommodation (England) regulations in April 2023. For placements after April 2023, the report refers to registered or unregistered settings. For placements that occurred prior to the regulation of supported accommodation, the report may refer to unregulated placements where this more closely matches the information and terminology used in the case files (although these homes would have been effectively operating as unregistered children's homes).

Information on children and young people's experiences of placements, and changes to placements, were challenging to extract from case files. Case management systems were not typically structured to provide extracts of discrete placement or legal events, so information was collected from free text reporting, address histories and other sources as much as possible. As such, these findings about the number, type and duration of placements should be taken as indicative giving a sense of the types and reasons for changes the children and young people experienced. Some children and young people had moved between different local authorities for various reasons, including 2 instances where parental separation meant they had addresses in different authority areas.

At the point where a DoLO was considered or applied for, 15 of the 21 children and young people were living apart from their family in a care placement. Most often this was a residential home, with a small number of children and young people living in foster care or other arrangements. In 1 file, a young person had over 10 address entries; these

showed they had been detained for assessment, been under the care of CAMHS, had previously been in foster care and in a residential home. However, the sequence and timings of the different moves were unclear. One interviewee discussed over 20 placements for another young person, which would not easily show up in the address history on file because they left and returned to the same home and foster care addresses at various times, sometimes for very brief stays.

There were examples of children and young people's views being taken into account in making placements. Several children and young people were supported to make multiple attempts to reunify, as they wished to live with their parent or parents. One young person was supported to stay living with a friend's family, due to their bond and despite concerns about suitability as a foster care placement. Residential homes were found for children and young people who showed or expressed difficulty coping in the family-environment of foster care.

This ability to tailor placement decisions to the needs and wishes of young people had clear limits. Lack of availability of specialist placements meant that the DoLOs had sometimes been implemented in what would be less restrictive but potentially unsuitable environments. Two young people were living in residential placements that were unregistered. In 1 of these, Ofsted had been notified of the placement and the local authority were trying to establish whether an application to register the home had been made. In the other, an unregistered placement in a static caravan was endorsed by the court, as a temporary measure until a secure bed became available. During the DoLO application process a third child was moved into an unregistered placement; this was at first to temporary, holiday-let accommodation followed by a bespoke placement created by the local authority (which was awaiting Ofsted registration).

Placements under a DoLO

Following a DoLO made by the courts, local authorities had made a variety of different types of placements including kinship carers, children's homes, supported accommodations and other arrangements. Seven children and young people were in placements outside their local authority area because there were no local therapeutic residential children's homes available with space, or which were willing to accept a child or young person with a DoLO. In several cases it was also a choice made to distance the young person from networks of exploitation or detrimental relationships with family. Out of area placements included a service used by 2 local authorities, which provides homes in rural settings with wilderness activities and pastoral support aimed at children and young people recovering from trauma or exploitation.

Examples of placement decisions constrained by the available provision and thresholds to access different accommodation included 2 children and young people who had extended stays on hospital wards. For 1 of these, over 60 settings were contacted, and

no appropriate placement could be found. For the other, after initial stays in hospital and mental health assessment their psychological needs were considered to be due to trauma and not an assessed mental illness. Evidence in the case files indicated there was disagreement between the clinical staff, allocation for hospital beds, and the local authority about the most appropriate placement. The local authority and clinical team supported hospital detention, but a Tier 4 bed was refused as the young person was not considered to meet the criteria, and the young person was discharged from the clinical care. The local authority did not have alternative provision to accommodate their needs, and the level of psychological care required; the DoLO was used to make a placement in an unregistered home and to allow restrictions to liberty, while seeking a more suitable placement. For a third young person, a registered residential home for high needs children and young people was available, but it was not willing to accept them while subject to the DoLO.

Once the DoLOs were granted by the court, the number of placements that were in unregistered settings increased to 7. This included a placement registered with CQC (and an application pending to Ofsted), placements with applications pending to Ofsted, and placements where no application for registration or notification to Ofsted was noted (including unregistered residential care and short-term holiday let accommodation).

Concerns about the suitability of the placements were recorded on the case files for 8 children and young people, these concerns expressed regarding both registered and unregistered settings. Concerns included lack of communication and quality of care from the placement, with 2 safeguarding concerns raised; and the fact that placements chosen due to availability were not able to mitigate all the risks that led to the DoLO. The other issues were specific to individuals: the distance of a placement from family; the use of an unregistered setting as a temporary safety measure; and the social work team feeling a hospital setting was required to meet the child's needs.

There were at least 16 placements made for those children and young people subject to a DoLO, across the following types of accommodation:

- kinship carers
- other alternative accommodation (including holiday let, private rental and an outdoor activity residential centre)
- registered children's homes
- semi-independent supported accommodation
- unregistered residential placement
- secure children's home placement.

Placement changes during the DoLO were recorded for 10 of the young people. For these, the number of moves ranged from 1 to 10 with an average of 3 placement

changes. Eleven of the DoLOs had ended at the time of the review, and after their order closed 5 children and young people had remained in the same placement.

Restrictions

The type and degree of restrictions granted by the courts varied between children and young people, and over time. Typically orders included restrictions across several of the following domains:

Close supervision: ratios of staff to young people ranged from 1:1 to 4:1, including use of CCTV in some areas of placements and secure transport. There were variations between day and nighttime supervision, and changes to levels of supervision when the young person left the placement.

Internet and phone access: Sometimes this was entirely restricted, for others supervised access was permitted.

Restraint: physical intervention or restraint to prevent acts of self-harm, harm to others or leaving the placement. Alarms and locks were also used to prevent the young person leaving.

Property: Regular searches of rooms and/or clothing. Permission to remove any items that could cause harm to self or others (such as lighters, scissors, shaving equipment, medications). Restrictions to access and use of money.

The restrictions were typically given on the condition that the minimum level of intervention needed would be used. Sometimes these were described as ‘permissive’, meaning restrictions that could be stepped up in response to escalation of risk or specific triggers but otherwise would be reduced or paused. There were examples of orders returning to court to be extended, but with gradual reduction in the number and intensity of restrictions to liberty.

There were examples of some young people struggling to cope with the intrusive and intense nature of the surveillance and restrictions placed upon them.

> ‘It was like she was a caged animal, she just needed to get out… DoLO was not the answer.’ – *Social worker reflections on escalation of behaviours following a DoLO*

At times, they also struggled when restrictions began to be stepped down or removed, highlighting the need for structured, clear care planning, relational approaches and strong therapeutic supports alongside the legal safeguards. Changes to placements, conditions and unsuitable staffing (due to training or turnover) added to the challenges of the

DoLOs, and at times made it difficult to ensure restrictions were being used proportionately.

Impact of the DoLO

Children and young people responded differently to the DoLOs and practitioners faced challenges in ensuring that restrictions remained proportionate and necessary, particularly for young people resistant to intervention. Case files evidenced frequent review processes, senior management oversight, weekly multi-agency 'hub' meetings, and a multi-agency approaches to understanding children and young people's needs. In interviews, the value of leadership, legal advice, and multi-agency support was strongly emphasised by the social workers in providing structure and safety to their implementation of the DoLO conditions.

Incidents recorded in the case files showed that the DoLOs were not always effective in reducing immediate harm - either by self-harm or otherwise, nor physical harm to others. Sometimes the DoLO restrictions appeared to escalate children and young people's behaviours; restrictions were felt to exacerbate and further traumatise, causing the frequency and severity of behaviours and emotional dysregulation of trauma to increase. This was noted especially around acts of self-harm or violence requiring restraint. A small number of DoLOs were not sustained due to placement instability or young people absconding, raising concerns about long-term protective measures. A safeguarding incident at a placement led to the abrupt, unplanned end of 1 DoLO; the young person no longer trusted the team and left to return to family.

From the case files it appeared that some DoLOs caused young people to lose significant relationships due to distance or contact restrictions. This could be with schools or support workers, as well as friends and family. For 1 young person, long-standing support from a CAMHS team ended when the DoLO led to a placement out of their area. Placement out of area was sometimes chosen to distance young people from contacts and peer networks who were exploiting them; but this also removed them from more supportive relationships.

However, for others the DoLO was seen to have created a period of respite, safety and relative stability. Supportive factors appear to be where the young people were cared for by trained staff who were consistent and available to form trusting and reliable relationships. Some young people were more able and willing to engage with support than they had been in previous placements, with signs of progression. High level of professional practice was noted following 1 DoLO where there had been close working with CAMHS due to escalating concerns about mental wellbeing and incidents of self-harm. Where children and young people had greater insight into their situation, the DoLO was sometimes understood by them as a sign of how seriously the risks against them were being taken and the lengths the professionals were willing to go to keep them safe.

For others, the period of stability was attributed to the strict standards of the DoLO. Children and young people were seen to be waiting, knowing the order would end, without engaging in support or therapeutic work. One young person consistently understood the DoLO to be a short-term arrangement, counting down to the end of their order and minimally complying with the imposed restrictions. There were other examples where support was refused by the young person, or where it was not available in the placement.

Outcomes

Some orders were still open at the time of the review. Some were extended because no suitable alternative or step-down provision could be found. There were records of further DoLOs, Care Orders or family and youth court proceedings for 7 of the young people. A small number of orders were ended because they were seen to have escalated young people's distress, resistance or dysregulated behaviours.

Positive outcomes were described in case files and by interviewees for children and young people. These included orders being ended – or extended with much reduced restrictions – due to decreasing risks. This looked different for individual children and young people but included things like reduction in the number or severity of:

- going missing or attempting to leave the placements
- self-harm
- violence or destruction of property
- emotional dysregulation.

Some of the professionals' comments in the interviews and case files reflected that, although the DoLO had been successful in responding to immediate safety risks, similar patterns and behaviours had re-emerged quickly after the end of a DoLO. In the case files of 1 young person, it was noted that they worried about the support ending. In interview, their worker described the young person saying that - as the end dates of the DoLO approached - they would 'do things' in the hope of having it extended again.

It is clear that most of the children and young people were still facing significant challenges and the majority continue to be open to children's services or have transitioned to adult ones. However, there were some good outcomes and signs of progress or recovery noted at the time of the review. These included increased independence, engaging and progress in education, increasing understanding and self-awareness, unsupervised contact with family, and establishing relationships with siblings and friends. One young person, who is no longer subject to a DoLO, is active in the community as a volunteer and will soon be starting college.

Considerations for Practice and Policy

Early identification and intervention: strengthening preventative family help and social care, in tandem with joined up therapeutic mental health support for trauma may well reduce the need for a DoLO as a crisis measure for some children and young people.

Improved placement options: increasing sufficiency of suitable, high-support, trauma-informed placements where the DoLO conditions can be effectively implemented, or where young people with challenging needs relating to trauma can be effectively supported and safeguarded without such restrictions.

Guidance: at present the Court can order the local authority to inform Ofsted if it is placing a child in an unregistered placement. This should occur whenever an unregistered placement is made under a DoLO. Ofsted should also be provided with the local authority's grounds for considering that the placement proposed is in the best interest of the child.

Multi-agency coordination: enhancing collaboration between social care, health, police, and legal teams to streamline processes and reduce delays.

Monitoring use and outcomes of DoLOs: improved data about the grounds, length, conditions, healthcare input, and outcomes for young people subject to a DoLO could support learning for improvements to practice and policy. These features were difficult to establish from case file audit alone.

Profiles of journeys

These are composite profiles that draw together factors from across the 21 case files to generate a sense of the personhood of the children and young people that may be more accessible to many than statistical data. The research team have been scrupulous in composing these to ensure that no actual child or young person could be identified through these composite stories.

Child A

Throughout Child A's life with their birth mother there had been multiple referrals regarding neglect, unexplained injuries and general behavioural issues. On some occasions the matter remained open under Child in Need but was closed soon afterwards due to 'non-engagement'. This term was often used in A's case file and in notes on referrals; it was problematic as 'non-engagement' does not describe what was actually going on, the reasons the family were declining support, or what might help in future to change this. The family were very private, either refusing or not responding to approaches by different services. No professionals from health, early years nor school ever managed to form effective relationships with the mum or the children.

A was separated from their birth mother at age 11, after making allegations of sexual abuse against her mother's partner. A had 2 younger half siblings and all 3 were placed with their aunt and uncle under a Special Guardianship Order. Soon after, Child A's mother gave birth to her fourth child who was initially placed with a foster carer, followed by an early adoption placement.

A had a good relationship with her aunt. They had previously spent weekends together, and the aunt had often provided childcare support for Child A's mother. A stayed with her aunt for around 6 months. Her emotional presentation and behaviours were observed to be acutely dysregulated and extremely complex. These included graphic discussions about self-harm; as well as actual self-harm by burning, cutting and ligature, swallowing batteries and other dangerous products, and frequent purging of food. After an initial assessment, the CAMHS team declined the referral stating they were unable to work with A until she was more settled.

A frequently went missing from school and would return late at night, spending increasing time with adults and young people who were well known to the police and social care for sexual exploitation, drugs and criminality. A had a lot of contact involvement with the police and was often taken into their custody. She struggled at school and had several exclusions.

A's aunt struggled to cope, and the advice she was given from professionals about setting boundaries and limits were not well received. She agreed with the social care

team that she was unable to continue looking after A, who then went to live with grandparents where her self-harming behaviours continued to escalate, and she had violent outbursts against them. With risk to her family seen to be increasing, contact with her siblings and half-siblings was suspended. A's social care team advocated for a full assessment under the mental health act and treatment in hospital under Section 3. However, after Section 2 assessments, the clinical team advised that A did not suffer with a mental disorder and that therefore neither medical treatment, nor detention in hospital would be suitable.

Now aged 12, A became subject to an Interim Care Order. She had multiple placement breakdowns in foster care, residential placements, private specialist residential placements; all of whom were unable to offer the safe care, stability and treatment A needed. At times she was over 200 miles away from her home city. There was a heightened state of professional fear as the multiagency team tried to keep A alive, and the Interim Care Order became a full care order.

Whilst waiting for suitable accommodation to become available, A was moved to an Airbnb with 3:1 supervision from private agency care staff. An application for a DoLO was made on the request of a support worker, who had been extremely concerned about the possible illegality of such intensive supervision of A without a DoLO being in place. The DoLO was granted and restricted A's access to the community; supervision at all times in the placement with observations in bed every 15 minutes; the doors and windows were kept locked; and A had limited access to electronic equipment. Despite this, A still managed to go missing from the placement on several occasions, including a time where she was severely injured. The local authority and CAMHS jointly commissioned a crisis service specialising in work with children and young people who have been sexually abused and were at risk of criminal or mental health detention. It was soon after this that things changed for A.

The key worker allocated spent long periods of time with A, showing up during times of crisis, finding A when she was missing, helping attend to her injuries, and advocating for her when police were called by the agency care staff; consistently showing physical and emotional care. Eventually, rather than contacting police, the care staff would call the key worker. The key worker raised concerns that the agency care staff were overwhelmed and had not been implementing a least restrictive principle, instead using the full force of the DoLO as standard. The key worker also identified that accommodation was increasing A's feelings of paranoia as she was constantly being watched by multiple adults with frequent changes in the staff provided by an agency. A had been able to re-establish contact with her aunt, who was also concerned about her quality of life under the DoLO and had asked for A to be returned to her care. However, there was apprehension from the professional team, and the aunt was not approved as a foster carer.

