



Intervention Methods in Secure Care: What Is Going on for Society's Most Vulnerable Children?

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Abstract

Secure care is used for the most vulnerable and high-risk children in society; however, there is insufficient research examining the way intervention methods are used in this context. This study uses a qualitative approach to examine the use of intervention methods with children in secure care. Data is obtained from 21 meetings with 81 professionals who are involved with children in secure care. The findings suggest that considerable variation exists in the way intervention methods are discussed by professionals. Of the 21 meetings, each regarding a different child, professionals discuss at least one method of intervention with 13 of the children. However, there is often a level of vagueness surrounding what is happening to a child as well as an absence of intervention methods for some children. This problem reflects a disconnect between assessment and intervention methods. We believe that applying ideas from Foucauldian discourse theory to secure care settings shows that the (over-)assessment of some children cannot be understood solely as a supportive element of practice, but instead it operates as a discursive and disciplinary mechanism that reinforces institutional controls and norms while marginalising intervention methods and concealing neglect.

Keywords: intervention methods; secure care; children; discourse

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1. Introduction

There are long-standing controversies about the role of secure care in terms of the morality of locking up children, effectiveness of support, and validity of outcomes (Roesch-Marsh 2014; Moodie and Gough 2017; Kilkelly et al. 2023). To date, little is known about the use of intervention methods in secure care, which is surprising given that its primary role is to rehabilitate children and protect the public. This study offers an examination of discussions between professionals in relation to the way intervention methods are used with children in secure care. Whilst there is recognition that secure care provides potential benefits (Nowak 2019), children can also suffer from isolation, neglect, and violence when contained in a locked environment (e.g., Medway Safeguarding Children Board 2019). By examining the way professionals discuss the intervention methods used in secure care, this study contributes to our understanding of practice with society's most vulnerable children. Although the study is conducted in Scotland, the focus on intervention methods and secure care makes it relevant across the United Kingdom (UK) and

internationally for those professionals working in childcare systems that have a responsibility for rehabilitating children and protecting the public.

A Secure and Varied Context

Secure care (locked residential provision) is the most controlling and contentious form of support for children under 18 years of age and serves a dual purpose of rehabilitation and protecting the public (Souverein et al. 2013, 2022). Yet, the nature of intervention methods used in secure care is less well understood (Hart and Valle 2021; Gutterswijk et al. 2023). This is not a minor omission in our understanding of practice, given that secure care provides support to some of the most vulnerable, traumatised, and high-risk children in society (Gibson 2018, 2021; Andow 2024; Martin et al. 2021). A major problem in understanding intervention methods arises from the complex and varying nature of the secure care context. In the UK and internationally, there are considerable variations in the ideologies around welfare, justice, and mental health, as well as different approaches in the provision of secure care (Souverein et al. 2022; Enell et al. 2022). In Scotland, children are admitted to secure care via the children's hearing system due to welfare issues (e.g., protection of themselves or others) or the criminal justice system arising from offending behaviour. Whilst there are different routes into secure care (Nolan 2019), the policy framework—including Scotland's Independent Care Review (the Promise) (Independent Care Review 2020) and secure care pathway standards coproduced with children living within secure care (Scottish Government 2020)—makes it clear that secure care is not designed as a punishment for a child but as a protective and therapeutic intervention. Irrespective of the national context, evidence suggesting that secure care 'works' by achieving desired outcomes is acutely limited (Wood et al. 2024). Pates et al. (2021) found that despite staff being convinced of the success of secure care, there remains a lack of objective and measurable outcomes of the benefits for children. The central critique of secure care arises from the acute power imbalance between staff and residents within a locked environment that creates conditions for unprofessional behaviour (Zimbardo 2011) and where treatment is incompatible with detention to the extent that locking up children can inadvertently increase recidivism (Hermanns 2010; Hanrath 2009). Essentially, locked residential care causes harm because it exposes children to institutional repression and generates negative peer interactions and influences (Dishion et al. 1999; De Valk et al. 2019). Yet, despite such power imbalances, Ellis and Curtis (2020) show that staff can have positive relationships with, and be emotionally invested in, children in secure care. Given such complexities, it is plausible to assume that intervention methods will influence, and be influenced by, the secure care context.

