care inspectorate

mental welfare commission for scotland

# The journey to trauma-informed restrictive practice in Scotland's secure accommodation services

A joint report by the Care Inspectorate and the Mental Welfare Commission



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# Introduction

**The promise was clear that Scotland must strive to become a nation that does not restrain its children and young people[1]. It heard from care experienced children and young people about how frightening, painful and embarrassing the use of restraint was for them.**

Between 2025 and 2026, the Care Inspectorate and the Mental Welfare Commission for Scotland (the Commission) worked collaboratively to review children and young people's experiences of restrictive practices, including restraint, in secure care.

This report collates the thematic findings of the joint visits undertaken across all four of Scotland's secure services: Good Shepherd Centre Bishopton, Kibble Safe Centre, Rossie Secure Accommodation Services and St. Mary's Kenmure.

Each service was also inspected by the Care Inspectorate at the same time, covering the full scope of their care practices and wider outcomes. The public reports of these inspections are available on our website at http://www.careinspectorate.scot

The Care Inspectorate and the Commission would like to thank all the young people receiving care and support across the secure care settings for their engagement and trust prior to, and during, our visits. We are also very grateful to their families, the staff providing care, and other professionals who we met with and/or who provided their views.

We also wish to acknowledge the additional burden that the shared scrutiny by the Care Inspectorate and the Commission placed on each of the four services and the positive and constructive approach from each of their leadership teams.

## What is secure care?

Secure care for children and young people in Scotland is a type of residential care that restricts the freedom of young people under the age of 18 years. Secure care aims to provide intensive support and safe boundaries to help young people move forward positively in their lives while keeping them and/or other people safe.

It is for a small number of young people who may be a significant risk to themselves or others in the community, and where it has been determined by a children's hearing, together with a chief social work officer, or by a court, that their needs and risks can only be safely managed in a secure, controlled setting.

[1]The terms 'children', 'young people' and 'children and young people' are used interchangeably throughout this report in accordance with the context of the various subject areas.

At the time of our joint work, there was accommodation for 77 children and young people across the four independent charitable organisations which provide secure care in Scotland.

Young people who are cared for in secure accommodation services have often had significant adverse experiences during their childhood, such as bereavement, loss, trauma, exposure to violence, abuse or neglect. Many also experience mental health needs and/or have additional support needs.

## What are restrictive practices?

Restrictive practices are any act of making someone do something they do not want to do or stopping them from doing something they do want to do, by restricting or restraining them, or depriving them of their liberty[2]. Restrictive practices relate to different types of restraint. This can be physical, mechanical, chemical, cultural, environmental or psychological restraint, surveillance or blanket rules.

All young people living in secure care will face restriction by the nature of being placed there, which will create limits on freedom of movement and access to some people and possessions. Some of these restrictions will be imposed by the courts and the legislation under which a decision has been made. Other restrictions are informed by multi-agency risk assessments and are intended to protect young people from harm, which should be individually considered, with clear justification and consideration for a young person's rights.

Restriction, restraint and/or seclusion should therefore be a last resort, used according to best practice guidelines and utilised only to prevent significant risk of harm to the young person and/or others. It is not a form of behaviour management.

## How we approached this review

Our joint approach was underpinned by the promise, Scotland's Secure Care Pathway and Standards, our respective organisations' corporate parenting duties and the rights of children and young people under the United Nations Convention on the Rights of the Child (UNCRC), specifically:

- the right that all decisions are made in the best interests of the child (Article 3)
- the right to have views respected (Article 12)
- the right to safety and protection (Article 19)
- the right to recovery from trauma and re-integration (Articles 39, 40).




[2] CQC 2023

These rights and standards informed our understanding of the experiences that children and young people should expect.

- Young people would experience therapeutic and stable care, which supported their emotional wellbeing. This would be grounded in children and young people enjoying warm, trusting, and nurturing relationships, with well trained, knowledgeable and trauma-informed staff.
- Children and young people would be supported to understand their rights, and advocated for, so these were met.
- Restriction, restraint and/or seclusion would be a last resort and used only to prevent significant risk of harm to the young person and/or others. The significant risk of young people experiencing trauma, from being subject to and/or witnessing restraint and seclusion, would be minimised by a culture, policy and practice which progressively reduced the likelihood of this.
- Searches that required to be carried out on young people would have proper regard to respect and dignity and sensitively recognise the individualised trauma this can cause.
- The implementation of any restrictions, restraint and/or seclusion would be individualised, minimised, risk assessed and subject to regular review. All restrictive practice interventions would follow best practice.
- Robust policies would be in place, which staff understood and consistently implemented.
- There would be clear accessible communication on the use of restrictive practice and the therapeutic follow-up.
- All relationships and interventions would support the young person's understanding and help them progress in their care journey, without having to experience these restrictive practices repeatedly or without very good reason.
- Children and young people would have access to good mental, physical and emotional health support.
- Families and carers would be fully engaged in the ongoing care and contact with their child.
- There would be good multi agency working and communication between all the professionals with responsibility for supporting the young person.
- Young people would understand their rights under UNCRC and we would find this threaded through all documentation and approaches to care.

A central focus for our shared work was therefore to speak to, and hear, the voices of young people and staff across the secure care sector and to gather information directly around their experience of restrictions, restraint and the use of seclusion.

## Our methodology

The Care Inspectorate's inspection visits took place over five days in each of the four secure units; the Commission joined the Care Inspectorate for one of these days in each setting. Our joint approach reflected the Care Inspectorate's key role as independent regulator (with particular focus on Key Question 7 of the Quality Framework for secure accommodation services) and drew on the Commission's expertise in restrictive practices based on Rights, risks and limits to freedom.

As part of our preparation and commitment to hear the views of young people, families, carers, staff and visiting professionals we issued a pre-visit questionnaire. We asked about general experiences of

receiving and providing care in a secure setting, including how safe and cared for young people felt and how their rights were promoted. We also asked several specific questions about their experience of restraint and restrictive practice.

