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Community-Based Alternatives to Secure Care for Seriously At-Risk Children and Young People: Learning from Scotland, The Netherlands, Canada and Hawaii

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Abstract: This article identifies community-based alternatives to secure care being utilised in The Netherlands, Canada, Hawaii and Scotland. These countries offer ways to not only reduce or eliminate the need to deprive children and young people of their liberty in secure care but also reduce rates of child removal and alternative care placements. Secure care is the containment of children and young people, often subject to child protection interventions and residing in residential care, in a locked facility when they pose a significant risk of harm to the community and themselves. An admission to secure care exposes children to restrictive practices, such as seclusion, use of force and restraint. Jurisdictions have an ethical imperative, and often legislative obligation, to ensure there are less intrusive community-based supports available, which could be utilised instead of a secure care admission where possible. However, there is little research on what alternatives effectively divert secure care admissions. Hawaii, Canada, The Netherlands and Scotland demonstrate how countries can reduce the number of vulnerable children deprived of their liberty and exposed to restrictive practices by enhancing research linkages, responding to the voice of lived experience, and positioning secure care and alternatives within system-wide reform.

Keywords: secure care; alternatives to secure care; alternative care; residential care; at risk; deprivation of liberty; child protection; First Nations; trauma; rights

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1. Introduction

There is no consistent and comparable definition of secure care neither in Australia nor internationally. Research and evidence relating to secure care efficacy and risk are also limited [1–3]. However, of the evidence available, we know that secure care can be experienced as punitive and retraumatising [4–6], does not alter their long-term trajectories [7], is an ineffective response for young people subject to sexual exploitation [8,9], and that there can be a high rate of fatality post-discharge for young people placed in secure care due to extremely risky use of substances [10]. This research builds on comparable international evidence and attempts to answer the research question: 'is it possible to manage the serious risk of harm children pose to themselves in the community without depriving them of their liberty?' This research aims to provide alternative approaches to seriously vulnerable children who are a risk to themselves, arguing that community-based alternatives can successfully divert and/or eliminate the need for secure care admissions.

2. Secure Care, Community-Based Alternative Models of Care, and Cohort—Definitions, Practice and Research

2.1. Secure Care

This article considers secure care as the deprivation of children's liberty up to the age of 18 years old when they are deemed by a jurisdiction to be at risk of harm from themselves [11], when they are a risk to others (e.g., Western Australia [12]), or as punishment when they are in conflict with the law (as a substitute youth justice or youth justice

diversionary response, e.g., England [13]). Sometimes, jurisdictions do not distinguish between children in conflict with the law and those in need of care and protection (e.g., Scotland [14]). Regardless of whether secure care also admits children who are a 'risk to others', admission relating to 'risk to self' accounts for a large proportion of secure care admissions in Australia and internationally, which is a significantly under-researched and overlooked practice [15,16]. The terms children and young people are used interchangeably in the article to acknowledge both the legal status (as children under the age of 18) and social categorisation as teenagers, and identification as youth/young people [17].

Internationally, there is no single model or definition of secure care. Secure care models differ in their key features (e.g., target group, secure care operating model, length of stay, who delivers secure care (public or private), regulatory environments and their restrictive measures) [15]. Secure care can also be referred to as and used interchangeably with secure accommodation, secure homes, secure children's homes, secure service, secure care estates, secure welfare services, secure care services, safe care, secure residential care, special care, closed care, closed youth care, closed accommodation, intensive therapy place or secure residences.

Admission to secure care is generally a short-term (a few days to a number of months) intervention for the purpose of stabilising children when they are in crisis [11–14], and it is intended to be a circuit-breaker to protect children from the risks their behaviours can pose. Jurisdictions can often claim detention is required to provide children with treatment [3,12,14]. Regulatory and operating frameworks underpinning secure care are generally located in child welfare systems and guided by the principle of the child's best interests [18]. However, it can be argued that these welfare-based frameworks and principles undermine children's rights, camouflaging the punitive practices evident in criminal justice systems [19–22].

Secure care research is predominately located in the United Kingdom and Nordic countries. However, the research is limited, sometimes conflicting, and often anecdotal [13,23–25]. This likely relates to the vacuum of cultural silence relating to secure care [16,26,27]. The mandate of most research is based on long-term treatment-based confinement programs, not specifically secure-care-type shorter-term stabilisation-based interventions. Research identifying positive outcomes associated with 'secure youth interventions' is generally associated with mental health service delivery systems, i.e., 'inpatient' facilities [28], or secure care facilities delivering intensive mental health treatment [13,28].

Available research suggests that an admission to secure care can be experienced as punitive and harmful [5,6,17]. Further, Sköld and Swain [29] found that secure care admissions and the use of restrictive practices can be retraumatising and have long-lasting impacts.

The longer-term trajectories of children appear unchanged by a secure care admission [7]. Secure care has been found to make little to no difference for substance misuse or mental health outcomes [7]. Klag [30] (p. 1777) highlighted:

> *Regrettably, three decades of research into the effectiveness of compulsory treatment have yielded a mixed, inconsistent, and inconclusive pattern of results, calling into question the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users.*

For most children and young people, secure care is also ineffective in improving externalised and internalised behavioural problems [31,32]. Secure care appears to be an ineffective and punitive response to sexual exploitation [8,9]. Gutterswijk [33] also found that an increased length of stay in secure care does not correlate with improved outcomes. Studies have also found that after secure care, children and young people are often placed in other secure facilities in the youth justice or mental health sector [10,13].

A small recent Canadian study, specifically relating to secure care in response to extremely risky substance use, suggested it may be ineffective and can have an extremely high rate of death post-discharge: 4 out of 17 (24%) young people died from an overdose and 11 continued to struggle with addiction after being in secure care [34].