Although there are no intervention methods designed specifically for secure care, the sector draws on interventions from the wider social work and residential care contexts, which use theories and concepts from other disciplines such as psychology and health. These intervention methods generally refer to structured approaches, techniques, and strategies. This is reflected in the intervention methods listed on websites of secure care establishments in Scotland which allude to discrete treatments or programmes and include Cognitive Behavioural Therapy, Counselling, Family Work, and Play Therapy; each of these is applied within a 'therapeutic' and 'nurturing environment' aligned to a 'trauma informed framework'. Similar approaches can be found in other parts of the UK (Atkinson et al. 2023; Teggart et al. 2022). It is important, however, to recognise that not all forms of care and support appear in discrete methods of intervention. Smith et al. (2013) highlight the importance of 'life space' and 'milieu' to fully understand the complexity of the residential environment and the importance of everyday interactions (e.g., mealtimes, play, informal conversations) on a child's wellbeing. In secure care settings, staff may engage in a variety of activities and interactions that support and build relationships with

children as part of daily routines, even though these activities may not be formally recognised or labelled as intervention methods. From this perspective, secure care itself and many of the interactions that occur between children, staff, and other professionals can be considered an ‘intervention’, but not an ‘intervention method’.

From a children’s rights perspective, the application of intervention methods in secure settings is not an optional aspect of care, but it ought to be an integral feature of a child’s support and rehabilitation. Children often feel excluded from this process, however, despite research pointing to features of care that they find beneficial (Templeton and Hayes 2025; Walker et al. 2025). Secure care demands more than mere containment and requires care and support that are proactive and therapeutic in addressing the causes and consequences of children having their liberty taken from them. Article 37 of the United Nations Convention on the Rights of the Child (UNCRC) stipulates that any deprivation of liberty—such as placement within secure care—must only be used as a last resort and for the shortest appropriate time. Applying effective intervention methods is a fundamental way for professionals to adhere to Article 3 by acting in ‘the best interest of the child’ (United Nations 1989) and to ensure a child receives the necessary support whilst remaining in secure care. However, applying intervention methods that respect and uphold human rights within a secure setting is not without its challenges. In particular, the management of risk can be prioritised over more relational and therapeutic approaches, serving to marginalise and undermine children’s human rights (Templeton and Hayes 2025; Haydon 2025; Wroe et al. 2023). This preoccupation with risk is part of a wider neoliberal agenda that is reshaping welfare (Brown et al. 2013; Rogowski 2024) and contributes to the increased use of out-of-home provision such as secure care (Wood and Forrester 2023; Williams et al. 2022). The disproportionate focus on risk highlights how intervention methods in secure care are shaped by wider political and structural factors ranging from early interventions (Featherstone et al. 2013) to the ‘national shortfalls’ that can adversely impact safeguarding systems for children (Firmin and Lloyd 2022). From a rights-based perspective, the application of intervention methods and associated challenges is critical to constructing a more robust understanding of what professionals undertake with children whose liberty has been removed. Without effective intervention methods, secure care can deny children fundamental rights and reinforce cycles of disadvantage, and fail to address the underlying factors that precipitated the child’s entry into the secure environment.

2. Methodology

This study examines the way professionals discuss intervention methods in multidisciplinary meetings in relation to children in secure care. This study is retrospective in that it examines audio recordings from meetings that took place between five and eight years prior to this study. The study examines the following:

1. The extent to which intervention methods with children are discussed by professionals in a consultation meeting;
2. The barriers that limit the application of intervention methods in a secure care context.

The value of this study is in providing insights into the realities of practice, as well as illuminating the way discussions by professionals incorporate and articulate intervention methods aimed at affecting change in the lives of vulnerable children.

Data for the study is obtained from a specialist project that provides consultation, advice, and support to practitioners involved with children who present a serious risk of harm to others. The project is based in Scotland, within a university Social Work and Social Policy department, with its funding linked to the Children and Young People’s Centre

for Justice in the department. The Children and Young People's Centre for Justice provides operational oversight and governance. Referrals to the project could be made from any source, with these predominantly coming from social work practitioners. The consultation meetings (hereafter referred to as meetings) aimed to provide advice to those in attendance as to how best to support the child and their family. Discussion within meetings included consideration of the child's development and early years, family dynamics, previous episodes of harm, relationships with peers and community, existing care plans, accommodation, mental health, education, and legal status.

The project carried out 207 meetings over a five-year period. Whilst the majority of children supported by the project live in the community, the focus of this study is the 21 children (15 boys and 6 girls) who are in secure care at the time of the meetings. Given that the meetings aim to provide an assessment of the child's harmful behaviours and needs along with a support plan, an understanding of intervention methods by the professionals attending the meetings is crucial to the outcomes for children, as well as the decision-making process leading to admission, remaining in secure care, or transition back into the community. Of course, a positive outcome for a child in secure care might involve support from others, such as family and community services (Gutterswijk et al. 2023; Gibson and Whitelaw 2024), and whilst this is important, the current study focuses solely on intervention methods discussed in the meetings, which primarily address the needs of the child.