At the next court hearing for renewal of the DoLO the judge received a letter from A, another from her aunt, and a position statement from the key worker in favour of the relaxing of the DoLO and a placement with the aunt. The judge directed the local authority to test out the placement, supported by the key worker, with the DoLO restrictions and on call care staff to be used only as strictly required. A is now 15 years old and living with her aunt. The arrangement is still supported intensely by the key worker and A continues to have some periods of self-harm. She has accepted some work with a clinical psychologist and begun to open up about her experiences of sexual abuse. A has aspirations of completing her GCSEs but has missed several years of school and is currently struggling to find a college that will accept her.

Child B

Child B is a 13-year-old with a history of extensive childhood trauma, including neglect and exposure to domestic abuse. She had only been working with the social care team for a little over a year; initially with a Child Protection Plan, then interim and full care orders. However, concerns had been raised about her care from a very young age including unexplained injuries, drug use by her parents, possible neglect, and about violent or inappropriate sexual behaviour towards her peers. This intelligence came from schools, a GP, and a support worker; however, the family had frequently moved between 3 local authority areas and changed healthcare providers. As a result, it appears that none of the different agencies had a full understanding of her vulnerabilities.

B had difficulties at school; her attendance was low and she struggled to engage in the lessons or with her peers. Frequent violent outbursts resulted in the police attending the schools on several occasions, and injuries to other pupils led to several referral orders for supervision and support by the Youth Offending Service. This did not reduce her outbursts or risk-taking behaviours; and B was permanently excluded. Around this time B began spending a lot of time online and formed a strong attachment to a group of young people and adults.

While showing affection and care towards her, these older individuals used their relationship to B to involve her in sexual exploitation, coercive control and criminal activities. After taking part in a violent assault against another child; the police, Youth Offending Service and social care jointly referred her to a specialist exploitation team. She was placed with several foster carers and then residential homes, but experienced multiple placement breakdowns due to her complex needs, escalating risk-taking behaviours, and difficulties in forming trusting relationships with the professionals and caregivers. B’s parents frequently encouraged her to leave the placements and return to them. However, they would quickly become overwhelmed by her behaviour, disengage with the social care support and an emergency placement would be made. This cycle meant that in just a year, B had moved more than 6 times.

The Local Authority applied for a DoLO at the same time as a full care order; seeking to move B out of area, restrict contact with her parents, remove access to the internet, and require supervision at all times when outside the placement. They arranged a single-bed residential placement and provided adaptions for the DoLO restrictions to be implemented (improving the strength of materials to prevent damage, adding cameras and additional physical security measures). The placement was initially unregistered, but the local authority worked closely with Ofsted to keep them informed and apply for appropriate registration. An assessment was made by CAMHS, however B was not considered to meet the clinical threshold; therapeutically informed pastoral care was offered at the placement, although B did not consistently engage with this relationship. Previously other referrals had been made for mental health support; each had been closed due to the frequent moves B experienced.

Despite the restrictions of the DoLO and repeated safeguarding interventions from the exploitation team and police; B remains highly susceptible to manipulation, often going missing for extended periods and being found in high-risk situations. Although removed from the immediate risk and network of exploitation, with no connection to the new area B has struggled to make connections and friends. Her mental health has deteriorated, with frequent incidents of self-harm, suicidal ideations, and increased risk-taking behaviours. She has expressed a strong wish to end the DoLO and desire for a more ‘normal’ life like her peers. At the same time, she has described the structure and staff as a safety net. After a period of stability, she has recently had several missing episodes, which her social worker believes is an escalation in response to her knowledge that the current extension of the order is coming to an end.

Child C

Child C is a 15-year-old who has experienced significant trauma due to multiple adverse family events. These experiences often contributed to instability within the home environment, ultimately leading to a breakdown in parental control. Despite efforts from family and professional services, she became increasingly vulnerable to extra-familial harm, mainly through associations with individuals in the community who exploited her. These relationships were some of the most consistent in her life, with both parents experiencing events that took them away from home (including treatment for mental and physical illness, and imprisonment).

C was responsible for her own care – and often that of her parents and siblings – from a very young age. She was frequently exposed to heightened risks, including criminal and sexual exploitation, substance misuse, and coercion by those seeking to manipulate her vulnerability and desire for connection to others. She went missing for extended periods and was believed to be involved in county lines criminal exploitation after repeatedly being found far from home by police. Although she strongly denied any sexual

exploitation or abuse, she was found to be pregnant at age 13. She strongly believed she could take care of herself, showed little insight into the dangers she was facing, and exhibited resistance to any attempt to set boundaries by caregivers and professionals. Despite various safeguarding measures, risk levels often remained high for almost 3 years. After a placement at a specialist residential home for complex care broke down, the local authority opted to apply for a DoLO to implement restrictions to stop her missing episodes. She was initially placed in a 3 bed residential children's home but found the interactions with the other children to be too intense and overwhelming; she remained there for a short period longer, while the local authority searched for a provider able to offer a single bed placement.

She received support from 2 specialist services for young people at risk of sexual exploitation and youth violence. However, she resisted this input and disagreed with their assessment of her situation. Despite the expertise and commitment of these services, little progress was made towards stabilising her situation. The pervasive and highly complex nature of extra-familial harm meant that existing interventions often struggled to entirely disrupt the risks, leading to continued concerns for the young person's safety and well-being. The DoLOs provided additional safeguards around her movements and associations, she would comply with these restrictions and wait for the order to lapse; then return to the same situations and people involved in her exploitation.

Once a DoLO was granted, placements were frequently identified at substantial distances from C's home area to provide a place of safety for stabilisation. However, these placements were typically short-term and offered limited access to education and therapeutic support, raising concerns about C's long-term development and recovery.

Child D

Child D is a 14-year-old who identifies as non-binary and uses they/them pronouns. They have lived with their father and stepmother from a very young age, after experiencing severe neglect as an infant. D has extremely dysregulated emotional presentation, struggles in social situations, anxiety and frequent serious acts of self-harm. They have often refused treatment for wounds. At times they have engaged with mental health support from their GP, the community team and CAMHS but have frequently withdrawn and disengaged from this care too. This has prevented continuity of care, and although both the social care and clinical teams agree that D has mental health needs; there has been disagreement over their exact nature, with varied diagnoses and treatment plans over time as different assessments and referrals have taken place.

This has led to a great deal of instability for D, with frequent changes to their care status, and degree of mental health support. The result has been a cycle of escalating risks, treatment at either Tier 3 or Tier 4 of CAMHS. After 2 extended stays on secure wards D has experienced emergency, short-term foster placements once discharged into the

community. The local authority has struggled to find an appropriate placement or care arrangement in the home to step down support and keep them safe following the structure and restrictive nature of Tier 4.

D's parent and grandparents have expressed the desire to care for them at home but have previously struggled to keep D safe. There have been times when D has gone missing from home and found under the influence of drugs or needing emergency care from acts of self-harm. Neither their parent or grandparents are fully accepting of D's identity, frequently using their previous name and pronouns, which has damaged trust between them. D acknowledges that they do not feel safe there, but they still wish to be able to return to live at home and hope for a better relationship with their family.

After the second period under the secure mental health order, the local authority applied for a DoLO; arguing that a mental health bed continued to be more appropriate but, if being discharged, then the severe restrictions of a DoLO were the only way they felt able to keep D alive given the extreme levels of mental distress, self-harm, dysregulation attributable to trauma that they were displaying.

The court agreed and approved an unregistered placement in holiday accommodation, requiring the local authority move D to a registered, secure bed as soon as 1 came available. With a lack of available provision, the DoLO was extended on several occasions, although gradually with lower levels of restrictions. The current aim of the social work team is to support and stabilise D to feel able to re-engage with CAMHS then to move into a less restrictive, registered residential home. However, despite some signs of progress D continues to have a high degree of violent or destructive behaviour in the placement and local authority has required frequent treatment for injuries from self-harm.

References: Case file analysis

Nuffield Family Justice Observatory (2023) National deprivation of liberty court: Latest data trends – June 2023 [Available here]

Roe, A (2022) What do we know about children and young people deprived of their liberty in England and Wales? An Evidence Review. Nuffield Family Justice Observatory [Available here]

Roe, A. (2023) Children subject to deprivation of liberty orders. Briefing. Nuffield Family Justice Observatory [Available here]

Chapter 4: Case Study Review

About the case studies

Chapter 4 describes findings from online fieldwork conducted between January and March 2025 in order to develop case studies of 3 residential homes. This was not a comparative analysis nor an evaluation. The purpose was to draw together insights from examples of the variety of emerging approaches to residential care provision for children in complex situations with multiple needs. Informed by DfE's engagement with the sector via the peer collaborative activities and their scoping of the research commission, Research in Practice worked with the Department to identify 3 homes known to be recently opened and to take different approaches to multi-disciplinary working and care. The homes are referenced here as homes A, B and C. The selection of sites was chosen to provide:

- at least one home with joint health and social care funding arrangements. All 3 of these homes met these criteria
- at least one home to be part of NHSE funded Vanguard activity and Framework for Integrated Care funding wraparound clinical intervention or multi-agency professional team around the child (see: Framework for Integrated Care: Supporting Service Integration). Home A met this criterion
- a site with innovative building design to enable flexibility in occupancy. Homes A and C met these criteria
- a geographic spread across various English regions. The 3 sites were each in a different region.

The fieldwork used qualitative interviews, focus groups and document analysis to explore drivers, enablers and challenges in setting up and delivering this provision including the leadership, set up and operationalising of the homes, models of care and areas for further investigation. The analysis considers the extent to which the work of these homes appears to align with the principles of care for children with complex needs set out by Nuffield Family Justice Observatory (NFJO) (Bevington et al., 2023).

Research by NFJO generated a typology of 3 broad groups of children subject to a DoLO:

- children with learning and physical disabilities needing support/supervision
- children experiencing (or at risk of) sexual or criminal exploitation

- children with multiple complex needs often recognised to be a response to complex and ongoing trauma (Roe, 2023, p.20)

It was the last of these groups (which was the largest of these groupings in the NFJO study) which DfE aimed to focus on in this research. However, as discussed in the findings section (p.146), interview/focus group participants reported that children and young people in the selected homes have a range of intersecting needs which crosscut the groupings outlined above.

Methods

A total of 11 online interviews and focus groups were conducted across the 3 sites, involving 25 participants in a range of roles, including senior leaders with strategic oversight, home managers, clinical leads, commissioners, and operational staff. Nineteen participants were from children's social care and 6 from NHS provider organisations.

The discussions were semi-structured to allow the research team to tailor the questions to the different homes and staff roles using common topic areas. These covered: decision-making and design processes in commissioning and establishing the home; model(s) of care; experiences and outcomes for children and young people; workforce and development; governance and financial sustainability.

The interviews/focus groups were recorded, transcribed and quality assured for accuracy and to remove any personal or sensitive information. The data were then analysed thematically across the 3 homes using a framework based on the interview topic areas. This allowed the research team to explore both common themes and differences across the 3 homes.

Documents provided by the 3 homes were also analysed to triangulate and expand on the data gathered from interviews/focus groups. Examples of documents submitted included business cases, audits, quarterly reports, sufficiency reports and evaluations. A thematic framework was developed to analyse the data; based on the framework used for analysing the interview/focus group data, to allow these sources to be synthesised.

Findings

Overview of the 3 homes

Home A

Overview

Home A opened in 2024 and is registered with Ofsted as a multi-site children's home providing both short and long-term placements for community-based residential care across 3 buildings in the same location. Each is designed to meet the different levels of children and young people's needs:

- a 3-bed home for children and young people whose needs are not (or no longer) considered to be 'complex'
- a 2-bed home for children and young people for whom there are concerns about exploitation or other harms outside the home, going missing, use of drugs or alcohol
- a 1-bed home for those with high, complex levels of need, such as aggression and violence, property damage, histories of self-harming behaviours, and complex neurodevelopmental needs

The funding arrangements vary depending on the reasons and legal basis of the placement. While some children and young people's placement are funded fully by children's social care based on needs, others are funded 50/50 between children's social care and health, either through Section 117 arrangements (due to prior inpatient status) or via Continuing Care Funding, depending on their clinical history and current needs. These arrangements are made on a case-by-case basis. The clinical team, funded by the NHS Trust, is seconded to and based at the local authority's administrative offices. While not co-located within the home, they work closely with and provide direct support to staff in home A, with workers from the clinical team at the home 2 to 3 times per week and often attending meetings relating to the home or children and young people as needed.

The internal and outside spaces of all 3 homes at site A have been designed to provide a nurturing environment that feels as close as possible to a family home. For the 1-bed home, specific features and materials have been used to ensure it provides a safe environment for children and young people with complex needs and challenging behaviour. For example, dividing walls were modified for sound proofing and durability; the plumbing, electrics and underfloor heating are concealed to help prevent injury or the home becoming inoperable through damage.

At the time of the interviews, there were 3 children and young people living across the 3 homes at site A. No children or young people had yet moved on from these placements

to either a family setting or independent living, although it was reported that, since opening in 2024, 1 young person had been moved to another placement because of risks related to criminal exploitation. Average length of stay data was not available; however, 1 interviewee discussed 1 child who had been living at home A for approximately a year after having 17 previous placement moves before the age of 14 years.

Workforce and workforce development

There are 2 core teams at home A, one clinical and the other providing residential care. Staff from both teams are deployed flexibly across the 3 homes.

The multi-disciplinary clinical team is funded as an element of the 2-year pilot National Health Service England (NHSE) Vanguard Programme[38] though which 11 local areas across England are involved in the design and testing of innovative models of care. The Vanguard Programme aims include improving 'patient outcomes', reducing reliance on hospital services and building better integrated health and social care provision, with the overall aim of reducing escalation to restrictive settings, such as secure children's homes, inpatient mental health services, or custody (see following sections for further information on outcomes).

Home A's clinical team is commissioned to 'wrap around' the residential care staff, providing clinical input and expertise to develop care and support that responds to the complexity of needs seen in the children and young people entering these homes. Staffing includes:

- clinical psychologists, who provide leadership and specialist input on key interventions, including formulation and reflective practice
- assistant psychologists, who support the delivery of psychological interventions and conduct screening assessments. They play a leading role in data collection and analysis, as well as in evaluating and contributing to service development
- speech and language therapists who support care staff to tailor verbal and written communication for children and young people and work to enhance the language and communication skills of children and young people
- advanced practitioners, with backgrounds in nursing, social work and occupational therapy, are recruited for their expertise, knowledge and skills in trauma-informed care and practice development, rather than for their specific professional qualifications

The clinical team does not provide direct clinical interventions but provides an interface with local Child and Adolescent Mental Health Services (CAHMS) which helps to avoid

[38] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

service duplication. Part of the service includes monthly consultations with the residential team and supporting them in developing formulations.

The residential care team is made up of 42 staff across the 3 homes, and the diversity of the team (demographically and professionally) is seen as a strength:

- one manager and 2 deputy managers
- 6 senior staff (2 per home)
- 33 residential care officers (RCO) (11 per home). Across each home there are 2 sleep-in staff and a ‘cover’ shift for additional support to staff during morning handover

Flexibility in the way in which staff work across the 3 homes on the singly registered site enables staff respite from dealing with the most complex and challenging needs, which is seen to be supporting retention and staff wellbeing. Managers had been able to deescalate situations by moving staff and children across the 3 different properties and by better matching staff and children to support good relationships and placement stability.