2.2. Alternatives to Secure Care

Every model of secure care in Australia and internationally has variations, but what is consistent is that secure care is always intended to be a last resort. However, there is limited guidance on what interventions should be tried prior to a secure care admission. What is the hierarchy of support—the interventions that must be exhausted before a young person's liberty is removed?

This article defines 'alternatives to secure care' as diversions and therapeutic interventions designed to address the specific issues or needs of children identified as at-risk of involuntary containment in a locked facility. This article considers alternatives to secure care as alternatives to the restriction of liberty, while other forms of detention (e.g., involuntary inpatient mental health) or Deprivation of Liberty Orders (the restriction of liberty where a young person resides) are not considered as alternatives to secure care. The effectiveness of an alternative to secure care is determined by its ability to minimise or eliminate secure care admissions.

Types of alternatives to secure care could include intensive community-based wraparound support, intensive alternative care placement options (i.e., intensive residential care or intensive foster care), and outreach/transitional support as part of secure care models of care. This article considers alternatives to secure care as fulfilling either or both diversionary and transitional functions.

This research found that many jurisdictions were conflating the provision of alternatives to secure care as part of secure care reform, with the aim to also reduce residential care placements and rates of child removal. As such, alternatives to secure care are not just utilised when a secure care admission is being considered but at an earlier stage to prevent the need for child removal arising and change the potential trajectory in secure care.

The aim to reduce the use of residential care is in line with the United Nations Global Study on Children Deprived of their Liberty [1] and the Ending Deprivation of Liberty of Children, Institutions: A Review of Promising Practice [2], which consider residential care as an institutionalised response that deprives children of their liberty. The Ending Deprivation of Liberty of Children, Institutions: A Review of Promising Practice [2] (p. 6) report provides guidance for the 'elimination of all forms of care that can in its very nature carry characteristics that are harmful to children and where children are at risk of deprivation of liberty due to the organisational and functioning characteristics of care'. As such, while residential care options are being considered as alternatives to secure care, this article prioritises the investigation of community-based forms of alternatives to secure care.

Research over the last two decades has consistently identified the need for alternatives to secure care to be identified and implemented in order to divert children from secure care [35–39]. Marshall's report on Child Sexual Exploitation in Northern Ireland: Report of the Independent Inquiry in 2014 [35] (p. 88), stated:

> *The challenge for society is to provide the kind of structure, safety and quality of care that these [secure care] facilities provide without depriving young people of their liberty and of the opportunity to develop into individuals who can cope with freedom.*

Research suggests that decisions to admit a child or young person to secure care continue to be made due to a lack of suitable alternatives [40–43]. It is often a jurisdiction's judicial system that highlights a lack of alternatives to restrictive orders and places pressure on a system to reform [7].

The need for a robust suite of alternatives is driven by the ethical imperative to ensure there are effective, less intrusive supports available, which could be utilised instead of a secure care admission when possible [7] (p. 196). Clark [44] outlined criteria that ethically justify a secure care placement. Criterion 2 suggests the provision of 'a continuum of care to ensure access to the least intrusive services'. A continuum of care ensures secure care does not exist in isolation. As Warshawski [38] (p. 198) suggested, 'Secure care is not a panacea and must be nested in a fabric of comprehensive care'; however, diversionary alternatives to secure care are often limited and lacking [40,45].

Youth justice in Australia and international best practice has a suite of diversionary options, court orders and interventions, which form a hierarchy of supports leading up to and diverting a young person from detention. Diversionary practice is considered to be rights-affirming, and obligations are as outlined in youth justice international treaties, such as Rule 11 of the Beijing Rules. This rule emphasises the need for alternatives to institutionalisation and that jurisdictions should develop and promote community-based alternatives to detention. Secure care often lacks clear and/or direct diversionary options. Reasons for this could include secure care's position within welfare structures and child rights frameworks.

Transitional support from secure care is also consistently highlighted as crucial to maintaining and building on any progress and/or stability achieved in secure care [12,40,46]. However, transitional support is frequently highlighted as something that is not well managed [12,40,46], and the needs of young people are not being adequately met after secure care placement [34,46]. Harder's [47] study identified that the problems young people experience during their transition from secure care include those in relation to finances, education and employment, and living arrangements (homelessness and insecure living arrangements).

As is the case with secure care, there is very limited research on the models, outcomes and efficacy of alternatives to secure care. A number of studies suggest that close support, an intensive residential support that often operates as a step down/transitional support from secure care, is a promising alternative [12,40,48]. Walker's [7] study also presented intensive foster care as a viable alternative to secure care, provided the carers are adequately trained, rewarded, supported and recognised. However, the risks associated with the use of alternatives have also not been researched.

Williams' [13] report, Unlocking the Facts: Young people referred to Secure Children's Homes, highlights the risks for young people when they are deemed as needing a secure care admission but secure care is at capacity and they are placed in alternative options. Williams stated, "the lack of knowledge of what alternative accommodation consists of demands further exploration to discover whether it is appropriate and if it can be viewed as a real alternative to a SCH [Secure Children's Home]" (2020, p. 9). Williams' [13] report highlighted significant and legitimate concerns about the quality, outcomes for young people, and research surrounding alternative accommodation; however, it defined alternatives to secure care as 'unregistered placements' in the existing service delivery system and found that nearly half were placed in children's residential care and one-tenth in a Youth Offending Institution. This article suggests that alternatives to secure care are tailored interventions, enhancing and/or navigating the existing service delivery options, to prevent admissions to secure facilities when possible.

2.3. Profile of the Children Admitted to Secure Care

Knowing who the cohort are for alternatives to secure care is vital to the development and implementation of interventions that can effectively respond to their needs. Research on the client group is predominately from the United Kingdom; however, there appears to be an international trend suggesting that secure care and alternatives respond to a child protection population, with a significant over-representation of First Nations (a country's earliest inhabitant, e.g., Indigenous Australia) children, who are an extremely vulnerable, traumatised and marginalised population, particularly susceptible to systematic maltreatment [13].