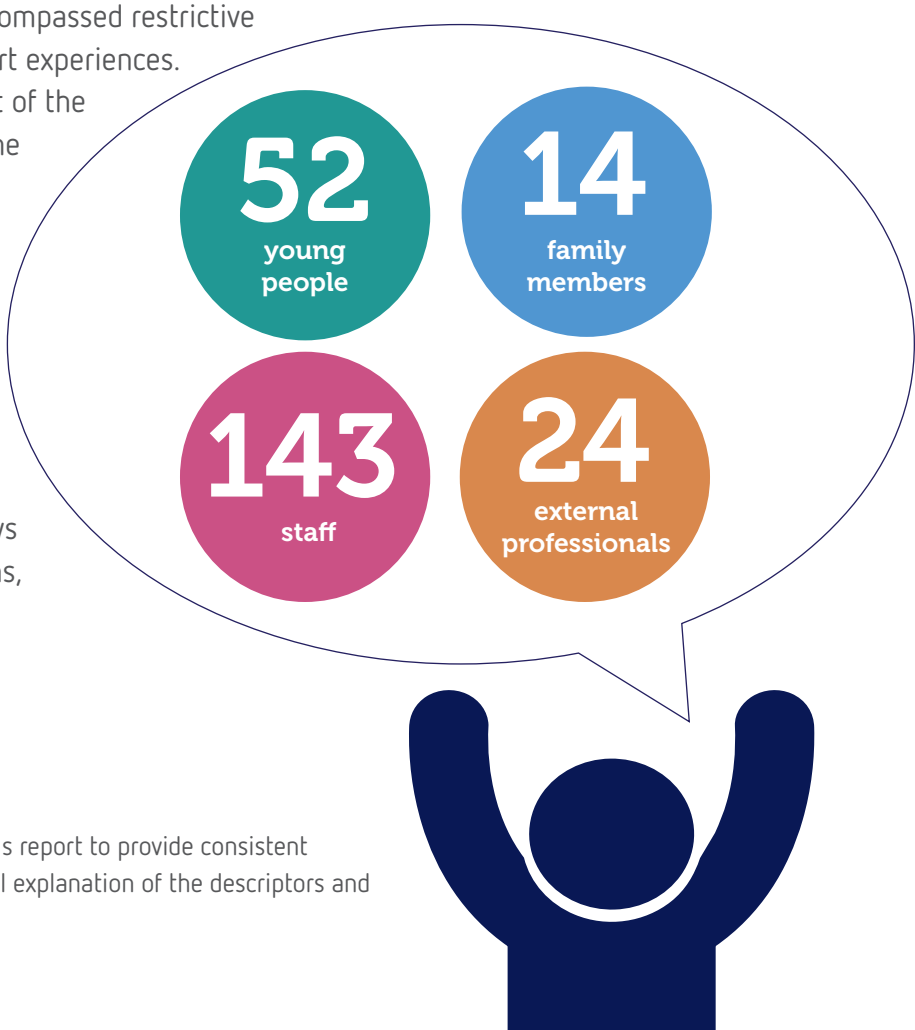
We received pre visit feedback from 39 young people, 37 visiting professionals, 9 carers and 65 staff. As noted previously, the Commission joined the Care Inspectorate on one of their days, visiting each service to concentrate on speaking with young people and staff, and gathering information directly around restrictions, restraint and the use of seclusion.

The Commission met with a total of 24 young people, most of whom were male. We asked them how many times they had lived in secure care. Some did not wish to respond, six told us this was their first time in secure care. 10 had been in secure care once before, including in a different service from the one they were currently in. Five or fewer told us they had been in a secure service more than twice.

The majority (79%) of the young people the Commission met were from White British ethnic backgrounds. Half had a mental health diagnosis, and a majority had entered secure care through court processes. These 24 young people came from nine health board areas in Scotland and two from English health board areas.

The Commission also met with 12 staff, including nurses, psychologists, front line care staff and department managers who gave their views on the use of restrictions, restraint and seclusion and told us about their access to related training.

The Care Inspectorate met with a further 52 young people, 14 family members, 143 staff and 24 external professionals as part of the broader regulatory inspection, which included five days on site at each of the services. These views also encompassed restrictive practices, as well as wider care and support experiences. To ensure these views were shared as part of the joint scrutiny, the Care Inspectorate and the Commission met frequently during the inspection period to share information.




As part of our triangulation of evidence both organisations also observed care practice and reviewed a wide range of each service's polices, training records and restrictive practices documentation. Evidence from the visits, and the interviews undertaken by the respective organisations, was also corroborated as part of the production of this report.

[3]Measurement descriptors are used throughout this report to provide consistent narrative descriptions of percentage findings. A full explanation of the descriptors and percentage ranges is provided in Appendix 1.

## What we learned about when we visited

### 1. Children and young people's experience of a safe and therapeutic culture

**I know that people care about me and are meeting my needs because the way they relate to me shows this.**
Standard 24: Secure Care Pathway and Standards Scotland



Therapeutic and nurturing practice, based on loving and trusting relationships with children and young people, is a principal component to both the sensitive and appropriate use of restrictive practices and a culture in which they are minimised.

Prior to our visits young people informed us, via confidentially completed questionnaires, that a large majority felt safe (82%), cared for (92%) and treated with respect (97%):

> "I have identified my safe people. I feel safe and supported living in this house."

A large majority also felt their needs were understood, stating they were satisfied with their support.

When speaking to young people during our visits a majority again told us that they felt safe, but they were clear that this was conditional on developing trusting relationships, with staff who knew them well and understood their needs.

We also heard from around half of the young people that there were some things that could make them feel safer. such as:

> "I would feel safer if staff believed me when I tell them about being bullied by others."

> "Staff could manage any incidents better."

> "Staff could get better at using de-escalation."

Most young people felt safe, listened to and that their views were taken into account.

> "I get to speak at the YP meeting...and also get to see my advocacy."

> "(I) struggle to voice my opinions but I'm supported to write them down."

> "I am asked (my views) every Monday at (the) young person's meeting."

We asked the young people we met with about feeling listened to and understood. We were pleased to hear that the majority of young people knew who their keyworker was (75%) and felt able to speak to them openly (79%). However, this was not the same for all the young people we met with across Scotland's secure units. We emphasised the need for one of the four services to address this where we identified this as a concern during visits.

