Advice Note: Secure Care
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1. Context and purpose

This advice consolidates the position I have set out in correspondence and advice since February 2025, updated to reflect the evidence now available and the policy choices that are coming into view. The immediate capacity pressures of early 2025 required action, but I was clear then that short-term restoration must move Scotland towards, not away from, the conclusions of the Independent Care Review and the Reimagining Secure Care vision.

The central advice is now sharper - Scotland should use the space that has emerged in the secure care estate to begin a planned transition to a smaller, more specialised and more flexible model by 2030. This should not be an indiscriminate reduction in beds. It should be a deliberate reconfiguration of national capacity around the needs of the small number of children who genuinely require highly restricted care, alongside a substantial strengthening of community, family and mental health alternatives.

That transition cannot safely be delivered through the current governance and commissioning arrangements alone. The capacity problem and the governance problem are connected. Scotland is trying to manage a national, rights-based function through four independently governed charitable providers, local and national purchasing arrangements, and no single national mechanism that owns placement coordination, demand, capacity, outcomes and the relationship with alternatives. A bed can therefore be vacant without being genuinely usable for the child who needs it.

2. What keeping the promise in Secure Care requires

The promise did not describe a future in which Scotland simply maintains or fills the existing estate. It described a radically different response to the small number of children who need security, care and protection.

- Fewer children will live in secure care, and highly restricted environments will be used only when necessary - not as an escalation when other interventions have failed.
- Planning and provision will reflect the needs of children in Scotland, with sufficient places for those who need them and accessible community-based alternatives for those who do not.
- The underlying principle of secure care will be therapeutic, trauma-informed support, with a range of interventions capable of meeting children's health, education and additional support needs.
- Specific residential and therapeutic provision will be available where particular needs require it, including for girls who have been sexually abused and exploited.
- Children will remain connected to family and community wherever it is safe to do so, and transitions out of secure care will be supported through appropriate intermediate and community provision.

The test for 2030 is therefore not whether Scotland has the largest possible number of secure beds. It is whether the country has the right specialist capacity, in the right form, for the right children, while ensuring that far fewer children need secure care at all.

How will Scotland move from managing vacancies across four independently governed providers to planning and governing a national system of therapeutic support, so that it can deliberately reduce the use and footprint of secure care while guaranteeing the right specialist support for every child who needs it?

3. The evidence

In February 2025, the presenting issue was acute pressure on capacity. My advice was that this should be treated as a symptom of wider systemic challenges rather than answered by simply enlarging the estate. By November 2025, greater stability had been reported and I advised that the focus should shift from contingency to the future. The evidence published since then strengthens the case for making that shift.

Issue	What the data shows	Why it matters
Long term use	Admissions fell from 256 in 2016 to 128 in 2024/25. Average residents fell from 82 in 2020 to 58 in 2024/25.	Use has reduced substantially over time. Future planning should not assume historic demand will return.
Capacity	Up to 70 standard beds were available in 2024/25. The maximum occupancy during the year was 65; the minimum was 51. There were 52 children and young people in Secure Care on 31 July 2025.	There was aggregate headroom even during a period remembered for acute pressure. There is space from which transition planning can begin, although this is a point-in-time snapshot and vacancies are not interchangeable.
Emergency use	Emergency/short-term beds were used for 145 nights in 2024/25 despite average occupancy being below the available bed numbers.	Spare beds can coexist with placement pressure. Matching, suitability, staffing, coordination and system design matter as much as headline bed numbers.

The important conclusion is that the problem can no longer be understood as a shortage of generic beds.

The coexistence of vacancies, falling long-term use and periods of emergency-bed pressure is better understood as a mismatch between nominal capacity and usable, needs-matched capacity. Published sources also use different methods of understanding capacity - contracted places, registered or operational capacity, reported vacancies and actual availability for a particular child. That lack of a single national picture is itself a governance issue.

4. The governance problem behind the capacity problem

Scotland's four secure care centres are independent charitable organisations, each with its own governance arrangements, leadership, workforce and operating model. The current system relies on spot purchasing and local commissioning, while the Scottish Government's 2026 consultation acknowledges that Scotland does not have a national placement commissioning mechanism or national oversight of placement decisions, demand or how the needs of individual children map to vacancies across centres.

This matters because secure capacity is not interchangeable. Individual centres can make decisions about whether they are able to meet the needs of an individual child, taking account of the children already living there, staffing, risk, mix, therapeutic capability and other operational considerations. Those decisions may be entirely appropriate when viewed from the perspective of that child and centre. Centres can also make collective decisions or take common positions that affect the wider operation of the sector. But there is no single national decision-maker responsible for reconciling the cumulative impact of those decisions with Scotland's statutory duties, national capacity requirements and the rights of every child seeking a place.

The result is a structural contradiction - a place may exist on a capacity return but not be available in practice, one provider's locally rational decision can contribute to a national shortage, and government can be accountable for access without controlling all of the decisions that determine access. This helps explain how Scotland can experience both vacancy and crisis at the same time.

The funding model compounds the problem. The Scottish Government consultation notes that providers require occupancy at around 90% to break even. A model that depends on consistently high occupancy creates obvious tension with a policy objective of reducing the number of children deprived of their liberty. If Scotland is serious about shrinking the use and footprint of secure care, it must first or simultaneously change how resilience, specialist availability and unused contingency capacity are funded.

The central structural challenge is that Scotland is seeking to deliver a national, rights-based function through dispersed governance, fragmented purchasing and provider-level control over much of the capacity that government must ultimately guarantee.

