Secure settings for young people: a national scoping exercise

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Version number: Version 1.0

First published: 2018

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Classification: OFFICIAL

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Glossary

ASD: autism spectrum disorder

Block contract: Whereby a health services provider is paid an agreed annual amount to provide a defined set of services such as a defined number of beds available.

CAMHS: child and adolescent mental health services

CHAT: comprehensive health assessment tool

DBT: Dialectical behaviour therapy. This is a type of psychological therapy based on principles of cognitive behavioural therapy (CBT), designed for people who self-harm or have personality disorders. cognitive behavioural therapy

EMDR: eye-movement desensitisation and reprocessing therapy

HDU: High dependency unit

LD: Learning disability

MBT: Mentalisation based therapy. This is a type of psychological therapy, based on psychodynamic principles, designed for people with personality disorders.

MDT: multi-disciplinary team

MHA: The Mental Health Act, 1983, as amended 2007Nidotherapy: This is a therapeutic approach, where the focus is on changing the environment a person is in to fit around their needs, rather than focusing on changing the individual.

PACE: Police and Criminal Evidence Act, 1984

PICU: psychiatric intensive care unit

ROTL: release on temporary license

SCH: secure children's home

> SCH mixed: secure children's homes that take both welfare and YJB placements
>
> SCH welfare: secure children's homes that take placements under the Children Act (1989)
>
> SCH youth justice board: secure children's homes that take placements through the youth justice system (via the youth justice board)

Spot purchasing: beds that can be bought for a set period of time by an external provider (for example, the YJB might purchase a bed in a secure children's home originally designated for welfare placements, for a specific period of time).

STC: secure training centre

YJB: youth justice board

YJS: youth justice system

YOI: young offender institution

Acknowledgements

We would like to thank the following people and organisations as without them this scoping project would not have been possible:

- NHS England, who funded this project.
- The YJB and Department for Education, who have provided representatives for our steering group and facilitated contact and interviews with the secure units they commission.
- Members of our steering group (Tim Bateman, Ginny Boyd, Roger Bullock, Louise Doughty, Carla Garnelas, Nick Hindley, Laura Janes, Daniel Shotter, Claire Owens, Mayura Deshpande and Louise Bridson), who have met regularly to guide us through this process, your support, enthusiasm and comments have been invaluable.
- All the staff members in every secure unit for young people who put time aside to participate in the scoping interviews and sent back comments about the draft scoping reports, particularly staff at Clayfields House, Aycliffe, St Catherine's secure centre for their comments, and Alnwood psychiatric unit, Aycliffe, Beechfield, HMYOI Wetherby, and Aldine House who showed us around their units to give us a flavor of different types of units.

We would also like to take this opportunity to note the needs of the young people in secure care, and their families, for whom this service evaluation project was devised.

Executive summary

This report summarises the findings of the first (scoping) stage of a service evaluation, evaluating the provision of secure services for detained young people, under 18 years of age, from England, between February and September 2016. This involved identifying every secure unit in Great Britain (the United Kingdom excluding Northern Ireland, Channel Islands and the Isle of Man, none of which had secure units in which young people from England could be placed) that could detain young people from England and establishing the basic characteristics of each unit, in order to identify similarities and differences between them, prior to further exploration in the later stages of the study.

This report addresses two questions: to what extent and in what ways are the types of secure service for children similar or different? Table 1 below presents a summary of these findings. There will be two later stages of this service evaluation including a census of all young people from England detained on 14 September 2016 considering their needs and qualitative interviews of professionals and carers about the strengths and weaknesses of the secure system for young people in England.

Table 1. Summary of characteristics of secure units[1]

	HDU	PICU	Low Secure	Medium Secure	SCH: Welfare only	SCH: mixed	SCH: YJB only	STC	YOI
Legislation	Mental Health Act	Mental Health Act	Mental Health Act	Mental Health Act	Children Act	Children Act, Criminal Justice	Criminal Justice	Criminal Justice	Criminal justice
Average length of stay (months)	2.2	2.9	10.5	14.2	4.9	4.5	6.0	3.6	4.5
Rooms locked at night?	No	No	No	No	Yes	Yes	Yes	Yes	Yes
Average staff ratio per YP (day, night)	0.63, 0.48	0.72, 0.71	0.73, 0.57	0.67, 0.41	0.65, 0.36	0.53, 0.51	0.45, 0.35	0.44, 0.18	0.13, 0.10
Average number of interventions	12.5	14.4	12.6	14.1	10.8	11.5	10.8	7.3	10.8
Total number beds[2]	27	147	138	90	80	94[3]	48	243	906
Gender specific beds	0 M, 13 F, 14 mixed	6 M, 27 F, 114 mixed	34 M, 56 F, 48 mixed	40 M, 0 F, 50 mixed	0 M, 22 F, 58 mixed	12 M, 17 F, 65 mixed	24 M, 0 F, 24 mixed	130 M, 33 F, 89 mixed	906 M, 0 F, 0 mixed
Possible age range	11-18	<10[4] - 25[5]	12 -18	<10 – 18	<10 - 18	<10 - 18	10-18	12-18	15 - 18
No of units in England	3	10	8	7	7	5	2	3	4

[1] All types of hospital units have service specifications except HDUs, which are HDUs often linked to an open ward. For this scoping exercise we only considered HDUs with four or more beds.
[2] Hospital beds: these numbers only include NHS commissioned beds. Some units had additional capacity, as non-commissioned beds.
[3] One SCH had capacity for an additional six welfare beds, but these were not open at this time.
[4] <10 was used to represent "no minimum age of admission"
[5] Although generally services are commissioned up to age 18, one PICU commented that they accepted young people up to age 25.

In this service evaluation, the term 'secure' is used to mean any setting that deprives a young person of their liberty, such that the young person cannot leave if they choose and there are additional physical security measures above and beyond that available in open residential, educational or mental health units, under one of three legal frameworks used to detain young people in England. The three legal frameworks under which young people can be deprived of their liberty in England are: The Mental Health Act (1983, as amended 2007) placing them in hospital; Section 25 of the Children Act (1989) placing them in a secure children's home (SCH); or under the YJS on remand or serving a sentence in a SCH, secure training centre (STC) or YOI.

The data presented here is based on self-reported information provided by the individual being interviewed as the key informant for each unit. Information was sought about:

- Geographical location of the unit
- Capacity
- Unit inclusion and exclusion criteria
- Service type and areas of specialist service
- Referral systems
- Interventions offered
- Education provided
- Discharge processes.

Full versions of the questionnaires used are included in Appendices A and B.

Types and location of secure units

- There are 60 secure units for young people in Great Britain (the United Kingdom, excluding Northern Ireland, Channel Island and Isle of Man; see *3.1.1 Types of unit*)
    - 28 hospitals in England and one in Wales (a mixture of high dependency units (HDUs), psychiatric intensive care units (PICUs), low and medium secure units)
    - 14 SCHs in England, five in Scotland, one in Wales
    - Three STCs, all in England
    - Four YOIs – for under 18s) in England, three in Scotland, one in Wales
- These units are not equally distributed around England. The closest unit might not be suitable to meet the young person's needs (see *3.1.2 Maps of secure estate*, *3.1.1 Types of unit*). The southwest of England is poorly served with hospital units and there are no STCs in the north or southwest of England.

  Both the independent sector and the NHS provide secure hospital beds; the independent sector dominate psychiatric intensive care and low secure provision and the NHS dominates medium secure provision. SCHs may be run by local authorities or charities. SCH placements are commissioned either by local authorities (welfare

placements) or the YJB, very few YJB beds are available in SCHs in the south of England.

- All units are able to take national referrals / placements for young people from across England.

Number of beds – distribution for gender, age and need

- Within England, there are 1,773 secure beds. Just under two thirds, 1,260 beds, are for Youth Justice Board (YJB) placements (111 SCH, 243 STC and 906 YOI), just under a quarter, 402, (27 HDU, 147 PICU, 138 low secure and 90 medium secure) beds are for people detained under the Mental Health Act and a small number, 111 beds, are for welfare placements. (See 3.2.1 Number of beds)

- The distribution of beds specifically for males and females varies across the different settings. In HDUs and PICUs, there are more designated female beds, whereas a higher proportion of medium secure beds are specifically for males. All YOIs only take males. (See 3.2.2 Gender specific accommodation)

- The arrangements in mixed gender units varied. Some units had separate gender wards/living units feeding into mixed education as in STCs, others had designated male or female bedroom corridors but shared living space and 10 hospital units and 10 SCHs had mixed bedroom corridors. (*See 3.2.2 Gender specific accommodation*)

- It appears there is no wide-spread procedure for accommodating young people who identify as transgender (see 3.2.2 Gender specific accommodation).

- The age range for admission/reception varied across units; some units stated that there was no minimum age, though the majority of units stated that the minimum age of admission was 12 years. Most units reported an upper age limit for discharge of 19, though one hospital stated it could take people up to the age of 25. SCHs tend to take the younger children considered to need secure care. It should be noted that the age of criminal responsibility in England is 10, and therefore the youth justice system (YJS) can accommodate young people aged from 10 to 18. (See 3.2.3 Age specifications).

- Although some units are specifically designed to accommodate young people with learning disabilities, there appears to be limited availability and variety of placements for young people with other neuro-developmental disorders who require a secure environment, particularly for those without co-morbid mental illness (see 3.2.5 Specialist areas and exclusion criteria).

- Neurodevelopmental disorders were the most commonly identified specialism in hospital settings, but also the most commonly identified exclusion criteria. There appeared to be a lack of specialist secure care for young people with eating disorders. (See 3.2.5 Specialist areas and exclusion criteria).

- It is unclear where a pregnant young person would be placed if she required secure accommodation outside of the YJS; only one unit (STC) has a specialist mother and baby facility, and it appears likely a young mother requiring secure accommodation would be separated from her child. (See 3.2.5 Specialist areas and exclusion criteria).

- Outside of the YJS, there appears to be a lack of specialist provision within the secure estate for young people requiring clinical treatment for substance misuse (see 3.2.5 Specialist areas and exclusion criteria).

Phased release

- Most units, 84% (41/49), regardless of type, reported that discharge/release can be phased (See *3.4.2 Phased discharge/release*).

Theoretical framework, interventions and MDT team

- Most hospitals (25/28, 89%), some SCHs (10/14, 71%), and a few STCs and YOIs (2/7, 29%) identified an overarching theoretical approach to interventions with young people. (see 3.5.1 Theoretical treatment models).

- However, the degree of fidelity to a specified model was unclear. The most common overarching approach in hospitals was a multi-therapeutic milieu (7/28 units, 25%). This grouped models such as the recovery model, bio-psycho-social model, and multi-therapeutic child and adolescent mental health services (CAMHS) together undermining coherence (See 3.5.1 Theoretical treatment models).

- Many interventions are in use across the secure estate for young people. Manualised evidence based interventions are often not trialled with young people in secure settings; therefore these interventions are not specifically evidence-based for this population. (See 3.5.2 Available interventions).

- The mean number of different interventions offered varied by type of unit. Hospitals offered the largest number / widest range of interventions (M = 13.7, SD = 2.8), and STCs the least (M = 7.3, SD = 1.7). (See 3.5.2 Available interventions).

- All units offer some form of psychiatry, psychology, and nursing or care work, to enable assessment, supportive care, medication, and psychological therapy. Education is also offered by all units, but vocational training is only available in 77% (38/49) of units, understandably being less in the shorter term units. (See *3.5.2 Available interventions*).

- Behaviour targeted interventions were favoured by the YJB establishments, but also offered by most (11/13, 85%) short term hospital units, and 83% (5/6) of welfare SCHs. (See 3.5.2 Available interventions).

- Family therapy was offered in most hospitals (25/28, 89%), especially the longer term units, and most YOIs (3/4, 75%), but in few SCHs and no STCs. However, the definition of family therapy in some cases is unclear and not all units have a family therapist (See 3.5.2 Available interventions).

- Sensory interventions, often facilitated by occupational therapists, are more often available to young people in hospital units than elsewhere. Even in hospital settings this is less likely to be on offer than other, traditional forms of occupational therapy. Sensory interventions are recommended for those with autistic spectrum difficulties. This may be a significant intervention deficit in the SCH, STC and YOIs. (See 3.5.2 Available interventions).

- Hospital settings tend to have the widest variety of professionals in their multi-disciplinary team (MDT), and SCHs the least, only reporting psychiatry and psychology input. The frequency of input from different professions was not established (See 3.5.3 MDT staff profile).

Unit staffing

- Staff to young people ratios were obtained for all kinds of unit, recognising that the role of staff, as designated, was very different across the settings. STCs and YOIs have significantly fewer staff (on the ground) available to young people on both day and night shifts, in comparison to other types of unit. The average ratio of staff to each young person on day and night shifts was highest in hospital settings, with the overall highest average ratio of staff to young people being in PICUs (a mean of 0.72 staff to one young person during the day, 0.71 staff to one young person during the night). (See 3.5.8 Staff ratios).
- Welfare settings tended to have a higher ratio of staff to young people than did YJB settings (in welfare settings, during the day there was an average of 0.65 staff to one young person and at night an average of 0.36 staff to one young person, compared to SCHs that take YJB placements, STCs and YOIs. In particular, YOIs had the lowest ratios of staff to young people on both day and night shifts (a mean of 0.13 staff to one young person during the day, and a mean of 0.10 staff to one young person at night). (See 3.5.8 Staff ratios).
- In general, hospitals had higher ratios of staff to young people on the night shift and young people were not locked in their rooms. (See 3.5.8 Staff ratios).

Security issues – bedroom locks and internet access

- Young people were locked in their rooms at night (and therefore not able to leave their room by choice) in all SCHs, STCs and YOIs but not in any hospital. (See 3.5.8 Staff ratios).
- In most units, young people did have access to internet, including all hospitals, but detail was not consistently given about where or when. The only units to respond that young people did not have any access to the internet were two STCs and three YOIs (See 3.5.9 Access arrangements).
- One PICU specified that internet access on the ward was unsupervised (internet in these cases was accessed via mobile phones), and six (6/49, 12%) of units were unclear about the level of supervision that would be used. (See 3.5.9 Access arrangements).

Education provision

- No hospital and only a few (2/7, 29%) welfare SCHs confined young people to their rooms if they refused education. Conversely, all YJB-only placements reported that young people were confined to their rooms, or it was unclear from their response where the young person would go in this situation. (See 3.5.9 Access arrangements).
- On average, hospitals had significantly fewer hours allocated to education (M = 17.67, SD = 6.49), than both SCHs (M = 27.00, SD = 3.80; t (39) = -4.94, p = .001)

and STC/YOIs (M = 25.71, SD = 5.35; *t* (32) = -3.01, *p* = .003), which were comparable with each other (*p* > .05). (See 3.6.1 Education hours).

- The average proportion of teachers to young people was higher in hospitals (M = 0.33, SD = 0.14) and SCHs (M = 0.30, SD = 0.09) than in STC/YOIs (M = 0.14, SD = 0.02). This finding should be understood in the context of less therapeutic opportunity for those in STC/YOIs, less time out of their cells for other activities, and an emphasis on education. (3.6.4 Teaching staff ratios).

Hospital units

- Within hospital settings, there is a difference between PICU / HDUs as short term units, and low secure / medium secure as longer term settings, in terms of therapeutic provision and educational aims. (See 4.0 Discussion and conclusions).
- There appears to be little difference between HDUs and PICUs, and so clear specification for HDUs and PICUs would be useful. (See 4.0 Discussion and conclusions).
- There also seems to be little difference between low and medium secure units in terms of what is offered. The main difference appears to be in the young people referred to these units; medium secure units accept referrals through the YJS, whereas low secure units do not. (See 4.0 Discussion and conclusions).

Summary discussion points

- There is an uneven geographical spread of units. There is a paucity of STCs in the north of England and a lack of SCHs with YJB beds in the south of England. Some young people might be placed long distances from their families or homes; this is likely to have an impact both on the young people and their families.
- The spread of beds across the secure system is uneven, with the number of welfare placements particularly low (111). Does this represent less demand for welfare beds, or are young people who require welfare secure accommodation being directed elsewhere?
- It is unclear where a young mother who has children or is pregnant at the time of needing secure care might go, if they were not detained through the YJS this is an issue in adult populations, although from this scoping exercise it is unclear how many young people this might affect. Would the mother and child be able to stay together?
- It is interesting that in hospitals, neurodevelopmental disorders was the most commonly identified specialism, but also the most common exclusion criteria. This suggests that for a young person with a learning disability or autistic spectrum disorder, there are only a selection of specific places they can be accommodated. It is unclear from this scoping exercise whether the number of beds for this population reflects the demand.
- In general, referrals come from within the same system (for example, a mental health professional refers to hospital, and a social worker refers to a welfare SCH placement). It is not clear from this scoping exercise what impact this might have; does this reduce ability for movement across the types of secure accommodation?

- As per the nature of HDUs and PICUs being shorter term, crisis management units, the average length of stay is estimated to be shorter than in low secure and medium secure units. Further analysis in the census stage of this project will consider whether these self-reported timeframes are reflective of what happens in practice.
- There was some variation in the processes for, and availability of, phased discharge in different places. This varied both between and within unit types. Therefore, it appears there are no standard procedures for use of phased discharge / release, although this scoping exercise does not investigate the impact this might have on young people.
- There is some variety in the range of professionals at the different types of secure unit, along with the range of interventions available. Hospitals appear to have a wider variety both in the professions represented in their MDTs, and the variety of therapeutic interventions offered, compared to other units. It is likely this stems from the purpose of hospitals being able to provide a therapeutic environment to manage mental health difficulties, compared to welfare secure and the YJS, where the purpose and focus of the units appears to be less on mental health and therapeutic work.
- The numbers of staff available also varies, with criminal justice settings (particularly YOIs and STCs) having lower ratios of staff to young people. If staff are required to manage large numbers of young people at once, this suggests that less attention might be paid to individuals' needs.
- On average, hospitals appeared to provide fewer education hours per week than other settings. However, as this data was self-reported, and not based on individual cases, it cannot be assumed that the hours stated by hospitals or other units are actually what happens in practice.
- Similarly, some hospitals mentioned that other meaningful activities, including therapeutic work, made up the remaining hours during the day; it is not clear exactly how many hours of educational learning (for example, working towards a qualification), compared to other activities were offered in each type of unit.

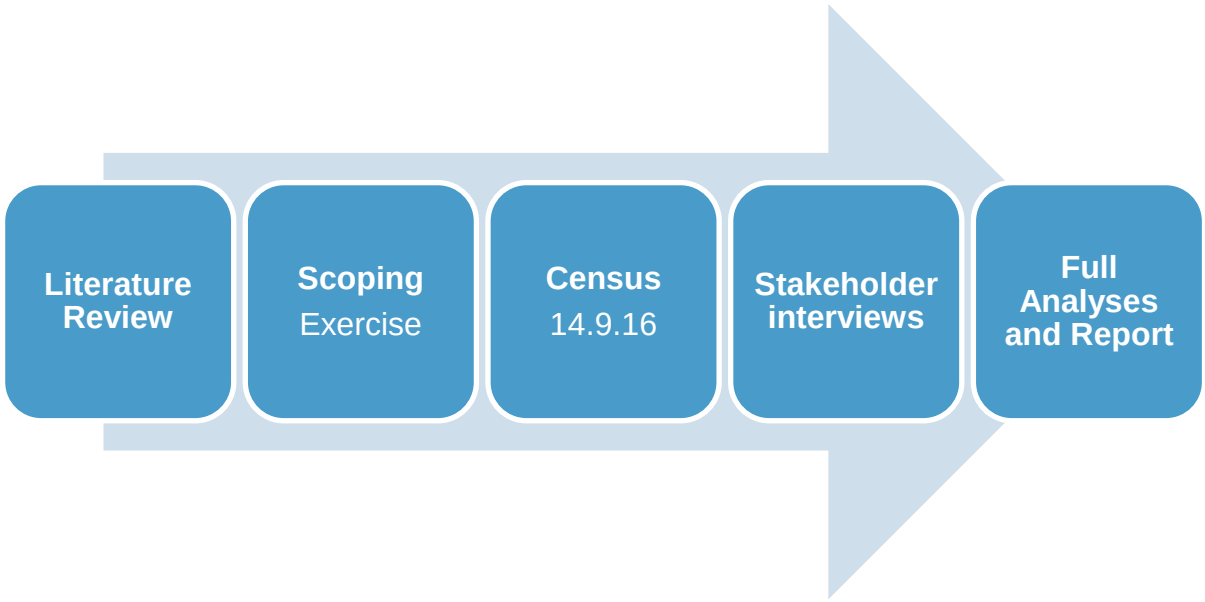
1. Introduction

This report was commissioned by NHS England, within the Children and Young People's Mental Health Transformation Programme as part of the Health and Justice and Specialised Commissioning Work stream. The project was planned and commissioned from September 2015. Contact with units for this scoping study was completed over the nine months from February 2016 to September 2016.