The secure care and alternatives to secure care client group are often children at the acute end of the child protection system. The children admitted to secure care are generally cared for 'by the State'—children on child protection orders [3,43]. At the time of admission to secure care, most children and young people are residing in residential care [13].

Research suggests that the secure care client group have inflated levels of Adverse Childhood Experiences [49]. It suggests they have experienced serious trauma associated with childhood neglect and abuse [43,48,50,51]. As such, they have multiple and complex

needs [52], generally have significant behavioural issues—including violent, inappropriate and/or sexual behaviour [13]—emotional deregulation and are at acute risk of exploitation.

Reasons for admission to secure care can include (and are often a combination of) sexual exploitation, self-harm, substance misuse and/or mental health issues [13,53]. Children admitted to secure care will generally have had multiple placement breakdowns prior to a secure care admission [43] and will experience multiple secure care admissions [15,43]. Internationally, children subject to criminal exploitation are also increasingly either admitted to secure care or recognised as being part of the secure care client group [13].

The over-representation of First Nations children in secure care, while an unchallenged assumption in the sector, is difficult to evidence, as jurisdictions in Australia generally do not make secure care data publicly available. Internationally, data for secure care rarely go into this level of detail. However, considering the evidence of over-representation in youth justice and child protection systems [44], it can be assumed that there is an over-representation that also exists in secure care. This assumption is also supported by data made available by the Australian jurisdiction of Victoria [15].

Secure care is described by Williams [13] as being the consequence of a system, primarily the mental health system, struggling. The secure care client group often do not have access to appropriate mental health or disability support, despite high levels of self-harm and suicide attempts [51], with problematic consequences [54]. The Royal Commission into Victoria's Mental Health System highlighted the problematic distinction between trauma and mental health [55], which is still starkly represented in some models of secure care.

3. Materials and Methods

This article is an extension of the research completed by the author as part of a Churchill Fellowship on effective alternatives to secure care for children and young people at serious risk of harm. The Winston Churchill Memorial Trust offers Australian citizens the opportunity to travel overseas to learn more about a topic they are passionate about and have expertise in, and to bring back best practice that can be applied to Australia. The Churchill Trust funded eight weeks of overseas travel for this researcher to investigate effective alternatives to secure care for children and young people who place themselves at risk of serious harm.

This article aims to identify alternatives to secure care, focusing on the Churchill Fellowship research best-practice case studies. While this research is based on the findings of the Churchill Fellowship and its Australian application, this article departs from that in order to improve the cultural and practice transparency of secure care and instigate investigation and reform of secure care internationally. This research highlights consistent issues that plague secure care internationally.

Key questions underpinning this research included:

- Background: What is/are a jurisdiction's model/s of secure care? What is the evidence to support its effectiveness? What were the enablers for reform—what is the context, how did the alternative to secure care come about?
- Service: What is the alternatives to secure care model? Who delivers it?
- Efficacy: Is there any evidence of effectiveness of the alternatives to secure care?
- Challenges: What are the primary challenges relating to alternatives to secure care?

This article compared four Organisation for Economic Co-operation and Development (OCED) countries or specific jurisdictions with comparable systems in an attempt to compare experiences, seek answers to common challenges, identify good practices, and develop an evidence base and guide to thinking about social policy alternatives to secure care. Hawaii, Canada, The Netherlands and Scotland were selected because they offered innovative alternatives to secure care and because the countries demographically and systemically reflected elements that were conducive to application in other OECD countries:

- Hawaii has a First Nations population and has a bifurcated youth justice and child protection system. Hawaii offers a unique, culturally grounded, evidence-based

alternative model of care, characterised by self-determination and responding to the needs of traumatised youth. Hawaii also has two non-secure models for responding to sexual exploitation.

- Canada (Alberta) has a First Nations population and a bifurcated youth justice and child protection system. It has secure care that is also a short-term crisis intervention, similar to the Victoria/Western Australian models of secure care. Canada (Alberta) offers a comprehensive spectrum of intensive specialist interventions surrounding and diverting from secure care within a mental health framework.
- The Netherlands has a bifurcated youth justice and child protection system with a very similar timeline as to why and when this occurred. The Netherlands demonstrates how powerful the voice of lived experience of secure care can be in driving reform. The Netherlands have committed to using virtually no secure care by 2030 and demonstrated how providers of secure care can quickly evolve to open models of care focusing on outreach and multidisciplinary alternatives.
- Scotland has introduced the *Children (Care and Justice) (Scotland) Act 2024*, which ended the placement of under 18-year-olds in Young Offenders Institutions and raised the age of referral to the Children's Hearings System to include all 16- and 17-year-olds. The future model of secure care is being considered in light of these reforms. Scotland offers models of intensive community-based support. The alternatives to secure care are the culmination of system-wide reform and reflect strong research partnerships and a rights-based approach.

This research used an investigative analysis of predominately qualitative data, site visits to international jurisdictions, policy and practice contextualising for reform consideration. The research required a high level of researcher reflexivity. The researcher was explicit with stakeholders as to the assumptions and the secure care context (Victoria, Australia) of their research to enhance the self-reflective process and collaboratively critique the research process and findings.

This research is the combination of an initial desktop review and literature review, including the analysis of publicly available information. This was further synthesised with findings from the initial jurisdiction online and email discussions and further supplemented with site visits and in-person meetings with representatives responsible for policy, funding, delivery, research and oversight of the secure care and alternatives sector.

Seventeen case studies were completed as part of this research [15]. The case study included in this article for each jurisdiction was the intervention identified by their key senior subject matter experts as being the most successful alternative to secure care, had the most evidence of effectiveness, and that this researcher determined as having the most potential in terms of 'transferability' to other jurisdictional contexts. Due to the lack of evidence/research relating to secure care and alternatives, the information presented is a synthesis of often multiple oral sources. The challenges relating to each case study are also often the synthesis of those identified by the researchers and/or stakeholders in the sector and/or service.