The majority of young people told us they felt staff listened to them but only around half felt responses from staff were given in an understandable way. Although around half of the young people knew what they needed to do to progress from secure care, others were unaware of there being a plan in place for them. A minority of the young people we spoke with told us they felt treated differently to other young people in secure care. It was clear from the range of young people's responses that communication about the services, how they work and the overall plans of care for children and young people needed to be reviewed.

This is what they said.

> "Some staff don't like me, and I don't get on with others in the unit."

> "I feel females get away with things that males are pulled up for."

> "It depends on the reason for being in the unit and how you behave - different rules for different people. Don't feel it's right to have people from court here with young ones who really struggle with their mental health."

When 'rules' or staff responses on restrictive practices (including 'blanket restrictions') vary to take account of individual young people's needs, how this is communicated by care staff needs to be taken more fully into account, particularly for those in minority groups such as females or those with specific neurodivergent needs.

All secure services had service level agreements with independent advocacy services that could provide children and young people with good access, and which was utilised. Over half of the young people said they were aware of and had contact with such advocacy services, although we would have expected that all young people would at least be aware of their right to advocacy given this universal provision.

Prior to our visits we also asked visiting professionals for their views on children and young people's experiences.

- All who responded were happy with the care provided to young people and had no concerns.
- A majority felt the service supported young people's wellbeing through individual consideration of attachment, trauma and child development.
- They told us contact was encouraged and that most young people had regular contact with their social workers.
- Just over half felt staffing levels were right.
- A large majority felt staff had the right skills.

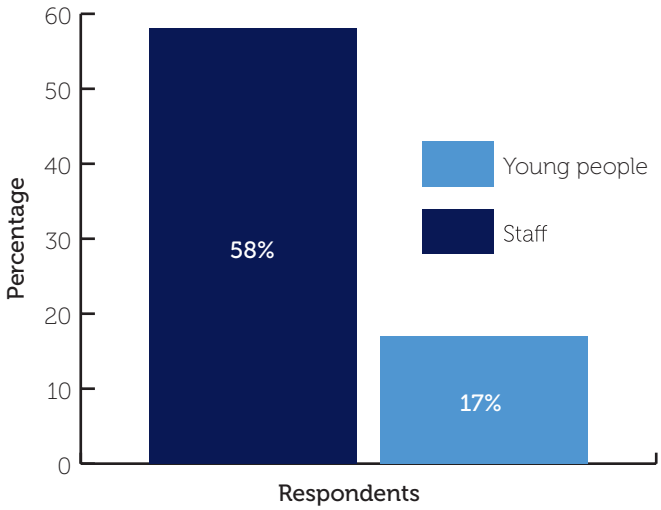
## 2. Children and young people's understanding of the use of restrictions

**I know the details of where I will stay, and I have access to information which explains daily life there. Every effort is made to enable me to visit before going to stay.**
Standard 14: Secure Care Pathway and Standards Scotland

All young people living in secure services will face restriction by the nature of being placed there, which will create limits on freedom of movement and access to some people and possessions.

Of the secure care staff we spoke to just over half believed restrictions were explained to young people prior to their arrival at the service. By contrast, very few of the young people we spoke to said the restrictions were explained to them verbally before their arrival and none said they had any information about restrictions in writing or any other concrete / visual format. The following chart shows the difference between the perception of secure care staff and young people about young people's knowledge of restrictions prior to arriving at the service.

### Perceptions of restrictions knowledge prior to submission vary




Ensuring children and young people are comprehensively and accessibly reassured about expectations and daily life, in a form which is understandable to them, prior to their arrival, would significantly ease this very traumatic experience.

Secure services themselves provided a range of information to children and young people on daily life, and some had made attempts to supply this prior to young people arriving. All services, for example, had produced short films for young people to explain daily life and routines. Some services had also developed more innovative communication techniques, such as the use of VR headsets, to let young people know about expectations and to reassure them.

A majority of the young people told us that, on arrival or after a few days of settling in, they were advised verbally about the restrictions which were in place, but had not received any information in writing, visually or via media. A large majority reported that they had been helped to understand both the use of restraint and seclusion, although a significant minority of young people still believed the rules of living in secure care were not clear nor fair.

Although a majority of parents and carers reported they were aware of the restrictions their child would experience, they also confirmed they found that some 'rules' were confusing, for example what they could or could not bring in for their child or young person during a visit.

The mechanisms used in secure services for physically checking people and possessions, and their significant impact, should also not be underestimated. Where young people and their families are not expecting this, the experience can be daunting and re-traumatising. Practices differed, depending in which service the young people were being cared for. Two services had full scanners, that offered a less intrusive approach to safety, whilst the others relied on physically checking people and their belongings with the assistance of handheld detectors.

We asked the young people how they believed restrictions were enforced. This is what they told us.

> "They [staff] explain as much as they can why restrictions are in place. Control room staff alert house staff to any concerns about things coming in and then they speak to the person."

> "Staff ask individuals and there are searches after appointments and outings."

> "There are regular 'bedroom health checks' to make sure everything in the room is okay."

> "Verbally - tell you what you can't have or do."

## 3. The practice and experience of restraint for children and young people

**I am well supported to manage my feelings, and I am only ever restrained when this is absolutely necessary to prevent harm. I am treated with respect, dignity and compassion and I am held in the least restrictive way for the shortest time possible. I am well supported afterwards.**
Standard 30: Secure Care Pathway and Standards Scotland

Physical restraint is an intervention in which staff hold a child to restrict his or her movement and which should only be used to prevent harm[4]. The stipulated purpose of restraint for regulated services is set out in The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.This specifies that:

> *"A provider must ensure that no service user is subject to restraint, unless it is the only practicable means of securing the welfare and safety of that or any other service user and there are exceptional circumstances."*[5]

The majority of young people we met with told us they had been subject to restraint. The chart below shows the number of young people who had reported being restrained, measured as a percentage of the 24 young people the Commission met with.

### Experiencing restraint




[4]CELCIS Holding Safely

[5]The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. s.4(c)

Of the young people who reported having been restrained, just over three quarters told us the staff spoke to them during the restraint and explained what was happening and spoke with them afterwards around why the restraint had happened. This is what young people told us.

> "I feel when I have been restrained or seen others it was for right reasons."

> "I feel safe and understand it's to help me 'regulate'."

> "I feel safe with staff when restraining me."