For the residential staff team, knowledge and skills development has focused on the primary importance of building relationships; ‘holistic approaches to safeguarding’ and how to work with the clinical staff team’s support in undertaking formulations. There has been training in reflective practice; coaching and supervision; theory on attachment and trauma.

Care approaches

Formulation underpins home A’s care approach and is undertaken at the point of a child and young person’s placement. Formulation is a multi-disciplinary approach that aims to provide a holistic understanding of the ‘drivers and mechanisms' that produce a ‘complex needs’ profile’ (Bevington et al., 2023, p.4). The homes use the Secure Stairs framework[39] which promotes young person involvement in team formulation (McKeown et al., 2020) to build a narrative of their lived experiences, enable tailored care and support, inform preferred ways to communicate and respond to any additional needs identified. Formulations are reviewed at minimum every 6 months to ensure that care plans remain relevant, effective and responsive to children and young people’s changing needs.

The principles of care for children with complex needs highlight the need to break down siloed working and avoid ‘unhelpfully certain (and frequently inaccurate) convictions about what other professionals are doing, could do, or should be doing’ (Bevington et al., 2023, p 4). The home teams focus on system-wide collaboration to coordinate care, aiming to provide greater consistency and integration for children and young people who

[39] The Framework for Integrated Care: SECURE STAIRS

have typically had multiple prior placements and extensive contact with multiple services, often over long periods.

The direct work carried out by home staff with children and young people is grounded in trauma-informed practice and emphasises collaboration with those who have the most influence in the lives of young people with developmental trauma; families are an important part of this picture where their involvement is appropriate. The approach aims to promote compassionate, reflective responses that meet the needs of the young person, rather than simply reacting to risky or harmful behaviour. The clinical team support residential care staff to provide care that prioritises emotional safety and relational security, recognising the importance of young people being cared for by people who know, understand and support them.

The approach places emphasis on building consistent, stable and trusting relationships. When describing the home, interviewees underlined that there are no quick fixes with multiple, complex needs. The relational care of the residential team, who are spending the most time with children and young people, was seen as the primary facilitator of change and positive influence. Team members described the importance of generating a sense of belonging and avoiding punitive approaches to challenging behaviours. All behaviour is viewed as understandable in its context, staff work with children and young people to understand what is behind the behaviour and together identify individual strategies.

The clinical team provide monthly consultations with residential care staff across the homes to reflect on what is working well and to address any areas of concern. Where there has been increases in problematic incidents, these sessions help the team to understand what may have contributed to the changes, reflect on any recent events in a child or young person's life, and co-develop strategies to support them. The clinical team also provide support directly to practitioners in the residential team in relation to:

- training and assessment of the team's views of the child or young person's behaviours
- team support to carry out behavioural analysis and formulate positive behaviour plans
- team support to analyse and review data and redesign plans

Areas of improved outcomes

As Home A is relatively new (opened in 2024), 4 children or young people have lived there so far (including the young person who moved to an alternative placement) and there has not been a formal evaluation. However, the professionals who took part in the case study had observed several positive outcomes and perceived benefits for children and young people in the home:

- decreased frequency of incidents such as self-harm and property damage
- greater consistency and stability in the placement, including the 14-year-old who previously had 17 placements and had at the point of interviews been living in home A for a year
- use of secure accommodation and/or DoLOs avoided for children and young people with complex needs
- fewer children cared for by external providers, which is expected to result in a more consistent staff team and significant cost savings to the council

Home B

Overview

Home B opened in 2023. It comprises a 4-bed home, with 3 beds situated in the main house plus a single occupancy annex with a bedroom, kitchen and staff sleeping room. The entire building, including the annex is all included under the same registration.

The home provides therapeutic care for children and young people who are stepping down from or at risk of entering Tier 4 mental health care. It was set up to provide 12-week placements to aid successful discharge and provide intense intervention to support transition back into the community. Although intended for 12-week placements, this is often extended, and the average duration has been 20 weeks. Outreach work supports with transition out of the home, including referrals for ongoing support.

Funding was initially for 2 years on a 60/40 basis by children's social care and health; the health element split between NHS Foundation Trust and the local Integrated Care Board. The business case proposed that money would be saved by preventing some children and young people going to Tier 4 inpatient care. At the time of the fieldwork, there were ongoing discussions about securing longer-term funding. Subject to securing additional funding, there are aspirations to extend the reach of the service. Interviewees discussed having a dedicated outreach support team where children and young people (not living at the home) can be provided with support when the home is at capacity and/or as step-down support service for children and young people transitioning in or out of the home. This would likely include a separate building for the outreach team to work with children and young people.

The design process for the home involved working with a clinical lead to ensure a nurturing environment to meet the needs of 'high-risk' children. Care experienced children and young people helped pick out tiles, colours, flooring, walls, kitchens and furnishings to create calm, aesthetically pleasing décor. The home includes en-suite bedrooms, a communal area and specialist aspects such as anti-ligature design. The annex is designed for young people who have potential to move to independent living to prepare them for independence.

Workforce and workforce development

The home uses an integrated staffing model, with a highly experienced multi-disciplinary team of residential care workers and mental health staff who provide a balance of care, therapeutic approaches (including key work sessions) and risk management (see below for list of staffing roles). Enabling coherent and joined up working is of primary importance and the team work closely together, incorporating knowledge and expertise across professional groups. For example, trauma informed training, including Non-Violent Resistance (NVR), is provided by the local authority.

Staffing includes:

- 1 registered manager – providing overall leadership and oversight of the home
- 1 NHS Team Leader (CAMHS) – providing clinical leadership and supporting integration between health and care
- 4 full-time CAMHS practitioners – offering consistent mental health support and therapeutic input.
- 1 part-time CAMHS practitioner – adding flexibility and specialist capacity to the team
- 2 senior ARC (Attachment, Regulation and Competency) trained residential workers – experienced staff who support the implementation of the ARC framework and provide leadership
- 6 ARC trained residential workers – delivering daily care with a focus on attachment, regulation, and relational safety
- an educational support worker – working closely with schools and supporting children's engagement in education
- a psychotherapist (for children and young people) – offering 1-to-1 therapy, (including art therapy), available weekly
- a psychotherapist (team focus) – supporting team dynamics and case reviews.
- office manager – ensuring the smooth running of administrative systems and compliance processes
- handy person – responsible for ongoing maintenance and repair of the home environment.
- cleaner – maintaining hygiene and cleanliness across the home.
- therapy dog – an integrated part of the therapeutic model, providing emotional comfort and co-regulation for children

CAMHS practitioners are employed by the health trust and provide assurance around managing risk (alongside residential staff); oversight of children and young people’s

plans; support in understanding presenting behaviours from a health perspective; swift access to health records; and knowledge of the 'landscape of services' around eligibility and system navigation.

Leadership was described as 'trauma informed' and vital to establishing the overall culture of the home. There are fortnightly operational meetings between the head of residential services, the service manager and other service managers from children's social care and health who have oversight of the home. Monthly strategic leadership meetings discuss children and young people's progress and any incidents that have occurred. There is also a weekly multi-agency Team Around the Child meeting to review interventions and progress.

Staff at the home have regular access to supervision and team reflection. A clinical psychotherapist is available for 4 hours a week for debriefs, to support staff dynamics and discuss children and young people's behaviours.

Workforce development is a priority. Staff are trained in Attachment, Regulation and Competency (ARC)[40] and Non-Violence Resistance (NVR)[41] has been adopted across the whole of the local residential estate.

Care approaches

Children and young people benefit from having a key worker that gets to know them really well. There is a focus on reducing any restrictions as swiftly as is appropriate but also of ensuring a 'level of presence' from staff during times when a child or young person may be struggling. The home places emphasis on building trust and a positive relationship with risk, such as trusting some children and young people with their own fob (key) to the front door.

Formulation is used when children and young people arrive to build an understanding of life experiences, with care and support tailored to their needs. Social care and health staff work together to set goals and outcomes, which form the basis of the care plan. When the plan includes the aim to return home, family and networks are actively engaged and offered support through the Supportive Parenting for Anxious Childhood Emotions programme[42] (SPACE).

Structure and routine provide a predictable and safe environment for children and young people. Days are structured to include, for example, 1-to-1 work and activities such as trips out, mindfulness and yoga. The 'toolbox' of therapeutic and care approaches, facilitated by the multi-disciplinary team, includes:

[40] https://arcframework.org/what-is-arc/
[41] https://nonviolentresistance.org.uk/
[42] https://www.spacetreatment.net/

- dialectical behaviour informed therapy (DBT) (some children and young people also have a CAMHS DBT therapist)
- cognitive behavioural informed therapy (CBT)
- SPACE (parent programme)
- PHSE (Personal, Social, Health, and Economic Education) services
- bespoke online education through the virtual school
- non-violent resistance (NVR)
- educational psychology assessment
- securing education, health and care plan (EHCP)

Outcomes

A locally commissioned evaluation in 2024 showed:

- 5 out of 6 young people saw a positive reduction in their risk assessment rating[43] from the start to the end of their stay
- reductions in delayed discharge from hospital and reduced need for high-cost placements. Four of the 6 young people were in the Tier 4 mental health/Home Treatment Team prior to moving to the home and (according to the evaluation) would probably have been placed in solo residential placements had the home not been available. The cost for this would have been substantially higher and the location probably out of area
- young people either going home or to a more cost-effective placement than previously. Half of the young people had shorter stays at the home than their last placement or hospital admission (or are likely to). Two of the young people had returned home, 1 had moved into a bridging semi-independent placement prior to moving into university halls and another was in CQC registered adult provision
- cost savings on NHS/Tier 4 mental health beds and reduction in A&E visits and admissions for 5 of the 6 young people whilst they were resident at the home. This had been sustained after leaving the home (at the point of reporting)

Home C

Home C opened in 2023 and is registered with Ofsted as a single site children's home. It is described as a 'community recovery home' and designed as a hybrid between an inpatient care and community-based home. The home can run as a 2-bed house, or as 2, separate 1-bed units as required. The aim is for the environment to feel like a family

[43] Measures included in the evaluation: Children's Global Assessment Scale, Behavioural and Emotional Rating Scale.

home, but with robust materials and safe design features used to manage risk in a similar way to an inpatient care facility. There are plans to add an additional external staircase so staff can enter and leave without walking through the main living areas of the home, an improvement identified as useful after feedback from placement experiences to date.

The home is registered to care for children for up to a year; the aim is to stabilise and help children and young people start their recovery sufficiently to transition to less intensive placements. There is flexibility to extend this subject to their needs. The home has been accepting placements for around 3 years. To date there have been 5 adolescents who have lived at home C. All were previously in out of area placements, which were described by interviewees as high cost, with limited opportunity for local oversight of therapeutic input. Although not a requirement for placement at the home, 4 young people were – or had previously been – subject to a DoLO.

Funding is 50/50 between health and children's social care. This is automatically renewed each year and is built into both budgets, with joint responsibility in the event of any overspend. The cost of the placements in the home were benchmarked against other provisions in the business case for funding for the home. The proposed costs were 'benchmarked favourably against the highest cost placements', which are the comparable placement costs for the children and young people for which home C is intended. Benchmarking also took account of the potential for cost avoidance as a result of improved outcomes for children and young people, thereby needing less intensive support in the future.

Acquiring, designing and refurbishing the property took some time. There were some difficulties securing suitable contractors for both initial adaptations and ongoing repairs. Building design uses robust (often highly specific) materials and fixings (stronger partition walls, safe furniture) to withstand damage and keep children and young people safe without losing the feel of a home. Adaptations have been made during and between placements, so that the physical environment meets the individual needs of the children and young people living there, in addition to decorative touches to help them personalise their space. Repairs, adaptations and decoration represent on-going running costs, beyond the original refurbishment of the property.

Workforce and workforce development

The home emphasised the importance of recruiting an experienced, multi-disciplinary team, with social work and clinical staff on site. The exact staffing can adapt depending on needs, but includes:

- one manager
- 2 assistant managers
- senior and residential support workers

- 2 senior mental health practitioners (previously assistant psychologist)

More stringent recruitment and appointment criteria were used than for roles in the local authority's other homes, with a focus on resilience in challenging circumstances and prior experience of holding risk with children and young people with complex needs. The home has a ratio of 2 staff to each child or young person during the day. Overnight staff are present but not required to provide supervision or observation, unless there is a significant cause, or this has been required by a DoLO.

Depending on the needs of individual children and young people, there are agreements and partnership working with other local services. The onsite clinical staff can provide direct interventions with the child and / or support the care team to deliver a therapeutic parenting offer. In addition, there are clear pathways to specialist mental health services including psychotherapy, psychiatry and psychology to meet more complex clinical needs.

There is increased cooperation and pathways to other services which are tailored to the child or young person's needs. This collaboration was described as developing and strengthening over time and was attributed to the home becoming more established and better known to the other services, in particular healthcare and exploitation teams. Working with the police involves having plans in place for their work with/contact with young person in the home. An example was given for one young person who had become highly dysregulated when awaiting care in A&E, where a specific response plan for any future incidents was agreed between the home, the police and emergency care.

High levels of knowledge and skills development for staff are provided by clinical staff onsite and offered both individually and as a team to ensure an aligned and consistent care approach. This includes training in physical restraint and non-violent resistance (NVR).

Staff retention was described as high. This was attributed to the focus on skills and resilience in the recruitment process; the enhanced supervisory and well-being supports for staff in role; higher pay relative to homes supporting children and young people with less complex needs; and ensuring development and progression opportunities within the team.

Care approaches

The care approach at home C is closely interwoven with the overall model of the 'recovery home'. This is focused on providing a safe environment that is as close as possible to a 'normal' family home and a highly skilled staff team able to hold high levels of risk and challenge while providing relational, consistent and supportive care. The home uses processes and an overall approach to care and care planning consistent with

those used in other homes locally; the key differences are in the physical environment, the higher intensity of staffing in the home and increased clinical input.

A joint initial clinical assessment identifies needs and defines the care package using formulation. The focus is on meeting immediate needs, de-escalating risk and building safe relationships; seen as the necessary foundation before starting therapy. Care is coordinated through joint health and social care assessments, which take place monthly, and through regular Team Around the Child meetings. The model draws upon Golding's pyramid of need[44] and Dyadic Developmental Psychotherapy (DDP). Therapeutic crisis intervention techniques are used when necessary to protect the safety of the child or young person.

Ofsted reports have noted love and care provided to the children through trauma-informed practices and the home-like environment, along with compelling feedback from young people about what was good about living there.