This research project has the following limitations:

- Findings are primarily based on qualitative data provided by system experts. Due to the highly politically sensitive nature of secure care and reluctance of jurisdictions to share quantitative data, only a limited amount of quantitative data was available.
- No outcomes or comparative data (between secure care and alternatives) were evident and/or made available by any jurisdiction.
- International case study data are limited in scope to the representative meetings and sites visited in the countries of Hawaii, Canada, The Netherlands and Scotland.
- Case studies were, in part, chosen by the researcher, who has experience predominately specific to the state of Victoria, Australia. Further analysis will need to be completed to determine applicability to other jurisdictional contexts.

No ethics approval was sought for this research. It was not required by the Churchill Trust and no children under 18 years of age were engaged with as part of this research.

4. Results

4.1. Alternatives to Secure Care in Scotland

Secure care has been considered as part of the Independent Care Review [56], the promise, Getting it Right for Every Child, and the whole systems approach. As part of these system-wide reforms, there is a drive to enhance the availability and standardisation of alternatives to secure care across Scotland. As part of the whole system approach, pilots were funded, and guidance was developed that highlighted good practice in relation to alternatives to secure care and the need to promote these wherever possible. Alternatives to secure care in Scotland, focused on alternatives for children in need of care and protection, were primarily diversionary community-based intensive support, intensive specialist residential care and transitional/diversionary residential care support.

Case Study 1: Glasgow City Council community-based intensive services demonstrate how system design and the provision of long-term, family-based, community-based intensive services can result in dramatic reductions not only in secure care but also rates of child removal and use of residential care.

These intensive community-based/family services are important to consider as part of this research. Secure care is often a trajectory from residential care. Young people usually enter residential care when other forms of care breakdown, i.e., kinship and foster care. Young people also only come into these alternative care settings when interventions in the home are not successful. Early and stronger intervention in the community and home is critical to stem the trajectory into alternative care, then to residential care and then likelihood of secure care exposure.

Case Study 1. Glasgow City Council community-based intensive services.

Background:
Informed by the Independent Care Review [9] and the promise, Glasgow City Council have developed a suit of intensive services and continued care up until the age of 26, with a corresponding Family Support Strategy. Glasgow City Council's intensive services are enabled by the local authorities' collective leaderships' willingness to hold risk in the community. It is based on the belief that secure care provides system relief rather than being driven by children's outcomes.
Glasgow City Council have a Secure Screening Group with representation from mental health, education, residential care and Alcohol and Other Drugs providers. The Secure Screening Group was initially developed to determine who met the criteria for secure care and make referrals to intensive services when possible as a direct, immediate, bespoke wraparound support, as opposed to a secure care admission. The scope of the group later expanded to also consider young people on the edge of a secure care intervention. As such, the Secure Screening Group divert away from secure care to intensive services when appropriate.

Service
Intensive Services:
The suite of intensive services include the following (with additional information on some interventions in the following, and a spotlight on ISMS):

- Intensive Support and Monitoring Services (ISMS)
- Intensive Monitoring and Support Services Education
- Outdoor Resource Centre
- Functional Family Therapy
- Support and Intervention
- Glasgow Intensive Family Support Services

Intensive Support and Monitoring Service: ISMS was launched as a pilot in 2005, in order to provide a direct community-based alternative to secure care for children aged 12 and over. An intensive, multi-agency service package is coordinated around each young person according to their individual needs and risks. Where necessary, a young person can be subject to a Movement Restriction Condition (MRC) that is monitored by use of an electronic tag, requiring the young person to remain at home or some other specified location for up to 12 h per day. The use of the monitoring component is very low, and there are significant limitations to the use of the monitoring function (e.g., the electronic tag uses RF not GPS technology, meaning it can tell when a child has left a house; however, it cannot track/locate a child). It is sometimes used in cases such as sexual exploitation.
Initial pilot funding of ISMS helped introduce a new mindset in Scotland regarding the use of alternatives to secure care. There is also evidence to suggest it is an effective alternative to secure care (e.g., Glasgow City Council ISMS evaluation, detailed below). However, there has been inconsistent availability and implementation across Scotland.
Intensive Monitoring and Support Service Education: Provide education directly to young people (3 × 1.5 h sessions) in conjunction with school and Interrupted Learners Services. They also bring together the three education providers and coordinate service delivery. There is consideration that this service converts to education facilitation rather than education provision.
Outdoor Resource Centre: A highly flexible, creative method of responding to crisis. Support is provided by 8 trauma-trained staff who can work 1:1 with children up to 25 h a week for a long period of time (e.g., 2–3 years). Staff work alongside other intensive supports. Support varies significantly depending on the children's interests and can include boat trips or weekends away.
Glasgow Intensive Family Support Service: Support service for families going through tough times with children at risk of being placed elsewhere. About 50% of the Glasgow Intensive Family Support Services provide placement support (e.g., in foster care), with a particular focus on support in kinship arrangements so the child can return to the family.

Effectiveness
Glasgow City Council attribute their intensive services to **dramatic reductions in their rates of child removal and use of residential care**, which they believe has led to a significantly reduced demand on secure care. Based on the cost of secure care (approximately GBP 6500 a week) and intensive services (approximately GBP 2000 a week), it is believed that for approximately every 30 children, Glasgow City Council are saving about 10.4 million pounds. The evaluation of ISMS found that 'evidence from the case studies and local evaluation and monitoring work indicate that the ISMS and intensive support service programmes have been effective for . . . improved attendance rates on programmes, reducing absconding and reducing substance misuse. There is particularly wide support for the intensive support provision'. Glasgow City Council have also reported:

- A 45% overall reduction in the use of secure care over the last seven years.
- A reduction in expenditure on Secure Care from GBP 3.5 million to 1.7 million in the last five years.
- A reduction in the number of individual children admitted to secure care.
- A 75% reduction in the use of secure care by courts for remand.
- A reduction in the average stay from 21 weeks to 10 weeks.
- 83% of cases meeting the secure care criteria are diverted to ISMS following discussion by the Secure Care Group [57].