> "I really trust staff."

> "Staff wouldn't speak to me during a restraint as it would make me worse, they speak to me afterwards."

Although some young people may not be subject to restraint, we know that witnessing this can be traumatic and can also affect what happens to them such as where they can go in the unit whilst restraint of someone else is happening. The majority of young people said they had seen restraint happening to others.

The chart below shows the number of young people who had witnessed restraint, measured as a percentage of the 24 young people the Commission met with.

**Witnessing restraint**



This is what young people told us.

> "Once I saw someone being restrained by two staff, it looked unsafe and I was really worried someone was going to get hurt."

> "I've been prevented from freely moving around while someone else has been restrained and although I did not see what happened to them, I could hear things kicking off."

> "I witnessed others in the unit being restrained by staff members and I was unable to use the toilet until things 'calmed down' if the restraint happens in lounge."

From the information shared by each service prior to our visits, we understood that different policies and approaches to restraint were being used. Staff in secure services were trained in three different models of restrictive physical intervention, with the same model used in two different services. For some young people who had experience of restraint in different secure services, this was confusing.

> "They [referring to another unit] trust you and will only do stuff if you show them you're a risk. Here, they start by thinking everything is a risk and you have to prove to them you're not."

> "I preferred being restrained in [other service] as someone would hold my head but here, they just remove my glasses."

> "The restraint here feels better."

> "They use prone there, which is probably better for the staff so I can't get out of it."

When we asked staff about their views on the use of restraint, this is what they told us.

> "Restraint is definitely a last option and has been for a long time. I've seen staff trying everything else before moving to restraint."

> "It's encouraging to see the improvements in restrictive practice overall but especially what we are working on here around restraint use. It's more appropriate and is now clearly used as a last resort."

> "In-depth training and weekly input has been essential."

## Good practice example

Louise was living in a residential house where she had been finding it difficult to live safely with others and manage the demands of day-to-day life. As a result, her residential placement broke down, and she was placed in secure care.

When Louise arrived at secure care, the team recognised that she may have additional needs, although the full impact on her wellbeing and behaviour was not yet understood. The team suspected that Louise was communicating her very significant distress through behaviours that reflected how overwhelmed she felt and, at times, placed herself and others at risk of significant harm. This led to frequent and prolonged incidents of restraint.

The extensive multi-disciplinary team caring for Louise had the knowledge and skills to gradually build trusting and attuned relationships, review the impact of her experiences growing up, and undertake a range of assessments that clearly identified her needs. This guided the staff to build a detailed story (formulation) that explained what approaches might overwhelm Louise and why, and what she needed from her support to feel safe and calm. Using the formulation to develop an individual support plan that everyone understood, the team altered the way and words they used to communicate with and support Louise. They understood what spaces she needed to feel safe and calm and they began to explain and explore restraint and emotions using pictures and words (Social Stories) that Louise could understand. This helped her to understand that staff were trying to protect, not hurt her, when she was overwhelmed.

The service had also ensured that these details were clearly recorded in Louise's care records. This informed all staff supporting Louise and helped to maintain consistency, reinforcing her sense of safety and trust. Staff were consistently recording interventions in line with their local policy, including incidents of restraint. This enabled the service to review and audit records effectively and ensured that Louise was receiving consistent and safe care at all times.

Gradually there was a reduction in incidents. Louise was given the means, through art and communication tools, to tell staff what it was like before, during and after restraint. After every restraint, the team were well supported to reflect on what they were doing. Staff felt safe to express how they felt when caring for Louise and what they needed to do this well (debrief). Leaders carefully reviewed every incident of restraint to determine if it was justified, why it happened, what worked to support Louise and what the staff needed to do to alter their approach. Over time incidents of restraint became very rare as the team had learned to predict what might be difficult for Louise, recognise early signs of distress and dysregulation, and had supported her to communicate her feelings and needs in safer ways.

**I get the care, comfort and individual support I need when I am distressed and so I am only ever isolated from other people when this is absolutely necessary to keep me or others safe. This is for the shortest time possible.**
Standard 31: Secure Care Pathway and Standards Scotland



All secure services we visited had policies in place which described the use of, recording of, and reporting of seclusion. The majority (75%) of the young people we met with told us that they understood what seclusion was. However, just over half did not know about the use of seclusion prior to their arrival. The majority of the young people said they had experienced seclusion, with most telling us that the reason for the use of seclusion had been properly explained to them and just over half said that they had been asked how being secluded had felt for them. When describing the use of seclusion and how they were supported, this is what young people told us.

> "Only some staff take time to explain why things happened and separation [seclusion] was used."

> "The reasons for the use of seclusion could be given more clearly. Staff tolerate too much from young people who go at it all the time but for folk who behave most of the time they get sent to their rooms quickly if they kick off."

When asked about reasons for the use of seclusion, this is what young people told us.

> "I get put in my room if I don't do what I am told or be bad, so I try to do what staff say. I'll sometimes be in there for hours, but they do check on me and bring me food if needed."

> "You just get put in room for anything you do wrong."

> "I needed it when it happened."

> "We were fighting so it was for our own good to calm down and that, only for a wee while and staff check on you all the time."

The chart below shows the number of young people who had reported being secluded, measured as a percentage of the 24 young people the Commission met with.

Experiencing seclusion




This is what staff told us.

> "I have seen a lot of changes in how restrictions are managed and responded to. It's encouraging to see the improvements in restrictive practice overall."

> "We are all fully aware of the effects of using these [restraint and seclusion] and safety is the backbone of any use of them. There is always the risk of retraumatising a young person when restraint or seclusion is used so risk assessments are important."

> "Documentation around incidents is good. Staff are knowledgeable and highlight any concerns to health staff to follow-up when required."

The use of seclusion should be for the shortest time necessary, justifiable and subject to regular review. Whilst many staff were recording incidents of seclusion appropriately, this was not consistent in all four secure care services. We found some staff did not always understand when a young person was being secluded, which led to inaccurate recording and/or reporting of incidents. Where we identified such concerns, we fed these back to the service provider and identified necessary improvements.

## 5. Children and young people's contact with their families and carers

**I am actively supported to be in touch with my family, friends and other people who are important to me unless this is not in my best interests. I have a say in how and when this happens.**
Standard 25: Secure Care Pathway and Standards Scotland

An area of importance for all young people living in secure care is being supported to maintain contacts with family where appropriate and possible.