Outcomes

With relatively few placements to date, there has been no formal evaluation of the home. However, the professionals taking part in the case study had observed positive changes and outcomes:

- reductions in level of DoLO restrictions
- increased engagement in education
- increased stability of placements
- reduction of risk
- identification of needs, which had previously been missed including autism, and speech and language difficulties
- appropriate move-on placements allowing for a reduction of need for a DoL
- relationships are remodelled, allowing for more successful and appropriate relationships and networks in the future

Children and young people in the homes

As set out in the Principles of Care for Children with Complex Needs (Bevington et al 2023) children with 'complex needs':

- may have undiagnosed and unmet treatable mental health needs

[44] Golding's pyramid of need

- are often referred to a particular mental health ‘pathway’ for treatment, limiting a more holistic view of their needs
- have often lacked access to CAMHS services at earlier stages in their lives. Research (e.g. Garside et al., 2024) demonstrates that this may be because they are deemed not to meet eligibility criteria and/or because they are unable to adhere to rigid service restrictions and time limitations. These barriers are particularly acute when, as is the experience of many children and young people with complex needs, they are experiencing high levels of placement instability. Bevington et al. (2023) suggest that the combined impact of multiple and intersecting needs, ‘rather than the impact of ‘severity’ of any individual risk factor’ (p.2) is the reason children’s needs are not being effectively responded to by the system

Across these 3 homes there were relatively few (n=4) children or young people who were subject to a DoLO in the home at the time of the research. When asked about care model or care planning differences for children and young people subject to a DoLO, interviewees at home A reported limited experience as the local authority had been using the DoLO route very seldom. Home B’s local authority had 12 children and young people placed on DoLOs in other settings (such as secure children’s homes, unregistered placements and/or out of area placements) and 1 DoLO in place at the home reviewed in this report. All the children and young people placed in home C had been subject to DoLO; this was not part of the placement criteria but reflected the complexity and high level needs the home had been set up to provide for. Two of the homes were accommodating children and young people who had previously been detained under the Mental Health Act, as a 'step down' from Tier 4 mental health provision. Table 18 below summarises examples of needs identified.

Table 18 Children and young people's needs and experiences

Home	Children and young people's needs and experiences
A	placements for children and young people 'stepping down' from Tier 4 mental health settings histories of placement breakdowns children who had spent time in 'unregistered' single occupancy placement due to complex needs histories of trauma and challenging behaviours experiences of child sexual exploitation/criminal exploitation learning difficulties or disabilities and/or autism
B	needs were described as 'a multitude of complexities' all had complex mental health needs. The home provided step down placements from Tier 4 mental health provision and placement for those at risk of admittance to Tier 4 provision histories of placement breakdowns. Short term therapeutic placements were offered for children and young people in crisis in their current placement those at risk of out of area placement that would not meet their needs most of the children and young people were described as having 'some form of neurodivergence'
C	complex presentations which the authority was struggling to match to appropriate placements and where there had been a history of placement breakdowns children and young people who 'tended to bounce' in and out of CAMHS services and referrals, with needs not deemed to reach Tier 4 mental health threshold previously in out of area and/or secure placements emotional dysregulation histories of trauma learning difficulties or global development delay

Source: Fieldwork interviews/focus groups and documentary analysis

Use of DoLOs

The High Court's powers under its inherent jurisdiction to authorise a DoLO is 1 of 4 legal mechanisms for authorising under 18-year-olds' deprivation of liberty. It applies only where the legislative powers for authorising a deprivation of liberty do not apply (secure accommodation orders (section 25 of the Children Act 1989); an order of the Court of Protection (Mental Capacity Act 2005) and detention in hospital (Mental Health Act 1983).

The single occupancy provision in 2 of the homes was seen to offer an alternative to the use of a DoLO or placement in a secure setting and was also described as a 'step down' option for those leaving secure or mental health hospital settings and needing levels of care difficult to provide with other children and young people present.

When compared to other legal routes to deprivation of liberty, the ‘permissive’ nature of a DoLO was seen by interviewees as being more adaptable to a child or young person’s needs, as it allows the potential to manage behaviours in the least restrictive way. However, care that is genuinely applied at the least restrictive level viable was seen by the interviewees to require high levels of clinically informed support to staff and close, frequent oversight and management in order to keep the child or young person’s needs in focus and adapt responsively to escalation or de-escalation of behaviours and risk.

> The conversations around restrictions and how restrictions are applied is actually complex and again needs to be clinically informed in my view. Restrictions are not what you would do as a parent – young people being followed, 2 or 3 staff with them all day every day. - *A interviewee*

Interviewees reflected on confusion in the sector about the purpose of DoLOs and how and when to enact them. The negative consequences for a child or young person of being subject to a DoLO in hindering step down to prospective future placements were frequently noted. The case was also made by some interviewees that it was better to avoid the use of DoLOs where possible and focus more on ensuring that the network around the child engaged in regular review of risk management plans and risk assessments.

> There's a lot of confusion I think about what these orders are for and when to enact them. - *A interviewee*

> So, what you see is you've got the DoLO in place, restriction in place. Then the young person increases the intensity of their behaviour or activity, that's an unhelpful coping mechanism. So, the restrictions get tighter and tighter, and tighter, often with less opportunity for reducing those again to be able to get to a place of safely, therapeutically managing that need. - *C interviewee*

> DoLOs are put in place with good intentions but are implemented in ways which increase the anxiety in the child and make them more likely to re-enact those behaviours. - *B interviewee*

Therapeutic approaches

The 2014 consensus statement of the international work group on therapeutic residential care offered the following definition of therapeutic care:

> ‘Therapeutic residential care’ involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families

> and in collaboration with a full spectrum of community-based formal and informal helping resources. (Whittaker, Del Valle, & Holmes, 2014, p.24*)*

Interviewees at these 3 homes described key aims of the therapeutic care provided in the following way:

Stabilisation: To make sure children and young people feel safe, wanted and secure. Building stability and relationships was seen as a pre-requisite and necessary foundation for children and young people before providing intensive recovery support or focusing on engagement with education, drug and alcohol and mental health support.

To work towards this initial stabilisation and preparation for therapy, staff at one home receive support from a wraparound service of multi-disciplinary staff, another is delivered in partnership with health services with an on-site clinical team and the third has a mental health in-reach service who attend on site.

Intensive recovery support: Interviewees expressed aspirations beyond keeping children and young people safe. They highlighted the importance of moving towards recovery through therapeutic work and sustained relationships of trust to enable those in their care to thrive in relation to their health, education and future goals, prevent placement breakdown and/or enable step down to a lower level of care provision. For children and young people who are placed in the home on a DoLO, the aim is to reach the point of recovery where the Order can be safely ended before they leave the home.

Keep children and young people in the local area: This means that they are near local schools and other services, with the aim that engagement with local services can be sustained when transitioning out of care or into a new, less restrictive placement. By providing placements for complex needs within the local authority area, all three homes sought to help children and young people build and maintain relationships with family, friends and wider community. Working with families enables them to manage the child's 'risk' and support reunification where appropriate.

Provide an alternative to inpatient Tier 4 mental health care: The homes provide placements for children and young people who were either not accepted for inpatient care, at risk of requiring inpatient care, or to provide a 'step down' for successful discharge and transition back into the community. This is achieved through intensive support in homes designed with some elements of secure accommodation, and working with children and young people to support them to manage behaviour and access support to prevent future mental health crises.

Principles of care for children with complex needs

The principles of care developed by NFJO and Anna Freud Centre (Bevington et al., 2023) are intended as a guiding framework to support changes to ways of working, and

to the type and availability of services and provision. They aim to better meet the needs of children and young people with complex needs and circumstances, including those subject to DoLOs. Some of the homes were operating prior to publication of these principles. However, the fieldwork at the 3 homes suggests all are informed by or reflective of these principles to some degree.

Stable and trusted relationships: All 3 homes have a primary focus on creating stability and trusted relationships. There is a focus on clinical expertise and support to the staff aiming to build these relationships in the context of everyday care.

Holistic assessment, formulation and a tailored plan of intervention and support: All 3 homes used formulation approaches to enable staff to understand a child's story, the impact of trauma in their lives and reasons for their presenting behaviours and to develop plans. The involvement of children and young people in co-producing these warrants further development in some of the homes.

Long-term support that is tailored to young people's needs: Tailoring support to children's needs and preferences came through strongly in interviews and documentation. Less detail was gathered in our fieldwork about longer term plans for transition.

Highly experienced multi-disciplinary teams: These are structured in different ways in each of the 3 homes, but all benefited from the range of expertise including clinical psychology, speech and language, occupational therapy and advanced social care practice. Relationships and increased understanding of multi-agency roles developed over time. The homes had adapted their teams in light of different needs, such as ensuring clinical care for diabetes was brought into the team around one young person.

Cultural, procedural, regulatory, and practical differences between health and social care ways of working require attention, for example, in relation to managing levels of risk if a child is supported to return home. Policies (for instance on medication management) need to be aligned and communicated to staff. Job roles also need clear definition, particularly for co-located teams as the qualifications requirements for staff are not aligned. The Children's Homes (England) Regulations 2015 require social care staff to undertake Diploma 3 in residential childcare, which it is not an expectation for CAMHS staff.

Agency and respect. While involvement of children in formulations and care planning was discussed, there was not a clear use of independent advocacy or formal ways in which children could influence the ongoing development of the homes. The involvement of family and wider networks was also discussed, though not explored in detail. However, in home C, children regularly provide feedback about their care, the home and vote for their team member every month. This allows them an opportunity to voice how they feel and for the home to complete a 'You said We Did' form. Home C also have regular

independent advocacy who visit monthly and will visit children more often where there is a need.

Key factors in setting up and development of the homes

The needs which led local authorities and health partners to commission and develop these homes were described as driven by 2 interlinked drivers: gaps in services, and placement insufficiency.

Needs unmet earlier in the child's journey A range of unmet needs were identified for the children and young people in the homes, despite most of them having long histories of service involvement in their lives. Professionals from all three case study homes described identifying mental and physical health conditions, neurodiversity, speech, language and learning difficulties/disabilities that had not previously been identified or consistently addressed. Unmet needs were particularly noted in relation to appropriate mental health provision, with children and young people experiencing cycling in and out of CAMHS involvement, which interrupted sustained therapeutic input.

While we cannot estimate the extent to which earlier support to address these issues might have diverted these children and young people from such heightened levels of concern and distress, it is certainly a strong hypothesis that appropriate earlier intervention would prevent at least some of this cohort's needs escalating. Providing this requires resource to develop skills and knowledge for the wider workforce in the community with children and young people with interacting experiences of trauma arising from inter-familial issues, extra-familial risks and harms and mental ill health.

Insufficiency of appropriate care placements Insufficiency was referenced by interviewees in the quantity and quality of available placements for children and young people with multiple, complex needs. The issues arising from gaps in services and placement insufficiency were seen to compound one another, leading to poor outcomes for the children and young people involved.

Insufficiency was seen to result in crisis-led decision-making. Placement breakdowns, when carers or residential providers give notice in response to 'escalating' behaviours, lead these children and young people to experience multiple moves between foster care, secure or residential homes, inpatient hospital settings and bespoke provision in unregistered or unsuitable settings.

> We just weren't getting the outcomes for these young people; they were just spiralling downwards. - *C interviewee*

> I think what we were able to reflect actually is that the system inadvertently produces a context in which children's behaviours escalate... we fall out with each other as agencies, the children are left without a response. When we feel uncertain, they certainly feel uncertain… the system provides the least for them quite by default. - *C interviewee*
>
> We were really struggling on a weekly basis with a particular cohort of young people that were bouncing around the system. - *B interviewee*

Common aims and drivers for setting up the provision in these 3 homes included:

- reducing costs through avoiding low quality placements which were frequently out of area and did not improve outcomes for children and young people
- keeping children and young people local to improve oversight and continuity of care, while strengthening links with family, community, schools and local health and social care providers
- reducing the use of DoLOs
- avoiding placements in temporary or unregistered settings for children and young people with multiple and complex needs
- reducing Tier 4 mental health admissions or enabling discharge into the community
- improved outcomes and costs therefore avoided in relation to demand for emergency services and long-term, intensive mental health and social care support

This research did not assess the relative merits of different types of providers, and there are certainly independent and voluntary sector providers who place children and young people with the most complex needs with considerable expertise. Nevertheless, in the current climate of insufficiency, high costs and concerns about ‘profiteering’ (Ablitt et al., 2024; MacAlister, 2022) interviewees expressed the view that local authority-led homes would give them greater control over the quality of the placement environment, staffing and overall care. Joint local authority and health operated homes were described by interviewees as more likely to ‘stick with’ and support children and young people through difficulties (rather than give notice on placements in response to challenging behaviours). Together this was felt to be effective at reducing negative impacts on children’s mental health, which would improve their future placement prospects and transitions leaving care.

Enablers

Interviewees identified the following enablers in setting up and development of the homes.

Building shared purpose and vision: This included considerable investment over some years in strengthening cross system relationships, as well as joint leadership and working arrangements between children's social care, health and education. The interface with a wider network of local services and expertise was facilitated to ensure timely and tailored support.

Early engagement with Ofsted: This included sharing the aims and reasoning behind approaches to managing risk and increasing stability.

Shared ownership and whole system approach: Securing joint funding involved recognition that these children and young people are poorly served by current provision across both health and social care systems which is producing poor outcomes for the children and young people and doing so at a high cost.

Levels of partnership: The three homes reflect different levels and models of partnership between local authorities and health services. There were also varying degrees of long-term financial planning and budgetary integration. All aimed to reduce spending on costly out of area or inpatient placements, with additional savings through costs avoided as a result of better outcomes. Cost benefits and potential savings were estimated through audit of complex cases and financial mapping of long-term costs of admission to mental health hospitals. However, the mechanisms for funding the homes differ in relation to capital investment, joint commissioning and seconded clinical teams. The homes use different budgets and commissioning tools, and this has implications for long-term sustainability and replicability. These differences related to staffing; on-going maintenance and operating costs; as well as needing to navigate the varied commissioning requirements and budget cycles where funded in partnership.

Trauma-informed, everyday care and support for staff in joined-up multi-disciplinary and integrated teams: All 3 homes place high value on ensuring those building relationships with the children and young people are well supported by clinical and multi-disciplinary staff. This is identified as key to staff retention, which in turn enables consistency and stability for children and young people in the homes. Ongoing therapeutic support is integral to the approach across the 3 homes, including specialist training that recognises the challenges and impact of caring for children and young people in acute and complex circumstances.

Formulations: Multi-disciplinary, joint ownership and involvement in assessment, formulation and planning was highlighted across all 3 sites as 1 of the most impactful elements. It was described by 1 interviewee as 'the glue that holds everything together'.

Ongoing management and discussion of risks was rooted in the context of understanding a child or young person's background and story.

Proactive risk management: This involves every day, relational care which places trust in children and young people and provides positive activities within a structured environment. It also involves proactive engagement with parents where appropriate. Interviewees highlighted the importance of strong relationships, with frequent and responsive case reviews. This was felt to allow a high level of risk to be held safely through keeping restrictions to a minimum, while being able to identify and quickly respond to triggers and signs of heightened risks.

Workforce development: Staff are equipped with knowledge and strategies for understanding and responding to developmental trauma and presenting behaviours. There is a focus on stability and recovery, rather than prioritising management of risk at the expense of children or young people's liberty and opportunities to develop and thrive. Clinical psychologists help in building staff skills and understanding of issues such as neurodiversity.

Creating a trauma sensitive environment: Considerable attention is paid to adapting buildings to a high specification to create safe, homely, and calm environments, while also involving children and young people and allowing some personalisation of decoration. All three homes are small and designed to offer flexibility for single and small group occupancy, enabling options and adaptations to suit individual needs.