Challenges:

- Outcome-based data collection and research comparing secure care and alternative service provisions and relating to how to best respond to young people who require care and protection (as opposed to children and young people who offend).
- Standardisation and consistency of service availability and quality of provision for both secure care and alternatives to secure care across all 32 council areas.

4.2. Alternatives to Secure Care—The Netherlands

The Netherlands refer to secure care as JeugdzorgPlus (youth care plus/closed youth care). In November 2021, The Netherlands Parliament passed a motion to end closed youth care by 2030. The Minister responsible for closed youth care (Ministry of Health, Welfare and Sports, Youth Directorate) responded to the motion by committing to converting closed youth care to open, small-scale residential care by 2025 and to reduce closed youth care to 'close to 0'—with a 'no, unless' principle by 2030. The government of The Netherlands has funded local municipalities EUR 80 million to implement a closed youth care reform agenda, transforming closed youth care to small-scale residential care facilities, setting a strong precedence for other jurisdictions.

The Netherlands Parliament motion to close closed youth care was in large part the result of an influential media campaign led by young people with lived experience of secure care who were supported by The Forgotten Child and Experienced Experts Foundation [58]. The high-profile campaign called for the service sector to stop locking up young people who had not committed an offense and often experienced significant trauma and complex problems. There was public outrage that the practice of closed youth care occurred in The Netherlands and pressure for the closures of closed youth care.

Many closed youth care providers in The Netherlands are in various stages of transition to alternative service provision options. Some providers of closed youth care have completely converted their closed youth care service provision to open community-based alternatives, and some are in the process of transition (e.g., converting 'closed' bedrooms and facilities to 'open' bedrooms and facilities). Providers of alternatives to closed youth care believe alternatives are as expensive as the delivery of closed youth care, coupled with significant reform costs. However, it is believed the long-term costs may be lower as the result of a more effective intervention.

Case Study 2: Thuis voor Noordje outlines how a large, closed care facility can completely convert to outreach and 'open' housing stability. This case study provides an example of how the sector can come together to provide an effective alternative to secure care when there is a coordinated vision and service delivery.

Case Study 2. Een thuis voor noordje—Bovenregionaal Expertisenetwerk Jeugd Noord-Holland (bennh.nl)

Background:

Thuis voor Noordje is a cooperation in the north of Noord Holland (province), which came together with a shared commitment to no longer provide secure care. This cooperation has brought together those responsible for care provision and governance to support children and young people in North Holland who are threatened in their development by complex problems or situations. Parlan is the care provider in this cooperation [59]. Thuis voor Noordje covers a large geographical area with approximately a 2 million population.

Parlan previously delivered a large 80-bed closed care facility with restrictive practices. The average length of stay was six months. Young people admitted to closed youth care had high levels of placement breakdown and/or movement (averaging 8–10 placements) between open residential care and secure residential care. As such, Thuis voor Noordje see housing stability as core to their reform agenda of closed youth care.

As the result of funding changes, including the decentralisation of services to local municipalities, in 2018 it became clear to Parlan that its large-scale closed youth care was no longer financially viable. Parlan believe this financial crisis provided an opportunity for reform. It prompted the establishment of Thuis voor Noordje and what they described as a moral decision to no longer provide closed youth care.

Service:
The following three elements form the crux of Parlan's alternative service delivery response:

- Customisation
- Outpatient care
- Small-scale residential care

When a closed care referral comes through to the organisation, an assessment process is conducted by an individual trained in child development. Intensive outreach and a range of specialist supports are administered (including family group conferencing, individualised treatment/counselling) to support a young person and their caregivers in placement/home and at school. If required as a last resort, an open intensive residential care response is provided. In implementing this new approach, Parlan have also seen a significant decline in demand for residential care, as well as closed youth care.
The residential care offered is intended to provide housing stability and, as such, there is no time period allocated. Parlan currently have two, four- to six-bed (three 'in-house' and three independent living units linked to housing for the older/transitioning cohort) centrally located mixed-gender houses, with 24/7 wraparound support and high staff ratios. Young people are supported to engage with nearby generalist education. There are no restrictive practices or cameras—a harm reduction approach and relational security are utilised.

Effectiveness:
Thuis voor Noordje believe the key to the success of their reform agenda is that their vision/commitment to no longer provide closed youth care is shared by all key stakeholders, across all levels of government (e.g., local municipalities and councils), secondary education partnerships and youth care providers. Ending the use of closed youth care reflected a shared cultural change to the conceptualisation and response to risk—in line with values/principles of all areas/sectors.
Saying 'no' to a closed youth care response has meant a lot of crisis management in the community and supporting stakeholders through this time. Parlan initially converted their closed youth care to a combination of closed and open residential care; however, it quickly became clear once alternatives were in place that they could convert all closed placements to open placements.
The below Figure 1 clearly demonstrates the effectiveness of their alternative service provision in ending the use of closed youth care.
The process of closed youth care reform commenced in 2020, and the area now generally has no closed youth care admissions.

Challenges
Parlan identified the following challenges associated with the implementation of their alternative service provision model:

- It is a struggle to find and gather research to support effectiveness.
- Cultural change has occurred prior to systems change:
    - Funding models—alternatives are not being equivalently funded and can be just as expensive, as there are no benefits of scale and the process of reform is expensive.
    - Education is a challenging component of the model, and at times, very intensive support is required. There is a need for the education models and funding to align with new care service delivery models.
- Outpatient care must be available immediately in order to prevent placements in residential care. They would like to integrate more flexible staffing models and have staff nearby if there is an escalation and additional staff are required quickly.
- It is difficult to provide support to children from their areas when they are placed in other parts of the country.
- Sometimes, other healthcare organisations demand that a child is sent to a closed placement.