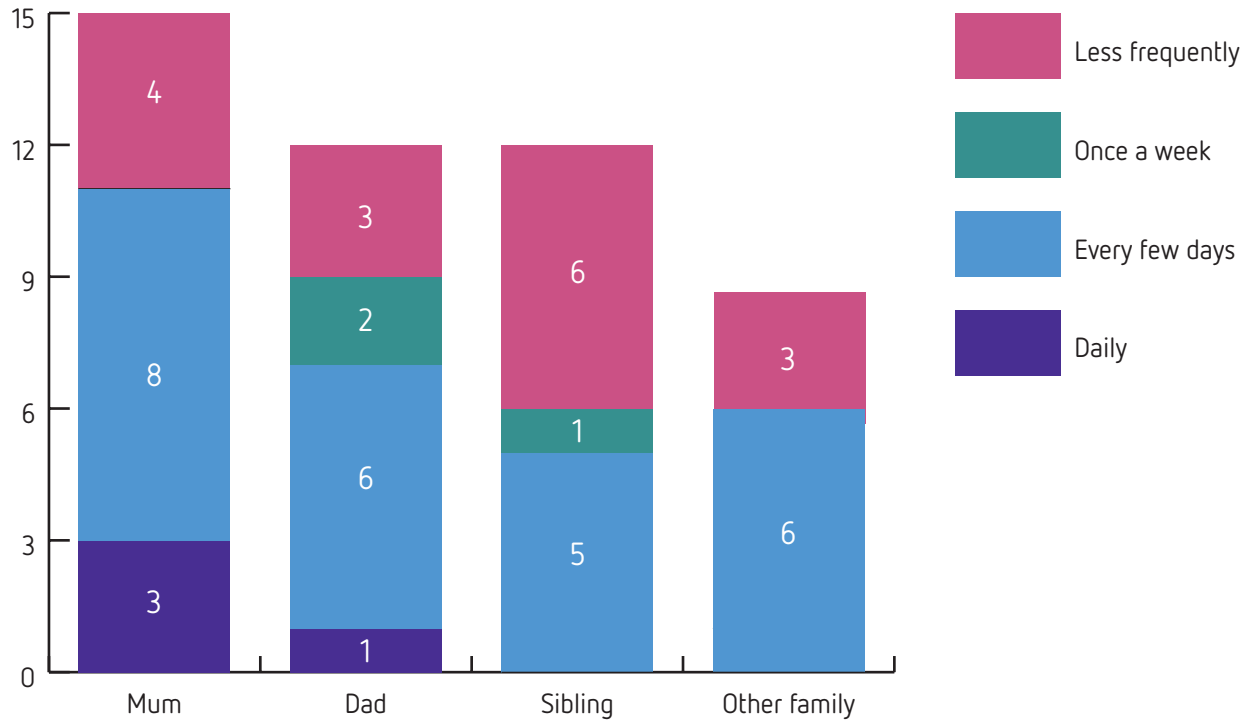
The impact for a young person of being deprived of their liberty means contact and communication with those who are closest to them outwith the service becomes even more important.

A majority of young people felt they could keep in touch with those who were important to them.

> *"I get to see them every week in the centre."*

Across the services we saw clear efforts to ensure continued engagement, where appropriate, as detailed in the graph.

**Young people's contact and the frequency of contact**



This contact mainly consisted of telephone calls and in-person visits, which most of the young people we met with said they were satisfied with.

Prior to our visits parents and carers informed us, via confidentially completed questionnaires, that:

- all felt their child's needs were being met
- a large majority (88%) believed their child felt safe
- all felt well informed about restrictions
- a large majority felt informed about searches
- a large majority felt they could raise a concern and that feedback was acted upon
- all were satisfied overall about their child's care.

Parents and carers, however, informed us of varied experiences in most services in terms of the ease of contacting their child.

> "I'm confident my child is safe but speaking with them can be so difficult as often I can't get through to hear their voice."

> "Overall, I'm happy they are safe, but sometimes it can be difficult to get the visits we would like due to staffing, this has a big impact on us and him."

The innovative use of technology was successfully responding to these views of parents and carers in one of the services.

**I am supported and encouraged to attain and achieve at the highest standard and this helps to develop my interests, skills, strengths and hopes for the future.**
Standard 35: Secure Care Pathway and Standards Scotland



Whilst not a focus for our scrutiny of restrictive practices, we received positive feedback on the educational opportunities and facilities which children and young people experienced. This is what one parent told us.

> "I'm really happy as now my child is safe. Education is going at their pace and they are achieving. I get weekly updates; staff are kind and nothing I would want to change."

Two services provided wider ranging educational and training opportunities, with one in particular developing an innovative and risk enabling approach.

Young people also had good access to social work, health, wellbeing and intervention teams within each setting, with this provision resourced differently depending on the service. External partnerships with health professionals had regional variation. Young people placed in the west of Scotland benefitted from some access to the local child and adolescent mental health service (CAMHS), and more frequently specialist forensic CAMHS. For those placed in the north of Scotland, they had access to local CAMHS but there was no available forensic CAMHS provision. We are aware this was being considered in partnership with the relevant health boards.

Wider care practice and opportunities, such as learning and social activities, were seen as playing an important and integral role to a culture which minimised the use of restrictive practices. Across the services a variety of activities were available to young people ranging from physical activities such as gym, swimming and indoor sports to cooking, personal grooming, card and board games and arts and crafts.

All services enabled young people to access outdoor space, both in large sports areas and also smaller areas adjacent to individual houses where children and young people lived. In three of the four services outdoor space had to be shared with a number of houses in the service, reducing the flexibility and spontaneity of the use of these spaces.