Although the project is not located within mainstream or statutory social work, it has considerable relevance to contemporary practice. Meetings normally involve the child's social worker, who has responsibility for the child's care plan, and the other professionals in attendance are employed by or have links to secure care establishments. As such, the meetings have the potential to enhance our understanding of the intervention methods taking place within secure care. The duration of residence within secure care for the children varies from one month to seven years, with a mean of 14.9 months. Slightly fewer than half of the children (n:10) were in secure care for six months or less. Most children (n:16) were in secure care for the first time, five children were in secure care for the second time, and one child was in secure care for the fifth time. At the time of the meetings, the children were aged between 12 and 18 years old and were all described as being of white ethnic origin.

A total of 81 professionals were involved across the 21 meetings, including 9 project staff and 72 professionals who made the referrals and/or knew the children. One of the authors of this paper acted as a member of the project staff at that time and was involved in a small proportion of the consultations. Meetings were audio-recorded, and each had between three and nine professionals attending; normally, two or three professionals were from the project and between one and four professionals who knew the child attended (i.e., social worker, residential worker, teacher, psychologist, police officer, nurse, and psychiatrist). Professionals were not represented equally in terms of attendance; social workers, residential workers, and psychologists were the most frequent attendees; hence, the data was not generated evenly across professional groups. All of the meetings took place within a private office within the aforementioned university Social Work and Social Policy department. The project did not permit service users (children, family members, or laypersons) to attend meetings. This might be considered problematic in terms of good practice around participation and involvement (D'Cruz and Gillingham 2017); however, the project's rationale for excluding this cohort is to establish a practice forum where professionals have the opportunity to express their views and feelings in an open and explicit manner and with scope to argue and debate with colleagues. All meetings were scheduled for a duration of two hours. This study adhered to internationally accepted ethical guidelines and was approved by a University Ethics Committee. The professionals participating

in the meetings gave consent for the content to be used for research purposes. All names of the professionals and those discussed at the meetings have been changed to protect their anonymity.

Data Collection and Coding

Discourse analysis is employed to explore how professionals articulate the use of intervention methods when discussing children in secure care. Hardy et al. (2004) argue that discourse analysis facilitates an understanding of written and spoken language in relation to the specific contexts in which it occurs. As such, it provides a means to examine the discussions of intervention methods for children within the distinctive environment of secure care. While there is no singular definition or methodology for discourse analysis, Potter's (1996) focus on the socially constructed and interpretative nature of reality underscores its relevance to this study: professionals play a central role in interpreting and implementing intervention methods. A notable feature of discourse analysis is its capacity to support the coding of language, enabling the identification of frequency and patterns between interactions (Crawford 2004). This allows for the identification of key themes or issues within individual cases and across a broader cohort of children. The discourse analysis is applied to the 21 audio recordings, each relating to an individual child.

The audio recordings of the meetings were listened to by both researchers, and those sections relating to secure care were transcribed. This included any discussion of the child by the professionals about all aspects of being in secure care. Focusing on secure care rather than the content of the full meeting provided a specific and relevant context in which to examine the intervention methods used. The transcript of each meeting was read by both researchers, and any words or phrases indicating intervention methods used with the child whilst in secure care were coded in terms of the type of intervention method and frequency for each child. The coding included words and sentences relating to the intervention that might provide a context for understanding the actions of professionals. For the purpose of this study, intervention methods are considered to be any action or support that is part of a recognised programme or treatment plan involving the active participation of the child with one or more professionals. Any single action or response (e.g., physical restraint, medical examination) when dealing with a child is not deemed to be an intervention method. To illustrate, the social worker refers to the psychologist's input with Donald:

She's doing some family work with Donald and taking it day by day and hadn't been doing too much into his offending behaviour and consequential thinking.

'Family work' is coded as an intervention method. Not all coding is self-evident. Professionals often refer to intervention in a general sense without specifying or naming the particular method. As such, the actions being referred to are not always clear; hence, only intervention methods that are named or evident from the description of activities are coded. For example, a social worker states 'we have several anger management sessions arranged'; hence, 'anger management' is coded as a method of intervention. There are also instances where it is difficult to distinguish between methods of intervention. To illustrate, Jim is cited as 'doing life story work' and involved in 'reparative work in the form of writing letters to others'. It is not clear if the writing of letters is part of the life story work or a separate intervention. Whenever a lack of clarity exists on such matters, they are coded as distinct intervention methods. When there is a discrepancy between the researchers about coding the intervention methods or contextual information, the transcripts are re-read and discussed until a consensus is reached. In an attempt to enhance clarity, extracts from the transcripts relating to intervention methods are used.