5. The impetus to shrink and specialise

There is now enough evidence to begin planning the transition rather than waiting for the estate to become full again. The direction should be towards a smaller overall footprint and a more

differentiated offer, with capacity defined by children's needs rather than by the number of generic beds. The conclusions of the Independent Care Review provide a clear framework for the experience children should have and for the way the national system should be designed, funded,

commissioned, governed and evaluated. The principles below translate that framework into practical implications:

The promise secure care commitment	Issues for consideration in practice
Last resort and shortest time	Highly restricted care should only be used where necessary. Hearings, courts and professionals need confidence that viable community and health alternatives are available, understood and considered before Secure Care is used.
Therapeutic and trauma-informed	The estate must be commissioned around therapeutic capability, not simply bed availability. Children should have reliable access to mental health, education, specialist and additional support while in Secure Care.
Needs-led and individualized	A place is only real capacity if it can safely meet the child's needs. National planning should therefore understand capability, mix, staffing and suitability rather than relying on a single vacancy number.
Specialist where required	Scotland should commission distinct functions and settings where children require them, including smaller home-like or flex-secure models and specific therapeutic provision for particular groups.
Family and community connection	Distance and placement decisions should minimise disruption to relationships wherever safe. Community alternatives and transition services should be part of the same national planning framework.
Continuity and transitions	Children leaving Secure Care need planned intermediate and community support. Length of stay should not be extended because onward support or accommodation is unavailable.
Rights and participation	Children's rights, views and best interests should shape individual decisions and the design and evaluation of the system. Scrutiny should test lived experience as well as compliance.
National sufficiency	Scotland needs enough usable, needs-matched capacity, including an explicitly funded contingency reserve. Sufficiency should be judged nationally rather than centre by centre.
Integrated alternatives	Intensive family support, community multidisciplinary responses, mental health and education provision should be treated as part of the infrastructure that determines Secure Care demand.
Sustainable governance and funding	Governance, commissioning and funding should support lower use, specialism and resilience. Provider financial viability should not depend on keeping occupancy close to full.

Achieving the commitments set out above in practice is a sequencing challenge. Scotland should not remove capacity faster than alternatives and specialist capability are created. Every bed closed or repurposed should be matched by demonstrable capability elsewhere in the system. The aim is not scarcity - it is a planned reduction in reliance on secure care while increasing confidence that the right place will always be available for the small number of children who need it.

6. Specific actions for Scottish Government

There is now broad agreement about the direction of travel - fewer children in highly restricted care; stronger alternatives, more therapeutic and specialist provision, and better coordination. The barriers to implementation are increasingly structural. They require government to create the conditions in which the desired model can operate.

barrier	action
Fragmented governance means no single body owns national capacity, access and outcomes.	Establish a national placement and coordination function with live visibility of referrals, actual availability, admissions decisions and alternatives, and clear authority to coordinate and escalate across the system.
Provider-level decisions can be individually rational but collectively create national access problems.	Create explicit national decision rights, escalation arrangements and transparent reasons when a place is unavailable, while preserving providers' responsibility to make safe decisions for individual children.
Headline bed numbers obscure whether places are usable for particular needs.	Move to needs-based capacity planning and publish one national picture covering referrals, grounds, admissions, refusals and reasons, staffing constraints, vacancies, actual availability, length of stay and unmet need.
Generic provision cannot reliably meet the range of needs of children entering Secure Care.	Commission defined specialist functions - including small-house/flex-secure provision, therapeutic settings for particular groups and capability for complex health or additional support needs.
Occupancy-dependent funding can penalise successful reductions in Secure Care use.	Move towards national, block or hybrid funding that pays for readiness, resilience, specialist capability and contingency capacity as well as occupied beds.
Secure Care planning is disconnected from the services that determine demand.	Plan Secure Care, Foxgrove and wider mental health provision, intensive family support, community multidisciplinary support, education and transitions as one continuum.
Short-term capacity management competes with long-term reform.	Publish a national Secure Care capacity and reconfiguration plan to 2030, using scenarios and clear milestones for creating alternatives, repurposing capacity and reducing the overall footprint safely.
Cross-portfolio responsibilities make accountability diffuse.	Put cross-government and local-government governance around the transition, with clear ownership, decision rights, milestones and mechanisms to resolve barriers that sit between portfolios or organisations.
Workforce capacity and specialist capability can determine whether nominal capacity is usable.	Build workforce planning into national capacity planning, including the skills, staffing model and therapeutic capability needed for specialist and smaller settings.

The timing is important. The Scottish Government and COSLA have said that the next joint action plan will follow the future of secure care consultation, and the Programme for Government 2026-31 commits government to respond to that consultation so that future plans, resourcing and the legislative landscape deliver access to the specialised services children need. This creates a clear opportunity to move from restoring the existing model to deliberately designing the 2030 model.

The action plan should therefore not freeze the current estate in place or treat restored capacity as an end in itself. It should set a route from the present four-provider, occupancy-dependent model towards nationally coordinated provision in which fewer children are deprived of their liberty, the estate is smaller and more specialised, and every child who truly needs secure care can access an appropriate therapeutic place without delay.

7. What next?

The immediate opportunity is to use the Scottish Government response to the future of Secure Care consultation, the forthcoming joint action plan and the commitments in the Programme for Government to establish the direction and sequencing of this transition.

Further work is needed to determine the national governance model, the commissioning and funding mechanism, the specialist functions required, the scale of contingency capacity, and the

milestones against which capacity can safely be reduced or repurposed. This work should be undertaken alongside the expansion of community, intensive family and mental health alternatives so that change in one part of the system does not create crisis in another.
The Independent Strategic Advisor and The Promise Scotland stand ready to work with Ministers, officials, local government, Secure Care providers, health partners, the third sector, children and families to develop the transition and ensure that decisions taken now make it more, not less, likely that Scotland will keep the promise by 2030.