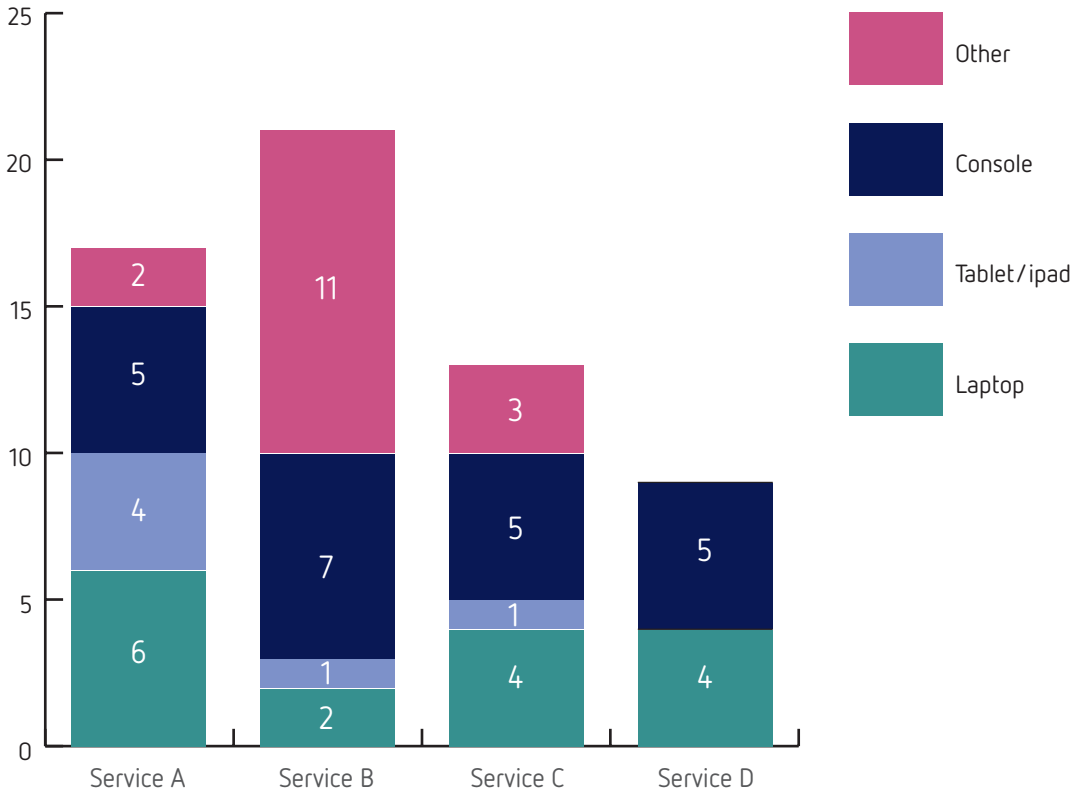
We were pleased to see young people involved with local colleges, where appropriate, and having access to outings with staff. The majority of the young people we met with said they were involved in choosing activities to participate in and that the activities were based around their interests.

## 7. The environment and use of technology

**My rights to safely access digital technology are upheld and actively supported. This encourages connection with people who are important to me.**
Standard 21: Secure Care Pathway and Standards Scotland

Some services had accelerated their use of technology to promote young people's rights and improve their experiences within the inevitable environmental restrictions of a secure setting. This promoted choice and control over aspects of the environment, such as lighting, heating and access to fresh air. One service was also actively introducing the use of multimedia to promote safe communication with loved ones. Other services lagged behind these developments. The general standard of physical environments was also variable across services.

For young people, access to technology to keep up with contacts and daily life is important. However, by the nature of living in secure care this access is closely monitored. We were pleased to see that there was supervised access to some technology to allow for recreation and shopping. All young people also had access to televisions where this had been individually risk assessed as safe. We did not have any concerns about inappropriate access to technology and understood that access varied, based on individual risk assessments. This bar graph[6] demonstrates an overview of what we found.




[6]The responses are based on the young people's responses. Service D respondents chose to answer based only on 'technology' and 'console' questions only. Young people within service D have access to televisions.

## Good practice example

One centre had begun to take steps to adapt the environment through starting to implement 'technology enhanced care', which offered young people with sensory needs choice and control in some aspects of their environment, for example being able to adjust lighting in their bedrooms. The service had replaced alarm and ring tone communication systems with quieter handset devices which used vibrations and light to alert staff of any incidents and/or assistance required to support young people. We observed this created a much calmer environment and one young person told us that "It's better here as the pit [alarm] isn't constantly going off with people running to respond".

The service had also installed opening windows in all bedrooms that offered young people choice to introduce air and light into their space, whilst continuing to provide the safety and security required in this setting. The impact on people's wellbeing had been significant. The service reported a correlation in a reduction in incidents at evening transition points, often a difficult time when young people go to their bedrooms for the night. One young person described feeling more comfortable in their bedroom as the space was cooler. It helped them feel more relaxed in their personal space and improved their quality of sleep.

The service had also engaged with international mental health design experts and installed a media wall into their arrival bedroom and one secure bedroom as a pilot. This system offered young people the opportunity to control the sound and light in their space and also promote engagement in their care, as the system acted as a communication tool where needs and preferences could be recorded. The media walls also had the capacity to support young people to safely stay in touch with people who were important to them. The system was being tested by young people over a period of time and adapted based on their feedback. An implementation programme is now in place to introduce these systems into all secure care bedrooms in the centre.

The service development plan identifies clear goals and timescales for ongoing aspirational environmental change in recognition of people's needs and rights.

**I have everything I need when I arrive to keep me safe and healthy and so do the people looking after me.**
Standard 18: Secure Care Pathway and Standards Scotland



Leaders in all centres stated their commitment to restraint reduction. Some services were progressing this vision and developing more sophisticated trauma informed responses to risk.

All staff in their completed scrutiny questionnaires reported they were encouraged and enabled to prioritise safety and develop relationships with young people. Further evidence of this commitment by leaders was that a large majority (97%) of care staff stated they were trained in a model of restraint, with a large majority also confirming they had training in relation to seclusion. A large majority felt skilled and supported in the use of restraint.

The outcomes from this commitment and training were not consistent however, with some services stated ethos and care practices being more markedly evident in day-to-day practice than others. A large majority of staff we spoke with had a good understanding of the policies in relation to restrictions, restraint and the use of seclusion, with everyone knowing where to locate them. A large majority also felt that restraint and seclusion were used proportionately and only as a last resort and that training opportunities were in place. Here are some comments that we heard.

> "The use of any restraint isn't and shouldn't be the first reaction to a situation."