A limitation of this study is the extent to which discussions in meetings accurately reflect what is happening in a secure care context. In particular, discussions at meetings

can be affected by the recall of information, and it might not be realistic or possible for childcare social workers with large caseloads to remember the details of different intervention methods with children in secure care. Similarly, there may be some intervention methods that are more tacit in nature and not subjected to discussion at the meetings. Another consideration is that the professionals requesting the consultation meetings have to self-refer (i.e., they have identified specific problems and are actively seeking help and support); hence, they might present differently and demonstrate more insight, openness, and understanding compared to a mandatory child protection meeting. In addition, the dominance of social workers, residential workers, and psychologists in the study serves to limit the range of perspectives, thereby narrowing the potential scope of the analysis. Future studies should consider other research methods such as interviewing staff and children or an ethnographic approach in order to examine the intervention methods in situ. Finally, caution is necessary when making generalisations from this study because of the small size of the cohort and the uniqueness of the secure care context.

3. Results

There is considerable variation in the way intervention methods are discussed by professionals in relation to children in secure care. Of the 21 meetings, professionals discuss at least one method of intervention in secure care with 13 of the children. Figure 1 shows the frequency of references to intervention methods.

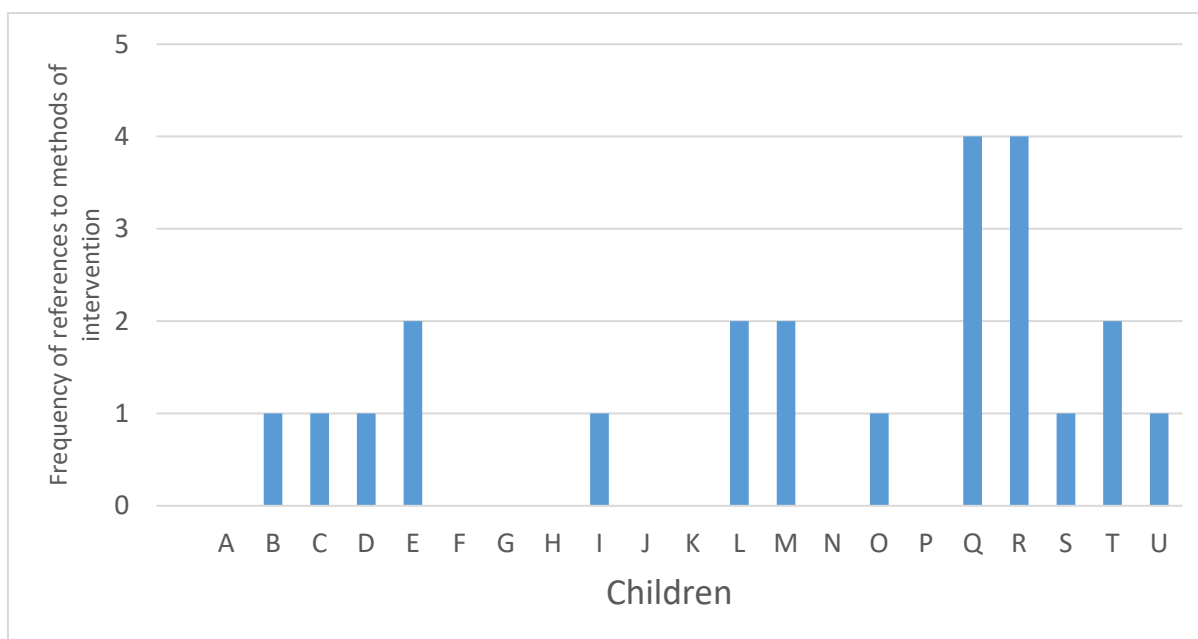


Figure 1. Frequency of references to intervention methods.

A total of 23 methods of intervention are cited by professionals across the meetings and include the following: Trauma Work, Offence-Focused Work, Family Work, Behaviour Work, Film Making, Life Story Work, Reparative Work, Substance Misuse Work, Relapse Prevention Work, Cognitive Behavioural Therapy, Emotional Resilience, Problem Solving, Attachment-Based Support, Holistic Therapy, Counselling, Psychosocial Work, Anger Management, and Mediation. Some intervention methods are cited more than once (e.g., Cognitive Behavioural Therapy), and six children have more than one intervention discussed during the meeting, with a maximum of four interventions for two children. There are eight meetings with no discussion of intervention methods with the children. A possible explanation is the short time some of these children had spent in secure care when

the meetings took place: four of the children had been in secure care between three and five weeks, but the other four children had been in secure care for over 10 months.

All of the intervention methods discussed in this study are generic in that they can be used with other service user groups and in various settings; hence, they are neither specific to children nor secure care. Also, the intervention methods require the child to have some degree of mutuality or reciprocity in the professional relationship. Put simply, the intervention methods are not designed to be imposed upon a child; hence, some level of autonomy and engagement is necessary for meaningful participation. Subsequently, it is not clear how genuinely the intervention methods can be applied when authentic participation is required from a child deprived of liberty. Overall, the low frequency of intervention methods discussed by professionals in this study raises some fundamental issues about the nature of support provided to children in secure care. In order to examine these issues further, it is useful to consider three key areas: insight and shared understanding; barriers to intervention; and effectiveness and a lack of curiosity.