This report summarises the findings of the first (scoping) stage of a service evaluation, evaluating the provision of secure services for detained young people, under 18 years of age, from England. This involved identifying every secure unit in Great Britain (United Kingdom excluding Northern Ireland, Channel Islands and Isle of Man) that could detain young people from England and establishing the basic characteristics of each unit. This has enabled similarities and differences to be flagged, prior to further exploration in the later stages of the study. This report addresses two questions: to what extent and in what ways are the types of secure service for children similar or different?

The two other stages to the service evaluation are a census of all young people from England detained on 14 September 2016 including information about their pathways into secure care, needs and release plans, and a SWOT analysis of stakeholders about the strengths and weaknesses of this secure system in meeting the needs of young people detained in secure care.

Figure 1. Diagram of all three phases of the full service evaluation process



The data presented here is based on self-reported information provided by a professional at each unit. A census of the number of young people in secure settings on 14 September 2016, and their health/care needs, and pathways into secure services, has been conducted following this scoping exercise, and the details of each young person's experience will be used to compare with information reported here as part of the scoping exercise.

In this service evaluation, the term 'secure' is used to mean any setting that deprives a young person of their liberty with a level of physical security above and beyond that is avail-

able in open residential, educational or mental health units, such that the young person cannot leave if they choose, under one of three legal frameworks used to detain young people in England. The three legal frameworks under which young people can be deprived of their liberty in England are: The Mental Health Act (1983, as amended 2007) placing them in hospital, Section 25 of the Children Act (1989) placing them in a SCH, or under the YJS on remand or serving a sentence in a SCH, STC or YOI.

Secure establishments vary from a locked ward through to custodial criminal justice settings, including: psychiatric wards divided into HDUs, PICUs, low secure units and medium/forensic secure units, SCHs – of which some take welfare placements only (section 25 of the Children Act), others take YJB placements only, and some take both), STCs, and YOIs.

This scoping exercise included making contact and mapping units in Scotland and Wales which take English children, but they were not included in the summary analyses of units as they only take small numbers of young people from England. The units were also contacted for the census exercise to ensure that all detained English young people were described. We were unable to make contact with one low secure hospital unit in Wales.

The aims of this scoping exercise were:

- To ascertain and understand the different types of secure establishments available, nationally, for young people under 18 years of age.
- To map out the locality of all the secure units in Great Britain in which young people under 18 years of age from England can be detained.
- To identify the number of beds in each type of secure establishments for young people.
- To clarify specifications on bed availability for gender, age and need / diagnosis.
- To describe the similarities and differences between units where placements are under mental health, welfare, or YJS legislation.
- To describe the similarities and differences between HDUs, PICUs and low secure units, as there is currently no CAMHS specification for HDUs, lack of clarity on how these differ from PICUs and concern that PICUS overlap the role of low secure units.
- To describe the similarities and differences between low and medium secure units.
- To describe the similarities and differences between STCs and YOIs.
- To ascertain and understand the variety of therapeutic services available for young people in England in different secure establishments.

2. Method

A provisional list of secure hospital units was initially provided by NHS England. All of these units were contacted and a snowballing method (asking each contact with other secure units in their area) was used. We also completed an internet search using combinations and variations of the terms 'secure', 'adolescent', 'hospital' and 'unit'.

From the provisional list provided by NHS England, three further units were found (one by snowballing, one through the internet search, and one through a response on a census questionnaire at a later stage of this project). Two units closed during the course of this scoping process. These latter two were not included in the analyses.

A list of SCHs was found via the Secure Children's Homes website, and a list of YOIs and STCs was identified from the Ministry of Justice website. Again, when contact was made with each of these units, we asked whether there were any additional units not included on the website lists. No additional units were found.

Contact was made with each unit and the service evaluation explained. A representative was identified as the primary contact for the unit (someone with a broad knowledge of the unit, usually the service manager, ward manager, or consultant). We went through a questionnaire over the phone, or via email, with this person. Following initial conversations, questions were clarified via email, where necessary. Information provided in all sections is the self-report of the individual(s) being interviewed, and should therefore be interpreted with caution.

The questionnaire was designed by the service evaluation team and steering group and piloted with two clinical colleagues working in open adolescent wards and with a senior YJB representative. The questionnaire included 50 questions for SCHs and YOIs, and 53 questions for hospitals, relating to overarching topics of:

- Geographical information
- Capacity
- Unit criteria
- Service type
- Referring systems
- Interventions
- Education
- Discharge processes.

Full versions of these questionnaires are included in Appendices A and B.

Units in Wales and Scotland were asked an additional question about whether they could accommodate young people from England, to ensure they met the criteria for inclusion in this study. We mapped all units in Great Britain but have only fully described units located in England.

In some cases, the unit representative declined to answer certain questions, or stated that they would provide further information at a later date. This additional information was requested via email. There remains some missing data, usually information that the contacts told us was commercially sensitive – this includes commissioned MDT staff profiles.

Where appropriate, quantitative data was used to examine characteristics of secure units. Results were recorded as percentages for proportion variables and means and standard deviations were calculated for variables with continuous distributions. In cases where numbers allowed, chi-squared tests were used to compare proportions across units where placements are in hospital, SCH, or STC/YOI settings. Independent group *t*-tests were also administered to compare continuous variables between different types of units, with bias corrected and accelerated (BCA) bootstrapping using 2,000 replications employed where variables did not meet requirements for univariate normality. The criterion for statistical significance was set at $p < 0.05$, with no adjustments for multiple comparisons. All statistical analyses were completed with the Statistical Package for the Social Sciences, Release 21.0 (SPSS, IBM).

Tables have been colour-coded to allow for easy comparison between short term hospital units (HDUs, PICUs), long term hospital units (low and medium secure), units that take welfare placements, and units that take YJB placements.

3. Findings

3.1 Geographical information

3.1.1 Types of unit

This service evaluation identified 49 units in England and a further 11 units in Scotland or Wales, making a total of 60 units on the island of Great Britain, including:

- 28 hospitals in England, one in Wales (including HDUs, PICUs, low secure, and medium/forensic secure)
- 14 SCHs in England, five in Scotland, one in Wales
- Three STCs, all in England
- Four YOIs- for under 18s in England, three in Scotland, one in Wales.

Some types of hospital unit are clearly defined, whereas others do not have formal specifications. There is currently no CAMHS specification for HDUs, but these are usually considered to be locked wards with a level of security beyond that of an open CAMHS inpatient ward. PICUs are considered to be for short term interventions during an acute mental health crisis, whilst low and medium secure units are considered to be for longer term interventions, with higher levels of relational and physical security.

Young people from England (where the funding for the placement is from England) can be placed in four of the SCHs in Scotland, the SCH, low secure hospital and YOI in Wales. However the three YOIs and one of the SCHs in Scotland do not take young people from England. During the completion of this scoping exercise, there was a change in the law regarding English young people being placed in Scottish SCHs for welfare reasons such that a court appearance in Scotland will be needed for a young person to be detained for welfare reasons in Scotland; this report outlines the system as it was in June 2016, when English young people were still able to be placed in units across the border without this.

Seven of the 14 SCHs in England take welfare placements only, two take YJB placements only, and five both welfare and YJB placements. There are three STCs and four YOIs in England, all taking YJB placements.

Independent sector HDUs, PICUs and low secure are thought to have developed in response to local and national need. Conversely there has been a reduction in the number of young people in custody (a fall of around 3,000 in recent years), which has led the YJB to decommission beds across the estate, with location being one of the factors taken into consideration when determining from which establishments to withdraw beds; those that remain have been identified as the best geographical distribution.

In total, 28 units take mental health placements, all commissioned by NHS England (16 where the provider is from the Independent or charity sector, and 12 where the provider was an NHS Trust). From this study, we identified three HDUs, 10 PICUs, eight low secure units, and seven medium secure units (see table 2). There are specifications for PICUs, low and medium secure units, for which the criteria must be met in order for a unit to be considered of this level of security. HDU, however, is a more self-defined term. As a result of this, there may be additional units not covered in this study that could fit into the category of HDUs, but

due to the lack of consistency in use of the term 'HDU' and lack of any specific service specifications, some may have been missed through the methods of identification used in this scoping exercise. Two of the medium secure and three of the low secure units are described as specialist units for learning disability / neurodevelopmental disorders. In some cases, multiple units are on the same site; this has been split according to different types of unit (for example, if there is one mental illness ward and one learning disability ward on one site, these are counted as two separate units) as for two of the medium secure units.

One independent sector medium secure unit is part of the national network and therefore beds are blocked commissioned by NHS ENGLAND. Beds in all other independent / charitable sector provider units are spot purchased by the local clinical commissioning group when needed.

Though it is recognised that HDUs are not considered 'secures in the same sense as the other units in this study, HDUs have been included as this service evaluation looks at all units where young people are detained under a legal framework in a locked environment where they cannot choose to leave. The criteria for inclusion was that the unit self-defined itself as a locked HDU, with more than four beds (thereby ensuring whole units were included, rather than small areas of general acute wards that can be locked).

Table 2. Number of hospital units NHS / independent sector providers

	HDU	PICU	Low	Medium	Total
NHS	1	3	2	6	**12**
Independent	2	7	6	1	**16**
Total	**3**	**10**	**8**	**7**	**28**

Five hospital units specified that their security level could be flexible (two PICUs, one low secure, two medium secure). All these units noted that their buildings were designed in a way that allowed for this:

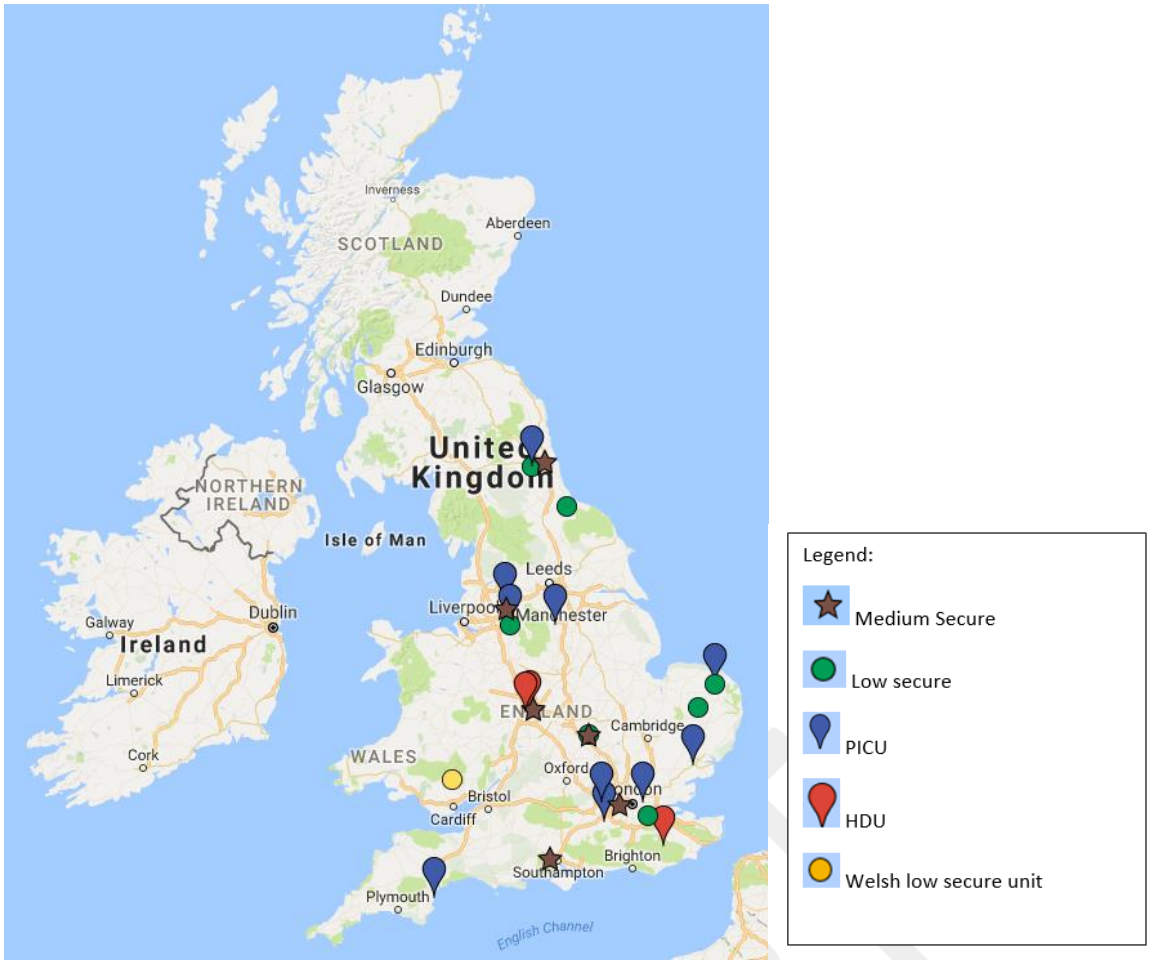
- One low secure, one medium secure: built to medium secure regulations. Can change level of security for individual patients at a lower secure level, if it would be more detrimental to the patient if they were moved to a new unit.
- One medium secure: commissioned as adolescent forensic stated that it could be of low or medium secure level.
- One PICU: local clinicians described it as a HDU, but noted that it was commissioned as a PICU. Clinicians also said that this unit could also take young people requiring low secure accommodation if a better option was not available, and manage the young people within a low secure type environment.
- One PICU: built to low secure specifications, with swing zones within the ward such that young people who required higher levels of security could be accommodated separately to the rest of the ward.

A further five units specified that they could be flexible to some extent (for example, could accommodate a young person needing a different level of security whilst awaiting transfer, managing their care plan and conditions as much as possible in accordance with their needed level of security).

3.1.2 Maps of secure estate

The maps below show the spread of different types of unit across England, Scotland, and Wales, where English young people under the age of 18 can be placed (with funding from English organisations). This includes the low secure unit in Wales and the SCH in England that did not participate in the scoping exercise; these locations were found on the units' websites.

Map 1: All secure hospital units for young people in Great Britain [6]

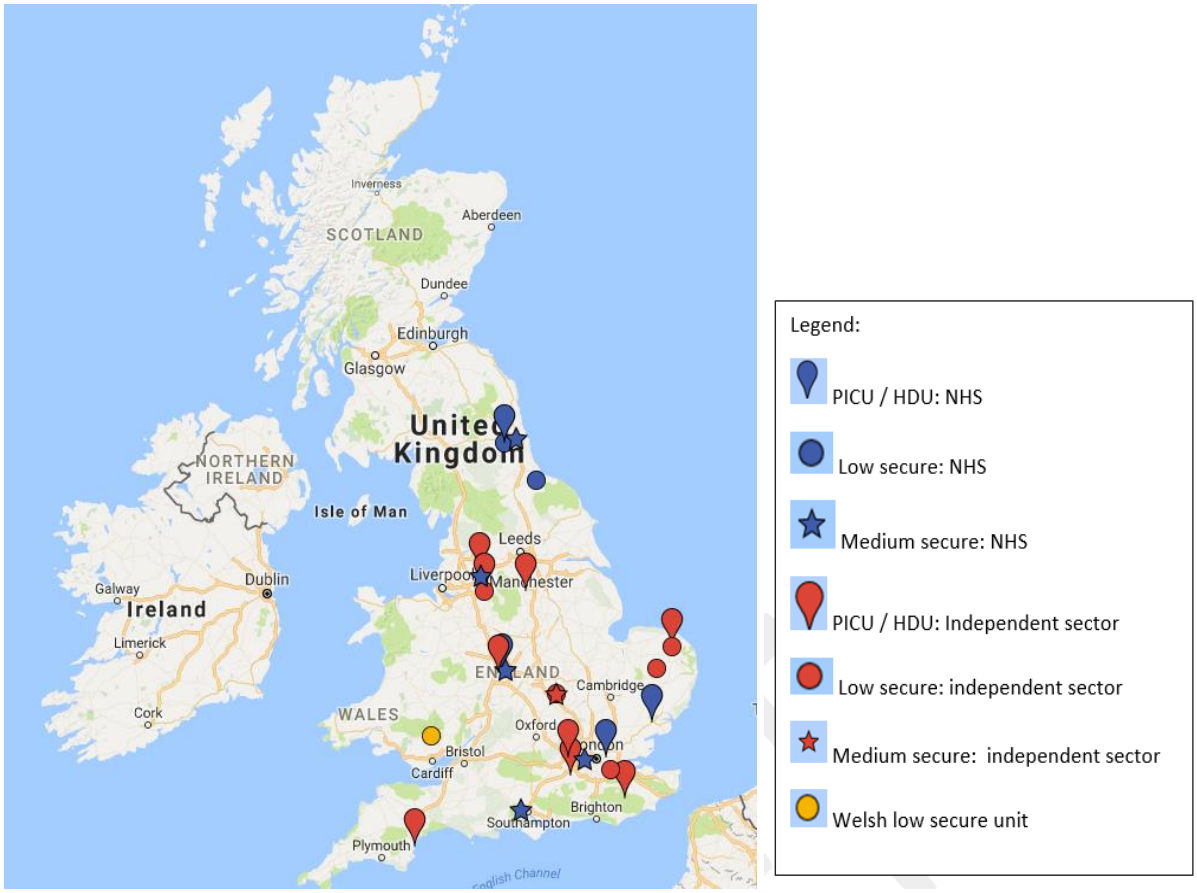


From this map, it is clear that some types of hospital unit are more widely available than others. This scoping exercise found only three HDUs in England, two of which are in the midlands and one in south east England; however, as noted above, due to the lack of specifica-

[6] For the purposes of this study, Great Britain is the United Kingdom excluding Northern Ireland, Channel Islands and Isle of Man. For detailed version of map: https://drive.google.com/open?id=1TZr1UtPXH3ClvJqTYJyRg2Mjyl0

tions for HDUs, there may be other units of similar criteria and role to these which were not included in this study. In contrast, PICUs appear fairly widely spread, with several around the London area. Low and medium secure units are also available across England. However, there is a lack of provision of secure services for young people living in the south west (one PICU). It should also be noted that although there is a spread of units across England, many have small numbers of beds, and therefore young people are often placed far away from home.