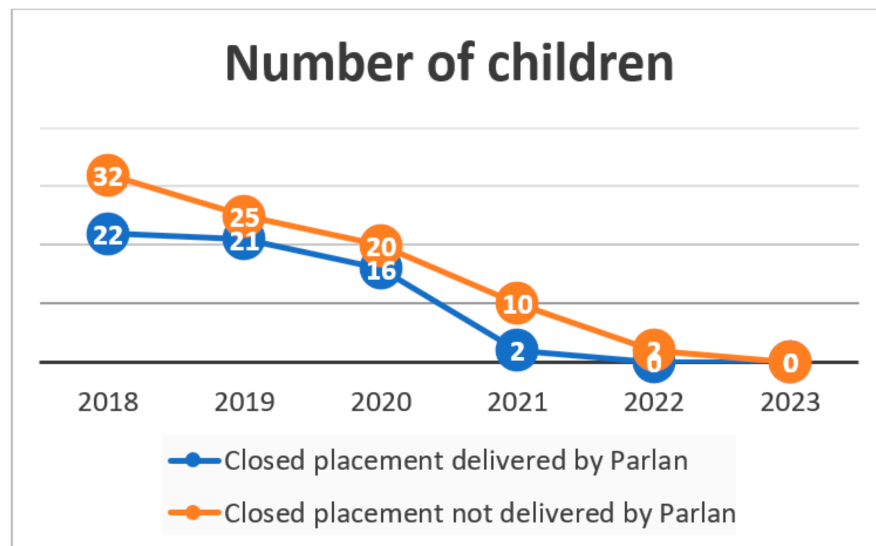

Figure 1. Number of children in closed youth care. Source: Provided by Parlan Jeugdhulp on 20 June 2023.

5. Alternatives to Secure Care—Canada (Alberta)

Hull Services and Wood's Homes are two large campus-based mental health organisations that offered a large suite of alternatives to secure care. Effective alternatives to secure care were considered by the organisations to be intensive community-based specialist supports or residential intensive specialist support targeting issues that face the secure care cohort disproportionately, such as FASDs and harmful sexual behaviour.

Canada has experienced a cultural and practice shift enhancing how interventions respond to the family and community of a young person. There are now specific roles, such as Family and Connections Facilitators (Hull Services) or Family Support Counsellors (Wood's Homes). Both Hull and Wood's Homes have integrated family support services into their models of care and stated that there has been enhanced funding of these interventions, although it is acknowledged that funding systems have not figured out how to fund such services that work across the funding silos.

Wood's Homes, who do not provide or often utilise secure care, offer Therapeutic Campus-Based Care as an alternative to secure care. It provides 24 h intensive, therapeutic support for children and youth who have often experienced multiple placement breakdowns and have complex emotional and behavioural needs. Therapeutic Campus-Based Care is not considered a long-term placement option and has a strong transitional focus. Young people have access to the Whole Family Treatment and the Transitional Services Program, which offer direct clinical engagement and oversight for a 90-day period in the community. Wood's Homes reported that 70% of clients have successfully maintained a stable, less-intensive placement 6 months after exit from Therapeutic Campus-Based Care.

Case Study 3. Acute@Home (Wood's Homes)

Background:
In 2018, Wood's Homes partnered with the Alberta Children's Hospital—Psychiatric Emergency Services—to provide immediate, in-home support, advocacy and system navigation for young people and their families/carers. The aim is to provide a continuum of mental health care through short-term support, which will keep a child at home when there is no imminent risk but the child or young person is:

- at-risk of an involuntary hospital admission, or
- being discharged and waiting for outpatient support, or
- to assist with emergency department overflow.

<u>Service:</u>
The Acute@Home team includes five family support counsellors, a team leader and psychiatric and nursing support from the hospital. The top-five presenting disorders they respond to are:

- Attention Deficit Hyperactivity Disorder
- Generalised Anxiety Disorder
- Adjustment Disorder
- Unspecified Anxiety Disorder
- Major Depressive Disorder

The Acute@Home program provides immediate and intensive outreach to families/carers as they transition from a hospital setting to their family home and community.
Through safety planning, psychoeducation, facilitating referrals and building family connections, Acute@Home supports families in developing the tools to prevent further escalation and establish stability. This program offers one to three sessions that take place with the family over the course of six to eight weeks to help mitigate the need for further hospital presentations.
Clients are referred to the Acute@Home program by Alberta Children's Hospital Emergency Department following a mental health assessment. Once the child is referred, the Acute@Home team will contact the family/carer within 72 h to discuss the child's needs.
The Acute@Home program provides:

- Collaboration with mental health professionals to develop a plan to connect the child and family with immediate and long-term services/resources.
- Short-term flexible care to meet the needs of the child and family/carer (availability seven days a week in your home, school or community).
- Parent and caregiver support and psychoeducation.
- Emotional and mental health support.
- Mental health system navigation.

<u>Efficacy:</u>
The hard-copy factsheet for Acute@Home stated that the outcomes of Acute@Home include:

- 100% of families/carers were satisfied with the care they received.
- 96.8% of clients had a clinically significant improvement in distress.
- 85% of clients had improvement in functioning (Health of the Nation Outcome Scales for Children and Adolescents).
- Increased accessibility, decreased the length of stay in the hospital, shortened the wait time for community clients and eased the presume on emergency rooms.

<u>Challenges:</u>
This intervention primarily supports community (as opposed to children on child protection orders) clients at risk of a mental health inpatient admission; however, it could be adapted to support transitions from secure care facilities.