3.1. Insight and Shared Understanding

The insight and understanding amongst professionals appear to vary considerably when discussing intervention methods. There are occasions where the professionals involved with the child know of the different methods of intervention being used. The social worker for Mary (16 years old), who has been in secure care for four months, gives an account of the intervention when asked about the care plan.

Project team: so what is the care plan whilst she is in secure care?

Social worker: there is quite a lot of input. There are interventions identified in relation to social skills and emotional intelligence both within the school and the unit. She is just at the end of 'My friends youth resilience' programme. The purpose of that is to build on emotional resilience and problem solving abilities. She has also started 'Communicake'. I don't know if you are familiar with that. It is an intervention, attachment-based to promote communication and trust. It can be used within Contact (meetings between the child and parents), so we're talking about using it with dad, but at the moment we're doing it with staff members... the clinical psychologist comes once per week and is carrying out a stage one treatment plan for complex post-traumatic stress disorder. She is focusing on stabilisation, behavioural change and positive behaviours for Mary to aim for. Also, you are probably aware of the holistic therapies available, massages, reiki, tai chi. I think she quite enjoys it.

The discussion refers to four intervention methods: this number represents the highest in terms of frequency, with only one other child discussed having received as many different intervention methods. The social worker provided some details about each method; however, this level of insight was the exception rather than the norm.

There are occasions when the professionals involved with the children are uncertain, lack insight, or are confused about past and current intervention methods. When discussing Peter (16 years), who has been in secure care for over two years, there is confusion about intervention methods:

Project staff: had he had any work around substance use?

Psychologist: not in terms of education or anything like that. I don't know if our programmes worker did anything. She initially, after my assessment, did bereavement work with him and then the Ross programme (Cognitive Behavioural Approach) to look at problem solving strategies and coping strategies. I don't think there has been any drug or alcohol work with him.

Nurse: I've done some psychosocial work with him in terms of substance misuse.

The professionals were certain about some interventions and less so about others. It is unclear why the psychologist did not know that the nurse had delivered an intervention with Peter around substance misuse and only found out during the meeting. This was not an insignificant omission, given that drug misuse in the community was a key factor in the child being admitted to secure care. When interventions do occur, they are often presented in a vague way, with some professionals discussing certain actions or tasks without naming the specific intervention method. The psychologist discusses hallucinations in relation to Peter:

we haven't found any evidence that he is experiencing a psychotic illness. We do think he experiences pseudo hallucinations when he is extremely distressed. They fall into two camps. There is one that is quite comforting and I've explored this with him and he sees them as voices. When he was more settled and better, he says it might have been his own voice. The comforting ones are generally around gran and grandpa. The other ones are male voices which usually say just kill him, just get him. Again, it is generally at times he is feeling aroused.

The psychologist refers to the nature of the psychotic experiences and mentions that she 'explored' them with Peter. However, it is unclear if the exploration is part of an assessment or intervention method in the form of counselling or therapy. The lack of precision in labelling intervention methods adds to the confusion about their use.

Despite the majority of the children having been known to social work for several years prior to entering secure care, several months often elapsed before any intervention methods were used. This is surprising as the impact of the problems and difficulties experienced by these children (e.g., abuse, exploitation, violence, drug misuse, offending, arson) is often long-standing, and it is unclear why intervention did not start sooner in secure care. To illustrate, the staff were struggling to undertake an assessment of Lenny, who had been in secure care for over 10 months and was continuing to exhibit some violent behaviours.

Psychologist: We've got to that stage where I think we need to stop and get a real handle on Lenny, but we are really struggling just to get any assessment done and access to his world at all.

Social worker: There does not appear to be much remorse. The last incident he kicked a staff member to the head. He was bragging about it to other young people a few days afterwards and he'll make casual threats constantly to staff.

The lack of any robust assessment, as noted by the psychologist, even when a child continues to exhibit serious violence, might be a factor explaining the complete omission of intervention methods. Put simply, without an assessment, it is impossible to know what intervention method to apply with a child.

There was no discussion of intervention methods for eight of the children, which raises some fundamental issues about the purpose of secure care and the role of professionals. Janice (16 years) has been in two separate secure units (consecutively) for almost 18 months in total and was transferred to the current secure unit 10 weeks prior to the meeting. The complete lack of intervention methods for this child is apparent.

Project staff: so what work had been done with Janice?

Psychologist: well she has been in secure for a year.

Project staff: what did they do with her?

Senior social worker: we started off with her offending. It would have been the Loss programme. There would have been an Anger Management programme.

Project staff: was this before secure care?

Senior social worker: yes, it was before secure care ...I wasn't convinced at that time she needed secure.