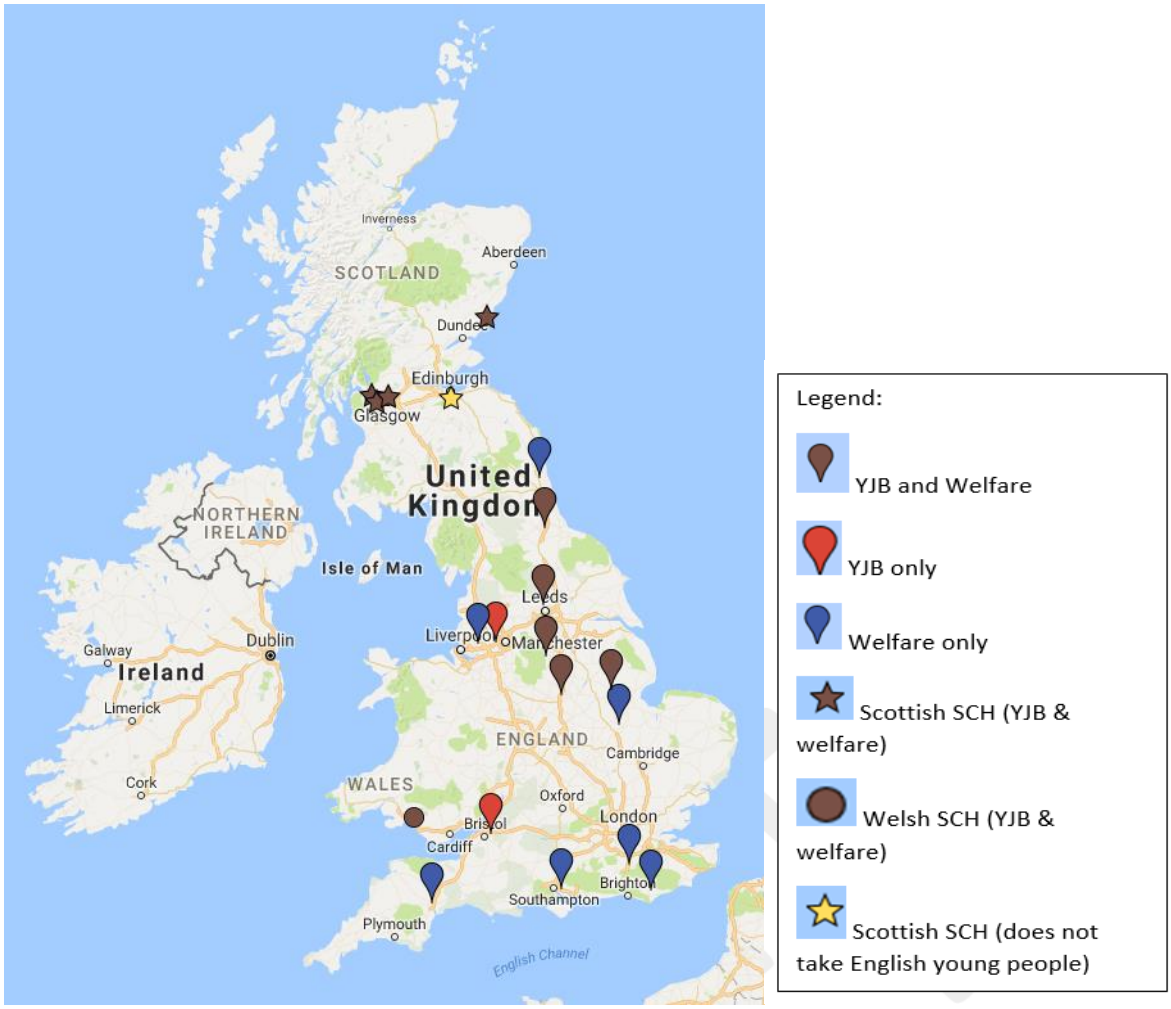
Map 2: Spread of NHS and independent sector hospitals[7]



This map shows the spread of hospital units where the service is provided by an NHS trust or an independent sector provider (including one charity – St Andrews Healthcare). The geographical spread of NHS to independent sector hospitals is fairly equal across England, although it varies by type of unit; only two low secure units are provided by NHS trusts (one being a learning disability low secure unit, provided by Northumberland, Tyne and Wear NHS Foundation Trust), and only one medium secure unit is provided by a non-NHS organisation (this unit is part of the national medium secure network, with block booked NHS England commissioned beds).

[7] For detailed map: https://drive.google.com/open?id=1Se8e1Wcx_h55DFz1MsiUm4vx_IY

Map 3: SCHs that can take young people from England[8]

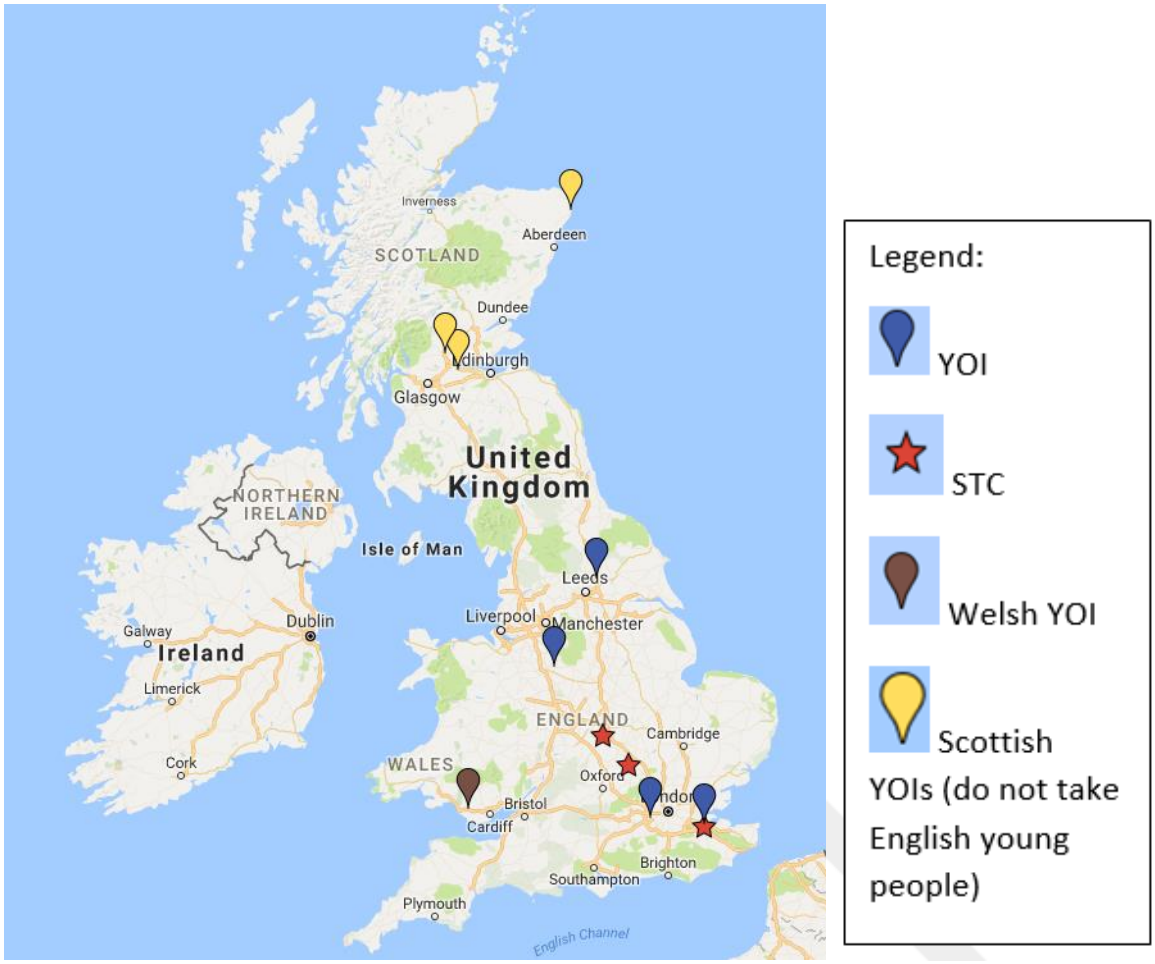


Although there is a fairly wide spread of SCHs across England, there is a lack of any SCH provision in the midlands and East Anglia; further investigation in the census part of our service evaluation will identify where young people from these areas might be placed when requiring an SCH placement. For example, it appears that a young person living in Norfolk would have to travel a long way for any SCH provision. If a young person lived in Southwold, it is approximately 160km to the nearest SCH that can accommodate YJB placements, and 140km to the nearest SCH for a welfare placement.

This map also indicates that there are very few units in the south of England that can take young people on YJB placements, with the focus instead being on welfare placements in these areas. For example, a young person from Canterbury would have to travel approximately 250km to reach the nearest SCH that can take YJB placements.

[8] For detailed map: https://drive.google.com/open?id=1mL90gBcAssFOnwD9Kzkywj8Z5ek

Map 4: YOIs and STCs that can take English young people[9]



This map shows the spread of STCs and YOIs for young people under the age of 18 in Great Britain (the United Kingdom excluding Northern Ireland, Isle of Man and Channel Islands), but English young people can only be placed in the YOIs in England and Wales. Therefore, the Scottish YOIs are not within the scope of this study, but included in the map for a complete picture of secure settings in Great Britain.

The five YOIs are fairly spread out across England, but STCs are clustered in the South East / Midlands.

For all units, it should be noted that the distance only tells a part of the story. As there are specific exclusion / acceptance criteria in some units, the nearest unit to a young person's home might not be one that is most suitable for their needs. Similarly, distance measured in kilometres does not reflect the differences in time it can take to travel across different urban and rural areas. The disparate spread of units affects the ability of families to visit, particularly as many families will travel by public transport, which is likely to exacerbate the difficulties

[9] For detailed map: https://drive.google.com/open?id=1hvCMq2LXZqyhLCaahy7HxMzYXQ4

with distance. The units are rarely in the centre of towns/cities for purposes of security, thus travel for families is in several stages when using public transport. These journeys can be time consuming and expensive. Some families are making these journeys with young children, which can make it even more stressful.

Although funding is available to reimburse travel costs for families visiting young people in secure care, the process to apply for this appears to differ per type of setting and type of visit, and families have previously reported that the application process is difficult to navigate. This topic will be investigated further in the stakeholder interview stage of this project, and covered in a subsequent report.

3.1.3 Geographical spread of referrals

Each unit was asked where (geographically) they could receive referrals from: international, national, regional, local. All units can take English referrals. For hospitals, 21% could also receive referrals internationally (including Ireland, Channel Islands, and countries further afield). Although only 60% of YOIs reported that they took national referrals and 40% that they took regional referrals (one of which noted that they had a complex needs unit which takes national referrals), we have clarification from a representative from the YJB that all YOIs can take national placements, but as each youth court is associated with a particular YOI based on location, there is usually a regional basis to the placements.

Discussion points

- There is an uneven geographical spread of units. There is a paucity of STCs in the north of England, lack of SCHs with YJB beds in the south of England and lack of SCHs with welfare beds in middle England such that some young people might be placed long distances from their families or homes. This is likely to have an impact both on the young people and their families, making visits more time-consuming for families and family therapy harder to arrange.

3.2 Unit type

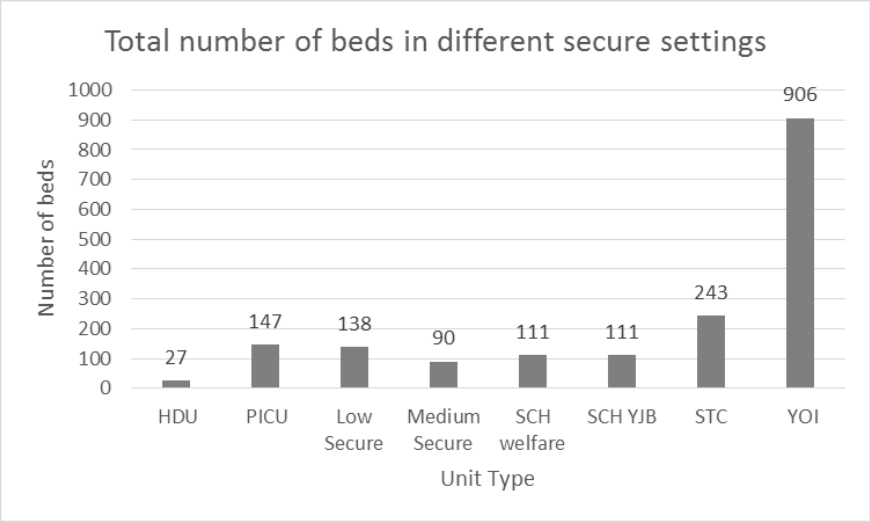
3.2.1 Number of beds

This service evaluation scoping has identified a total of 1,773 commissioned beds for young people in secure settings in England (June 2016). Additionally, there were six further welfare beds that were not open. The chart below details the number of beds for each type of unit, with YOIs having the largest number of beds (Figure 2). In addition, there are 82 Scottish SCH beds, 64 Welsh YOI beds, 22 Welsh SCH beds (16 welfare, six YJB), which can be used by English young people, if required. There are also further beds in the Welsh low secure unit that did not participate in this scoping exercise; the number of these are unknown. The total number of STC beds are recorded, although it is noted that these were capped at the time of this scoping, following security incidents, meaning that many STC beds were closed and young people dispersed into SCHs or YOIs. It is known that on 14 September

2016, there were a total of 142 beds in STCs that could be used, meaning that 101 beds were closed at this time.

Figure 2. Total number of beds in different secure settings.

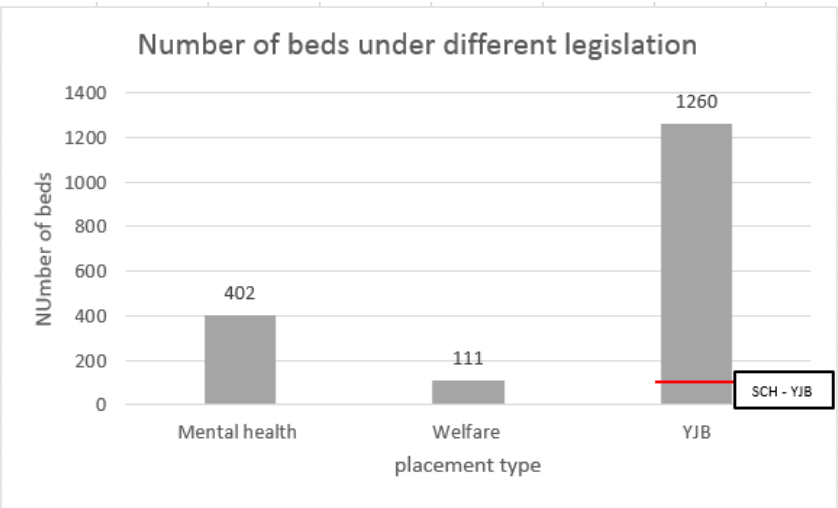
Note: data labels represent the number of beds



Of these 1,773 secure beds, 402 (27 HDU, 147 PICU, 138 low secure and 90 medium secure) are designated for young people detained under The Mental Health Act (1983), 111 beds are designated for welfare placements, and 1260 beds are for YJB placements (111 in SCH, 243 in STC and 906 in YOI). This does not include additional hospital and SCH beds available in Scotland and Wales. Therefore, the majority of secure beds for young people are commissioned by the YJB, (most in YOIs and STCs), and there are nearly four times as many mental health beds than welfare beds. In SCHs that take both YJB and welfare placements, all had a specified number of beds for each type of placement – however, we were informed that the YJB can spot-purchase beds that are usually designated for welfare placements, if necessary.

Figure 3. Total number of beds under each type of legislation

Note: data labels denote number of beds



For hospitals, table 3 shows the number of beds in the independent sector and NHS for each type of unit. Very few beds are provided by NHS services (less than half the number in the Independent sector), especially for PICUs and low secure units.

Table 3. Number of NHS and Independent sector beds in each type of hospital unit

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	Total (N = 28)
Independent	19	129	120	20	288
NHS	8	18	18	70	114
Total	27	147	138	90	402

3.2.2 Gender specific accommodation

Thirteen units are single-sex only (with eight taking only males, and five taking only females). Additionally, one unit stated that although they were commissioned to take both males and females, it was rare that they accommodated any females (this is included here as being mixed beds). All other units can take both males and females; whilst seven specified the number of places for each gender, the others were flexible in the numbers of each that they could take (see table 4).

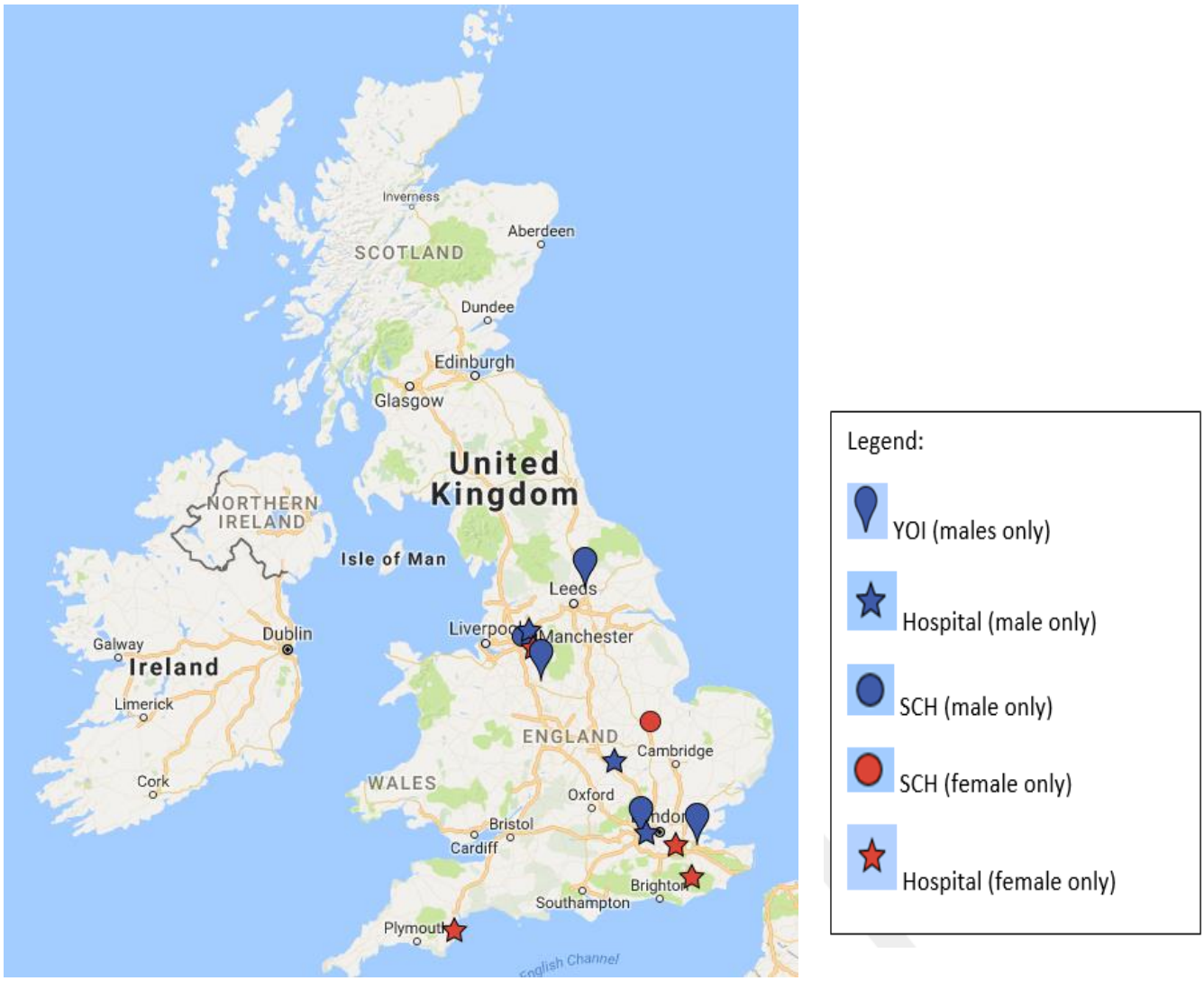
In the units that can take both males and females, the majority housed male and female young people on mixed corridors (20 units, 69%), at least some of the time, and only 2 (7%) housed males and females in separate units.

Table 4. Total number of beds specifically for males or females

	HDU (N= 3)	PICU (N = 10)	Low Secure (N = 8)	Medium Secure (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 49)
Number of male only beds	0	6	34	40	0	12	24	130	906	1152
Number of female only beds	13	27	56	0	22	17	0	33	0	168
Number of beds for unspecified gender	14	114	48	50	58	65	24	80	0	453
Total	27	147	138	90	80	94	48	243	906	1773

The distribution of beds specifically for males and females is varied across the different settings. In HDUs and PICUs, there appear to be more designated female beds, whereas a higher proportion of medium secure beds are specifically designated for males. All YOI beds are designated for males only. There used to be female only YOIs but the last one closed in 2014. Females under 18 are now placed in STCs; however, there are only 103 STC places available to females across England (although additional capacity could be commissioned by the YJB if required).

Map 5: Gender-specific units[10]



Each of the mixed gender units was asked whether they had separate gender living units (or wards), and if not, whether they had separate gender bedroom corridors leading to a shared living space, or completely separate living space, but shared education (see table 5). Totals have not been calculated, as some settings had more variety of units on site – for example, there might be a mixed living unit and a single-gender living unit, on one overall unit site.

The level of gender mixing varied from those with separate gender wards feeding into mixed education like in the STC, to separate gender bedroom corridors, but shared living space, and then nine hospital units and 10 SCHs with shared bedroom corridors**.** Although all STCs had separate gender units feeding into shared education, wards/units tended to be mixed in hospital settings and SCHs. Nine hospital units and 10 SCHs had at least part of their unit where both male and female young people were accommodated in the same living area and

[10] For detailed map: https://drive.google.com/open?id=1iVxxTH1FSiWmvEPc0zY8qGa81fs

with bedrooms on the same corridor. This accounts for the majority of all SCHs, and the majority of PICUs.

A few units mentioned that when shared bedroom corridors are used, they maintained safety by young people being allowed to lock themselves in and / or CCTV, and others mentioned door alarms to alert staff when a door was opened, or that although no specific additional security measures were in place, the young people would not be taken to / from their bedroom at the same time as another young person and supervision was constant in mixed areas.