> "All policies are clear. Also, the use of CCTV in public areas is useful when reviewing incidents which then informs wider learning."

> "In-depth training and weekly input have been essential. I benefit from being able to speak to my mentor and talk things through. There is a clear change around moving away from restraint practices."

> "Feels that the use of restraint and seclusion are reducing. There is an overall will to be inclusive. The right to safety is well balanced."

Some staff in some services reported that their local policy in relation to restraint and seclusion was not always explicit enough to guide and support their practice. Some staff also recognised the need for ongoing training in their service, particularly for new staff and for everyone since the enactment of the Children (Care and Justice) (Scotland) Act 2024.

> "For new staff it would be good if there was more frequent training to help them understand things better especially in trying to understand the difference between time away and seclusion."

> "... now that we are getting a different type of young people [young men from the courts] it would be good to have some specific training in relation to their mental health issues and how to help them. Boys find it harder to open up. Also learning more about the transitions on to the prison system would be good."

We asked staff about their knowledge and understanding of wider policy and legislation that safeguards the rights of, and authorises the care to, children and young people within their service. This included the use of restrictions, restraint and seclusion. All staff we met with cited UNCRC, and a majority mentioned the Secure Care Pathway and Standards appropriately.

However, there was a mixed response from staff in some services in relation to referencing other polices and/or legislation, such as the promise; the Secure Accommodation (Scotland) Regulations 2013; the Children and Young People (Scotland) Act 2014; or the Children (Care and Justice) (Scotland) Act 2024. We are of the view that all staff should fully understand their legal remit and duty when imposing restrictions for each child and young person they support. Where it was necessary we provided written feedback that further training in this area to support staff knowledge would be beneficial.

**Good practice example**

Senior leaders in the service developed a project plan with their specialist training provider to take a whole system approach to reducing, then eliminating the use of prone restraint - one of the most restrictive and high-risk forms of physical intervention that children can experience. They had identified that as staff became more skilled in trauma informed practice, the use of prone restraint was reducing.

The service invested further in training staff to develop co-regulation skills, thus ensuring they had alternative ways to support children to feel safe. Environmental improvement was a parallel process that was improving children's wellbeing. Senior leadership had effective systems in place to closely monitor all incidents of restraint, and detailed analysis informed their targeted approach to change.

In partnership with the specialist provider, independently verified contingency interventions were in place to ensure staff still had the capacity to manage high levels of risk without the use of prone restraint.

Staff engagement was critical to the change process and regular reflective and practice sessions were built into people's working week that supported them to understand the vision and feel equipped to deliver.

This systemic approach to change was successful in eliminating the use of prone restraint in this service. On our most recent inspection some newer staff did not know what prone restraint was, as it was no longer part of the policy, training or practice of the centre.

Senior leaders in all services stated that a significant current priority for their leadership was the recent implementation of the Children (Care and Justice) (Scotland) Act 2024. They described pressures relating to admissions, matching and the changing demographic of children and young people they were caring for. In this context it is noted that the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment reported that children detained under criminal legislation should, in principle, not be held with children deprived of their liberty on other grounds.

It was difficult to discern any themes relating to practice or outcomes from the new legislation, and that was not the focus of this joint review. Senior leaders were aware, however, that service and sector development, including that related to restrictive practices, needed to take this into account.

## 9. Policy, recording and reporting

**I fully understand the reasons for any decision to further restrict my rights and freedoms. These are proportionate and recorded.**
Standard 32: Secure Care Pathway and Standards Scotland



Robust polices, operational frameworks and recording practices are key drivers of safe and accountable restrictive practices. They also facilitate individual and organisational reflection, learning and improvement.

We reviewed the 24 care records of the young people who we met with on the day the Care Inspectorate and the Commission visited each centre together, with the Care Inspectorate reviewing a further 32 records as part of their inspections. The documentation included records of restrictive practices, risk assessments and care plans. We wanted to understand how policies in relation to restrictive practices were being implemented and utilised to minimise the use of restrictive practices.

In all the secure services visited, we saw policies in place to support care provision in practice. Each policy referenced the importance of young people's rights, with physical restraint being used as a last resort when other interventions to support distress had not worked.

We found, however, variation across the four settings, with some policies more robust than others. Some services had focused on making their policy documents concise and accessible for all staff and it was easy to see how this translated into practice. However, other services were working on improving their policies to ensure clarity for everyone and to assist in explanations to young people on practices in place. All staff across the services were able to reference their service's policies and understood the importance of documenting any incidents clearly but we saw a mixed picture of this in practice in some services.

When reviewing care records, we found that some services were not clearly documenting incidents in line with their service policy, such as a lack of detail about what individual strategies were used to support young people prior to restraint, and/or where a deviation from accredited forms of restraint was used to keep the young people safe.

Where services had evidenced that a robust policy was being effectively implemented in practice, we found that the use of restraint had significantly reduced for some young people, with clear documentation on the use of supportive relationships and development of coping strategies. There had also been some good outcomes such as removing the need and practice of prone restraints which needed to be accelerated more consistently across all services.

We were very pleased to see efforts made by some services to use 'Social Stories' to support young people's understanding of why restraint may be used, and what they could expect. This included pictures of types of restraint, with reassuring and trauma informed language which emphasised safety. We found a lack of consistency of recording of restrictions and the use of restraint and seclusion across some of the services. In half the services we visited, we identified the need for improvement in the recording of restrictive practice to ensure decision making and practice was clearly evidenced as accountable, justified and proportionate. Under UNCRC, article 24, the right to health and health services, the Commission would expect to see that all of the young people subject to restraint had a health check following each incident and that this would be documented. However, this was found to be the case in less than half of the young people we met with. Young people mentioned only being given checks following an injury and not as a matter of course. We highlighted this to each service during our visits.

When we looked for details of consent to searches of young people and their rooms we again found inconsistent practice across the services. Where necessary, we highlighted the need to ensure that all searches were authorised and documented, with a clear justification that took account of young people's preferences, privacy and dignity.

# Key findings

1.

Many of the young people we met with told us that they felt safe in secure care settings and enjoyed trusting relationships. All services had a clear, child-centred vision, with organisational values that were trauma-informed and rights based. This reflected a positive ethos in terms of their understanding of the impact of restrictive practices on children and young people and their aim to minimise and reduce their use. We also found many staff to be dedicated and knowledgeable, providing compassionate support to young people which made a positive difference to their time in secure care.