It was apparent at this point in the meeting and from the full transcript that none of the professionals who requested the meeting could answer the questions about the intervention methods in secure care. Interestingly, the senior social worker referred to interventions (e.g., offending and anger management) undertaken before Janice entered secure care; hence, there might have been a level of embarrassment or avoidance when answering the question. Later in the meeting, the psychologist made the lack of intervention methods explicit.

Psychologist: in terms of the work undertaken in secure, there wasn't any.

Senior social worker: No, I'm not convinced there was a lot.

Project staff: so there was no therapeutic work.

Psychologist: there were elements offered and she was referred to CAMHS (Child and Adolescent Mental Health Services), which she refused, but was offered another appointment and was seen, but not offered any ongoing intervention.

Project staff: from my own experience, if she was to come through my local authority secure screening she probably wouldn't get into secure care. She wouldn't be high tariff enough. So there is something about having a careful think about what you want secure care to do.

The complete lack of intervention methods for this child calls into question not only the role of professionals but also the purpose of secure care, especially when a child such as Janice has been deprived of her liberty for 18 months. Moreover, the lack of any intervention method appears to be common knowledge; hence, there are issues of accountability that seem to be marginalised or suppressed within key areas of practice. Essentially, there appears to be a complacency regarding locking up certain children among some professionals who have a key role in their care and treatment.

3.2. Barriers to Intervention

The discussions between professionals highlight a range of barriers to using intervention methods in secure care. These barriers include the following: suitability of resources; lack of continuity; and limited reasoning.

The suitability and availability of resources are often identified as problems in providing support to children. After being expelled from a residential school, Alan was returned home by the local authority, where he subsequently assaulted his mother. His violence towards family members was a key factor in Alan originally entering secure care, and there was recognition by professionals that the system had failed him.

Project staff: so he had been at home for a month.

Social worker: yes, he'd been at home for a month without any support, education, stimulation in terms of a routine.

Project staff: we're not really surprised he ended up in secure care.

Social worker: no.

The rapid deterioration in Alan's situation is linked directly to the lack of support after he was expelled from a residential school, which culminated in a serious assault and admission to secure care. The social worker believes secure care to be inappropriate.

Social worker: I don't want him to remain in secure care and the parents don't want him to remain in secure either, but we are struggling to find a suitable resource.

Project staff: there is something incredibly inconsistent about bouncing a child between secure care and a family setting with nothing in-between.

When secure care is deemed to be an unsuitable option for a child, it might be extremely difficult for professionals to know what intervention methods to use in this context.

A difficulty in ensuring continuity of intervention methods often arose during periods of transition for a child (e.g., entering secure care, returning to the community, or being transferred to another establishment). Mark (15 years old) is considered 'very dangerous' and 'extremely high risk' and was recently transferred from another secure care establishment because it offered better throughcare support for his eventual transition back into the community. However, gaps in an intervention method, namely trauma work, became apparent in the previous secure unit:

Project staff: did the secure unit not do trauma work?

Social worker: they did.

Educational psychologist: the difficulty is in following it through, when he left secure care and then he is in a different place, so no one picks it up and follows it through. It just falls of the agenda.

Project staff: if trauma work has been started and not done in the right place and the right way and sequence it can make things worse.

Failing to continue the trauma work has potentially made Mark's situation worse and has arisen because of the poor judgements by certain professionals. It is not a lack of resources per se that is the problem with this intervention method, but rather the failure to ensure that trauma work continues when the child is transferred to another secure care establishment. Continuity of service provision requires intervention methods, such as trauma work, to accompany the individual rather than terminate when a child leaves secure care. In the absence of such continuity, a failure to complete certain intervention methods can result in a child such as Mark, who is already described as very dangerous, presenting an even higher risk of harm to the public.

There is limited reasoning by some professionals in key areas of a child's life, which serves to constrain the use of appropriate intervention methods. The plans for dealing with Linda's (15 years old) self-harm and violence highlight this issue:

Project staff: until now you have all been firefighting, with some really scary situations. Is there a plan around secure care and what we do, for example, when someone is on her hit list?

Social worker: they have a risk assessment for that.

Project staff: ok, but does she understand what that does to relationships when she threatens to kill someone?

Social worker: no.

In the case of Linda, the need for a plan is acknowledged; however, the social worker notes the gaps in the assessment, particularly the child's insight and understanding of her own behaviour. Yet, developing an understanding of her behaviour and impact on others would seem to be a priority in any intervention method, rather than only having a 'risk assessment'. In the absence of more robust reasoning by professionals, it is possible that activities such as risk assessments become the end goal or outcome, rather than the platform on which to identify and apply intervention methods to effect change.