Table 5. Types of gender-specific accommodation across unit types

	HDU (N = 3)	PICU (N = 10)	Low (N – 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Number single gender units	1	1	2	3	1	0	1	0	4
Number accommodating boys and girls	2	9	6	4	6	5	1	3	0
Separate gender living units, separate gender bedroom corridors	0	1	2	0	1	2	0	3	0
Mixed gender living units, separate bedroom corridors	1	4	3	2	0	1	0	0	0
Mixed gender living units, mixed gender bedroom corridors	1	6	1	2	6	3	1	0	0

Whilst all STC/YOIs (three mixed gender STCs and four male only YOIs) stated that they could accommodate a young person who identified as transgender, along with 93% of SCHs, this was possible in only 78% of hospital units. The remainder were either unsure

whether or not they would accept someone who identified as transgender, or stated that they could not.

Of the 13 units that were single-gender, 6 (46%) could take a young person who identified as transgender.

Table 6. Number of units responding 'Yes' to question: Can you accommodate a young person who identifies as transgender?

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 6)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Total: Yes	2 (67%)	10 (100%)	5 (63%)	4 (67%)	6 (86%)	5 (100%)	2 (100%)	3 (100%)	4 (100%)

Units that specified they were able to take transgender young people primarily reported that the individual would be accommodated based on their individual clinical needs and preferences (14 hospital units, six SCHs, two STCs, three YOIs). Seven hospital units mentioned managing the environment as part of accommodating a young person who was transgender (eg separated bathrooms), but this was not mentioned by any other type of unit. Staff training and availability of healthcare services were mentioned by one SCH and one YOI, but not mentioned by hospitals or STCs. However, as this was a free-response question, this does not mean other units did not provide staff training, just that no other units specifically chose to mention this. Two units specified that they would accommodate a young person who identified as transgender, but were unsure of how specifically this might be done; it appears there is no wide-spread procedure for accommodating these individuals.

3.2.3 Age specifications

The age range varied across units; some stated that there was no minimum age (suggesting they would take any young person needing that type of secure care, regardless of age), though the majority of units stated that the minimum age of admission was 12 years, and most units reported an upper age limit for admission of under 19, one hospital stated it could take people up to the age of 25. It should be noted that the age of criminal responsibility in England and Wales is 10, and therefore the YJS can accommodate young people aged 10-18. In comparison, the current age of criminal responsibility in Scotland is eight years old. Approval from the Secretary of State is required to detain children aged younger than 13 who require welfare placements.

Results showed a statistically significant difference between the number of units admitting young people under the age of 12, compared to those admitting young people aged 12 or over, in hospitals compared to SCHs (X^2 (1, N = 42) = 12.64, $p < .001$). Similarly, minimum age of admission differed between SCHs and STC/YOIs (X^2 (5, N = 21) = 15.60, $p = .008$). There was no statistically significant difference between average age of admission in hospitals and STCs/YOIs. Therefore, minimum age of admission differs across the unit types. Of note most SCHs (79%, 11/14 units) would admit a young person younger than 12 years old, along with six hospital units; it appears that SCHs tend to take the youngest people.

The maximum age at which a young person needs to be discharged/released, or transferred to another service also differed across the types of secure unit (in terms of whether this occurred before or at the young person's eighteenth birthday, or whether they could remain in a unit beyond their eighteenth birthday). Whilst only one SCH allowed young people to remain on the unit after their eighteenth birthday, several hospitals and STCs and YOIs did – for varying amounts of time between eighteenth and nineteenth birthdays. In the case of hospitals, one PICU specified that young people could remain on the unit up to the age of 25. It is interesting to note that one medium secure unit and one low secure LD unit also stated they were CQC registered to take young people up to the age of 23, although in reality they would be moved by age 19.

It should be noted that in hospitals where young people stay beyond their eighteenth birthday, this is closely monitored by NHS England and nationally reported on a weekly basis.

Table 7. Average age of admission and discharge/release from all units

	HDU (N =3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 49)
Admission age <12	1	3	0	2	5	4	2	0	0	17
Admission age >=12	2	7	8	5	2	1	0	3	4	32
Maximum age for discharge <=18th birthday	2	7	6	3	7	5	2	1	0	33
Maximum age for discharge >18	0	3	2	4	0	0	0	2	4	15
Total	3	10	8	7	7	5	2	3	4	49

3.2.4 Accommodating vulnerability in relation to the group

Each unit was asked whether they were able to accommodate a young person who might be particularly vulnerable and at risk from their peers. The term 'vulnerable' was not defined, to allow units to interpret this in their own way. Reports on subsequent stages of this project – census and stakeholder interviews – will consider further the concept of vulnerability, in a population of young people in secure settings.

Only one unit (SCH) specified that this would not be possible, at the current time, due to the small size of the unit. All others confirmed that they would try to accommodate a young person in this situation, and discussed the ways in which they might accommodate this person.

The most commonly identified way of managing this situation was to move the vulnerable young person to a different area or unit (or, adapt the environment to separate specific young people) – 22/28 (79%) of hospital units, 9/14 (64%) SCHs, and 3/3 (100%) of STCs and 4/4 (100%) YOIs used this method. A large number of hospital units (19/28, 68%) also suggested they would use increased levels of observations, and some SCHs (6/14, 43% units) also suggested the use of similar strategies, such as increased supervision by staff, or increased numbers of staff. However, no STCs and YOIs described using these methods. The use of interventions (for example, mediation and intensive group work) was also suggested by some units (3/28, 11% hospital units, 2/14, 14% SCHs units, 1/7, 25% STCs and YOIs units). Additionally, 1 medium secure hospital unit also suggested they would use personal alarms for the young person, to increase safety, and 1 YOI stated that in rare cases they would use segregation for the young person's protection.

As these findings are based on responses to open questions; some units may use other strategies to accommodate a particularly vulnerable young person, but not have specified these in response to this question. Therefore, it cannot be assumed that these are the only strategies used.

Thus, it seems that similar methods for accommodating young people who are at risk from their peers are utilised across all secure settings. There appeared to be a preference towards adapting the environment as a way of managing this, for all units, although hospital units seemed more likely than SCHs or STCs and YOIs to make use of increased/enhanced observations, and STCs and YOIs were most likely to use mediation.

3.2.5 Specialist areas and exclusion criteria

Each unit was asked whether they considered themselves to be specialists in any particular area or diagnosis type. Thus, a specialist area was a self-defined concept. Several units stated that they did not consider themselves to be 'specialists' in a particular area, but found that their case-mix tended to be focused on particular needs / diagnosis types – these were not included in the figures below. Units were also asked to list exclusion criteria (behaviours, situations, or diagnosis types that they could not accommodate).

There was a wide variety of specialist areas, both between and within unit types. There was also a wide range of exclusion criteria, with several units stating they would not accept a referral from young people with a particular diagnosis. There was a wider range of exclusion criteria across hospital settings, than in other types of unit.

Fortunately, there were units specialising in many areas that others had as exclusion criteria. Therefore, the exclusion criteria and specialist areas are considered together in this section, to demonstrate the difficulties that might be faced in trying to place young people with specific difficulties / diagnoses in specific settings.

Autism and learning disabilities

Six units (three low secure, three medium secure hospital units) specified that they were specifically designed for young people with learning disabilities (LD) / complex neurodevelopmental disabilities / autism. Neurodevelopmental disorder was identified as the most common specialism in hospitals (three units stated that they specialised in management of

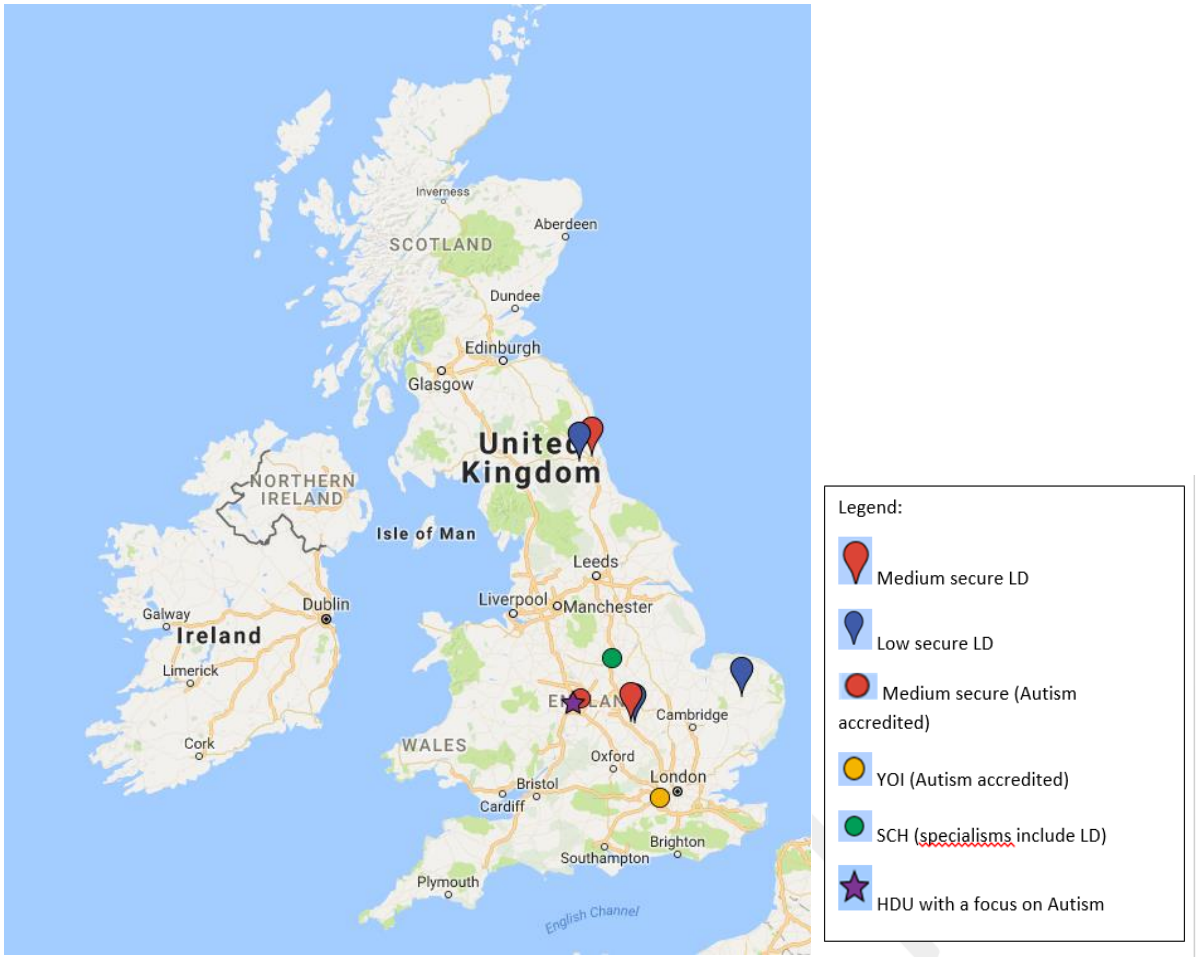
young people with complex neurodevelopmental disorders, two specified LD, and one specified autism). In addition, some other units considered themselves to specialise or be particularly good in the management of autism or LD, although they were not specifically designated for LD treatment; one SCH cited several specialist areas, including LD, and one HDU stated they were not explicitly specialists but worked well with young people who have an autism diagnosis.

One medium secure unit and one YOI have autism accreditation, which was described within the medium secure unit as an ability to specialise in the management of those with autism but mentioned as an aside for the YOI. However, it is recognised by clinicians in this field that this medium secure unit does not admit young people solely to support management of their autism spectrum disorder (ASD). We aim to further explore this through stakeholder interviews in a later stage of this project. These units differ from those specifically designed to accommodate young people with LD, as they can also take young people who do not have a LD diagnosis (usually, IQ < 70). No STCs claimed a specialist focus on accommodating young people with LD / autism.

In comparison, there were 16 units (all hospitals) that specifically stated they could not accommodate a young person with a primary diagnosis of moderate/severe learning disability (or ASD). Interestingly, this was therefore also the most common exclusion criteria for hospitals.

It should also be noted that some young people who do not have a clinical diagnosis of learning disability, may still have sub-threshold difficulties around low IQ, literacy, and numeracy.

Map 5: designated LD and autism units, and units whose specialisms include LD or autism



Eating disorders

Only one unit (a PICU) identified as being specialists in the treatment of young people diagnosed with eating disorders. This is in comparison to seven units (all hospitals) that explicitly stated an eating disorder diagnosis (or, at least, primary diagnosis of eating disorder) formed part of their exclusion criteria.

Pregnancy / perinatal

Similarly, it appears that there is a lack of secure units that accommodate pregnant girls, or young mothers and their children (one STC specified that it had a mother and baby unit). One low secure hospital also specified that pregnancy was part of their exclusion criteria, but it is not explicitly clear whether other units could take a young person who was pregnant (or whether they simply chose not to mention it as part of their key exclusion criteria). Likewise, only one unit has a specialist mother and baby facility.

Physical disabilities

It also appears that it could be difficult to find a suitable secure placement for young people with severe physical disabilities. Two SCHs specified that they could not take a young person with a severe physical disability (for example, due to not having provisions to accommodate a wheelchair). However, as a question about provision of appropriate conditions for

people with physical disabilities was not explicitly asked, it cannot be assumed that all other units were able to accommodate these young people; therefore, further investigation is needed into the provision of secure care for young people with physical disabilities.

Clinical treatment for substance misuse

Only one unit (an STC) reported having a specialist clinical drug detoxification programme, whereas two units (one PICU, one SCH) noted that young people with a primary diagnosis of substance misuse, or requiring clinical detox for substance misuse, could not be accommodated.

Other specialist areas and exclusion criteria

Other specialist needs / diagnosis types were more widely catered to; emerging personality disorder was a common specialism in hospitals (reported as the specialist area by 18% of hospitals; three low secure units in the independent sector, and two medium secure NHS units. Additionally, two low secure units stated that although they did not specialise in management of emerging personality disorder as such, the majority of the young people admitted had this diagnosis). Nowhere explicitly excluded young people with difficulties relating to emotional dysregulation or emerging personality disorder; therefore, it appears that young people experiencing these difficulties would have a wider range of suitable placements available than those with other diagnoses. However, it is known by clinicians working in this field that some hospital units do not admit young people with difficulties solely relating to emotional dysregulation. We aimed to explore this dichotomy further in the stakeholder interviews stage of this project.

There were a variety of different specialist areas identified by each of the SCHs as well, although the most commonly reported specialism was sexually harmful behaviour (29%, 4/14 units), followed by childhood sexual exploitation (CSE; 21%, 3/14 units). Interestingly, two SCHs reported specialising in both sexually harmful behaviours and CSE. The process for the co-management of these groups is not clear from this scoping exercise. In comparison to hospitals, there were very few exclusion criteria identified for SCHs, except the two units that specified they could not accommodate young people with severe physical disabilities, and one that said acceptance of a young person was dependent on their behaviour in relation to the group already in the unit. Eight said that they had no exclusion criteria. It has been noted by clinicians that SCHs are able to decline young people on secure orders, and sometimes do, which is contrary to them not having any exclusion criteria. This may be further explored in the stakeholder interviews.

HDUs and PICUs tended to not to specialise (only two PICUs and one HDU reported a specialist area), which is illustrative of the short-term and crisis-management nature of these services. However, all HDUs and nine out of 10 PICUs reported having exclusion criteria. One PICU noted that they would exclude a young person for whom the primary need was related to the breakdown of the family situation or placement; it is interesting that no other hospital units explicitly mentioned this, as for all hospitals the primary need should be a mental health need. In comparison, five medium secure units and one low secure unit stated that they did not have any exclusion criteria (aside from the appropriateness of the level of security).

Amongst STCs and YOIs, both exclusion criteria and specialist areas were rarely reported; two STCs reported a specialist area – one in clinical drug detox, and one having a mother and baby unit, and one YOI, which has a specialist complex needs unit. One YOI reported the exclusion criteria of young people on restricted status. However, as only two YOIs are

known to accept young people on restricted status the fact that only one YOI stated this shows that not all exclusion criteria were reported by all units.

Table 8. Comparison of exclusion criteria and specialist areas in hospitals

Note: several units listed more than one specialism / exclusion criteria

	Number of units: Exclusion criteria (N = 28)	Number of units: Specialist area (N = 28)	Number of units: not specified (N = 28)
Emerging personality disorder	0 (0%)	5 (18%)	18 (64%)
Neurodevelopmental disorder (including autism / LD specific units)	16 (57%)[11]	6 (21%)	6 (21%)
Trauma	0 (0%)	1 (4%)	27 (96%)
Eating disorder	7 (25%)	1 (4%)	20 (71%)
Drug induced psychosis	0 (0%)	1 (4%)	27 (96%)
Pregnancy	1 (4%)	0 (0%)	27 (96%)
Severe sexual or other offending	2 (7%)	0 (0%)	27 (96%)
Primary need due to breakdown of family / placement	1 (4%)	0 (0%)	26 (93%)
Primary diagnosis of conduct disorder	1 (4%)	0 (0%)	27 (96%)
Primary diagnosis of substance misuse	1 (4%)	0 (0%)	27 (96%)
Severe violence / aggression	2 (7%)	0 (0%)	26 (93%)
Arson	1 (4%)	0 (0%)	27 (96%)

[11] 14 hospital units specified they would not accept a young person with learning disabilities (although in some cases it was specified that this was only if moderate or severe), and two hospitals specified they would not accept a young person with either learning disability or an autism spectrum condition.

Table 9. Comparison of exclusion criteria and specialist areas in SCHs

	Number of units: Exclusion criteria (N = 14)	Number of units: Specialist area (N = 14)	Number of units: not specified (N = 14)
Substance misuse requiring clinical treatment	1 (7%)	0 (0%)	13 (93%)
Severe violence	1 (7%)	0 (0%)	13 (93%)
Severe physical disability	2 (14%)	0 (0%)	12 (86%)
Childhood sexual exploitation	0 (0%)	3 (21%)	11 (79%)
Trauma	0 (0%)	1 (7%)	13 (93%)
Attachment	0 (0%)	1 (7%)	13 (93%)
Restorative practice	0 (0%)	1 (7%)	13 (93%)
Sexually harmful behaviour	0 (0%)	4 (29%)	10 (71%)
Learning disability	0 (0%)	1 (7%)	13 (93%)
Complex mental health conditions	0 (0%)	1 (7%)	13 (93%)
Vocational and life skills	0 (0%)	1 (7%)	13 (93%)
Young people who identify as transgender	0 (0%)	1 (7%)	13 (93%)
Fire setting behaviour	0 (0%)	1 (7%)	13 (93%)

Table 10. Comparison of exclusion criteria and specialist areas in STCs and YOIs

	Number of units: Exclusion criteria (N = 7)	Number of units: Specialist area (N = 7)	Number of units: not specified (N = 7)
Restricted status	1 (14%)	0 (0%)	6 (86%)
Clinical drug detox	0 (0%)	1 (14%)	6 (86%)
Mother and baby unit	0 (0%)	1 (14%)	6 (86%)
Complex needs	0 (0%)	1 (14%)	6 (86%)

It should also be noted that placements arranged through the YJS are mandatory for units to accept, whereas referrals to hospitals and secure welfare orders can be rejected by managers if the referral is not deemed appropriate (which, amongst other reasons, could be due to the presentation of the young person, or the current mix of young people in the unit).

Discussion points

- The spread of beds across the different types of institution / legal framework for detention within the secure system is uneven, with the number of welfare placements particularly low (111). It is not clear what the driver for this is? - Does this represent less demand for welfare beds or are young people who could have been placed in welfare secure accommodation being directed elsewhere under different legislation and funding bodies?
- It is unclear where a young mother who has children or is pregnant at the time of being detained may be placed, if not detained through the YJS; though from this scoping exercise it is unclear how many young people this might affect. We wondered whether a mother and child would be able to stay together?
- It is interesting that, in hospitals, learning disability was the most commonly identified specialism, but also neurodevelopmental disorders (learning disability and ASD) the most common exclusion criteria. This suggests that for a young person with a learning disability, there are only a selection of specific places where they can be accommodated and limited placements with specified expertise in ASD. It is unclear from this scoping exercise whether the number of beds for this population reflects the demand.
- Units reporting that they specialised in emerging personality disorder were the second most common type of unit, though there is an active debate amongst professionals about where best to support and manage young people with these difficulties.

1.3. Referral systems

3.3.1 Referral pathways

Every unit was asked where they receive direct referrals from (which services, and which professions; see table 10). In all units, not all referrals are accepted, and decisions are made with consideration of exclusion criterion, bed availability, and the situation in the unit at that time. Further details about the complexity of referral processes will be explored in a later report from the stakeholder interviews stage of this project.