Alternatives to Secure Care—Hawaii

Hawaii does not have secure care. It offers a range of culturally grounded community-based intensive supports, including wraparound, 'navigation', mental health interventions, and supports specifically targeting sexual exploitation. Supports for children at risk of serious harm in Hawaii are driven by principles of self-determination, access to services and multi-systems approaches. Case Study 4—the Kawailoa Youth and Family Wellness Center—is a stand-out case study, an innovative multi-systems alternative model of care to youth justice involvement. Kawailoa Youth and Family Wellness Center demonstrates to countries with a First Nations population that real system change and self-determination are effective tools to address First Nations young people's over-representation in detention facilities.

Case Study 4. Kawailoa Youth and Family Wellness Center.

Background:

- The Office of Youth Services, Department of Human Services, has led the vision for Kawailoa Youth and Family Wellness Center, advocated for its statutory formation and continues to manage and oversee Kawailoa Youth and Family Wellness Center.
- In 2014, Hawaii legislatively repurposed the land of the Hawaii Youth Correctional Facility to be converted into a Kawailoa Youth and Family Wellness Center.
- A Kawailoa Youth and Family Wellness Center Programmatic Plan was led by the Office of Youth Services and developed by the University of Hawaii and draws on the Native Hawaiian concept of pu'uhonua (place of refuge) to offer young people with deep-rooted and complex challenges a safe place to heal—community-based residential and non-residential alternatives, which respond to the youth, their families and their communities' trauma and cultural needs.
- The process of justice re-investment (moving emphasis and funds to community-based interventions) has been a 20-year partnership approach initially led by the judiciary.

Service:

- The Kawailoa Youth and Family Wellness Center is a First Nations-led response to the needs of young people who have experienced significant family trauma [60].
- Kawailoa translates to 'long waters', describing an ecosystem of youth resources and supports that drive this transformative Indigenous initiative to replace youth incarceration with cultural and therapeutic services that empower youth and strengthen the community [61].
- The aim of the Kawailoa Youth and Family Wellness Center is to provide culturally grounded, strength-based programs in partnership with communities and families [61].
- In 2018, the Office of Youth Services invited community-based non-profits to deliver program services envisioned in the Kawailoa Youth and Family Wellness Center Programmatic Plan.
- In 2020, the Opportunity Youth Action Hawai'i (OYAH) was formally established at the Kawailoa Youth and Family Wellness Center. OYAH is a hui (collaboration/partnership) of state (Office of Youth Services, Department of Human Services) and not-for-profit agencies working to transform punitive modalities of treatment and incarceration with effective therapeutic community-based programs rooted in Indigenous knowledge systems and cultural practices [61].
- Service continuity is viewed as a crucial element of this service delivery. Kawailoa Youth and Family Wellness Center has a shared system framework across education, child welfare and social service sectors, which aligns with the Department of Education's Nā Hopena A'o (HĀ) framework: BREATH outcomes for youth [61] (p. 4).
- The OYAH partners located on-site at the Kawailoa Youth and Family Wellness Center are:
    - Hale Kipa—Hale Lanipōlua Assessment Center (HLAC): HLAC on O'ahu is open to youth ages 12 through 17 who are victims and survivors of commercial sexual exploitation and sex trafficking.
    - Kinai 'Eha: Kinai 'Eha, which means to extinguish pain, provides an alternative education option to 'opio/youth (14–24 years) to support purpose, personal empowerment, education, Hawaiian cultural identity and connection, workforce training in construction and the trades, job placement, community service and leadership.
    - Partners in Development Foundation—Kupa 'Aina Farm: Partners in Development Foundation (PIDF) inspires and equips families and communities for success and service using timeless Native Hawaiian values and traditions. PIDF's Kupa 'Aina farming program uses aloha 'āina (love of the land) to heal youth, families and communities.

- Residential Youth Services and Empowerment (RYSE): RYSE is a youth access centre and shelter that provides housing, medical and mental health support and vocational resources. The shelter serves youth aged 14–24 years, and its day program provides a safe space for unhoused youth to receive drop-in, basic needs services, 7 days a week.
- Department of Human Services, State of Hawai'i, Office of Youth Services—Hawai'i Youth Correctional Facility: Hawai'i Youth Correctional Facility provides trauma-informed care to reform juvenile justice practices, as is the goal of the Kawailoa Youth and Family Wellness Center. This pu'uhonua, referring to a sacred sanctuary or refuge, reclaims a culturally storied place for those in need of guidance and connection.
- Department of Education—Olomana Youth Center: Olomana School is an alternative education school of the Hawai'i Department of Education, offering project-based teaching and learning for students in seventh through twelfth grade, and giving students a fresh start in their learning journey.

Responding to unmet mental health needs:

- In Hawaii, it is believed that some youths were entering the youth justice system partially due to unmet mental health needs (Kawailoa Youth and Family Wellness Center Programmatic Plan, p. 16). There is currently mental health services' provision at Kawailoa Youth and Family Wellness Center; however, there is believed to be a service gap of acute residential services in Hawaii. It is envisioned that HRCY ultimately be repurposed as a mental health delivery residential facility, where young people with mental health issues can receive "individualised, professional treatment under safe and secure conditions" [61]. While there is the desire not to repurpose HRCY with another locked environment, the government are investigating the repurposing of HRCY to a combination of secure and non-secure mental health facilities, which would be run by the Department of Health [62].

Efficacy:

- OYAH were awarded a 2022 W.K. Kellogg Foundation grant of USD 20 million to continue to advance racial equality, continue to gather support and advance its innovative approach [63].
- Hawaii reform to date has resulted in:
  - Reduced incarcerated youth by 82 percent from 2012 to 2022.
  - Periods with no girls incarcerated.
  - Low rates of recidivism [64].

Challenges:

- Institutionalise Indigenous methods of learning and recognition of expertise/knowledge.
- Align contractual requirements and targets with a holistic, whole systems response to young people's needs, regardless of referral pathways or order status (e.g., youth justice or a child welfare client).
- Sharing information.