Barriers

The following barriers in setting up and development of the homes were identified.

Regulatory culture and risk averse leadership: Potential issues associated with the regulatory regime by interviewees included concerns about a lack of registered providers willing to place children and young people transitioning out of these homes (especially if also subject to a DoLO). Initially, more risk averse leadership and decision-making was felt to have excluded key partners from key decisions. All 3 case studies noted that, as their partnerships, and good reputations of the home developed, the wider collaboration and inclusion within their local systems had also improved.

Working with virtual school heads: Bespoke support to enable education is an area all 3 sites identified as an area for further exploration. Maintaining education for children and young people with the most complex needs can be challenging in the context of academisation and the demands on schools to achieve results alongside Ofsted school inspection requirements.

Sustainability and funding: Long term finances were a challenge in all 3 sites, and were budgeted for fixed, relatively short terms in 2. This was principally in relation to

funding clinical input into the multi-disciplinary teams and co-located services, due to recent and radical changes in NHS structures and the Integrated Care Board budgets.

Specific developmental needs and preferences of adolescents: The implications for practice approaches and service design are under-explored. This includes the agency and voice of children and young people as part of their care and participation and co-production in service design and development.

Sufficiency: Not enough is understood in relation to local sufficiency, numbers of children with similar needs and demand for this type of home and pathways and transitions beyond their care. However, some of the local authorities have a clear sufficiency strategy and ensure the needs of children are catered for when continuing to develop the residential model / portfolio, including collaboration and planning for provision once a young person reaches 18 years old.

References: Case Study Review

Ablitt, J., Jimenez Lugo, P., & Holland, S. (2024). *Eliminating profit from children's residential and foster care: evidence review*. Welsh Government. https://www.gov.wales/sites/default/files/statistics-and-research/2024-05/eliminating-profit-from-childrens-residential-and-foster-care-evidence-review_0.pdf

Bevington, D., Duschinsky, R., Hiller, R., Holmes, L., McCrory, E., Minnis, H. & Simon, A. (2023). *Principles of care for children with complex needs and circumstances*. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/resource/principles-of-care-for-children-with-complex-needs

Garside, M., Taylor, A., Dias, R., Powell, L., Parker, J., Fenton, C., & Roscoe, C. M. (2024). Safety Nets: A Social Prescribing Intervention to Support Young People on CAMHS Waiting Lists. *Child & Youth Services*, 1-20.

Golding, K.S. (2015). *Meeting the therapeutic needs of traumatized children.* https://kimsgolding.co.uk/backend/wp-content/uploads/2016/02/Pyramid-plus-matrix.pdf

MacAlister, J. (2022) The independent review of children's social care: final report. Department for Education. https://assets.publishing.service.gov.uk/media/640a17f28fa8f5560820da4b/Independent_review_of_children_s_social_care_-_Final_report.pdf

McKeown, A., Martin, A., Kennedy, P. J., & Wilson, A. (2020). "Understanding my story": young person involvement in formulation. Journal of Criminological Research, *Policy and Practice,* 6(4), 297-306.

Roe, A. (2023). *Children subject to deprivation of liberty orders*. Briefing. Nuffield Family Justice Observatory. https://www.nuffieldfjo.org.uk/wp-content/uploads/2023/09/CHILDR1.1.pdf

Whittaker, J.W, Del Valle, J.F., & Holmes, L. (Eds.). (2014). *Therapeutic residential care with children and youth: Developing evidence-based international practice*. Jessica Kingsley Publishers.

Chapter 5: Case Law Briefing[45]

Introduction

A crucial question for those engaged in providing care and support to people with health and/or social care needs is whether the proposed arrangements to meet such needs are likely to amount to a deprivation of liberty. If they are, unless the care arrangements for that person can be revised, action must be taken to obtain legal authority for the deprivation of liberty. Failure to do so would mean that the responsible public body (for example a local authority or NHS Trust) would be breaching the person's right to liberty under Article 5 of the European Convention on Human Rights (ECHR) and therefore acting unlawfully under the Human Rights Act 1998.[46]

The question of whether care arrangements for an individual give rise to a deprivation of liberty is as important for children and young people aged under 18, as it is for adults. However, there are additional factors to consider when determining whether a child or young person is being deprived of their liberty, in particular, the decision-making role of parents (and others with parental responsibility).[47] As a result, the law relating to the determination of a deprivation of liberty for under 18 year-olds whose health and/or social care needs require additional care and support is complex and not well understood.[48] It is also an area in which the law is continuing to develop.

Furthermore, there are concerns about the sharp increase in the numbers of applications made to the High Court for Deprivation of Liberty Orders for under 18 year-olds.[49] In turn the courts have expressed their serious concerns about the lack of appropriate placements for children and young people with significant and complex needs and/or have raised questions about the suitability of the proposed placements for some of these children and young people.[50] Such concerns were acknowledged in the Department for

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[45] This briefing was written by Dr Camilla Parker KC (Hon). The author thanks HHJ Carol Atkinson and Alex Ruck Keene KC (Hon), Susannah Bowyer, Deputy Director, Research in Practice and officials at the Department for Education and Department of Health and Social Care for their helpful comments.
[46] Human Rights Act 1998, section 6. See for example: *LBC of Lambeth v L (Unlawful Placement)* [2020] EWHC 3383, paragraph 32.
[47] People who are not parents may acquire parental responsibility through orders under the Children Act 1989 (e.g. a special guardianship order (sections 14A-14F)). A local authority which has obtained a care order (section 31), or interim care order (section 38) will have parental responsibility for that child or young person.
[48] Law Commission, *Deprivation of Liberty in the context of disabled children's social care. Research Paper,* September 2024, paragraphs 1.2 and 1.7
[49] See for example, Children's Commissioner, *Children with complex needs who are deprived of liberty – Interviews with children to understand their experiences of being deprived of their liberty,* November 2024 and Roe, A., *Children subject to deprivation of liberty orders, Nuffield Family Justice Observatory,* September 2023.
[50] See for example, *Re T (A Child)* [2021] UKSC 35 paragraphs 2–11 and 166; *Lancashire County Council v G (Unavailability of Secure Accommodation)* [2020] EWHC 2828, paragraphs 49-59 and *Re MK: Deprivation of Liberty and Tier 4 Beds* [2024] EWHC 1553 (Fam).

Education's policy statement, *Keeping Children Safe, Helping Families Thrive,* which states:

> 'There is a gap in provision for children deprived of their liberty, due to their challenging behaviour and complex needs, often linked to trauma. This can result in children being placed in unregistered or otherwise unsuitable homes. In recent years we have seen a steep rise in the number of children deprived of their liberty under the inherent jurisdiction of the High Court.'[51]

The purpose of this briefing is to provide an overview of the legal issues raised by the current 'gap in provision' for children and young people aged under 18. It focuses on the following three areas:

1. **Determining a deprivation of liberty**

   The circumstances in which a child or young person's care arrangements may give rise to a deprivation of liberty are considered together with what is meant by a deprivation of liberty, how it is identified and why these questions matter.

2. **The role of the High Court in authorising a deprivation of liberty**

   The High Court's extensive powers under its inherent jurisdiction includes the power to authorise the deprivation of liberty of children and young people aged under 18.[52] This power is 1 of 4 legal mechanisms for authorising under 18-year-olds' deprivation of liberty. It only applies where the legislative powers for authorising a deprivation of liberty do not apply (secure accommodation orders (section 25 of the Children Act 1989); an order of the Court of Protection (Mental Capacity Act 2005) and detention in hospital (Mental Health Act 1983)).

   Given the increased numbers of applications made to the High Court for Deprivation of Liberty Orders for under 18-year-olds, this briefing explains when the inherent jurisdiction may be engaged and how this relates to the current statutory legal mechanisms for authorising a deprivation of liberty.

3. **Placements in settings other than registered children's homes**

   One of the consequences of the lack of adequate provision for children and young people with significant and complex needs noted above has been that the courts have been asked to authorise the deprivation of liberty of under 18-year-olds in a range of settings, both in the community and in hospitals. In some cases, the courts have raised significant concerns about the suitability of the placement.[53]

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[51] Department for Education, *Keeping Children Safe, Helping Families Thrive, Breaking down barriers to opportunity,* November 2024, p.21.
[52] *A-F (Children)* [2018] EWHC 138 (Fam) at paragraph 27. Giving judgment, Sir James Munby, President of the Family Division set out the procedures to be followed where such applications are made (see paras 46-53).
[53] See for example, *Lancashire County Council v G (Unavailability of Secure Accommodation)* [2020] EWHC 2828; *Re W (Young person: Unavailability of Suitable Placement)* [2021] EWHC 2345 (Fam) and *Re J (Deprivation of Liberty: Hospital)* [2022] EWFC 121.

Another related issue that has troubled the courts is whether a deprivation of liberty can be authorised in cases where the child or young person is (or is intended to be) placed in a setting that is not registered with Ofsted (as the body responsible for the registration and inspection of children's social care services, including children's homes). The courts' approach to this question when considering whether a deprivation of liberty in such settings should be authorised is explained.

Determining a Deprivation of Liberty

Understanding whether the care arrangements for an individual may amount to a deprivation of liberty is important because everyone, whatever their age, has a right to liberty under Article 5 of the ECHR, which protects us all from arbitrary detention.

Article 5 states that no one shall be deprived of their liberty save for the limited cases specified, which for children and young people receiving care and support for their health and social care needs would either be 'the lawful order for the purpose of educational supervision' (Article 5(1)(d)), or the 'the lawful detention of persons… of unsound mind' (Article 5(1)(e)).

Whenever a deprivation of liberty arises and in whatever setting, Article 5 will be engaged. It requires any deprivation of liberty to be 'in accordance with a procedure prescribed by law' and action must be taken to obtain a legal authority for that deprivation of liberty. Accordingly, action to seek an authorisation of a deprivation of liberty must be taken if there are any concerns that a deprivation of liberty has, or is likely to, arise.

Compliance with the requirement to seek a legal authority depends upon those engaged in the care arrangements for a child or young person being able to recognise when such arrangements might amount to a deprivation of liberty. This entails the consideration of what is meant by a deprivation of liberty and how to identify whether the care arrangements for a child or young person may amount to a deprivation of liberty.

What is meant by 'deprivation of liberty'?

The essential characteristics of a 'deprivation of liberty' are now well established. The Supreme Court has adopted the approach developed by the European Court of Human Rights (ECtHR) when considering a deprivation of liberty in the context of the provision of health and/or social care. The care arrangements for an individual (of any age) will amount to a deprivation of liberty if the following 3 conditions are all met:

a. the objective component of confinement in a particular restricted place for a not negligible length of time; ('the confinement condition'),

b. the subjective component of lack of valid consent; ('the lack of valid consent condition'), and
c. the attribution of responsibility to the State ('the State responsibility condition').

This 3-part test was first articulated by the ECtHR in 2005, in the case of *Storck v Germany,*[54] so the conditions are sometimes referred to as the '*Storck* limbs' or '*Storck* components'. It was adopted by the Supreme Court in 2014, in *Surrey County Council v P; Cheshire West and Chester Council v P* (commonly known as *'Cheshire West')*.[55] Five years later, the Supreme Court confirmed in *Re D (A Child)* (2019)[56] that the *Storck* test also applies to those aged under 18.

A deprivation of liberty will only arise if all 3 of the *Storck* conditions are met. The challenge for the courts has been how to determine whether each of these conditions are satisfied.

An additional complexity for children and young people aged under 18 is the reality that they will be 'subject to some level of restraint'[57] by their parents (or others with parental responsibility). Accordingly, a significant question for the courts when considering cases concerning under 18-year-olds has been to what extent (if at all) the decision-making role of parents (and others with parental responsibility) is a relevant consideration to a deprivation of liberty determination.

Each of the '*Storck* components' (the confinement condition; the lack of valid consent condition and the State responsibility condition) are discussed below. The discussions highlight the significant difference in approach for determining whether a child aged under 16 is deprived of his or her liberty, compared to the approach adopted for young people aged 16 and over.

As the Law Commission's recent research paper on this issue explains, the circumstances in which a deprivation of liberty arises:

> '…is mostly determined by case law, which can be complicated and difficult to understand. This is also an area of developing law. It is not surprising, therefore that this deprivation of liberty is not as well understood as it should be.'[58]

To understand when a deprivation of liberty arises, it is necessary to consider each of the *Storck* conditions, starting with the first condition, referred to in this briefing as 'the confinement condition'.

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[54] (2005) 43 EHHR 96, paragraph 74.
[55] [2014] UKSC 19, paragraph 37.
[56] [2019] UKSC 42; paragraph 1.
[57] *Cheshire West* [2014] UKSC 19, paragraph 78 (Lord Kerr).
[58] Law Commission, *Deprivation of liberty in the context of disabled children's social care. Research Paper,* September 2024, paragraph 1.7.

The confinement condition

The confinement condition refers to the first of the *Storck* conditions, namely, 'the objective component of confinement in a particular restricted place for a not negligible length of time'. This is the starting point for the determination of a deprivation of liberty. It is concerned with the person's 'concrete situation',[59] meaning that it focuses on the restrictions being placed on the person's physical liberty. Such restrictions might relate to the person's choice of where to live (and who to live with), what activities to engage in, who to socialise with and when.