Hospital units primarily reported that they receive referrals directly from mental health services (with some medium secure units also receiving referrals from the YJS). However, these referrals through the YJS come from mental health teams within it. One medium secure unit stated that they could receive referrals from social services, although it is assumed that such referrals would be overseen by a psychiatrist, as no medium secure units receives direct referrals from social workers. All hospitals received referrals from psychiatrists, but many could also receive referrals from other mental health professionals (all HDUs and PICUs, but fewer low and medium secure units). This suggests that most referrals to these units will have come from – or have been signed off by – a psychiatrist. Some hospital units also noted that social workers within CAMHS could refer young people to these units.

In comparison, no SCHs, STCs, or YOIs received referrals from mental health services or mental health professionals. All referrals to SCHs that only take welfare placements came from social workers within social services, and all SCHs that can take both welfare and YJB placements stated that they received referrals from social workers within social services, as well as through the YJS. All STCs and YOIs solely receive referrals through the YJS, as all young people are placed there by the YJB.

Of note, in May 2016 (halfway through the scoping process), the system for managing secure welfare placements changed such that all referrals for secure welfare placements now go through a central National Secure Welfare Placement Coordination Unit, whereas before referrals were made directly to individual units.

These findings suggest that – in general – mental health services refer to mental health services, social services refer to social services, and referrals through the YJS are for YJB placements. However, mental health referrals appear the most permeable.

Table 11. Referral locations

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Social services	0	0	0	1 (14%)	7 (100%)	5 (100%)	0	0	0
Social workers	*0*	*4 (40%)*	*3 (38%)*	*0*	*7 (100%)*	*5 (100%)*	*0*	*0*	*0*
Mental Health / NHS ENGLAND commissioners	3 (100%)	10 (100%)	8 (100%)	7 (100%)	0	0	0	0	0
Psychiatrists	*3 (100%)*	*10 (100%)*	*8 (100%)*	*7 (100%)*	*0*	*0*	*0*	*0*	*0*
Other mental health professions	*3 (100%)*	*8 (100%)*	*5 (63%)*	*2 (29%)*	*0*	*0*	*0*	*0*	*0*
Youth justice system	0	0	0	4 (57%)	0	5 (100%)	2 (100%)	3 (100%)	4 (100%)
YOT workers / equivalent	*0*	*0*	*0*	*0*	*0*	*2 (40%)*	*2 (100%)*	*3 (100%)*	*4 (100%)*

Note: percentages may add up to over 100 as some units receive referrals from multiple different types of services.

3.3.2 Emergency referrals

Emergency referrals – or equivalent – are placements taken at very short notice, usually because the young person is in crisis. For purposes of this scoping exercise, this includes SCH placements under PACE (Police and Criminal Evidence Act, 1984). All HDUs and PICUs take emergency referrals. Fewer low and medium secure hospital units can take emergency referrals. The majority of SCHs could also take emergency referrals (or placements under PACE), along with most YOIs. Although no STCs reported being able to take emergency placements, their admissions policy is similar to that of YOIs, which is to accept young people sent to them by the courts.

Table 12. Number of units taking emergency referrals (or equivalent)

Able to take emergency placements?	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 49)
Yes	3 (100%)	10 (100%)	2 (25%)	2 (29%)	5 (71%)	4 (80%)	2 (100%)	0	3 (75%)	31 (63%)
No	0	0	6 (75%)	5 (71%)	2 (29%)	1 (20%)	0	3 (100%)	[12]1 (25%)	18 (37%)

Discussion points

- From responses to our scoping questions, referrals generally come from within the same system (for example, a mental health professional refers to hospital, and a social worker refers to a welfare SCH placement). It is not clear from this scoping exercise what impact this might have - Does this reduce the flexibility of the system to meet the specific needs of the young person such that they are referred to the known institution of the professional who first identifies their need, rather than considering which establishment / legal framework best meets their needs?

3.4 Discharge processes

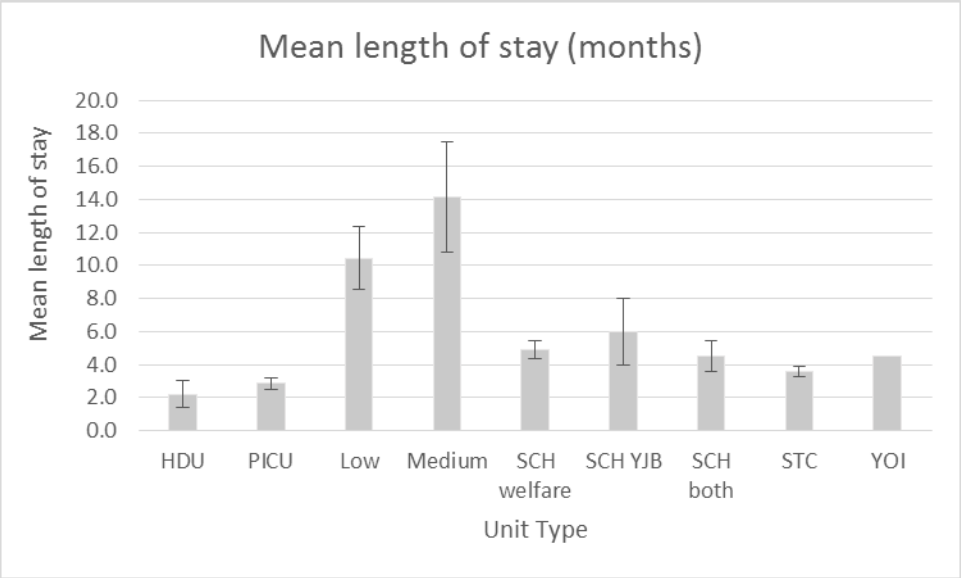
3.4.1 Length of stay

Mean length of stay was requested as part of the scoping exercise, but it became apparent that this information varied in accuracy. The mean length of stay in each unit varied from 2.2 months in HDUs to 14.2 months in medium secure units. The average length of admission to HDUs and PICUs was fairly similar (M = 2.2 months, M = 2.9 months). This is consistent with these units being used for short-term crisis management. The average length of admission in SCHs, STCs, and YOIs was slightly longer (M = 4.9 months, 3.6 months, and M = 4.5 months). Young people tended to spend the longest amounts of time in low and medium secure hospital units (M = 10.5 months, M = 14.2 months).

[12] Though STCs and YOIs stated they would not accept emergency referrals, they have to accept young people remanded or sentenced to custody from court on the day the ruling is given. This is akin to an emergency admission to hospital or SCH.

Figure 4. Mean length of stay in each type of unit

Error bars represent standard error



Only one YOI responded to this question, and therefore the average length of stay (4.5 months) might not be representative of all YOIs. For additional context, a representative of the YJB provided further information; in 2014/15, the average length of time a young person spent in the secure estate under criminal justice legislation was 100 days[13] (3.3 months), including all YJB placements in the secure estate, in both England and Wales, and therefore is not comparable with the other figures used in this report).

There was a statistically significant difference between the mean length of stay PICUs and HDUs (M = 2.70, SD = 1.11) compared to low / medium secure units (M = 11.94, SD = 5.51, t (20) = -5.70, p < .001). Young people stayed in HDUs / PICUs for significantly less time than in other hospital units, in line with these being shorter term units for young people in crisis. There was no significant difference between the average length of stay in hospital units compared to SCHs, and too few YOIs responded to this question to statistically compare with other units.

Table 13. Average length of stay (LoS) in each type of unit

	HDU (N = 3)	PICU (N = 9)	Low (N = 6)	Medium (N = 4)	SCH welfare (N = 7)	SCH mixed (N = 4)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 1)
Mean LoS (months)	2.2	2.9	10.5	14.2	4.9	4.5	6.0	3.6	4.5
Minimum	1.4	1.7	5.6	9.0	3.0	2.7	4.0	3	4.5
Maximum	3.8	5.0	18.0	24.0	6	6.29	8	4	4.5

[13] Youth justice statistics, 2014/15, England and Wales, YJB/Ministry of Justice (2016).

3.4.2 Phased discharge/release

The process of discharge / release from the secure units in this study varied; for those in hospital, discharge is usually decided on the basis of clinical factors, whereas for those on welfare orders in SCHs, it is usually determined by the expiry of the secure order. For those on criminal justice sentences in SCHs / STCs / YOIs release is in terms of the designated length of sentence and those released from being on remand in SCHs/ STCs / YOIs release is granted by court.

All units were asked whether discharge/release was phased. In the majority of cases (84%) across all unit types, discharge/release was phased (or, in most cases it would be phased, if possible). A small proportion of units (16%) specified that discharge/release was not phased – or was rarely phased – although no SCHs reported this, and few hospitals (see table 14). In the STC and YOI cases, discharge is phased via release on temporary license (ROTL), and is not likely to occur often, though it is encouraged.

Table 14. Number of units where discharge/release can be phased

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 49)
Phased: yes	3 (100%)	7 (70%)	6 (75%)	7 (100%)	7 (100%)	5 (100%)	2 (100%)	1 (33%)	3 (75%)	41 (84%)
Phased: no	0	3 (30%)	2 (25%)	0	0	0	0	2 (67%)	1 (25%)	8 (16%)

In the cases where discharge/release could be phased, units were asked to specify the process. In general, this involved varying periods and types of leave to the community / to visit new placements. Young people in each of the types of secure units are likely to be transitioning between different places. This influences the availability of, and types of, phased discharge/release in each setting. In several cases, it was noted that whether (and how) phased discharge was used depended on the individual.

In hospitals, the majority of units specifically mentioned using section 17 (The Mental Health Act) leave to allow the young person to visit new placements, or their home, initially during the day and then overnight (usually as a graded process, with increasing periods of leave). One low secure unit specifically mentioned that a young person's bed would be kept open for two weeks initially after their transition, for review.

SCHs tended to use mobility (agreed leave outside of the secure unit) to allow the young person to gradually transition to their next placement or to the community; the focus was on resettlement in the community. One SCH noted the process in detail, stating that in the lead up to discharge, they offered a phased mobility programme taking the young person outside of the secure perimeter, initially on-site with two members of staff, then off-site with reducing numbers of staff, and eventually leading to unsupervised off-site mobility (where this is risk-

assessed as appropriate). Another SCH specifically mentioned that in the lead up to discharge, the young person would be helped with life skills such as setting up bank accounts and finding their way around the local area, in order to help prepare them for leaving the secure environment.

YOIs and STCs that stated release could be phased noted that this was via release on temporary license (ROTL). If risk level is sufficiently low, the young person is able to go on visits to new placements, family, or work placements. In most cases, it was noted that this was not a frequent occurrence, in comparison to hospitals and SCHs, where it appears phased discharge is encouraged, where possible.

In several cases, it was stated that individual factors influence whether a young person is able to have a phased discharge/release; this includes individual risk behaviours, as well as location of their new placement/home, and the type of placement they are moving to.

Discussion points

- As per the nature of HDUs and PICUs being shorter term, crisis management units, the average length of stay in these units is estimated (by the service providers) to be shorter than that estimated in Low secure and Medium secure units. Further analysis in the census stage of this project will consider whether these self-reported timeframes are reflective of what actually happens in practice.
- There was some variation in the processes for, and availability of, phased discharge in different places. This varied both between and within unit types. Therefore, it appears there are no standard procedures for use of phased discharge / release. This scoping exercise was unable to clarify how often young people are actually given the opportunity to have a phased release / discharge in each establishment.

3.5 Interventions

3.5.1 Theoretical treatment models

Each unit was asked whether they had an overarching theoretical treatment model / ethos, and if so, what this model was; no definition of a theoretical treatment model was provided, in order to gain an idea of how each individual unit perceived this concept.

Most hospitals (25/28, 89%), some SCHs (10/14, 71%), and a few STCs and YOIs (2/7, 29%) identified as having an overarching theoretical treatment framework (noting that one SCH, and one YOI that did not respond to this question). The remaining hospital units (3/28, 11%) said they were working towards one currently, such that there are no hospitals not working towards or without an overarching treatment model. Similarly, two SCHs (2/14, 14%) and 2 STCs and YOIs (2/7, 29%) were working towards one, which leaves two SCHs (2/14, 14%) and three STCs and YOIs (3/7, 43%) stating that they had no model.

The full range of identified theoretical treatment models is shown in table 15. Similar models/ethos are categorised, in order to better demonstrate the range of different approaches (for example, one unit reported an overarching theoretical treatment model of ‘play, acceptance, and pro-social modelling” – this has been categorised as ‘social learning theory’).

In hospitals, the most common overarching theoretical treatment model category was a selection of non-specific / multi-therapeutic models (7/28, 25%), which grouped models such as the recovery model, bio-psycho-social model, and multi-therapeutic CAMHS, such that there was no common theme. Some of the CAMHS teams in SCH or STCs and YOIs may well describe their work as multi-therapeutic CAMHS or working towards the bio-psycho-social model, but did not. The most commonly identified specific treatment model in hospitals was based on DBT (4/28, 14%). This was not mentioned by any other type of unit.

Across SCHs, STCs, and YOIs, there was also a range of models identified – with most units identifying different models, although the frameworks used by SCHs tended to be more focused on social theories than in hospital settings (for example, corporate parenting and attachment). There is a small amount of cross-over between the types of models used by different settings; a multi-therapeutic milieu was used in several hospitals, SCHs, STCs, and YOIs, and an Attachment orientation was identified in two hospitals and two welfare SCHs, but no other unit types.

Linked with the variety in specialist areas, the wide range of overarching theoretical treatment models identified both between and within different unit types, suggests that each unit has its own ethos, and therefore certain units may be more suited to helping particular young people who are experiencing specific difficulties. It does seem, however, that where hospital units tend to focus on psycho-therapeutic models, the models identified at SCHs are more social-care oriented (in line with these being social care units, using less medicalised models).

It is not clear from this scoping exercise how the theoretical approach influences the interventions offered, as it is not clear which interventions were offered by on-site staff, or bought in through external agencies. It would be interesting to investigate further whether specific theoretical approaches are associated with specific internal provisions.

Table 15. Theoretical treatment models used in each type of unit

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 6)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 3)	Total (N = 47)
Multi-therapeutic milieu	1 (33%)	4 (40%)	1 (13%)	1 (14%)	0 (0%)	3 (60%)	1 (50%)	1 (33%)	1 (33%)	13 (28%)
Environment focus: family values systemic / family therapy attachment nidotherapy	1 (33%)	0	0	3 (43%)	3 (50%)	1 (20%)	0	0	0	8 (17%)
Dialectical behaviour therapy mentalisation based therapy psychodynamic	0	3 (30%)	3 (38%)	0	0	0	0	0	0	6 (13%)
Behavioural focus: risk-needs-responsivity non-violent resistance	1 (33%)	0	1 (13%)	2 (29%)	0	0	0	0	0	4 (9%)
Cognitive focused: cognitive behavioural therapy solution focused ideas	0	1 (10%)	1 (13%)	1 (14%)	0	0	0	0	0	3 (6%)
Social focus: total communications social learning theory	0	0	1 (13%)	0	0	1 (20%)	1 (50%)	0	0	3 (6%)
Working towards a framework	0 (0%)	2 (20%)	1 (13%)	0 (0%)	2 (33%)	0 (0%)	0 (0%)	1 (33%)	1 (33%)	7 (15%)
None	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (17%)	0 (0%)	0 (0%)	1 (33%)	1 (33%)	3 (6%)

3.5.2 Available interventions

Each unit was provided with a list of possible interventions, and asked which ones were available at their unit. The list of interventions is shown in table 15. Units were also offered the opportunity to add any further interventions that were not included on this list. The most common additional intervention was EMDR (eye-movement desensitisation and reprocessing therapy), which was mentioned by seven units. An intervention was considered to be available for young people in unit if they stated that they had access to it; this could be as part of the standard on-site interventions, or via an external service if required.

The average (mean) number of different interventions offered varied by type of unit; hospitals offered the largest number / widest range of different types of intervention (M = 13.7, SD = 2.8), and STCs the least (M = 7.3, SD = 1.7). The average number of interventions available in other unit types was fairly similar (SCH welfare M = 10.8, SD = 5.2; SCH YJB M = 10.5, SD = 2.5; SCH mixed M = 10.8, SD = 3.5; YOI M = 11.5 = 1.9). Of note, hospital units offer the widest range of interventions and have the largest MDT (see table 15). However, SCHs which have the smallest mental health MDT do not have the smallest number of interventions available. It should also be noted that the availability of any specific intervention does not mean this would be available to all young people within that unit.

All units offer psychiatry, psychology, and nursing, to enable assessment, supportive care, medication, and psychological therapy. Education is also offered by all units, but vocational training is only available in 77% of units, understandably being less in the shorter term units.

Speech and language therapy (SALT) availability appeared to depend on size of unit rather than type, in that it was mostly hospital units (where there is likely to be access to shared SALT services), and YOIs and STCs (which are large enough to warrant commissioning an individual service), but less in SCHs.

Behaviour targeted interventions were favoured by the YJB establishments, but also offered by most (11/13, 85%) short term hospital units, and 83% (5/6) welfare SCHs. Fewer longer term hospital units reported using this intervention, though it was still offered in the majority of these units (6/8, 75% low secure and 5/7, 71% medium secure). Vocational training also appears to be favoured by the majority of YJB sites, and is offered in most of the longer term hospitals and welfare SCHs.

Family therapy was offered in most hospitals (25/28, 89%), especially the longer term units, and most YOIs (3/4, 75%), but in few SCHs and no STCs. Of note, as not all units that offer family therapy have a designated family therapist, family therapy is not necessarily carried out by a specialist family therapist, and can be done by a variety of different professionals.

Occupational therapy is lacking in most YJB establishments, but available in most hospital units (27/28, 96%). Sensory interventions, often facilitated by OTs, are also predominantly available to those in hospital units, but less than occupational therapy.

Within hospitals, the longer term interventions (vocational training, DBT, psychodynamic therapy) were, appropriately, not often available in HDUs, which are meant to admit young people for short admission periods. These were more available in PICUs, which are also meant to only admit young people for short periods. Music and art therapy were available more often in the short term units.

Mindfulness interventions were mainly available in hospital settings, seen in most (27/28, 96%) units, but only one third (2/6) welfare SCHs, one quarter (1/4) YOIs, and one fifth (1/5) SCHs that take both welfare and YJB placements. Similarly, DBT was also available in the majority of hospitals (20/28, 71%), but few other units (although the hospitals did not neces-

sarily run a full DBT programme). Conversely, mentalisation based therapy (MBT), which is an alternate to DBT for those with trauma histories and emerging personality disorder, was more widely available to those in YOIs (2/4, 50% units), than hospital (6/28, 21% units) or SCHs (1/6, 17% of the welfare units, and 1/5, 20% SCHs that take both welfare and YJB placements).

Art therapy was the most common creative therapy (although it should be noted that this was self-defined, and may not mean that these units offered access to HCPC accredited art therapy) – this was available in just over half (25/49, 51%) of all units. Music therapy was popular in PICUs (6/10, 60%), but less so in the low secure (1/8, 13%) or medium secure (3/7, 43%) units. It was not available in any YJB-only sites, but available in 17% (1/6) welfare SCHs and 20% (1/5) of mixed SCHs. Drama therapy and dance therapy were much less available across the sites, only being available in around half (6/13) short term and (3/7) medium secure units, and around a quarter (4/14) of SCHs.

MBT, dance therapy, and EMDR were the least commonly available interventions.