6. Discussion

The case studies presented above highlight that it is possible to manage the serious risk of harm children pose to themselves in the community without depriving them of their liberty. Alternative community-based approaches to secure care are diverting and/or eliminating the need for secure care. However, a limitation of this research it that there is no evidence available to suggest that one is more effective than the other or that either the use of secure care or alternatives results in improved outcomes for children and young people.

This research found there are significant variations in alternatives to secure care design, provision, funding and availability. However, the jurisdictions believed that the alternatives that were reducing or eliminating the needs for secure care admissions were those that

are available immediately for the purposes of safety and stabilisation, are family centred, and provide continuity of care and long-term support. The successful alternatives could be categorised as either, or a combination of:

- Community-based multi-agency intensive support, i.e., holistic, multi-systems and bespoke.
- Intensive specialist services, i.e., alternative care or community-based targeted specialist interventions, such as mental health, sexual exploitation, disability or sexualised behaviours.
- Diversionary and/or transitional support, i.e., alternative non-secure interventions built into a model of secure care service provision, including outreach, support after discharge and transitional housing.

Alternatives were also believed to be effective in reducing secure care admissions when they were offered as a clear and accessible pathway away from a secure care admission. For example, Glasgow City Council has a Secure Screening Group that can make referrals to intensive services as a direct alternative to a secure care admission. The international case studies of alternative interventions and pathways from secure care offer other jurisdictions a range of options through which they can reduce or eliminate the need for secure care admissions.

This research found self-determination to be a key indicator of strong, culturally safe alternatives to the detention of First Nations children and young people. Typically, First Nations children are over-represented in secure care. Hawaii, however, do not have secure care, have minimal inpatient mental health facilities, no secure disability facilities and are in the process of converting their youth correctional facility site into a heavily culturally informed family youth and wellness centre. Self-determination is a key feature of Hawaii's alternative supports for seriously at-risk children. First Nations leaders were at the forefront of decision-making, system design and delivery. Cultural safety and connection to the community were at the forefront of supports. Hawaii has been recognised as a leader in progressing racial equality [63].

The design of secure care and alternatives is highly reflective of a jurisdiction's systemic gaps and political leanings/risk aversions. Due to the lack of evidence, a jurisdiction's decision not to use secure care was a political and/or cultural acceptance of risk. However, this research suggested that improving transparency and considering secure care as part of broader reform processes facilitates the implementation of and access to multi-system intensive community-based responses for this vulnerable cohort. The following elements were key to a jurisdiction's ability to pave the landscape for the provision of alternatives to secure care:

- Secure care was placed within the scope of broader system-wide reform, and there was a systems emphasis on alternative service provision and pathways from secure interventions.
- There was an interrogation of the need for and minimising/eliminating the use of restrictive practices relating to children and ensuring that legislation, oversight and practice relating to restrictive practices are consistent across disciplines (mental health, youth justice, disability and secure care).
- Analysis of children's pathways into secure care to identify and rectify service delivery gaps and/or blockers to service accessibility was completed.
- Insight was gained from children and young people with lived experience of secure care, listening to their views and placing them at the forefront of reform and ongoing policy decisions.
- All available legal protections were in place to adequately protect children's rights.
- Multidisciplinary approaches to secure care and alternatives were enabled.

Further research is urgently needed in order to measure children's outcomes in relation to the efficacy of secure care and alternatives, but also to compare their ability to manage risk [13,56]. The international jurisdictions that were part of this research reported that on

some occasions, young people and staff had died while in secure care, in non-secure emergency/contingency placements, and after leaving secure care admissions. A secure care facility in The Netherlands advised they recently had three young people commit suicide within an 18-month period. In Canada, a Wood's Homes staff member was murdered by a young person in Personalised Community Care (contingency/emergency placements). O'Brien and Hudson-Breen [10], in their research, found that 4 of the 16 young people with substance abuse issues had died within 6 months of discharge from a secure care facility.

Further research can be broken down into four key areas:

1. Can risk be better managed in non-secure alternatives than secure care?
2. Can alternatives lead to better outcomes than secure care?
3. How can outcomes be best measured?
4. What elements made alternative interventions effective in response to what cohorts need?

Jurisdictions with secure care and/or alternatives to secure care need to ensure they have rigorous data collection mechanisms to measure the short-, medium- and long-term effectiveness of secure care and alternative interventions for children. Consideration should be given to measuring the effectiveness of different interventions for different age groups and in response to distinct issues that result in secure care admissions (e.g., sexual exploitation or substance misuse).

7. Conclusions

This research identified case studies of community-based alternatives that various jurisdictions have identified as successfully reducing or eliminating the need for secure care. The case studies were in response to the research question: 'is it possible to manage the serious risk of harm children pose to themselves in the community without depriving them of their liberty?' They supported the argument that it is indeed possible to respond to the needs of children who pose a serious risk of harm to themselves in the community without depriving them of their liberty. The research further highlighted opportunities to learn from jurisdictions, such as The Netherlands—with their journey of transitioning from secure care to community-based models of care, and Scotland—in placing secure care within broader system reforms.

Further research, however, is required to determine what are the specific elements of alternatives that are effective and to evidence if alternatives are more effective and rights-affirming than secure care. The precedent studies from Hawaii, Canada, Scotland and The Netherlands suggest a number of ways other jurisdictions can bring secure care in line with international, contemporary practice of secure care, emphasising alternatives. These countries offer ways to not only reduce or eliminate the need to deprive children and young people of their liberty but also reduce rates of child removal and alternative care placements. Listening to children with lived experience, supporting First Nations people to decide what is best for their children and considering alternatives to secure care as part of broader reform reveals a pathway to progressing both self-determination and the de-institutionalisation of seriously at-risk children and young people in care.

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