The robustness of reasoning by some professionals on the broader issue of whether or not a child should be in secure care in the first place is also questionable. During seven of the meetings, the referral team changed their perspective about the suitability of secure care for the child. On two occasions, the referral team reversed their position about the appropriateness of secure care and stated that it was not necessary. On five occasions, where the referral staff had presented a plan to return a child to the community, they changed their position during the meeting and asserted that the child should remain in secure care. It is not entirely clear why this turnaround in viewpoints happens with a relatively small, albeit significant, sample of children. Importantly, the authors are not asserting that the new position taken by the referral team is right or wrong. The point is that professionals attend a consultation meeting (presumably) with an informed position on the purpose of secure care that is altered significantly during a two-hour discussion. The implications for intervention are considerable. All intervention methods occur in a context (e.g., family home, school, residential care, foster care) which has to be considered when trying to effect change in the child's life. If the child is placed in the wrong context, especially one as restrictive as secure care, it might limit both the rationale and purpose of any intervention methods.

3.3. Effectiveness and Lack of Curiosity

Whilst at least one intervention method is discussed in 13 of the 21 meetings, the discussions do not include any consideration of the effectiveness of intervention methods with the children. This means intervention methods are discussed without any robust consideration of their success, usefulness, or benefit to the child or other people. More general comments are made about a child 'progressing well' or 'settling into the routine' of the secure unit; however, these relate more to their overall wellbeing rather than any evaluation of a specific intervention method. When discussing Alice (16 years old), who has been in secure care for three months and is awaiting a court trial for attempted murder, the residential worker states:

She is doing a CBT (Cognitive Behavioural Therapy) programme, so she started that in the last couple of weeks and it is actually going quite well. We've been getting continued updates from her programme worker and she has been quite reflective.

The comments about CBT do provide useful information, although it tends to align more with a monitoring role rather than offering feedback about the effectiveness of the intervention method. Perhaps this is to be expected given that the intervention is at the early stages. However, the information provided (i.e., it is 'going quite well') is rather vague in regard to a child accused of murder and who has only been engaging in the intervention method for a 'couple of weeks'. It expresses very little about material changes to Alice's decision-making, her views, or likelihood of using violence to resolve conflict. Despite the lack of clarity, there are no questions from other professionals in the meeting that might prompt a more in-depth account or analysis of the intervention. This is a common aspect of all of the interviews.

A possible factor explaining why professionals do not show more curiosity or ask questions about the effectiveness of intervention methods might arise from the fragmented way in which information is often presented. In the following extract, the psychologist states that a mental health nurse is using CBT with Andrew (15 years old), who is in secure care for the second time:

Psychologist: He's doing CBT with the mental health nurse to address the intrusive thoughts. He's getting a short burst of CBT to address that. The mental health team and psychiatric assessment is to begin tomorrow and he was doing

programme work to address some of the attitudes and offending, but that's been put on hold to allow him to do the CBT, so that he wasn't overwhelmed. That's probably where we are at just now.

There is no explanation of what is meant by short bursts of CBT, any goals, or the nature of the programme work that has been undertaken; therefore, it is not clear if professionals share a common understanding of the intervention method with this particular child. Similarly, there is no account or justification for why the assessment by the mental health professionals is happening four months after the child's admission to secure care, or whether or not CBT is an effective method to adopt in this instance. When there is limited and vague information, professionals might be satisfied that an intervention method is being used, irrespective of whether or not it is effective.

4. Discussion

The range of problems and difficulties faced by the children in this study is often extreme and reflects ongoing trends in secure care (Roesch-Marsh 2014; Gibson 2022; Nolbeck 2024; Nolbeck et al. 2024). Research shows that such high levels of vulnerability, trauma, and risk experienced by children have an adverse impact on their development, particularly the ability to act autonomously and self-regulate emotions and behaviours (Hart and Valle 2021; Heron and Cassidy 2018; Whitelaw and Gibson 2023). Subsequently, there is considerable scope and necessity for effective intervention methods to be used in secure care, yet this is not evident in the current study. The problems and barriers affecting intervention methods in this study are reflected in other research (see Henriksen et al. 2023) and cannot be explained fully by any limitations of those professionals involved with the children. Instead, the deficits in secure settings are primarily located at an institutional and organisational level and are instrumental in creating a disconnect between assessment and intervention methods. Understanding this disconnect helps to explain, at least in part, why limited intervention methods are discussed by professionals in relation to this cohort of children accommodated within secure care.