Table 16. Interventions offered by each type of unit

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 6)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 48)
Psychology	3 (100%)	10 (100%)	8 (100%)	7 (100%)	6 (100%)	5 (100%)	2 (100%)	3 (100%)	4 (100%)	100%
Medication management	3 (100%)	10 (100%)	8 (100%)	7 (100%)	6 (100%)	5 (100%)	2 (100%)	3 (100%)	4 (100%)	100%
Behaviour targetted interventions	2 (67%)	9 (90%)	6 (75%)	5 (71%)	5 (83%)	5 (100%)	2 (100%)	3 (100%)	4 (100%)	85%
Vocational training	1 (33%)	6 (60%)	7 (88%)	7 (100%)	5 (83%)	4 (80%)	2 (100%)	3 (100%)	2 (50%)	77%
Speech and language therapy	2 (67%)	7 (70%)	6 (75%)	7 (100%)	3 (50%)	4 (80%)	1 (50%)	3 (100%)	3 (75%)	75%
Cognitive skills training	3 (100%)	5 (50%)	6 (75%)	7 (100%)	3 (50%)	4 (80%)	2 (100%)	1 (33%)	2 (50%)	69%
Occupational therapy	3 (100%)	9 (90%)	8 (100%)	7 (100%)	1 (17%)	1 (20%)	0%	1 (33%)	3 (75%)	69%
family therapy	3 (100%)	8 (80%)	8 (100%)	6 (86%)	2 (33%)	2 (40%)	0%	0%	3 (75%)	67%
Mindfulness	3 (100%)	10 (100%)	7 (88%)	7 (100%)	2 (33%)	1 (20%)	0%	0%	1 (25%)	65%
Targeted group	1 (33%)	8 (80%)	4 (50%)	4 (57%)	4 (67%)	3 (60%)	1 (50%)	1 (33%)	3 (75%)	60%
DBT	2 (67%)	6 (60%)	6 (75%)	6 (86%)	2 (33%)	2 (40%)	0%	0%	2 (50%)	54%
Art therapy	2 (67%)	8 (80%)	2 (25%)	4 (57%)	3 (50%)	2 (40%)	1 (50%)	1 (33%)	2 (50%)	52%
Sensory interventions	2 (67%)	6 (60%)	4 (50%)	5 (71%)	2 (33%)	0%	1 (50%)	0%	1 (25%)	44%
Psychodynamic	0%	6 (60%)	1 (13%)	1 (14%)	2 (33%)	2 (40%)	0%	1 (33%)	2 (50%)	31%
Open dynamic group	2 (67%)	5 (50%)	2 (25%)	0%	3 (50%)	0%	1 (50%)	0%	1 (25%)	29%
music therapy	1 (33%)	6 (60%)	1 (13%)	3 (43%)	1 (17%)	1 (20%)	0%	0%	0%	27%
drama therapy	1 (33%)	5 (50%)	0%	3 (43%)	3 (50%)	1 (20%)	0%	0%	0%	27%
dance therapy	0%	4 (40%)	0%	3 (43%)	1 (17%)	0%	1 (50%)	0%	0%	21%
MBT	1 (33%)	3 (30%)	1 (13%)	1 (14%)	1 (17%)	1 (20%)	0%	0%	2 (50%)	21%
EMDR	0%	3 (30%)	1 (13%)	0%	0%	2 (40%)	0%	0%	1 (25%)	15%

3.5.3 MDT staff profile

Each unit was asked to describe their commissioned MDT staffing profile for mental health staff (see table 17). All units that responded to this question stated that they were commissioned to have at least one psychiatrist working at the unit, with many units (mostly hospitals) stating that they also had junior doctors. Psychology provision was common across all units (whether this be a qualified clinical / counselling / forensic psychologist, or cognitive behavioural therapy (CBT) / other psychological therapist), and was available in nearly all units; only one SCH did not mention a psychologist/other psychological therapist being part of their mental health MDT. This does not correspond to the list on interventions available (see interventions section), where 100% of units had access to psychology or other psychological therapy provision. This suggests that the SCH that did not have a psychologist in their MDT will have had access to a psychologist from a different team or from an external source.

In addition, mental health / learning disability nurses, or other CAMHS practitioners were present in the mental health teams of all responding YOIs, STCs, and all except one SCH (mixed unit). In hospitals, mental health nurses are assumed to be the main care staff on the ground in the same way as prison officers are in STC/YOIs, and residential care staff in SCHs; the numbers of these are covered separately in section 3.5.8 Staff ratios).

Creative therapists (art / music / drama / dance therapists) were more common in hospital units (with all medium secure units that responded to this question having a creative therapist in their team) than other units. Only one STC and one YOI and no SCHs mentioned a creative therapist. Also, no HDUs mentioned this provision. It should be noted that presence of creative therapists does not necessarily correlate with the number of units having access to creative arts therapies (as in some cases a creative-type therapy was used, without being run by an HCPC registered arts therapist).

Similarly, hospital units were more likely to have a family therapist as part of their team – the only non-hospital unit to have a family therapist was an STC. As with creative therapists, these figures do not match the number of units offering a family therapy intervention, as this can be carried out by clinicians from other professions with family therapy expertise.

Most hospitals commissioned a social worker; although this is only reported in one other unit (one SCH), this does not mean that there are no social workers in other types of unit, just that they do not form part of the mental health MDT. In SCHs, social workers are the core care staff, and in STCs and YOIs social workers are often part of other teams (such as safeguarding and casework), but this was not specifically asked about in this scoping exercise.

It appears that hospital settings tend to have the widest variety of professionals in their MDT, and SCHs the least, only reporting psychiatry and psychology input.

Thirteen units did not respond to this question (nine hospitals, three SCHs, one YOIs), which in itself is interesting, given the more complete sets of responses to other questions.

Table 17. Commissioned MDT staff professions

	HDU (N = 3)	PICU (N = 8)	Low (N = 5)	Medium (N = 3)	SCH welfare (N = 4)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 3)	Total (N = 36)
Consultant psychiatrist	3 (100%)	8 (100%)	5 (100%)	3 (100%)	4 (100%)	5 (100%)	2 (100%)	3 (100%)	3 (100%)	**36 (100%)**
Other psychiatrist	3 (100%)	7 (88%)	4 (80%)	2 (67%)	0%	1 (20%)	0%	0%	3 (100%)	**20 (56%)**
Psychologist	3 (100%)	8 (100%)	5 (100%)	3 (100%)	4 (100%)	4 (80%)	2 (100%)	3 (100%)	3 (100%)	**35 (97%)**
Creative therapist	0%	5 (63%)	1 (20%)	3 (100%)	0%	0%	0%	1 (33%)	1 (50%)	**11 (31%)**
Family therapist	3 (100%)	4 (50%)	4 (80%)	2 (67%)	0%	0%	0%	1 (33%)	0%	**14 (39%)**
Assistant psychologist	1 (33%)	3 (38%)	3 (60%)	1 (33%)	1 (25%)	1 (20%)	0%	2 (67%)	3 (100%)	**15 (42%)**
Social worker	2 (67%)	6 (75%)	4 (80%)	3 (100%)	0%	1 (20%)	0%	0%	1 (50%)	**17 (47%)**
Occupational therapist	3 (100%)	7 (88%)	5 (100%)	3 (100%)	0%	0%	0%	1 (33%)	2 (50%)	**21 (58%)**
Occupational therapy assistant	0%	6 (75%)	3 (60%)	1 (33%)	0%	0%	0%	0%	1 (50%)	**11 (31%)**

3.5.4 Mental health reviews

All units were asked how frequently the young people had mental health reviews (see table 18). This question was interpreted inconsistently (as a mental health review could be defined in several different ways in each setting). In hospitals, most reported the frequency of the MDT reviews / ward rounds, although some mentioned timings for individual mental state examinations / individual consultant reviews. In SCHs and other YJB settings, most reported the frequency of individual CHAT (comprehensive health assessment tool) reviews, or equivalent.

In addition, it is known that in one medium secure unit, there are seclusion reviews, which involves a second opinion doctor reviewing a young person after a stay of seven days in seclusion. This has not been included in the analysis below, as this was not explicitly asked about, or mentioned by other units.

Unsurprisingly, mental health reviews were most frequent in hospital settings, with reviews on average every 1.8 weeks. It is interesting to note that in HDUs, PICUs, and low secure units, the average frequency of mental health reviews was between 0.14 and 12 weeks, on average two weeks, but the average for medium secure units was every 0.7 weeks. In comparison, young people in SCHs had mental health reviews on average every 5.5 weeks, in STCs every four weeks, and in YOIs the CHAT mental health screen is completed for all young people every 12 weeks, although team meetings review the needs of the young people on their caseload more often.

Although all hospital units gave specified time frames for regular mental health reviews, two welfare SCHs, one STC, and one YOI stated unspecified timings for reviews – that is, mental health reviews occurred on admission, but then as needed dependent on the individual, rather than at specified times. It is thought that as CHAT screening is starting to be used in more units, the number of units with unspecified timeframes for mental health reviews will decrease.

Table 18. Range of timings for mental health reviews

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 6)	SCH welfare (N = 6)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 2)	YOI (N = 3)
Average weeks	2.0	2.0	2.3	0.7	4.5	5.8	6.5	4.0	12.0
Minimum	1	0.28	0.14	0.14	1	1	1	4	12
Maximum	4	12	12	1	12	12	12	4	12
Unspecified	0	0	0	0	2	0	0	1	1

3.5.5 Second opinions

The hospital units were asked whether there was a process for second opinion or review, if a young person has had a particularly long admission. There were differing perceptions of what this question related to; a few units responded in terms of standard Mental Health Act (MHA) review timings, and others in terms of additional reviews if needed (not necessarily due to length of admission, other factors included lack of response to treatment, or by request from the young person or their parent/carer). In order to find out where second opinion / reviews were possible, outside of the usual MHA reviews, it is assumed that units that specified MHA reviews in response to this question do not have a process for additional second opinions or reviews. The majority of hospitals had a process for second opinion or review, whether this was formal or informal, although this was less common amongst PICUs than other units (see table 19).

Table 19. Second opinion reviews in hospital units

	HDU (N = 3)	PICU (N = 10)	Low (N = 7)	Medium (N = 7)	Total (N = 27)
Second opinion / review: Yes	3 (100%)	6 (60%)	6 (86%)	5 (71%)	20 (74%)
Second opinion / review: No	0	4 (40%)	1 (14%)	2 (29%)	7 (26%)

3.5.6 Exercise facilities

Each unit was asked whether the young people there had access to exercise facilities such as gym and swimming pool. This does not necessarily mean that the facilities were on site, but that the young people at the unit have access to these facilities. Every unit had access to some kind of exercise facilities. Two hospital units did not state the types of facilities available. Excluding these, all had access to a gym (or similar indoor exercise facilities) – although one HDU mentioned that this was access to a local gym, for young people who were allowed local leave. Swimming pools were less common, and not available in any STCs and YOIs, and only reported to be available in six (21/28) hospitals, and one (1/14, 7%) SCH. It is likely that some places also had additional exercise facilities not included in these categories; although not all specified any additional ones, one unit mentioned a climbing wall.

3.5.7 Alcohol and substance misuse services

In 100% of SCHs and STCs and YOIs, an alcohol or substance misuse service was available. Similarly, a service was available for this purpose in all seven of medium secure hospital units too, and seven (7/8, 88%) of low secure units. However, an alcohol or substance misuse service was only available in one (1/3, 33%) HDUs and six (6/10, 60%) PICUs, which are short term units.

These units were asked to specify whether the service was internally available (for example, as part of a targeted group programme, or with specifically training unit staff), or via a service external to the unit. One STC did not respond to this part of the question. Table 20 below shows the percentages of units with an alcohol / substance misuse service available that had either an external or internal service (or both). Across all unit types, there was a fairly even spread of units where an alcohol / substance misuse service could be provided internally, or externally. An internal service was slightly more common than an external service in SCHs, but slightly less common amongst hospital units.

Table 20. Percentage of units offering substance / alcohol misuse services

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
External service	1 (33%)	3 (30%)	4 (50%)	4 (57%)	3 (43%)	1 (20%)	1 (50%)	2 (67%)	1 (100%)
Internal service	0%	3 (30%)	3 (38%)	2 (29%)	4 (57%)	4 (80%)	1 (50%)	1 (33%)	0%
Both internal and external services available	0%	0%	0%	1 (14%)	0%	0%	0%	0%	0%
No service available	2 (67%)	4 (40%)	1 (13%)	0%	0%	0%	0%	0%	0%

3.5.8 Staff ratios

Each unit was asked how many staff members were on each shift (day / night). These figures include nursing staff (qualified nurses and HCAs), or equivalent core staff on the ground (eg prison officers, residential care staff) – excluding the MDT. In hospital units, it was noted that the number of nursing staff would vary dependent on the level of observations needed for the individuals in the unit at any particular time. Both waking and sleeping staff are included in these figures, where units specified these types. Units provided the number of staff on each shift, and these were split into day/night equivalent (where some had multiple day-time shifts, this was averaged to create an overall 'day' figure). To enable comparison, ratios for the number of staff per young person were calculated using the maximum number of young people who could be accommodated in the unit at any one time; therefore, these ratios represent the minimum number of staff available. Table 20 outlines the average ratio of staff to each young person across all unit types.

The average number of staff to each young person on both day and night shifts was significantly higher in hospitals (day – M = 0.70, SD = 0.36; night – M = 0.56, SD = 0.28) and SCHs (day – M = 0.58, SD = 0.11; night – M = 0.40, SD = 0.14) than STCs / YOIs (day – M = 0.27, SD = 0.18; night – M = 0.14, SD = 0.10; for both comparisons, t (33) > 2.43, $p < .05$). There was no significant difference between the staff ratios at hospitals and SCHs, on either day or night shifts, $p > .05$. Therefore, it appears that STCs and YOIs have significantly fewer staff (on the ground) to young people on both day and night shifts, in comparison to other types of unit.

In terms of raw numbers, the average ratio of staff to each young person on day and night shifts was highest in hospital settings, with the overall highest average ratio of staff to young people being in PICUs (a mean of 0.72 staff to one young person during the day, 0.71 staff to one young person during the night) – there was little difference between the staff ratios on day and night shifts in this setting, which was unusual in comparison to the other units, where there were usually fewer staff at night.

Interestingly, low and medium secure units that specialise in LD had higher averages of nursing staff on day shifts than other hospitals – 0.97 staff to one young person in low secure LD units, and 1.21 staff to one young person in the medium secure LD unit. At night,

however, these ratios were more similar to other low/medium secure units (an average of 0.64 staff to one young person in both the low and medium secure LD units).

Welfare settings tended to have a higher ratio of staff to young people than did YJB settings (in welfare settings, during the day there was an average of 0.65 staff to one young person and at night an average of 0.36 staff to one young person, compared to SCHs that take YJB placements, and STCs and YOIs. In particular, YOIs had the lowest ratios of staff to young people on both day and night shifts (a mean of 0.13 staff to one young person during the day, and a mean of 0.10 staff to one young person at night).

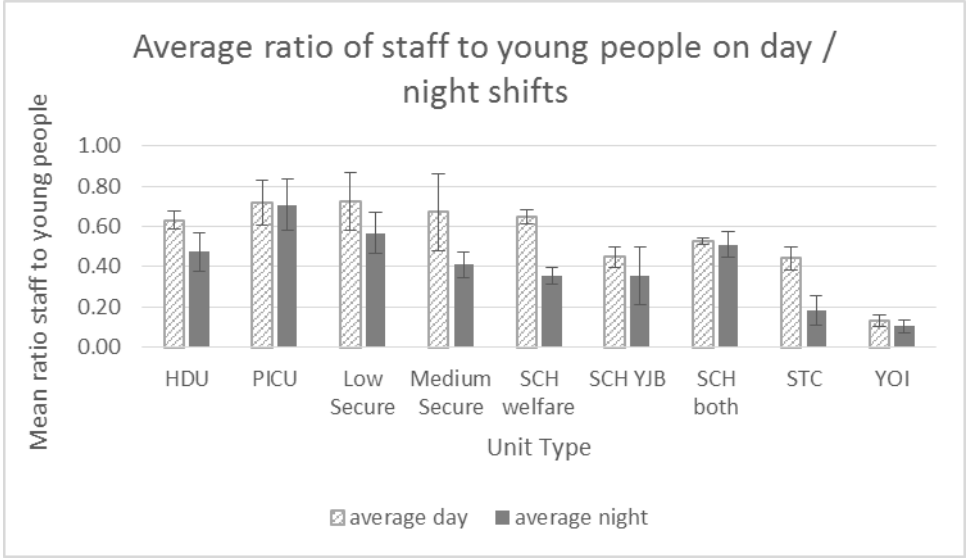
Notably, young people in hospitals are not locked in their rooms at night, but those in SCHs, STCs, and YOIs are. Though there is a statistically significant difference between staffing ratios in hospitals and STCs/YOIs both during the day and at night, this is not the case for SCHs. More specifically, there is not much difference between night staffing ratios between medium secure units and welfare SCHs.

Table 21. Average ratio of core staff to 1 young person on each shift

	HDU (N = 3)	PICU (N = 8)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 4)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Average day	0.63	0.72	0.73	0.67	0.65	0.53	0.45	0.44	0.13
Average night	0.48	0.71	0.57	0.41	0.36	0.51	0.35	0.18	0.10
Range day	0.54 - 0.69	0.21 - 1.25	0.15 - 1.50	0.25 - 1.71	0.50 - 0.78	0.50 – 0.58	0.40 - 0.50	0.33 - 0.50	0.08 - 0.21
Range night	0.38 – 0.67	0.14 - 1.25	0.10 - 1.00	0.20 - 0.70	0.20 - 0.50	0.33 – 0.63	0.21 - 0.50	0.09 - 0.33	0.05 - 0.14

Figure 5. Average ratio of staff to young people on night and day shifts in each type of unit

Error bars represent standard error



Each unit was asked whether there were staff who could be pulled in from other units or other areas (or similar), if an emergency response to an alarm call was needed. All hospital units and all STCs and YOIs had this provision, but only eleven (11/14, 79%) of SCHs. One additional SCH specified that they did have staff who could respond to an emergency incident, but only during day time hours (due to the small size of the unit).

Number of night staff and young people locked in rooms at night
In general, hospitals had higher ratios of staff to young people on the night shift, and young people were not locked in their rooms; this is as expected, as if young people are not locked in their rooms then more staff will need to be available in order to ensure safety.

Table 22. Comparison of core staff on night shifts and units where young people are locked in rooms at night

	HDU N=3	PICU N=10	Low N=8	Medium N=8	SCH welfare N=7	SCH mixed N=5	SCH YJB N=2	STC N=3	YOI N=4
Locked at night	0 0%	0 0%	0 0%	0 0%	7 100%	5 100%	2 100%	3 100%	4 100%
Average ratio staff to young people (night)	0.48	0.71	0.57	0.41	0.36	0.53	0.35	0.18	0.10

3.5.9 Access arrangements
Access to bedrooms:

Each unit was asked whether the young people were locked in their rooms at night (and therefore not able to leave their room by choice). There was a large difference across the settings; young people were not locked in their rooms overnight in any hospital, but all SCHs and STCs and YOIs responded that young people were locked in at night.

Whether young people have access to their bedrooms during the day was more complicated. The majority of young people in secure units are able to access their bedrooms during the day (dependent on individual care plan arrangements), although some specified that young people 'sometimes' had access to their rooms – for example, not during education hours. In most cases, it was not clear from this data whether those who responded 'yes' meant that young people could access their bedrooms at all times during the day, or only at specific times; further investigation is needed.

All HDUs, PICUs, SCHs, and STCs allow young people access to their rooms at some points during day time hours. In comparison, one (1/8, 13%) low secure units, two (2/7, 29%) medium secure units, and two (2/4, 50%) YOIs stated young people were not allowed to access their rooms during the day (see table 23). In the case of YOIs, however, it is assumed that if a young person refused to go to education, they would remain confined to their room.

Table 23. Percentages of units allowing access to bedrooms during the day

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Yes	3 (100%)	8 (80%)	4 (50%)	4 (57%)	7 (100%)	5 (100%)	2 (100%)	3 (100%)	1 (25%)
Some-times	0%	2 (20%)	3 (38%)	1 (14%)	0%	0%	0%	0%	1 (25%)
No	0%	0%	1 (13%)	2 (29%)	0%	0%	0%	0%	2 (50%)

Note: due to rounding, aggregated figures may not be exactly 100%.

Access to external health and education services

Each unit was asked whether the young people were ever escorted off site for external health or education purposes. In all units, young people could be escorted off-site for health appointments, and in some also for education purposes (eg to take exams, or attend college classes). It was less common for young people in hospital settings to be escorted off site for education purposes than in other types of unit (five medium secure, one low secure, and two PICUs specified that young people could only be escorted off-site for health purposes, but not education). It is interesting to note that medium secure units appear to escort young people off-site for education less often than any other type of unit, but it is not clear from this scoping exercise, whether this influences the quality or variety of education available to these young people.

Table 24. Access to external health and education services

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 2)	YOI (N = 4)	Total (N = 48)
Health	3 (100%)	10 (100%)	8 (100%)	7 (100%)	7 (100%)	5 (100%)	2 (100%)	2 (100%)	4 (100%)	48 (100%)
Education	3 (100%)	8 (80%)	7 (88%)	2 (29%)	6 (86%)	4 (80%)	2 (100%)	1 (50%)	4 (100%)	37 (77%)

Internet access

Each unit was asked whether young people were able to access the internet, and under how much supervision. Most units responded that young people did have access to internet, including all hospitals, but detail was not given about where or when. The only units to respond that young people did not have access to the internet at all were two STCs and three YOIs; see table 25.