There is little guidance on what is meant by 'not negligible length of time' and much will depend on the circumstances of the case and in particular the nature of the confinement and its impact upon the person subject to it. For example, in *ZH v Commissioner of the Police for the Metropolis,* police officers restrained a 16-year-old autistic young man and placed him in the back of the police van for a duration of 40 minutes. This was held to amount to a deprivation of liberty. The Court of Appeal noted that the restraint was 'intense in nature' and its effects on ZH were serious.[60]

When considering the confinement condition, it is important to be aware of an area of potential confusion. As this condition concerns the person's actual situation – the restrictions being imposed on them, it is directed to what many would regard as the essence of a deprivation of liberty. Therefore, where the restrictions imposed satisfy the confinement condition, there is a tendency to refer to this as being a 'deprivation of liberty'.[61] However for a person to be deprived of their liberty for the purpose of Article 5, all 3 of the *Storck* conditions must be met. This point was emphasised by Sir James Munby, President of the Family Division in his careful explanation of the relevant terminology in *Re A-F (Children)*:

> 'To ensure clarity of exposition, I use the phrase 'deprivation of liberty' to describe the state of affairs where all 3 components of *Storck* are satisfied, that is, where there is a deprivation of liberty within the meaning of Article 5(1)… …In contrast, I use the word 'confinement' to describe the state of affairs referred to in *Storck* component (a).'[62]

a. Determining the 'confinement condition'

In *Cheshire West,* the Supreme Court held that the confinement condition would be met where the person was *'under the complete supervision and control of those caring for her*

[59] *Guzzardi v Italy* (1980) 3 EHHR 333.
[60] *ZH v Commissioner of the Police for the Metropolis* [2013] EWCA Civ 69. See discussion in the Law Society, *Identifying a deprivation of liberty: a practical guide,* Chapter 3, paragraphs 3.30-3.33.
[61] See for example, Lady Hale's comment in *Re D (A Child)* [2019] UKSC 42, paragraph 7.
[62] *Re A-F (Children)* [2018] EWHC 138 (Fam), paragraph 9.

and is not free to leave'.[63] This test (commonly known as 'the acid test') is applied by the national courts when considering the care arrangements for an adult. However, the courts have recognised that it requires some modification for under 18-year-olds because supervision and control is part of normal parenting. Children and young people will ordinarily be subject to restrictions that would not be usual for adults, but equally such parental control and supervision should lessen as the child gets older.[64]

In *Re D (A Child)* the Supreme Court adopted an age-comparator approach when considering the restrictions placed on a young person who had learning disabilities and was autistic. Having noted the *Cheshire West's* acid test (which she had formulated when giving the leading judgment in *Cheshire West*), Lady Hale went on to consider how this might be applied to an under 18-year-old, given that restrictions are imposed on them by parents in the exercise of normal parental control. Lady Hale concluded that the 'crux of the matter' was to ask:

> *'Do the restrictions fall within normal parental control for a child of this age or do they not'?*

Accordingly, while the focus of attention remains the level of supervision and control, this age-comparator test reflects the role of parents in exercising control and supervision over their child, while also taking into account that such parental control and supervision diminishes as their child develops and matures. However, the courts have emphasised that such matters are fact specific. Determining whether the restrictions placed on the child or young person mean that they are 'confined' (i.e. that the *Storck* confinement condition is met) requires consideration of the particular circumstances of the case.[65]

b. Applying the 'normal parental control' test

The following 2 points are key to determining whether the confinement condition is met:

- Comparator is a child or young person of the same age, without disabilities: When considering whether the restrictions placed on the under 18-year-old go beyond normal parental control, the comparator is a child or young person of the same age, without disabilities. [66] This was made clear by *Lady Hale in Re D (A Child):*

[63] [2019] UKSC 42; paragraph 54. See also paragraph 48.
[64] See Lord Kerr's comment in *Cheshire West* [2014] UKSC 19, paragraphs 77-78, which were endorsed by Lady Hale in *Re D (A Child)* [2019] UKSC 42. See also *Re A-F (Children)* [2018] EWHC 138 (Fam) in particular paragraphs 21-24, 33 and 39.
[65] See for example, *Re A-F (Children)* [2018] EWHC 138 (Fam) where Sir James Munby, President of the Family Division noted the need to 'proceed on a case-by-case basis'.
[66] [2019] UKSC 42, para 41, As Lady Hale noted, the need for such an age-comparator approach had been highlighted by Lord Kerr in *Cheshire West* [2014] UKSC 19. Both Lord Kerr (in *Cheshire West)* and Sir James Munby P referred to other factors, such as 'familial background' and 'relative maturity', Lady Hale focused on age alone. All considered that the compactor is a child of the same age who is not disabled.

'It follows that a mentally disabled child who is subject to a level of control beyond that which is normal for a child of his age has been confined within the meaning of article 5'.[67]

- Focus is on **what** restrictions are *in place not* ***why*** *they are needed:* the confinement condition requires consideration of the restrictions being imposed. The justification for imposing such restrictions is not relevant to this question. It is relevant to the separate matter of whether a deprivation of liberty should be authorised, but not to whether a deprivation of liberty has arisen.

The fact that arrangements are put in place for a person's best interests and 'for the most benign of motives' is not relevant to the confinement condition.[68]

Lack of valid consent condition

The lack of consent condition is considered if the confinement condition is met. If the person is confined, then the next question is whether there is any consent to the restrictions that have been imposed. If a person is confined, but has validly consented to such restrictions, there will be no deprivation of liberty.

This condition therefore requires consideration of what it means to give valid consent. Guidance (based on case law) identifies three essential requirements for a person to be able to give consent to their care and support: sufficient information about the proposed intervention (including its purpose, nature and likely effects), the person's decision is voluntary, and they have the ability to make the decision (capacity (if aged 16 or over) or competence (if aged under 16)).[69]

a. Assessing capacity and competence

Whether an under 18-year-old can give consent to the care arrangements that give rise to their confinement will depend on whether they have the capacity to make the decision (for those aged 16 and 17) or they are '*Gillick* competent' (for those aged under 16).

- *Young people aged 16 and 17:* Under the Mental Capacity Act (MCA) 2005, young people aged 16 and 17 will (like adults), be assumed to have capacity to make such decisions unless evidence shows otherwise.[70]

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[67] [2019] UKSC 42, paragraph 42. A different approach was adopted in *Peterborough City Council v Mother & Ors* [2024] EWHC 493 (Fam) in which Mrs Justice Lieven held that a 12-year-old girl was not deprived of her liberty given that she was incapable of leaving because of her disabilities, 'not by reason of any restraints placed on her'. As the Law Commission notes, this decision is difficult to reconcile with *Cheshire West and Re D (A Child)* (see discussion in Law Commission, *Deprivation of liberty in the context of disabled children's social care – Research Paper,* September 2024, paragraphs 1.13-1.15).
[68] *Re D (A Child)* [2019] UKSC 42 paragraph 42; see also *Cheshire West* [2014] UKSC 19 paragraph 50.
[69] See Department of Health, *Mental Health Act 1983: Code of Practice* (2015), paragraphs 22.34-24.37. A child's competence to consent is considered in chapter 19 (paragraphs 19.34-19.37, 19.63).
[70] This presumption of capacity is the first of five principles of the Mental Capacity Act 2005, which apply 'for the purpose of this Act' (section 1(2)). As noted by the Law Commission in its paper, *Deprivation of*

- *Children aged under 16:* In contrast to people aged 16 and over, the law assumes that under 16-year-olds are not able to make decisions for themselves unless it is determined that they are '*Gillick* competent', a term derived from the House of Lords' decision in *Gillick v West Norfolk and Wisbech Health Authority (Gillick).* In that case, the House of Lords held that children aged under 16 could consent to their own medical treatment if they have 'sufficient understanding and intelligence to make the decision'.[71]

b. Consent to confinement by a child or young person

If able and willing to do so, children and young people can consent to their confinement. If they do give consent, they will not be deprived of their liberty. This is illustrated by *Re C (A Child),*[72] in which the court found that a child aged 15 was able to consent to his confinement so that there was no deprivation of liberty. Mr Justice Keehan stated:

> '54. …I accept the opinion of the guardian and of C's legal team that he is of sufficient understanding and intelligence to enable him to understand fully what is involved in him living at the unit and the restrictions which are imposed upon. I am satisfied, on the totality of the evidence before me, that he not only understands those matters but he also understands why they are necessary and why and how they benefit him, although he may from time to time find the pressures of living so closely a supervised and restricted life difficult to bear. He is, in my judgment, 'Gillick competent'.
>
> 55. I am wholly satisfied that C is capable, in law, of consenting to his confinement at the unit.'

c. The need for caution before relying on a child's consent

The courts have highlighted the need for careful consideration before concluding that a child is giving valid consent.

This point was raised by Lady Black in *Re T (A Child)* when considering the relevance of consent. Although recognising that a child may be 'expressing a carefully considered view', Lady Black noted 'the pressures that circumstances may place on a child to consent to a proposed arrangement' and stressed that 'an apparently balanced and free decision made by a child may be quickly revised and/or reversed'.[73]

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liberty in the context of disabled children's social care, the test for young people to be able to consent to their confinement is generally understood to be that of capacity under the Mental Capacity Act 2005 and this was the approach adopted by all the justices in the Supreme Court's decision in *Re D (A Child)* [2019] UKSC 40.

[71] *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112. See also *Bell & Another v Tavistock* [2021] EWCA Civ 1363.

[72] [2016] EWHC 3473 (Fam).

[73] *Re T (A child)* [2021] UKSC 35, para 161 (Lady Black).

d. The lack of valid consent condition and the relevance of parental consent

Another question for the courts has been the relevance of the decision-making role of parents in determining whether the second *Storck* component ('the lack of valid consent condition') is met: whether parents can consent to their child's confinement so that no deprivation of liberty arises.

The position is summarised below:

- *Young people aged 16 and 17:* For this age group, the Supreme Court in *Re D (A Child)* held that parents (and others with parental responsibility) **cannot** consent to their child's confinement.[74] This means that where the confinement condition is met for a young person and that young person does not consent to their confinement (whether because they have capacity and do not agree to their confinement, or they lack the capacity to make such a decision) that young person will be deprived of their liberty (provided that the third condition (State responsibility) is met).

- *Children aged under 16:* For this age group, the courts are of the view that it is **possible** for parents to consent to their child's confinement so that their child is not deprived of his or her liberty (because parental consent means that the second *Storck* component (lack of valid consent is not met)).[75] However, as noted below, the circumstances in which parents can consent to their under 16-year-old child's confinement can raise complex questions and is an issue that continues to be explored by the courts.

e. Limitations on parental consent: an area of developing law

The following 3 points are relevant to the question concerning the circumstances in which it might be possible for parents (or others with parental responsibility) to consent to an under 16-year-old's confinement.

- *The child's competence:* Based on current case law, parental consent to a child's confinement appears to be limited to where the child is not '*Gillick* competent' to make decisions about their care arrangements and the decision to consent to the confinement falls within the 'scope', or 'zone', of parental responsibility.[76]

Although this has not been addressed specifically by the courts, the cases in which the courts have considered the relevance of parental consent have concerned children who were not competent. In addition, comments from judges concerning children's medical

[74] *Re D (A Child)* [2019] UKSC 42.
[75] See: *Re D (A Child; deprivation of liberty)* [2015] EWHC 922; *Lincolnshire CC v TGA & Ors* [2022] EWHC 2323; *RN (Deprivation of Liberty and Parental Consent)* [2022] EWHC 2576 (Fam) and *Lancashire CC x PX & Ors* [2022] EWHC 2379 (Fam).
[76] See for example *Re D (A Child; deprivation of liberty)* [2015] EWHC 922, paragraph 66.

treatment suggest that parental consent would not be relied upon where the child is competent and does not consent to their confinement.[77]

- *Care orders:* Another limitation identified by the courts concerns children who are subject to a care order, or interim care order. The general view is that **neither** the parents **nor** the relevant local authority can consent to a child's confinement.[78]

This was the position of the then President of the Family Division, Sir James Munby in *Re A-F (Children).*[79] Although, in *Re J: Local Authority consent to Deprivation of Liberty*,[80] the court held that local authorities can consent to the confinement of a child who is subject to a care order, this decision has been overruled by the Court of Appeal.[81] The Court of Appeal explains that a local authority cannot consent to a child's confinement because this would be incompatible with Article 5's purpose of protecting individuals against arbitrary detention. It would 'remove the case from Art 5, thereby avoiding the important protection, safeguards and independent authorisation by a court that would be otherwise required'.[82]

- *Factors to take into account:* To date, there has been little detailed guidance on the circumstances in which parents (and others with parental responsibility, such as special guardians)[83] can give such consent. The courts have emphasised that such cases must be considered on their own particular facts.[84] It is also clear that in considering whether the decision falls within parental decision-making powers, the parents must be acting in their child's best interests.[85]

- The Law Society's guide on deprivation of liberty suggests that the factors set out in guidance concerning the 'scope of parental responsibility' in the *Mental Health Act 1983: Code of Practice* (the Code) are relevant to the question whether parents can consent to their child's confinement.[86] The factors include the type and invasiveness of the intervention and whether the child is resisting.

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[77] *Re AB v CD* [2021] EWHC 741, paragraph 114.
[78] *Re AB* (A child: deprivation of liberty) [2015] EWHC 3125 (Fam), paragraphs 26-29.
[79] [2018] EWHC 138 (Fam) at para 12(i). The judge also noted (at para 12(ii)) that 'a foster carer does not have responsibility enabling the carer to provide a valid consent for the purposes of *Storck* component (b)' i.e. the lack of valid consent condition.
[80] *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (Fam).
[81] *J v Bath and North East Somerset Council & Ors* [2025] EWCA Civ 478. The charities, Article 39 and Mind were given leave to intervene jointly. See Article 39, *Charities join forces to defend the human rights of children in care,* 15 November, 2024. The Department for Education and the Children's Commissioner also intervened. The Court of Appeal gave its decision on the day of the hearing of the appeal in February 2025. Its written judgment was published on 29th April 2025.
[82] [2025] EWCA Civ 478, paragraph 50 (Sir Andrew McFarlane, President of the Family Division). See also paragraph 57 (Lady Justice King).
[83] Children Act 1989, sections 14A-14F.
[84] See for example *RN (Deprivation of Liberty and Parental Consent)* [2022] EWHC 2576 (Fam), paragraph 46.
[85] See for example, *Lincolnshire County Council v TGA & Ors* [2022] EWHC 2323 (Fam).
[86] Law Society, *Identifying a deprivation of liberty: a practical guide,* Chapter 4, paragraph 4.22. The author in her capacity as a member of the Law Society's Mental Health and Disability Committee contributed to this publication.

- Another factor will be the level of restraint being considered. For example, in *Re Z (A Child: Deprivation of Liberty: Transition Plan) (Re Z)* the court concluded that the level of restraint that might be needed to transport a 14-year-old autistic boy from his family home to a residential school were beyond the scope of what his parents could lawfully agree.[87]

Although not an issue in *Re Z*, the Judge also observed that 'some of the more extreme circumstances that may arise in specialist schools for children with significant behavioural problems could fall outside the boundaries of parental responsibility, whether delegated or not'.[88]

State responsibility condition

This condition will be relevant if both the confinement condition and the lack of valid consent condition are met. Its threshold is low. Not only will it be met if a public body, such as a local authority or NHS body is directly involved in the person's care, but it will also be met if a public body knows, or ought to know of the situation. This was made clear in *Re D (A Child).* Lady Hale concluded that the State (in the form of the local authority) was 'actively involved in making and funding the arrangements' for the young person concerned and had assumed statutory responsibilities for him by accommodating him under section 20 of the Children Act (CA) 1989 (which meant that he was a 'looked after child').[89]

In addition, Lady Hale considered that the State responsibility condition could be met even if a public body is not directly involved in the confinement of the person. This is because States are under a positive obligation to protect individuals' right to liberty under Article 5 of the ECHR:

'... it is clear that the first sentence of article 5 imposes a positive obligation on the State to protect a person from interferences with liberty carried out by private persons, at least if it knew or ought to have known of this.'[90]

Given that the State responsibility question will be met if a public body is directly or indirectly involved in the person's care arrangements, the question whether such arrangements amount to a deprivation of liberty is likely to focus on determining whether the confinement condition and the lack of consent condition are met.

[87] *Re Z (A Child: Deprivation of Liberty: Transition Plan)* [2020] EWHC 3038, paragraph 44.
[88] *Re Z (A Child: Deprivation of Liberty: Transition Plan)* [2020] EWHC 3038, paragraph 39.
[89] *Re D (A Child)* [2019] UKSC 42, paragraph 43.
[90] *Re D (A Child)* [2019] UKSC 42, paragraph 43.

The role of the High Court in authorising a deprivation of liberty

As noted above, the High Court is 1 of 4 legal mechanisms for authorising an under 18's deprivation of liberty. However, there are limits on the use of the inherent jurisdiction: it should only be resorted to if none of the statutory frameworks for authorising a deprivation of liberty apply. These are: a court order under section 25 of the Children Act (CA) 1989,[91] an order of the Court of Protection under the Mental Capacity Act (MCA) 2005 and detention in hospital under the Mental Health Act (MHA) 1983).