However, there were inconsistencies in practice and outcomes across the services in Scotland. We found that not all young people benefitted from the most effective organisational approaches to minimising and reducing the use of restrictive practices. There are significant opportunities for shared learning across the sector.

2.

Children and young people who are being placed in secure care need, and have a right, to understand the nature of restrictions they will experience before they arrive at a service. We found this not to be the case during our visits and inspections. There is no doubt that the provision of accessible information to young people prior to arriving in secure care is crucial to support their understanding and to reduce anxiety about the unknown. Having someone that the young person trusts accompany them to the service for the first time would also assist with this, reducing understandable fears and be trauma informed.

Services had implemented a number of strategies to inform young people of daily life soon after their arrival, with some of these being creative and innovative, but further work is needed. The initial anxieties and trauma of children and young people could be significantly reduced with more effective communication. There requires to be a wider recognition that the trauma and additional support needs of young people mean this communication should be individually tailored, with young people's understanding and retention of information sensitively supported and tested out.

3.

Young people we spoke to, who had experienced care and support in more than one service, highlighted that the use of different practice models for restrictive practices, including searches, was confusing and unsettling. Having reviewed the range of models and approaches across the four settings, we can understand why this would be the case. There is potential merit to greater uniformity across a sector that is relatively small, specialist and has a nationally significant role.

4.

Whilst many young people were provided with emotional support via a debrief, or health check if an injury was visible, there was not sufficiently consistent and evidenced assurance around physical wellbeing following all restraint incidents for all young people.

5.

Whilst all secure services had access to CAMHS, there was inequitable provision of both dedicated psychological services and forensic CAMHS across the secure care sector in Scotland. We are pleased to hear the issue of CAMHS is being considered in partnership with the relevant health boards and we look forward to hearing about further progress.

6.

The shared visits to services were undertaken following the enactment of the Children (Care and Justice) (Scotland) Act 2024. It was not possible to evaluate the impact of its implementation from this particular piece of scrutiny. Senior leaders in all services were clear, however, that the changing demographic of children and young people, and their new responsibilities, were having a significant impact and there was a need for services to evolve and adapt accordingly.

# Recommendations

## Recommendation 1

Local authorities and partner agencies involved in the placing of young people into secure services should work collaboratively to ensure that every young person receives accessible information about the setting they are going to and about the restrictions that will be in place. This should include information about their rights, access to advocacy and to independent legal advice. Every effort should also be made for the young person to be accompanied by a trusted adult. Where the provision of information to a young person is not possible before their arrival, managers of each secure care setting should ensure information is provided at the earliest opportunity on the young person's arrival in the setting, and that this is recorded in the young person's care record.

## Recommendation 2

The Scottish Government should consider establishing a formal network with the singular purpose of disseminating innovative practice and learning between secure care services and policy stakeholders. This would ensure that good and innovative practice is modelled, replicated, and that there is a consistent approach to support all young people being placed in secure care in Scotland to receive trauma informed care which focuses on the reduction of restraint.

## Recommendation 3

Secure care services should engage with the provider of their practice model of restraint to ensure the robustness of mechanisms to review the physical health of young people who have been subject to restraint. Assurance on the physical health of the young person must be confirmed following every incident of restraint and be clearly documented and evidenced in care records.

## Recommendation 4

Secure care services should action any individual improvements identified through the shared scrutiny related to the recording and quality assurance of incidents of restraint and seclusion. Such records should accurately detail what happened before, during and post incident, including what post incident support and reflection took place with the young person, with their views clearly recorded. This process should also include that any support and learning for staff is identified and actioned. The broader quality assurance of restrictive practices should then identify themes for ongoing organisational development and learning, which contribute to achieving the promise's ambition of children and young people not being restrained.

# Next steps

We have written to Scottish Government to advise that research into the impact of the implementation of the Children (Care and Justice) (Scotland) Act 2024 should be considered. The results should inform all stakeholders on the strategic direction and resources required to deliver the reduction of restrictive practices within this new legislative landscape.

The Care Inspectorate will continue to monitor restrictive practice in secure care services as part of their ongoing inspections. The Commission and the Care Inspectorate will collaborate in 2027, to share progress made in relation to the four recommendations detailed above.

# Appendix 1: Measurement descriptors

The measurement descriptors used in the report are detailed below. The same descriptors are used for the results of pre-visit questionnaire results, the Commission's interview results and conclusions from Care Inspectorate inspection evidence notebooks.



# Appendix 2 : Glossary of restrictive practice terms

Please note: this does not mean that these restrictive practices are all used by secure accommodation services.

### Chemical restraint

Chemical restraint is the use of medication primarily to calm a person, control their behaviour, or restrict their movement, rather than to treat a medical condition. It may be considered only in exceptional circumstances where there is a significant risk of harm to the person or others, no safer alternative is available and appropriate legal safeguards are in place.

### Mechanical restraint

Mechanical restraint is when equipment or a device is used to limit a person's movement or stop them from doing something they want to do. Examples may include mittens used to prevent serious self-injury or straps used to keep someone safe where they would otherwise be at risk of significant harm.

### Physical restraint

Physical restraint is when trained staff hold a child or young person to limit their movement. It should only be used to prevent harm when there is an immediate risk to the child or others, and when there is no safer or less restrictive way to keep everyone safe.

### Prone restraint

Prone restraint is a type of physical restraint where trained staff hold a child or young person face-down on the floor to limit their movement. This is considered a high-risk intervention because it can affect a person's breathing and increase the risk of serious harm. Prone restraint should only be used in exceptional circumstances to prevent serious harm, when there is no safer or less restrictive option available.

### Restrictive physical intervention

A restrictive physical intervention is a physical action used by staff to help prevent harm. This may include standing in a doorway, blocking a child or young person's path, or guiding them away from danger. These actions restrict movement but do not involve holding the person in the same way as physical restraint.

### Seclusion

Seclusion is when a child or young person is placed alone in a room or area and is prevented from leaving. The purpose is to manage a situation where there is a significant risk of harm to the individual or to others and should be used for the least amount of time possible.

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