Table 25. Access to internet in each type of unit

	HDU (N = 3)	PICU (N = 9)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 48)
Number yes	3 (100%)	9 (100%)	8 (100%)	7 (100%)	7 (100%)	5 (100%)	2 (100%)	1 (33%)	1 (25%)	43 (89%)
Number no	0	0	0	0	0	0	0	2 (67%)	3 (75%)	5 (11%)

In terms of the level of supervision, there were a wide variety of responses, with some units focusing on other restrictions (e.g. firewalls, limited access to websites), rather than the level of staff supervision. Of the units that specified young people could access the internet, 86% stated this was under supervision (which could vary from groups to 1:1 supervision, and the level of supervision was often dependent on individual care plans). Only 1 unit (a PICU) specified that internet access on the ward was unsupervised (internet in these cases was access via mobile phones), and the remaining six (6/49, 12%) of units were unclear about the level of supervision that would be used.

Twenty four (24/49, 49%) of all units explicitly mentioned restrictions that would be in place for internet use (e.g. firewalls and other restrictions to prevent young people accessing certain websites, in some cases, individualised firewalls were used, dependent on individual care plans). Four SCHs did not mention firewalls / other content restrictions, nor did 18 hospitals. However, it cannot be assumed that these 22 units did not restrict the content of internet usage, as this was not explicitly asked by the question. Additionally, some units stated that internet could only be used at certain times – such as in education, or specified times at weekends. As the initial question did not explicitly ask about timings for internet usage, it is not clear if there are restrictions on timings in other units too, and therefore this has not been analysed.

Discussion points

- There is a variety in range of professionals at the different types of secure unit and range of interventions available. Hospitals appear to have a wider variety of both professions represented in their MDTs and therapeutic interventions offered, compared to other units. It is likely that this is because the prime purpose of hospitals is to provide a therapeutic environment to manage mental health difficulties, compared to welfare secure and the YJS, where the purpose and focus of the units appears to be less on mental health and therapeutic work and more about social interventions or rehabilitation respectively.

- The numbers of staff available also varies, with criminal justice settings (particularly YOIs and STCs) having lower ratios of staff to young people. Lower staff / young people ratios are likely to limit the input available to each individual.

3.6 Education

3.6.1 Education hours

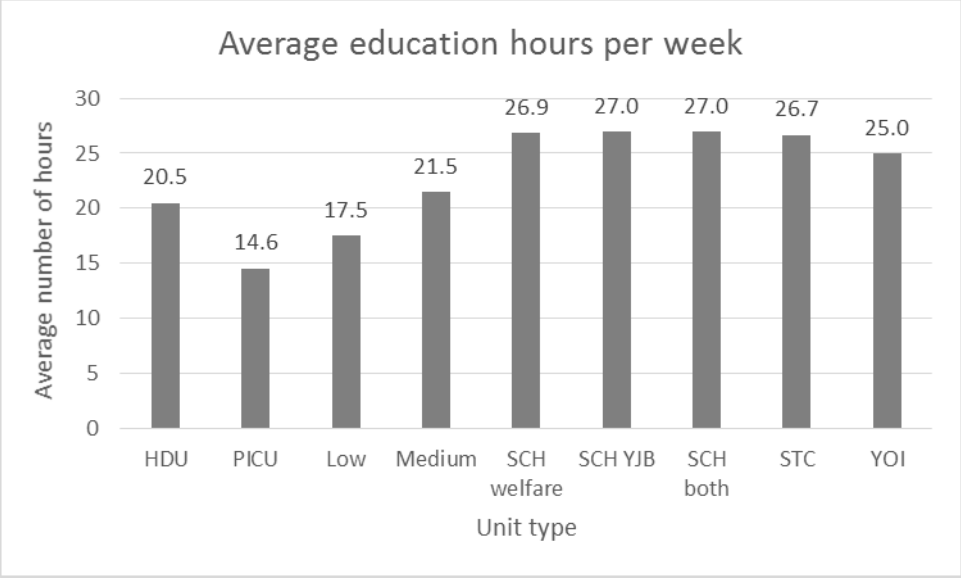
Each unit was asked how many hours per week are allocated for education (see table 26). It is assumed that these figures represent the minimum required number of hours (in some cases, the figure was specified as the minimum, but some young people may do more). In some cases, exact hours were not known, but timings equivalent to a full school day were suggested; in these instances, it is assumed that 25 hours per week are spent in education, excluding breaks[14].

On average, hospitals had significantly fewer hours allocated to education (M = 17.67, SD = 6.49), than both SCHs (M = 27.00, SD = 3.80; t (39) = -4.94, p = .001) and STC/YOIs (M = 25.71, SD = 5.35; t (32) = -3.01, p = .003), which were comparable with each other (p > .05). Therefore, hospitals tend to have the fewest number of hours allocated to education. There was no significant difference between the average hours for education in short stay (HDU / PICU) compared to long stay (low / medium secure) hospital (p > .05).

In hospitals, PICUs tended to have the lowest number of hours dedicated to education each week (M = 14.6).

The difference in number of hours of education in hospitals compared to other settings could be linked to the daily structure in each type of unit; in hospitals, there will be a focus on therapeutic activities and interventions, as well as education, whereas education may be the main daily activity in other types of unit.

Figure 6. Average number of hours allocated to education per week



[14] It is assumed that a standard school day lasts from 09:00 to 15:00 with a one hour break for lunch. This results in a 5-hour day, and therefore a total of 25 hours across a 5-day week.

Table 26. Range of hours allocated to education in each type of unit

	HDU (N = 2)	PICU (N = 10)	Low (N = 5)	Low LD (N = 3)	Medium (N = 5)	Medium LD (N = 2)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Average	20.5	14.6	17.8	17.0	23.5	16.5	26.9	27.0	27.5	26.7	25.0
Minimum	16	6	9	8	17.5	8	25	25	25	25	15
Maximum	25	22.5	22	25	25	25	38	30	30	30	30

Refusal of education:
Each unit was asked where a young person would go if they refused education, and what they would do during this time. There were three different responses to this question: their room, remain on the main unit/ward, or not specified. In the cases where it was stated that the young person would go to their room, it is assumed that this means they would be confined to their room. For those who would remain on the unit/ward, some were allowed access to their rooms during this time, others were not; as this was not explicitly asked about by the question, further investigation is needed to identify the arrangements at specific units. Units that did not provide a specific answer to this question focused their response on what the young person would be doing during this time, or the consequences of missing education, rather than where they would go.

No hospital (out of those that responded to this question) and only a few (2, 29%) welfare SCHs confined young people to their rooms if they refused education (see table 27). Conversely, all YJB only placements reported that young people were confined to their rooms, or it was unclear from their response where specifically the young person would go in this situation.

Table 27. Where young people go if they refuse education

	HDU (N = 2)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Room	0%	0%	0%	0%	2 (29%)	1 (20%)	1 (50%)	0%	2 (50%)
Unit / ward	2 (100%)	9 (90%)	6 (75%)	7 (100%)	5 (71%)	4 (80%)	0%	3 (100%)	0%
Unknown	0%	1 (10%)	2 (25%)	0%	0%	0%	1 (50%)	0%	2 (50%)

The majority of units did not specify what the young person would do during the time they refused to go to education, instead focusing their response on where the young person would go. The most common response following this was that if a young person refused to go to education, they would do some form of outreach education (whether this be one to one teaching on the unit, or homework, or similar); this was the case for 16 units, including 75% of YOIs (see table 28). Interestingly, whilst several hospital units specified that young people who refused education would be engaged in other meaningful activity during this time, no other type of unit specified this option. Two units (one PICU and one welfare SCH) stated that the young person would do nothing during this time, or would be left alone. Two YOIs additionally stated that the young person would either get a warning through the Incentive and Earned Privileges system, or a member of the psychology team would be brought in to help identify why the young person was refusing education. Several units commented that the young people rarely refused education.

Table 28. What young people do during the day if they refuse education

	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)	Total (N = 49)
Outreach education	1 (33%)	2 (20%)	2 (25%)	1 (14%)	2 (29%)	2 (40%)	2 (100%)	1 (33%)	3 (75%)	16 (33%)
Meaningful activity	1 (33%)	5 (50%)	3 (38%)	2 (29%)	0	0	0	0	0	11 (22%)
Nothing	0	1 (10%)	0	0	1 (14%)	0	0	0	0	2 (4%)
Unknown	1 (33%)	2 (20%)	3 (38%)	4 (57%)	4 (57%)	3 (60%)	0	2 (67%)	1 (25%)	20 (41%)

Note: one welfare SCH and two YOIs gave multiple options, and therefore the figures do not add up to the total number of units.

Access to rooms and refusal of education:

Table 29 shows a comparison of the units where young people have access to their rooms during day time hours, and where they would go if they refused education. There appears to be little consistency across these two variables; it appears that in some cases where a young person who refuses education would remain on the unit, they would have access to their rooms, but not in all cases. The way the responses to these two questions were gathered makes it difficult to ascertain the specific circumstances (for example, which exact areas of a unit a young person would have access to if they refused education, or whether having access to their rooms means they also have access to other areas of the unit during this time). Therefore, further investigation is needed before conclusions can be drawn.

Table 29. Comparison of units where young people can access their rooms during day time, and where they go if they refuse education

	HDU N=3	PICU N=10	Low N=8	Medium N=7	SCH welfare N=7	SCH mixed N=5	SCH YJB N=2	STC N=3	YOI N=4
Access to room? Yes	3 (100%)	8 (80%)	4 (50%)	4 (57%)	7 (100%)	5 (100%)	2 (100%)	3 (100%)	1 (25%)
Access to room? Sometimes	0%	2 (20%)	3 (38%)	1 (14%)	0%	0%	0%	0%	1 (25%)
Not in education? Stay in room	0%	0%	0%	0%	2 (29%)	1 (20%)	2 (50%)	0%	2 (50%)
Not in education? Stay on unit	1 (100%)	9 (90%)	6 (75%)	7 (100%)	5 (71%)	4 (80%)	0%	3 (100%)	0%

Note: not all units responded to both questions represented in this table

3.6.2 Subjects and qualifications

Each unit was asked what the highest level qualification a young person could work towards was; this could be a vocational or academic qualification (see table 30). In some cases, it was specified that the young people at the unit could work towards anything they were already doing in their home school – for these cases, the highest qualification was assumed to be A level. For this scoping exercise, the highest level of qualification was coded according to the Regulated Qualifications Framework, where GCSE or equivalent is level 2, and A level or equivalent is level 3[15].

The majority of units allowed young people to work towards a maximum of a level 3 qualification (24/28, 85% hospitals, 9/14, 64% SCHs, 4/7, 57% STCs and YOIs). However, the majority of SCHs that only take welfare placements (4/7, 57%) stated level 2 qualifications were the highest that a young person could work towards. In comparison, no SCHs that only take YJB placements identified level 2 as the maximum level qualification, and only one SCH that can take both YJB and welfare placements (1/5, 20%). Similarly, only four hospitals (4/28, 14%) and three STCs and YOIs (3/7, 43%) identified level 2 as the highest level qualification someone could work towards.

[15] https://www.gov.uk/what-different-qualification-levels-mean/compare-different-qualification-levels

Table 30. Highest qualification type that can be worked towards

	HDU (*N* = 3)	PICU (*N* = 10)	Low (*N* = 8)	Medium (*N* = 7)	SCH – welfare (*N* = 7)	SCH – both (*N* = 5)	SCH – YJB (*N* = 2)	STC (*N* = 3)	YOI (*N* = 4)
A level (Level 3)	1 (33%)	9 (90%)	6 (75%)	7 (100%)	2 (29%)	4 (80%)	2 (100%)	1 (33%)	1 (25%)
BTEC (Level 2/3)	0%	0%	0%	0%	1 (14%)	0%	0%	0%	3 (75%)
GCSE (Level 2)	1 (33%)	0%	1 (25%)	0%	4 (57%)	1 (20%)	0%	2 (67%)	0%
Function-al Skills (Level 2)	0%	1 (10%)	0%	0%	0%	0%	0%	0%	0%
Unknown	1 (33%)	0%	0%	0%	0%	0%	0%	0%	0%

One PICU noted that they only provide functional skills training for young people at their unit (see table 31). Units provided descriptions of the range of subjects that young people could study, and these responses have been classified as either fulfilling the full national curriculum for Key Stage 4[16], partial curriculum (academic subjects, but not covering the full curriculum), or vocational subjects. In some cases, there were multiple things on offer; some units offered full or partial national curriculum, as well as a selection of vocational studies. The findings show that vocational studies are least common in hospitals settings, but also in STCs. Mental health units tended to offer more academic subjects, with 68% offering the full academic curriculum.

[16] https://www.gov.uk/national-curriculum/key-stage-3-and-4

Table 31. Academic and vocational education opportunities at each type of unit

	HDU (N = 3)	PICU (N = 9)	Low (N = 8)	Medi-um (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
full curriculum	1 (33%)	7 (70%)	5 (63%)	4 (57%)	4 (57%)	2 (40%)	2 (100%)	2 (67%)	0%
partial cur-riculum	1 (33%)	2 (20%)	2 (25%)	3 (43%)	3 (43%)	3 (60%)	0%	1 (33%)	2 (50%)
vocational	0%	3 (30%)	3 (38%)	4 (57%)	4 (57%)	4 (80%)	1 (50%)	1 (33%)	3(75%)
Unknown	1 (33%)	1 (10%)	1 (13%)	0%	0%	0%	0%	0%	0%

3.6.3 Qualification levels and external education:

Table 32 shows the highest level qualifications young people can work towards in each unit, in comparison to whether the young people can be escorted off-site for education purposes (for example, to attend courses at college). There appears to be little consistency in the proportions of units that have each type of qualification, and whether the young people can attend external education programmes (for example, at their home college or school).

Table 32. Comparison of qualification types and whether young people can access external education

	HDU N=3	PICU N=10	Low N=8	Medium N=7	SCH welfare N=7	SCH mixed N=5	SCH YJB N=2	STC N=3	YOI N=4
A level	1 (33%)	9 (90%)	6 (75%)	7 (100%)	2 (29%)	3 (60%)	2 (100%)	33%	25%
BTEC	0%	0%	0%	0%	1 (14%)	0%	0%	0%	75%
GCSE	1 (33%)	0%	2 (25%)	0%	4 (57%)	1 (20%)	0%	67%	0%
Functional Skills	0%	1 (10%)	0%	0%	0%	0%	0%	0%	0%
Escorted off-site for education	3 (100%)	8 (80%)	7 (88%)	2 (29%)	6 (86%)	4 (80%)	2 (100%)	1 (50%)	4 (100%)
unkonwn	0	0	0	0	0	1 (20%)	0	0	0

Note: not all units responded to all questions represented in this table

3.6.4 Teaching staff ratios

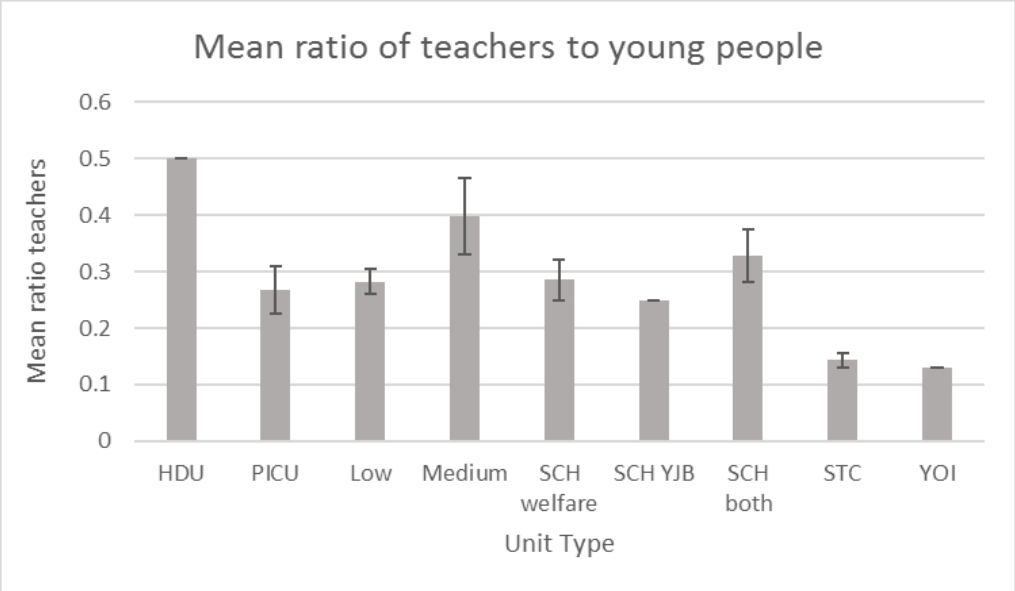
The average proportion of teachers to young people was higher in hospitals (M = 0.33, SD = 0.14) and SCHs (M = 0.30, SD = 0.09) compared to STC/YOIs (M = 0.14, SD = 0.02; for both comparisons, $t > 3.43$, $p < .05$). There was no significant difference between the average proportion of teachers to young people between hospital and SCHs ($p > .05$). Therefore, hospital and SCH units had on average similar proportions of teachers to young people, significantly higher proportions than in STC/YOI settings. These figures were based on the lowest number of teachers reported at each unit (where some units gave a range, the minimum was taken for purposes of this analysis). This is important, because those in STCs and YOIs are required to have a longer time in education, although clearly less funds are available to provide staff for these classes.

Table 33. Average ratio of teachers to one young person

	HDU (N = 2) 1 did not answer	PICU (N = 10)	Low Secure (N = 7) 1 did not answer	Medium Secure (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
average proportion of teachers to young people	0.50	0.27	0.28	0.40	0.29	0.33	0.25	0.14	0.13
Minimum	0.5	0.1	0.25	0.25	0.25	0.25	0.25	0.13	0.13
Maximum	0.5	0.5	0.4	0.71	0.5	0.5	0.25	0.17	0.13

Figure 7. Graph showing average ratio of teachers to one young person in each type of unit

Error bars represent standard error



3.6.5 Term times

Seventy-seven percent of all units followed term times (or, their own version of a term-time structure, which may not coincide with standard school term dates). The majority of hospital units followed term time structures, as did the majority of SCHs. However, this is not seen in STCs or YOIs, who run a continuous education programme except for weekends and bank holidays (see table 34).

Those units that do follow a term time structure were asked what young people do outside of term time (in place of school education, not in place of other aspects of daily routine, eg usual therapeutic work). In all cases, the young people had something to do outside of term time. In all hospitals and welfare SCHs (along with mixed SCHs), this was described as enrichment activities or a therapeutic programme. One SCH YJB unit that had a term time structure used a vocational programme during this time.

Table 34. Number of units following a term-time structure for education

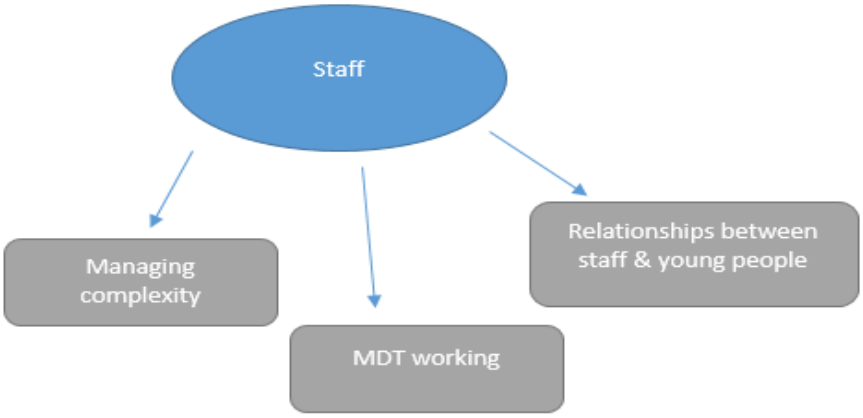
	HDU (N = 3)	PICU (N = 10)	Low (N = 8)	Medium (N = 7)	SCH welfare (N = 7)	SCH mixed (N = 5)	SCH YJB (N = 2)	STC (N = 3)	YOI (N = 4)
Term time: yes	2 (67%)	10 (100%)	6 (75%)	6 (86%)	7 (100%)	5 (100%)	1 (50%)	0	0
Term time: no	0	0	2 (25%)	1 (14%)	0	0	1 (50%)	3 (100%)	4 (100%)
Unknown	1 (33%)	0	0	0	0	0	0	0	0

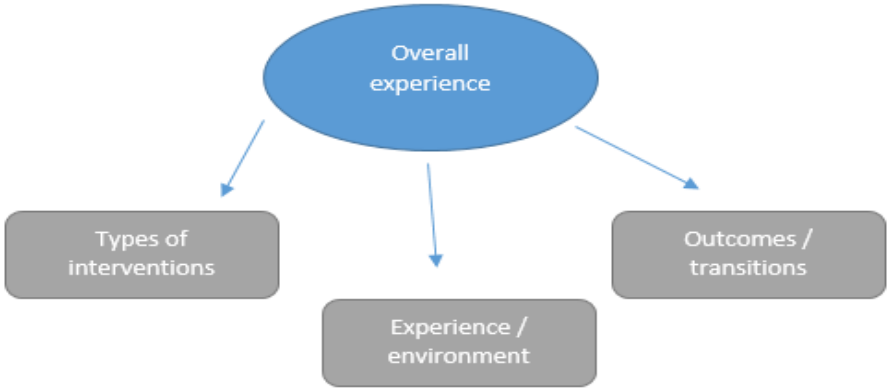
Discussion points

- On average, hospitals appeared to provide fewer education hours per week than other settings. However, whilst fewer education hours are available in hospitals overall, the scoping process did not ascertain how many young people were, on average, accessing education. Furthermore, some hospitals mentioned that other meaningful activities, including therapeutic work, made up the remaining hours during the day.
- There was a variation of teacher to pupil ratio, with fewer teachers available for the pupils in YJB settings.