The inherent jurisdiction cannot be used to cut across statutory schemes for authorising a deprivation of liberty. It is 'the ultimate safety net' where other legal measures are not available.[92] The Practice Direction on the inherent jurisdiction states:

> 'It is the duty of the court under its inherent jurisdiction to ensure that a child who is the subject of proceedings is protected and properly taken care of. The court may in exercising its inherent jurisdiction make an order to determine any issue in respect of a child unless limited by case law or statute'.[93]

In addition, where the application for an order authorising a child or young person's deprivation of liberty is made by a local authority, section 100 of the CA 1989 applies, which prevents the inherent jurisdiction from being used if the CA 1989 provides an alternative legal framework.[94] This means that the court must consider whether it has the jurisdiction to make a deprivation of liberty order, before it can then consider whether a deprivation of liberty order should be made.

Legal frameworks for authorising a deprivation of liberty

The lawful ways in which a child or young person can be deprived of their liberty are outlined below.[95]

a. Court order under section 25 Children Act (CA) 1989 ('Use of accommodation for restricting liberty')

Section 25 provides for the circumstances in which a court can order that a child or young person who is being looked after by a local authority is placed in 'secure

[91] In Wales, see section 119 of the Social Services and Wellbeing (Wales) Act 2014.
[92] *A Local Authority v EBY & Others* [2023] EWHC 2494 (Fam), paragraph 34.
[93] *Practice Direction 12D – Inherent Jurisdiction (Including Wardship) Proceedings* (updated 1 December 2021).
[94] See the Children Act 1989, sections 100(2) and 100(5).
[95] Details on where further information can be found for each of the legal frameworks are noted below. See also: 39 Essex Chambers *Guidance Note: Deprivation of Liberty and those under 18,* February 2022.

accommodation'.[96] This term means 'accommodation designed for, or having as its primary purpose, the restriction of liberty'.[97] Secure children's homes provide such accommodation.[98]

The court must be satisfied that the child or young person has a history of absconding and is likely to abscond again from any other type of accommodation (and if they do so, they are 'likely to suffer serious harm'),[99] or that if they are kept in any other type of accommodation, they are likely to injure themselves or some other person.[100]

An important limit on the use of secure accommodation orders is that they cannot be made where the young person is aged 16 or over and is being accommodated by the local authority under section 20(5).[101] In addition, children aged under 13 cannot be placed in secure accommodation without the prior approval of the Secretary of State.[102]

Given the lack of placements in secure children's homes (SCHs), a local authority might be required to apply to the High Court for the authorisation of the deprivation of liberty for a child or young person who falls within the scope of section 25 but a SCH placement cannot be found. Such applications will also be required in cases where, although section 25 is applicable, the local authority considers that the child or young person's specific needs would be better met in an alternative placement.[103]

In his judgment of January 2023, *Re X (Secure Accommodation: Lack of Provision)*, Sir Andrew McFarlane, President of the Family Division, noted that of the estimated 1,000 annual deprivation of liberty applications to the High Court, many would concern under 18-year-olds who should be in secure accommodation.[104] The President expressly stated that the primary purpose of his judgment was to 'draw attention to the very substantial deficit that exists nationally in the provision of facilities for the secure accommodation of children.' As the President noted, he was reiterating the views expressed by senior

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[96] See chapter 4 of *Court Order and Proceedings, For local authorities,* April 2014. The procedures for allocating a placement for the child or young person are outlined in *Re X (Secure Accommodation: Lack of Provision* [2023] EWHC 129, paragraphs 44-49. In Wales such placements are provided for under section 119 of the Social Services and Wellbeing (Wales) Act 2014.

[97] *Re B Secure Accommodation Order) (Rev 1)* [2019] EWCA Civ 2025 at para 59. See also *Re D (A Child)* [2019] UKSC 42 paras 113-115 and *Re T (A Child)* [2021] UKSC 35 para 133: 'the focus should be on the accommodation itself and the purpose for which it is provided, rather than the regime in the accommodation' (Lady Black).
[98] Children (Secure Accommodation) Regulations 1991 (SI 1991 No. 1505) reg 3 provides that (in England) they must be approved for such use by the Secretary of State.
[99] Children Act 1989, section 25(1)(a).
[100] Children Act 1989, section 25(1)(b).
[101] Children (Secure Accommodation) Regulations 1991 (SI 1991 No. 1505); (reg 5(2))(a).
[102] Children (Secure Accommodation) Regulations 1991 (SI 1991 No. 1505); (reg 4).
[103] *Re T (A Child)* [2021] UKSC 35, paragraph 17.
[104] *Re X (Secure Accommodation: Lack of Provision* [2023] EWHC 129 (Fam), paragraph 23. The President noted that given the lack of secure placements, some local authorities 'simply by-pass the s25 procedure and apply directly to the High Court for a [deprivation of liberty order]'.

judges in the previous 6 years and the call for 'action to address the gross lack of registered secure accommodation units'.[105]

Potential Reform: Extension to section 25 CA 1989

The Children's Wellbeing and Schools Bill, published in December 2024, includes a provision to amend section 25 of the CA 1989. Clause 10 (Use of accommodation for deprivation of liberty) makes provision for children and young people aged under 18 to be deprived of their liberty in accommodation that falls outside the definition of 'secure accommodation'.[106] It will allow under 18-year-olds to be:

> '…deprived of their liberty in accommodation that has the primary purpose of care and treatment, and where restrictions that amount to deprivation of liberty, can be imposed but it is not designed for that purpose alone'.[107]

This amendment therefore extends the scope of section 25 to provide a statutory framework for the authorisation of the deprivation of liberty of children in accommodation that is not a secure children's home. The Explanatory Notes to the Bill outline that an amended section 25 will include accommodation that is 'primarily to be used to provide care and treatment for a vulnerable, complex cohort who may need restrictions which deprive them of their liberty'.[108]

The intended effect of this legislative change (as stated in the Explanatory Notes to the Bill) is to provide an alternative statutory route to authorise the deprivation of liberty of a child in a more flexible form of accommodation. The Explanatory Notes add that this will bring 'more deprivation of liberty cases under a statutory framework via s.25 Children Act 1989, with clear criteria for access, mandatory review points and parity with SCH in terms of access to legal aid'.[109]

Like the current provision in section 25 the amendment is limited in its application. It applies to under 18-year-olds who either:

a. have a history of absconding and are likely to abscond from any other description of accommodation and if they abscond, they are likely to suffer significant harm; or

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[105] *Re X (Secure Accommodation: Lack of Provision* [2023] EWHC 129 (Fam), paragraph 62. For example, concerns have also been expressed by the Supreme Court in *Re T (A Child)* [2021] UKSC 35 and the Court of Appeal in *Re B (Secure Accommodation Order) (Rev 1)* [2019] EWCA Civ 2025.
[106] The Bill is now before the House of Lords (HL Bill 84 as brought from the Commons) and this clause is now clause 11 of the HL Bill.
[107] Children's Wellbeing and Schools Bill – European Convention on Human Rights Memorandum, 17 December 2024.
[108] Children's Wellbeing and Schools Bill, Explanatory Notes (Bill 151-EN) referring to the Bill, as introduced in the House of Commons on 17 December 2024, p.15, paragraph 16.
[109] Children's Wellbeing and Schools Bill, Explanatory Notes (Bill 151-EN) referring to the Bill, as introduced in the House of Commons on 17 December 2024, p.16, paragraph 18.

b. if they are kept in any other description of accommodation, they are likely to injure themselves or other persons.[110]

This proposed legislative change is intended to help ensure that under 18-year-olds with complex needs are provided with 'the right place to live, which offers the right level of care, and that can truly meet their needs and keep them safe'.[111]

To ensure compliance with the ECHR, the courts would need to be satisfied that the deprivation of liberty was justified under Article 5(1) (e.g. Article 5(1)(d) 'the lawful order for the purpose of educational supervision').[112]

b. An order of the Court of Protection (Mental Capacity Act 2005)

The Court of Protection (CoP) can authorise a deprivation of liberty in any setting.[113] As noted in *Re NRA & Ors,* the decision whether to authorise a deprivation of liberty 'is a best interests test, namely is the care package the least restrictive available option'.[114]

Regulations issued under the MCA 2005 provide for the transfer of proceedings concerning young people aged 16 and 17 from, or to, the Court of Protection where such a transfer is considered to be 'just and convenient' in all the circumstances.[115] The *Revised National Listing Protocol for applications that seek Deprivation of Liberty Orders relating to children under the inherent jurisdiction* (the 'National DoL List') highlights the need to transfer the case from the High Court to the Court of Protection where there is reason to believe that the young person 'may lack capacity and would be likely to be transferred to the Court of Protection at the age of 18 years'.[116]

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[110] See clause 11(3) of the Children's Wellbeing and Schools Bill (HL Bill 84)

[111] Department for Education, *Keeping Children Safe, Helping Families Thrive, Breaking down barriers to opportunity,* November 2024, p.21. The Explanatory Notes to the Children's Wellbeing and Schools Bill (Bill 151-EN), p.16, paragraph 17 state:
"Currently, the only statutory framework for depriving a child of their liberty on welfare grounds (outside other relevant legal frameworks such as in relation to mental health) is via section 25 of the Children Act 1989. This power enables a child to be placed or kept in accommodation provided for the purpose of restricting liberty (a SCH). A core feature of a SCH is that it should be designed for, or has as its primary purpose, prevention of a child from absconding or causing harm to his/herself or others. Other, highly therapeutic accommodation designed for a child would have as its primary purpose the care and/or treatment of the child, as opposed to prevention of absconding or harm, and so cannot currently be used to deprive a child of their liberty via section 25 of the Children Act 1989."

[112] Article 5 permits a deprivation liberty but only in the specified cases listed in Article 5(1) and 'in accordance with a procedure prescribed by law'. See commentary in 39 Essex Chambers *Children's Capacity,* February 2025, pp. 3-5.

[113] The authority for making such an order is set out in sections 4A and 16(2) and Schedule 1A of the Mental Capacity Act 2005.

[114] *Re NRA & Ors* [2015] EWCOP 59, paragraph 41 (i). See also *Re KL (A Minor: deprivation of liberty)* [2022] EWCOP 24, which considers the procedures involved where the application for a deprivation of liberty order is made in relation to young people aged 16 or 17.

[115] Mental Capacity Act 2005 (Transfer of Proceedings) Order 2007 (SI 2007/1899), paras 2 and 3.

[116] *Revised National Listing Protocol for applications that seek Deprivation of Liberty Orders relating to children under the inherent jurisdiction,* (October 11, 2023) paragraph 7). See also, *Practice Guidance in*

In relation to deprivation of liberty, the MCA 2005 is only relevant to individuals aged 16 and over who lack the capacity to make decisions about their care or treatment arrangements. Accordingly, this legal mechanism for authorising a deprivation of liberty is not applicable to young people who have capacity to make such decisions, nor to children aged under 16 (irrespective of their ability to make such decisions (i.e. whether or not they are '*Gillick* competent')).

Potential Reform: Liberty Protection Safeguards

The Mental Capacity (Amendment) Act 2019 was passed to replace the Deprivation of Liberty Safeguards (an administrative scheme within the Mental Capacity Act 2005) with the Liberty Protection Safeguards (LPS). The implementation of LPS was paused by the previous government. If implemented, LPS would apply to individuals aged 16 and over who lack the capacity to consent to arrangements for their care or treatment where such arrangements amount to a deprivation of liberty. The current government has said it will set out its plans for mental capacity policy in due course.[117]

c. Detention in hospital (Mental Health Act 1983)

The Mental Health Act (MHA) 1983 provides for the circumstances in which individuals (of any age) can be compulsorily admitted to hospital and treated for their mental disorder.

The powers of detention under the MHA 1983 will only be relevant to children and young people who are considered to require a period of inpatient psychiatric treatment and otherwise meet the criteria for detention under the MHA 1983.[118] Where the MHA 1983 is considered not to apply, for example because the child or young person does not have a mental disorder,[119] (or otherwise does not meet the criteria for detention under this Act), or this intervention is not considered to be an appropriate option, the High Court may be asked to authorise the child or young person's deprivation of liberty.

There are also cases in which the child or young person has mental health needs, but children and young peoples' mental health services have concluded that inpatient psychiatric care (often referred to as 'Tier 4 CAMHS provision') would not be appropriate for that child or young person.[120] Depending on the circumstances of the case, the High

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Respect of Transition of Matters From the National DoL List to the Court of Protection, The President of the Family Division, January 2025.

[117] In a letter dated 5 April 2023, the then Minister of State for Care (Department of Health & Social Care), Helen Whately stated that 'the Government has decided to delay the implementation of the LPS beyond the life of this Parliament'.

[118] Guidance on the application of the MHA 1983 is provided in the Mental Health Act 1983: Code of Practice (Department of Health, 2015). See in particular Chapter 14 (Applications for detention in hospital) and Chapter 19 (Children and young people under the age of 18).

[119] *Wigan BC v Y (Refusal to Authorise Deprivation of Liberty)* [2021] EWHC 1982 (Fam) paragraph 2. Mental Health Act 1983, section 1(2) defines 'mental disorder' as 'any disorder or disability of the mind'.

[120] *Blackpool CC v HT* [2022] EWHC 1480 (Fam).

Court may be asked to consider whether the child or young person is being deprived of their liberty, and if so, authorise that deprivation of liberty in a hospital (while an alternative placement is being found),[121] or in a community setting.[122]

Although holding that there is no power to require the provision of an inpatient bed for a child or young person,[123] the courts have in some cases asked the relevant NHS bodies to reconsider the decision not to offer a bed[124] or have arranged for a second opinion to consider the child's 'overall mental health care and direction of that care'.[125]

Potential Reform: Detention criteria under the MHA 1983

The Mental Health Bill [HL], published in November 2024, sets out extensive amendments to the MHA 1983, including the criteria for detention in hospital for treatment for mental disorder (section 3).[126] Clause 3 (Application of the Mental Health Act: autism and learning disability) removes people with a learning disability and autistic people (of any age) from the scope of the powers of detention under section 3 of the MHA 1983. The effect of such an amendment would be that it will only be possible for people with a learning disability and autistic people (including those aged under 18) to be detained in hospital for treatment for mental disorder under section 3 if 'they have a co-occurring mental disorder which is not learning disability or autism' (and the rest of the criteria for detention under this section are met).[127]

Concerns have been expressed that rather than preventing their admission, this amendment could lead to people with a learning disability and autistic people, being deprived of their liberty in hospital under alternative legal frameworks, such as under the Mental Capacity Act 2005.[128] In the case of under 16s, the alternative framework might be a deprivation of liberty order under the inherent jurisdiction of the High Court, which is considered next.

d. Inherent Jurisdiction: Where the statutory frameworks for deprivation of liberty do not apply

For children aged under 16 who do not fall within the statutory test for a placement in secure accommodation under section 25 of the CA 1989 (or where they do but such a placement is not available), and do not require admission to hospital for inpatient

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[121] *Re D (A Child)(Deprivation of Liberty)* [2015] EWHC 922 (Fam).
[122] *Blackpool BC v HT* [2022] EWHC 1480 (Fam).
[123] See for example: *Blackpool BC v HT* [2022] EWHC 1480 and *Lancashire CC v Claire X* [2023] EWHC 2667.
[124] *Re MK: Deprivation of Liberty and Tier 4 Beds* [2024] EWHC 1553. See also *Re X (A Child) (no 3)* [2017] EWHC 2026.
[125] *Lancashire CC v X* [2023] EWHC 2667.
[126] The Bill is now in the House of Commons (Bill 225 (2024-25 (as brought from the House of Lords).
[127] Mental Health Bill [HL] Explanatory Notes, 6 November 2024, paragraph 34.
[128] HC 696, HL Paper 128, Joint Committee on the Draft Mental Health Bill, *Draft Mental Health Bill 2022,* paragraph 152.

psychiatric care under the MHA 1983, the only legal mechanism for authorising their deprivation of liberty is through the inherent jurisdiction of the High Court.