4.1. Discourse Theory and Over-Assessment

We believe that Foucauldian discourse theory (Foucault 1997) offers a lens for analysing how institutions operate through systems of language, knowledge, and power. A focus on discourse theory is apt, given the study's examination of discussions between professionals who have knowledge about children and in settings where power is ultimately used to remove their liberty. Of course, when focusing on discourse, it is necessary to be cautious about overemphasising the role of language at the expense of the material conditions shaped by structural inequalities such as poverty and deprivation, which are manifest within the secure care population (Gibson 2022; Fook 2002; Rogowski 2021). According to Foucault, the 'discourse' between professionals is a system of knowledge and practices that defines what is considered true, normal, and acceptable in society (Foucault 1997). In professional practice, an analysis of dominant discourse highlights how language, policies, and institutional practices can sustain power imbalances, oppress service users, and regulate their behaviours (Ferguson 2007). In secure care, professional discourse does not merely describe reality; it also plays a role in its construction. Children are often described in assessments and discussed in meetings, as evident in this study, using terms like 'high risk', 'non-compliant', or 'difficult to engage'. Such terminology is not neutral and reflects institutional priorities focused on the management of risk that construct how children are perceived, diagnosed, labelled, and treated.

Over-assessment is central to this process of reality construction. Children in secure settings often undergo multiple and overlapping assessments by different professionals

on areas such as risk, mental health, trauma, education, and violent behaviour. This is an essential part of their care and support, yet it is problematic when the assessment becomes an end in itself, rather than a precursor to intervention methods. This over-assessment aligns with a bureaucratic performance of care, where various procedures and tasks such as excessive paperwork marginalise time for meaningful therapeutic engagement (Parton 2014; White and Featherstone 2005). A performative approach in secure settings distorts the nature of care by deprioritising intervention methods in favour of more assessment. This is not a benign process. Foucault's idea of disciplinary power (Foucault 1980) suggests that in secure settings, over-assessment serves a dual purpose of enhancing our understanding of the child whilst simultaneously acting as a form of surveillance and control. Continuous observation, recording information, and behavioural monitoring are all central to maintaining order in secure care settings. Unless children adhere to certain norms, rules, and routines and regulate their behaviour accordingly, they will be subjected to further assessment, creating a cycle whereby the child's presenting behaviours initiate and justify more assessment, rather than intervention methods to address the underlying problems. That some children in this study are in secure care for over one year without the delivery of an identified intervention method is a fundamental human rights issue and suggests that the insatiable appetite for assessment demonstrated by professionals is indicative of a wider system of neglect. This disconnect between assessment and intervention is a consequence of institutions' (both the secure setting and community-based organisations) rigid adherence to procedures and policy that demand continuous assessment, making it difficult to recognise, let alone challenge, the absence of intervention methods. Foucault's ideas therefore help to illuminate the way over-assessment becomes embedded in 'normal' institutional practices that serve to legitimise inaction around children's rights via the lack of intervention methods. We argue that this is an institutional and systematic form of neglect.

4.2. Implications for Practice

Practitioners responsible for supporting some of the most vulnerable and high-risk children in society often face challenges in engaging in clear decision-making and deliberation (Heron and Black 2024), exacerbated by acute barriers to successful intervention methods in secure care (Jacob et al. 2024). A limited use of intervention methods does not mean secure care has no role or purpose: the importance of keeping extremely vulnerable children safe whilst simultaneously reducing risks to the public should not be underestimated. Caution for practitioners is necessary, however, when secure care is used almost exclusively as a form of containment that does little to address the underlying causes of the heightened levels of risk. The void created by a lack of intervention methods can become filled with the over-assessment of a child that allows for a level of stagnation. This may well exacerbate a child's sense of alienation, with constant assessment not leading to any meaningful change and simply being experienced as hyper-surveillance. Such containment and reluctance to apply intervention methods might reflect contemporary trends in risk-averse practice (Whittaker and Havard 2016; Heron and Lightowler 2023). Put simply, not applying a method of intervention means no one can be blamed in the event of something going wrong. The actions of practitioners are therefore constrained to being 'knowledgeable' about the children via continuous assessment whilst failing to make material changes to the child's circumstances. Any attempt to address the disconnect between assessment and intervention methods at a practice level in secure care is extremely difficult without the support of policy makers and senior management. The value of discourse theory is not only in enabling professionals to better understand and critically reflect on their role, but to challenge oppressive practices and advocate for more inclusive and

empowering systems. As a starting point, the following two strategies should be given some consideration when supporting children within secure care:

1. Rather than accumulate knowledge about a child that does not lead to meaningful change, professionals should ensure assessments are time-limited and linked directly to the intervention methods subsequently adopted.
2. Professionals must evaluate the effectiveness of intervention methods or justify why none has occurred. This will help to foster a culture of reflection and outcome-focused practice with far greater accountability over the decision to deprive a child of their liberty.

These changes could play a small part in disrupting the bureaucratic performance of care and re-position assessment as a gateway to intervention methods that are both relevant and impactful for the child. In the absence of such changes, professionals should be cautious about offering services and support which deny rights to society's most vulnerable children.

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