3.7 Areas of good practice

The representative at each unit was asked what area of practice, or aspect of their service, they were most proud of. Three units (two YJB, one hospital) did not respond to this question. The responses were analysed using a thematic analysis approach (Braun & Clarke, 2006). This involved an inductive approach, carefully reading and coding the responses, and then identifying key themes that emerged from the codes. Overall, two main themes emerged: staff working, and the overall experience of the young person. The quotes listed in this section are not verbatim, as they were recorded in note form during phone interview, but provide the main points stated.





Theme 1:

The first overarching theme was identified as the value of the staff group: staff ability to manage complex young people, the quality of relationships built between the staff and young people, and the quality and style of MDT working. In hospitals, effective staff working (particularly the successes of their MDT working style) was the most commonly identified areas of good practice.

> Unit 1, hospital: *"…dealing with levels of acuity and challenge beyond what the unit is commissioned for – proud of staff for managing this without many serious incidents."*

> Unit 11, hospital: *"…rich MDT… the way the team relates to each other – support, passion, commitment, morale…"*

Similarly, it was widely noted that secure units provided staff with a challenging and complex job, and thus how the staff group worked successfully in a complex environment was identified as an area of good practice in STC/YOI settings too.

> Unit 50, YOI: *"…staffing group and what they deal with on a daily basis."*

Whilst the approach and relationships within the MDT were commonly highlighted as positive aspects of the work done by staff at hospitals and STCs and YOIs, in SCHs there was a focus on the strength of relationships between staff and young people. This is reflective of the social care nature of SCHs, where care staff take on an almost parental role.

> Unit 30, SCH: *"…build very good relationships with the children…"*

> Unit 41, SCH: *"Our ethos of corporate parenting means that relationships between young people and staff are very strong and allow for rapid progress to be made."*

Theme 2:

A second overarching theme identified was the overall experience for young people at the unit. This included the type and quality of interventions offered, the atmosphere and general environment of the unit, and successful outcomes/transitions from the unit. Some hospital units specifically mentioned that they were proud of the quality or range of interventions offered, including how these fit in with the overall experience of the young person. This links with hospitals having the largest variety of interventions, suggesting that this is an important aspect of the care young people in hospitals receive.

> Unit 13, hospital: *"...use innovative practice, for example sensory interventions that keep both the young person and worker safe…"*

> Unit 23, hospital: "*…two co-produced therapeutic groups, produced by the staff and young people…"*

The quality of interventions, or the overall therapeutic / care approach appeared as themes across all unit types; therefore, it appears that the interventions and approach offered by the unit is viewed as an important factor in the success of the unit. Some units mentioned specific interventions they were especially proud of, and others suggested that the general therapeutic environment and range of interventions offered led to an environment conducive to positive gains.

> Unit 34, SCH: "…*Direct care of young people – nurturing / therapeutic environment is good."*

> Unit 47, SCH: "*EMDR…has had quite dramatic results."*

> Unit 40, STC: *"…fatherhood group facilitated by one of the nurses to work with young fathers…"*

It should be acknowledged that these views are the opinions – in most cases – of one representative from each unit, working in a specific area (for example, in one YOI this question was answered by a member of the healthcare team, and in others by prison management staff). Therefore, there may be biases in the responses towards the particular area that the person responding works in and is most knowledgeable about.

4. Discussion & conclusions

This is the first complete scoping exercise across all types of secure settings in England for young people under 18 years of age. The information was collected in June 2016 and updated over our census date in September 2016. We are aware, though, that this is an ever changing landscape and there has been further redistribution of beds since then and changes continue to occur. Appendix C lists the units scoped.

This scoping exercise has highlighted several key areas of similarity and difference in availability of care for young people placed in secure accommodation as a result of their mental health concerns, welfare concerns, or via the YJS.

The geographical spread of units is uneven across England. It demonstrates a paucity of STCs in the north of England, a lack of SCHs with YJB beds in the south of England and welfare beds in middle England. This suggests that young people needing these types of secure accommodation may be more likely to be placed in units far from their homes, such that their families have to travel long distances to maintain contact. According to the United Nations Committee Report (2016)[17], young people should be placed in accommodation close to their homes, in order to enable contact with families/carers. However, it is not clear from this scoping exercise what happens in cases where local facilities are not able to accommodate a particular young person; the census on 14 September 2016 should offer a snapshot of distances that families need to travel to see their loved ones.

There is also a large difference in the number of beds available for young people under the different types of legislation. Only 111 beds are available to young people on welfare placements under the Children Act (1989), in comparison to 402 for young people detained under the Mental Health Act (1983). It is unclear from this scoping exercise whether the small number of welfare beds is reflective of the national levels of need or whether young people who require a secure placement on welfare grounds are instead being placed in other types of secure units.

As is expected, the focus in secure hospitals is on the stabilisation and treatment of mental health conditions, and to accommodate this, there is a varied MDT who offer many types of interventions and conduct frequent mental health reviews. These units tend to have overarching treatment models that are psycho-therapeutic in nature. In comparison, SCHs appear to focus on social-care models, with theoretical treatment models focused on the social environment and relationships with care workers, whereas STCs and YOIs tend to have less of a focus on health and social care, but focus more on behavioural management regimes. As STCs and YOIs detain more young people in England than any other secure settings, they do have the capacity to have some specialist units to meet specialist needs, such as a clinical detoxification unit, mother and baby unit, and complex care unit. In terms of young mothers who have children or are pregnant at the time of needing secure care, it is unclear

[17] Committee on the Rights of the Child: Concluding observations on the fifth periodic report of the United Kingdom and Great Britain and Northern Ireland, June 2016

where they would go if not detained through the YJS; though from this scoping exercise it is unclear how many young people this might affect.

The United Nations Committee Report (2016)[18] notes that there is a lack of child-specific mental health support available for young people in need, including a lack of interventions specifically tailored to their age range. In particular, it is noted that therapeutic communities for young people have not been widely developed. This links to the findings of this scoping exercise in terms of the interventions offered; very few units noted that interventions which are widely used for adults (such as DBT) had been tailored and assessed to be effective for adolescents. Further research is needed to evaluate the interventions offered in the secure units, to ensure that evidence-based effective interventions are offered to young people in secure settings.

Of note, the large YJB units (STCs and YOIs) show lower staff to young person ratios in the units and in education, suggesting less opportunity for individualised care. As most secure beds for young people are for young men based in the YOIs it is worrying that young men needing secure care, after committing crimes, are receiving the least tailored intervention. It is unclear whether these young men would have fared better had they been placed in a mental health or welfare secure bed prior to detention under the YJS, as is the case for the majority of young women in secure care.

Across the secure hospital settings, there appears to be little difference between HDUs and PICUs for the majority of these topics. Both unit types offer a similar range of interventions, and similar ratios of nursing staff to young people (although HDUs tend to have less nursing staff available on night shifts, which is perhaps representative of PICUs accommodating more challenging young people). There are a few minor differences, however, as there are only three HDUs currently open across England, and without clear specifications, it is difficult to ascertain exactly where the differences lie; some differences may simply be a part of an individual unit's style, rather than representative of the whole sector. Clear specification for HDUs and PICUs would be useful; there are currently no separate specifications for HDUs, although a new specification for PICU is currently being developed through NHS England.

Similarly, there appears to be little difference between low and medium secure units in terms of what is offered, based on the topics covered in this scoping exercise. In general, both types of unit have similar ratios of staff to young people, and offer a similar range of interventions. The main difference appears to be in the young people referred to these units; medium secure units accept referrals through the YJS, whereas low secure units do not. It is also interesting to note that whilst the majority of low secure units are run by independent sector providers, the majority of medium secure units are run by NHS trusts.

There are, however, clear differences between the PICU / HDU short term units and low secure / medium secure longer term settings, in terms of therapeutic provision and educational aims. The average length of stay reported by the units (not externally corroborated), suggests that stays in HDU / PICUs are indeed shorter than in low secure / medium secure units. In view of these differences it is important to ensure that this remains the case. If a young person is to stay detained in a secure setting for more than four to six weeks, they require a secure unit able to make long term plans in terms of therapy, education, and resettlement. Of note, the scoping exercise asked for unit self-report. Our census data will clarify

[18] Committee on the Rights of the Child: Concluding observations on the fifth periodic report of the United Kingdom and Great Britain and Northern Ireland, June 2016

if there is actually a difference in length of admission between those in the short term (HSU/PICU) units and the longer term (medium / low secure) units.

Overall, it appears that units aimed at accommodating young people under each of the different types of legislation do take different approaches to the care, treatment, and rehabilitation of these young people. Individual units within specific types also appear to take slightly different approaches, for example most hospital units having their own overarching theoretical framework, and several specialising in particular diagnoses / concerns. This suggests a need for further clarity within the secure system to ensure referrals are not only sent to the most appropriate type of unit, but also to the most appropriate individual unit.

As these findings are based on self-report, we are not able to draw any further conclusions at this point. These findings will next be explored in the light of the census information. This will enable a rigorous comparison between the units' self-assessments and the characteristics and needs of the young people detained.

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Appendices

Appendix A – scoping questionnaire, SCH/STC/YOIs

Unit name and code: Address: Postcode: Date:	Contact name: Contact email: Contact phone: Contact role:

Section 1: Geographical information

1) Are the referrals/placements you receive:
   - National
   - Regional
   - International
   - Local (if so, please define)?

2) Who is the service provider (for operational of the main establishment)?

3) Who is the commissioner / who pays for the placements?
   - YJB
   - Local authority
   - Both YJB and LA
   - NHS specialist
   - NHS local
   - Education

4) What type of unit are you?
   - SCH (England)
   - SCH (Scotland)

- YOI
- STC

5) What type of placement do you take?
   - Welfare only
   - YJB only
   - Both YJB and welfare
   - Mental health

Section 2: Capacity

6) How many young people can your unit take (total)?

7) How many of these places are specifically for male young people?

8) How many of these places are specifically for female young people?

9) Are there separate gender units? Yes / No

10) If no, are there separate gender corridors? Yes / No

11) Is this flexible? Yes / No

12) If yes, please explain how this is flexible.

13) If a young person identified as transgender, could you accommodate them? If so, how would you do this?

14) What age range does your unit cover?

15) Is there a maximum age for admission?

16) Is there a maximum age at which a young person needs to be discharged or transferred to another unit?

17) Are there any exceptions to these age limits where a young person may remain in the unit after the maximum age of discharge?

Section 3: Unit criteria

18) Are there any exclusion criteria for your unit (or types of young person you are not best placed to meet the needs of)? If so, what are these criteria?

19) Is your unit a specialist in any particular area? If so, which area?

Section 4: Service type

20) What is the average number of staff on the floor (prison officers / residential care workers, or equivalent) to the number of young people, for each shift (morning/afternoon/night)?

21) Are there staff from elsewhere that can be pulled in for an emergency response to an alarm call?

22) If a young person is vulnerable / at risk from their peers are you able to accommodate them? If so, what would this involve?

Section 5: Referring systems (note: we recognise that this section does not apply to YOIs)

23) What service types do you accept direct referrals/placements from?

- Mental health services
- Social services
- Criminal justice services
- Education
- Other (please specify)

24) Which disciplines refer to your unit?

- Psychiatry
- Other mental health professionals
- Social workers
- Education
- Other

25) Are you able to take emergency referrals/placements under PACE?

Section 6: Interventions

26) Who is the healthcare provider (for mental health services)?

27) Do you have an overarching theoretical treatment model for your unit?

28) What is your commissioned MDT staffing profile in the healthcare team for mental health staff?

Type/profession	**Band**	**Number in WTE**

29) What is your staff vacancy rate at present?

30) Are there particular difficulties filling specific staff roles?

31) Are the young people ever escorted off-site for external health/education input?

32) Can young people access their bedrooms during day time? Yes / No

33) Are the young people able to access the internet? Under how much supervision?

34) What interventions do you offer?

- Psychology
- Individual psychodynamic psychotherapy
- Family therapy
- Art therapy
- Music therapy
- Drama therapy
- Dance therapy
- Sensory interventions
- Speech and language therapy
- Targeted group therapy
- Open dynamic group therapy
- Prescribing / management of psychoactive medication
- Occupational therapy
- Exercise / sport
- Vocational training
- Cognitive skills training
- Mindfulness
- Behaviour targeted interventions
- DBT (group or individual)
- MBT (group or individual)
- Other (please describe)

35) Does your unit have access to exercise facilities such as a gym / swimming pool / outdoor space?

36) Is there a substance / alcohol misuse service available to the young people at your unit? Is this an internal intervention or an external service?

Section 7: Education

37) How many hours per week are allocated for education?

38) What range of subjects can be studied?

39) What is the highest level qualification the young people at your unit can work towards?

40) What is the average ratio of teachers to young people?

41) Do classes follow a term time structure?

42) If yes, what do the young people at your unit do outside of term time?

43) Where do the young people who refuse education go during these hours?

Section 8: Discharge processes

44) What is the average length of stay at your unit?

45) Is discharge/release from the unit phased (are there opportunities for temporary release to help plan for re-settlement)? Yes / No

46) If yes, in what way is it phased?

Additional questions

47) What is the average cost per person or per bed at your unit?

48) Are the young people locked in their rooms at night? If so, for what reason?

49) How often do the young people have mental health reviews?

50) What area of practice or aspect of your service are you most proud of? (this could include extra screenings, interventions, aspects of your MDT working etc).

Appendix B – scoping questionnaire, hospital units

Unit name and code:	Name:
Address:	Email:
	Phone:
Postcode:	Role:
Date:	

Section 1: Geographical information

1) Are the referrals you receive:
   - National
   - Regional
   - International
   - Local (if so, please define)?

2) Who is the service provider?

3) Who is the commissioner / who pays for the beds?
   - YJB
   - Local authority
   - Both YJB and LA
   - NHS specialist
   - NHS local
   - Education

4) What type of unit is this?
   - NHS
   - Third sector

- Independent sector
- Other (please describe)

5) What type of placement do you take?
   - Welfare only
   - YJB only
   - Both YJB and welfare
   - Mental health

Section 2: Capacity

6) How many young people can your unit take (total)?

7) How many of these places are specifically for male young people?

8) How many of these places are specifically for female young people?

9) Are there separate gender wards at your unit? Yes / No

10) If no, are there separate gender corridors? Yes / No

11) Is this flexible? Yes / No

12) If yes, please explain how this is flexible.

13) If a young person identified as transgender, could you accommodate them? and how would you do this?

14) What age range does your unit cover?

15) Is there a maximum age for admission?

16) Is there a maximum age at which a young person needs to be discharged or transferred to another unit?

17) Are there any exceptions to these age limits where a young person may remain in the unit after the maximum age of discharge?

Section 3: Unit criteria

18) Are there any exclusion criteria for your unit? If so, what are these criteria?

19) Is your unit a specialist in any particular area or diagnosis type? If so, which area?

Section 4: Security status / Service type

20) How would you describe the security level / type of your unit? (and what makes it this type of unit/level of security?)

21) Is this flexible? Yes / No

22) If so, please explain how this is flexible.

23) What is the average number of nursing staff you have on morning/afternoon/night shifts?

24) Are there staff from elsewhere that can be pulled in for an emergency response to an alarm call?

25) if a young person is vulnerable / at risk from their peers are you able to accommodate them and how?

Section 5: Referring systems

26) What service types do you accept direct referrals from?

- Mental health services
- Social services
- Criminal justice services
- Education
- Other (please specify)
-

27) Which disciplines refer to your unit?

- Psychiatry
- Other mental health professionals
- Social workers
- Education
- Other

28) Are you able to take emergency referrals?

Section 6: Interventions

29) Do you have an overarching theoretical treatment model for your unit?

30) What is your commissioned MDT staffing profile?

Type/profession	**Band**	**Number in WTE**

31) What is your staff vacancy rate at present?

32) Are there particular difficulties filling specific staff roles?

33) Are the young people ever escorted off-site for external health/education input?

34) Can the young people access their bedrooms during the day? Yes / No

35) Are the young people able to access the internet? Under how much supervision?

36) What interventions do you offer?

- Psychology
- Individual psychodynamic psychotherapy
- Family therapy
- Art therapy
- Music therapy
- Drama therapy
- Dance therapy
- Sensory interventions
- Targeted group therapy
- Open dynamic group therapy
- Prescribing / management of psychoactive medication
- Occupational therapy
- Speech and language therapy
- Exercise / sport
- Vocational training
- Cognitive skills training
- Behaviour targeted interventions
- Mindfulness
- DBT (group or individual)
- MBT (group or individual)
- Other (please describe)

37) Does your unit have access to exercise facilities such as a gym / swimming pool / outdoor space?

38) Is there a substance / alcohol misuse service available to the young people at your unit? Is this an internal intervention or an external service?

Section 7: Education

39) How many hours per week are allocated for education?

40) What range of subjects can be studied?

41) What is the highest level qualification the young people at your unit can work towards?

42) What is the average ratio of teachers to young people?

43) Do classes follow a term time structure?

44) If yes, what do the young people at your unit do outside of term time?

45) Where do the young people who refuse education go during these hours?

Section 8: Discharge processes

46) Is there a process for second opinion or review, if the young person has had a long admission? If so, at what point? And how?

47) What is the average length of admission?

48) Is discharge from the unit phased? Yes / No

49) If yes, in what way is it phased?

Additional questions

50) What is the average cost per person or per bed at your unit?

51) Are the young people locked in their rooms at night? If so, for what reason?

52) How often do the young people have mental health reviews?

53) What area of practice or aspect of your service are you most proud of? (this could include extra screenings, interventions, aspects of your MDT working etc).

Appendix C – list of secure units in England (June 2016)

High dependency units

- Ashfield ward, Birmingham Children's Hospital
- Rowan ward, Woodbourne Priory Hospital
- Ticehurst HDU, Priory Hospital

Psychiatric intensive care units

- Coborn Centre PICU, Newham
- Cygnet Hospital Bury PICU
- Cygnet Hospital Sheffield PICU
- Cygnet Hospital Woking PICU
- Huntercombe Hospital Norwich, PICU
- Larkwood ward, St Aubyn's Centre, Colchester
- Meadows ward, Priory Cheadle Royal Hospital
- Redburn PICU, Newcastle
- Severn and Thames wards, Huntercombe Group, Maidenhead
- Watcombe Hall PICU, Huntercombe Group, Devon

Low secure units

- Ellingham Hospital (LD specific)
- Huntercombe Hospital Norwich, Low secure
- Kent House Hospital
- St Andrews Northampton (Malcolm Arnold, LD specific wards)
- St Andrews, Northampton (Lowther)
- Stevenson ward, Ferndene, Newcastle (LD specific)
- Westwood Centre
- Woodlands ward, Priory Cheadle Royal Hospital

Medium secure units

- Alnwood
- Alnwood (LD specific)

- Ardenleigh
- Bluebird House
- Gardener Unit
- St Andrews, Northampton
- Wells Unit

Secure children's homes

- Adel Beck
- Aldine House
- Atkinson
- Aycliffe
- Barton Moss
- Beechfield
- Clare Lodge
- Clayfields House
- Kyloe House
- Lansdowne
- Lincolnshire
- St Catherines
- Swanwick Lodge
- Vinney Green

Secure training centres

- Medway
- Oakhill
- Rainsbrook

Young offender institutions

- HMYOI Cookham Wood
- HMYOI Feltham
- HMYOI Werrington

- HMYOI Wetherby