Similarly, the inherent jurisdiction of the High Court is currently the only legal mechanism available to authorise the deprivation of young people aged 16 and 17 who have capacity to make decisions about their care arrangements (so the MCA 2005 does not apply) and whose proposed placement is neither secure accommodation nor hospital admission for inpatient psychiatric care (so neither section 25 of the CA 1989 nor the MHA 1983 apply).[129]

The procedure for making an application to the High Court is set out in the Practice Guidance, *Revised National Listing Protocol of applications that seek Deprivation of Liberty Orders relating to children under the inherent jurisdiction* ('National DoL List').[130]

Key considerations for the court when considering whether to authorise a child or young person's deprivation of liberty will be whether the restrictions are 'necessary and proportionate' and are in the child or young person's best interests.[131] For example, in *Re J (Deprivation of Liberty: Hospital),* Mr Justice Poole observed that very often the court is told that there is only 1 place where the child can be accommodated and that the court's role is very limited in that it cannot direct that placements are made available, nor inspect potential placements, nor oversee care regimes. Nonetheless he added:

> '…even where there are no other placement options, the court does not merely provide a rubber stamp for the restrictions sought, and there are decisions to be made about the extent of the restrictions are necessary and proportionate and in the child's best interests'.[132]

In *Re T (A Child),* Lady Black noted that the court will not make a deprivation of liberty order 'without considerable exploration of the circumstances to ensure that the proposal is appropriate' and the court must be 'provided with evidence describing the nature of the proposed regime and justifying why the proposed arrangements are necessary and proportionate in meeting the child's welfare needs'. She added that the court 'will want to know the child's views on the matter'.[133]

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[129] See for example, *EBY (A Child) (Deprivation of Liberty Order: Jurisdiction) (17-year-old)* [2023] EWHC 2494.
[130] This guidance, which was published in October 2023, is referred to as the 'National DoL List' ('NDL'). It replaced guidance known as 'the National DoL Court' (see: https://www.judiciary.uk/guidance-and-resources/revised-national-listing-protocol-for-applications-that-seek-deprivation-of-liberty-orders-relating-to-children-under-the-inherent-jurisdiction/) See also *Re A-F (Children No 2)* [2018] EWHC 2129 which sets out the procedure to be followed when making an application to the court.

[131] See for example, *Blackpool BC v HT (A Minor) & Ors* [2022] EWHC 1480, paragraph 49.
[132] *Re J (Deprivation of Liberty: Hospital)* [2022] EWFC 121, paragraph 36.
[133] *Re T (A Child)* [2021] UKSC 35, paragraph 155.

In some cases, the courts have refused to authorise a deprivation of liberty on the basis that the arrangements for the child or young person were so inappropriate that it clearly was not in the child or young person's best interests to do so.[134]

The recent case, *Re EM (Deprivation of Liberty, Care Planning & Costs) (Re EM)*[135] HHJ Burrows highlighted the need for both clarity on language used when Deprivation of Liberty Orders are made and an understanding of the effect of such orders. While noting that such orders 'could be called a DoL or DoLs order' the children and young people subject to those orders, are 'not on a DOLS'. The term 'DOLS' is used as an abbreviation of 'Deprivation of Liberty Safeguards', which refer to a legal mechanism for authorising a deprivation of liberty under the Mental Capacity Act (MCA) 2005 that only apply to adults.[136] The Judge also expressed concern that DoL orders were sometimes seen as being mandatory, 'like a prison sentence', whereas they are permissive. [137]

That a deprivation of liberty order **does not require** the child or young person to be deprived of their liberty was also emphasised in *Re F (A Child) (Care Order: Deprivation of Liberty).* Noting that the restrictions authorised 'are permissive only and are not a requirement', the Judge asked that this be explained to the children's home in which the child, referred to as 'Fiona' was to be placed. He added that it 'would not be right for Fiona to be subject to a greater degree of control or supervision than is strictly necessary to protect her from harm' simply because of the order authorising her deprivation of liberty.[138]

Placements in settings other than registered children's homes

A significant question for the courts has been whether it is permissible to authorise the deprivation of liberty of under 18-year-olds in settings that are not registered with Ofsted as a children's home but should be, and as a result they do not benefit from the safeguards of regulation and inspection.

This is another area in which there has been some confusion in terminology. The courts have in some cases referred to such placements as being 'unregistered' and/or

[134] See for example, *Wigan BC v Y (Refusal to Authorise Deprivation of Liberty)* [2021] EWHC 1982 (Fam); *A county council v A Mother & Ors (Refusal to make a DOLS order)* [2021] EWHC 3303 and *An NHS Trust v ST (Refusal of Deprivation of Liberty)* [2022] EWHC 719.
[135] [2024] EWCOP 76
[136] *Re EM (Deprivation of Liberty, Care Planning & Costs)* [2024] EWCOP 76, paragraph 46. In *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (paragraph 1) the Judge referred to a 'Deprivation of Liberty Order ('DoLs order'). In *EBY (A Child) (Deprivation of Liberty Order: Jurisdiction) (17-year-old)* [2023] EWHC 2494, the Judge refers to the order as a 'DOLO'.
[137] *Re EM (Deprivation of Liberty, Care Planning & Costs)* [2024] EWCOP 76, paragraph 50.
[138] *F (A Child) (Care Order: Deprivation of Liberty)* [2021] EWHC 3527 paragraph 43.

'unregulated'.[139] Although these terms are often used interchangeably, as both the Supreme Court[140] and the Court of Appeal[141] have made clear, they are not the same:

> **Unregistered placement:** This term refers to a placement in an establishment that falls within the definition of 'children's home' and therefore should be registered with Ofsted, but despite this requirement to register,[142] has not done so.
>
> **Unregulated placement:** This term refers to placements for which there is no requirement to register with Ofsted as a children's home on the basis that it does not fall within the definition of a children's home: 'for example because it cannot be said that it '"provides care and accommodation wholly or mainly for children"'.[143]

This distinction is important because where an establishment 'provides care and accommodation wholly or mainly for children',[144] it will be a children's home. If it is a children's home 'it is undoubtedly "regulated", even if it is not registered'.[145] Furthermore, it has been suggested that although there is no definition of 'care' in this context, where a local authority is seeking a court authorisation for a child or young person's deprivation of liberty, it is 'hard to contemplate' that such a placement 'does not involve the child receiving "care" for the purposes of the definition of "a children's home"'.[146]

Although expressing serious concerns about the failings in the provision of care that present such a dilemma, the Supreme Court held in *Re T (A Child)* that a deprivation of liberty can be authorised in an unregistered children's home.[147] Lady Black highlighted that there was a need to balance the consequences of making such orders, for example, managing a children's home that is not registered is a criminal offence,[148] against the consequences of not authorising the deprivation of liberty. In addition to noting the extensive duties on local authorities to protect children and young people, Lady Black

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[139] See for example, *Dorset Council v E (Unregulated Placement: Lack of Secure Placement)* [2020] EWHC 1098 (Fam) and *Re H (Interim Care: Scottish Residential Placement)* (in which the court noted that the 15-year-old boy concerned had been 'placed in two consecutive short-term unregulated placements, one of which was a caravan' (paragraph 2).
[140] *Re T (A Child)* [2021] UKSC 35, paragraph 58 (Lady Black noting that this has caused 'some unfortunate confusion'.
[141] *A Mother v Derby City Council & Anor* [2021] EWCA Civ 186, paragraphs 19 and 20.
[142] Care Standards Act 2000, section 11(1).
[143] *Re T (A Child)* [2021] UKSC 35, paragraph 58.
[144] Care Standards Act 2000, section 1(2).
[145] *Re T (A Child)* [2021] UKSC 35, paragraph 58.
[146] *A Mother v Derby City Council & Anor* [2021] EWCA Civ 1867, paragraph 15 (Sir Andrew McFarlane President of the Family Division: simply noting that such submissions were made). See also the President's guidance: *Practice Guidance: Placements in unregistered children's homes in England or unregistered care homes in Wales,* November 2019, paragraph 16 which notes that registration may not be required because the provision is unregulated (e.g. it is supported living) but adds that if care rather than support is being provided 'then the provision is likely to require registration as a children's home'.
[147] *Re T (A Child)* [2021] UKSC 35. Lady Black noted that the shortage of provision provided the background to this case. Lord Stephens noted that the context to the case was 'the enduring well-known scandal of the disgraceful and utterly shaming lack of provision for children who require approved secure accommodation'.
[148] Care Standards Act 2000, section 11(1).

stated that ultimately, she recognised that: '… there are cases in which there is absolutely no alternative, and where the child (or someone else) is likely to come to grave harm if the court does not act.'[149]

In summary, the deprivation of liberty arising from a child's placement in an unregistered children's home can be authorised under the inherent jurisdiction 'where imperative conditions of necessity justify doing so and there is no alternative available'.[150]

Revision of the President's Practice Direction

Before concluding that the inherent jurisdiction could be exercised to authorise a deprivation of liberty in placements falling outside the regulatory frameworks in *Re T (A Child*), Lady Black considered the range of procedural safeguards that would apply in such cases. This included the President of Family Division's Practice Guidance which set out the actions to be taken by the applicant and the High Court when an application was made for a deprivation of liberty order relating to an unregistered children's home.[151]

Significantly, the Practice Guidance required the court to monitor the process for seeking registration and keep the case under review while the registration was being processed. Lady Black regarded this Practice Guidance as an important contribution to 'the procedural protection for a child'.[152] However, this guidance has been replaced by the *Revised Practice Guidance on the Court's approach to unregistered placements,* which reduces the role of court considerably. It notes that the monitoring requirements under the previous Practice Guidance had placed considerable burdens on the Court system and that it is not a function of the court 'to become a regulatory body or the overseer of the regulatory process'.[153]

The revised Practice Guidance states that the Court should enquire into the registration status of the proposed placement and if it is unregistered, the court 'should enquire as to why the local authority considers an unregistered placement is in the best interests of the child'. The guidance adds that the court 'may order the local authority to inform Ofsted/CIW within 7 days if it is placing the child in an unregistered placement'.

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[149] *Re T (A Child)* [2021] UKSC 35, paragraph 145.
[150] *A Mother v Derby City Council & Anor* [2021] EWCA Civ 1867, paragraph 83. The court concluded that the position taken by the Supreme Court in *Re T (A Child)* was unaffected by subsequent regulations (*Care Planning, Placement and Case Review (England) (Amendment) Regulations 2021* (SI 2021/161) placing restrictions on the type of accommodation in which local authorities can place children aged under 16 (see the amended *Care Planning, Placement and Case Review (England) (Amendment) Regulations 2010* (SI No.959) reg. 27A)
[151] Sir Andrew McFarlane, President of the Family Division, *Practice Guidance: Placements in unregistered children's homes in England or unregistered care homes in Wales,* November 2019, (an addendum to this guidance was issued in December 2020). Paragraph 16 covers the question on the need to register, noting that if care is being provided, this is likely to require registration as a children's home.
[152] *Re T (A Child)* [2021 UKSC 35, paragraph 147
[153] Courts and Tribunals Judiciary, October 11, 2023.

Conclusion

This briefing has considered 3 key areas: determining a deprivation of liberty; the role of the High Court in authorising a deprivation of liberty and the court's approach to placements settings other than registered children's homes.

Such matters will be of central importance to those responsible for the care and support given to children and young people whose highly complex needs, such as significant mental distress, require that their care arrangements include restrictions on their personal liberty (including, in some cases, the use of physical and/or chemical restraint).

Key points relevant to each of the 3 areas are set out below:

1. **Determining a Deprivation of Liberty**

   Those involved in the provision of care and support to children and young people must have a good understanding of the circumstances which may give rise to a deprivation of liberty. This will require keeping abreast of case law in this area, as well as any changes to relevant legislation.

   The legal frameworks for authorising a deprivation under the Children Act 1989 and the Mental Health Act 1983 are likely to be subject to reform given that Bills that would make changes to both these Acts are currently being considered by Parliament.

   Although the Mental Capacity (Amendment) Act 2019 includes an administrative mechanism for authorising a deprivation of liberty ('Liberty Protection Safeguards') which would be applicable to young people aged 16 or over, who lack the capacity to make decisions about their care arrangements, it is not known what plans (if any) there are to bring this legislation into force.

2. **The role of the High Court in authorising a deprivation of liberty**

   The High Court has played an important role in this area given the increase in numbers of applications seeking a deprivation of liberty order under the inherent jurisdiction.

   Cases coming before the High Court include cases where the child or young person meets the criteria for placement in 'secure accommodation' (section 25 of the Children Act 1989), but a placement cannot be found or where the local authority considers that due to the specific needs of the child or young person, an alternative placement is required.

   However, the types of cases before the court are not limited to such cases. There are also cases concerning children and young people with complex mental health needs

for whom admission to Tier 4 inpatient provision is deemed to be inappropriate. As noted, in *Re X (A Child: Deprivation of Liberty: Lack of Placement),* there are many children and young people who 'do not easily fit the criteria of established services'.[154]

It is hoped that the proposed changes to section 25 of the CA 1989 (currently being considered by Parliament in the Children's Wellbeing and Schools Bill) together with the non-legislative elements of the Government's programme, outlined in *Keeping Children Safe, Helping Families Thrive* to support the delivery of specialist care and accommodation for children and young people with complex needs will address such concerns.[155]

3. Placements in settings other than registered children's homes

The courts have expressed significant anxieties about the inadequacy of provision for children and young people with complex needs, particularly in cases where the lack of alternative placements, have necessitated the authorisation of a deprivation of liberty in 'unregistered children's homes'.[156]

It is therefore of some concern that the President of the Family Division's amended guidance (*Revised Practice Guidance on the Court's approach to unregistered placements*), reduces the monitoring and review role of the courts when the child or young person's placement is not registered as a children's home. However, as the Practice Guidance notes, this is not the function of the court. As noted above, at least some of the cases currently falling within the remit of the High Court would in the future be covered by the statutory framework of the amended section 25 of the CA 1989.

[154] *Re X (A Child: Deprivation of Liberty: Lack of Placement)* [2023] EWHC 3416 (Fam).
[155] Department for Education, *Keeping Children Safe, Helping Families Thrive, Breaking down barriers to opportunity,* November 2024, p.21.
[156] *Re T (A Child)* [2021] UKSC 35.

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