‘The Therapy Of Fear’ A Report On Complaints Received By Naypic From Young People In Adolescent Psychiatric Units.

THE THERAPY OF FEAR
A Report on Complaints Received by NAYPIC from Young People in Adolescent Psychiatric Units, both NHS and Privately Run.
By Mary Moss, London Development Officer & Chris Fay, Adult Adviser, 1990.

Introduction

We would like to make it clear that neither of us has any medical or psychiatric training. Our study is purely one based on casework and complaints received by us from children and young people in locked in adolescent psychiatric and secure units. What we have tried to do is express their views and feelings regarding their experiences. As an organisation concerned with the rights of young people, our conclusions are based on questioning the moral, ethical and human rights aspects of the treatment these young people experienced. However, we believe that the issues highlighted by this study raise serious questions regarding the ethical and moral basis of both the medical and social work philosophy that justifies the use of these establishments.

We are particularly concerned at the huge growth in private adolescent units. Our research shows it is now big business. We seriously question the regimes operated in these establishments, which appear to operate on the borderline of acceptable practice. Of major concern is the almost unrestricted and unsupervised use of drugs, a number of which are experimental. We certainly came across many cases where drugs intended to treat specific medical conditions were being used in ‘cocktails’ as sedatives or for restraint. As far as we can ascertain, no checks or monitoring are carried out by either Department of Health or Area Health Authorities. The regimes themselves are brutal, humiliating and degrading for the children. The long-term damage to these young people is incalculable.

Apart from the statistical analysis, we give individual case examples which highlight the issues raised. In both NHS and private units little, if any, regard appears to be paid to the basic human rights, legal rights or civil liberties of the young people concerned. The law itself seems to be widely ignored or flouted. We have omitted the names of young people and omitted referring authorities to protect the identity of the young people and maintain confidentiality. Wherever possible, we have obtained the young people’s permission to use their cases in this study.

On a personal note, there were two fundamental issues raised in all the cases seen that made it difficult to cope with the anger we felt. Indeed, all of us at NAYPIC felt these issues were at the very heart of what we stand for.

Firstly, all of these children were at the bottom of the heap. The intractable, long-term cases of children, most of whom had been in care for a long time. They had all suffered the worst the ‘care’ system could inflict – sexual, physical and emotional abuse, many placements, cut off from family and friends. They were isolated, vulnerable victims who were labelled ‘disturbed’, ‘maladjusted’ etc. These units were usually the end of the line – the dumping ground for difficult cases. We seriously question any justification for dumping physically handicapped, mentally handicapped, mentally ill and ‘disturbed’ children from care in the same units, in particular America Medical International’s (AMI) Langton House.

Virtually every social worker responsible for young people was extremely defensive and could offer little real social work justification for placement in such units. Mostly they were the only placements available that would take these children. One social worker opening admitted it was the only place that would take his client, a 15 year-old girl – it was either that, or prison on an unruly certificate. Given the way she was treated, prison would have been a preferable alternative in her view.

Secondly, there was an issue that goes right to the heart of living in a civilised, humane and caring society. It is the most basic of all human rights, not just for children and young people, but for everyone to be able to live their lives free from fear. The experience of every one of our referrals was of living in these places for months or years in a constant state of apprehension and fear. Afraid to laugh or cry; to smile; to protest; often to play or engage in any activity or even to show happiness or sadness. Living in constant fear of restraint and the 'jab', electroconvulsive therapy or even punishment. The fear of being humiliated and degraded just for showing normal human responses to mistreatment and neglect, the use of 'mood inhibitor' drugs to produce controllable zombies, devoid of human emotion. All of this 'justified' as behavioural therapy. There can be no justification, medical or moral, that uses fear, humiliation and degradation as a 'therapy' to treat the survivors of abuse. Children have a right to childhood and all that entails; to be robbed of this in the name of therapy is cruel, inhuman and unacceptable. This abuse of children must be stopped and these practices outlawed as they directly contravene basic human rights.

Chris Fay, July 1990

Statistical Data

1. Period of complaints: July 1988 to July 1990

2. Total number of complaints: boys 65, girls 169

3. As a percentage of all complaints received by NAYPIC:

Complaints against NHS Units 156

Complaints against private units and nursing homes 72

Complaints about others 6.

Details of Complaints

Sexual abuse girls 132/78%, Boys 16/25%

Physical abuse 97%

Improper/overuse of restraint 100%

Strip/body search 87%

Use of sedatives in restraints – 'the jab' 57%

Use of experimental drugs 34%

Unnecessary medical treatments 30%

Unlawful imprisonment 65%

Humiliating and degrading treatment 97%

Failure to investigate complaints 75%

Racism 39%

Sexist and verbal abuse 65%

Complainants of ethnic origin 39%

Reviews not carried out 48%

Failure to consult 98%

Denial of access to parents/relatives 72%

Denial of access to independent advice 100%

Emotional abuse/neglect 100%

Living in fear 100%

Failure to recognise/treat previous abuse 76%

Inappropriate placement 80%

Move away from home area (more than 100 miles) 85%

Wrongful use of therapy 12%

Analysis of Complaints

1. NATIONAL HEALTH SERVICE UNITS

We received complaints regarding the regimes at 17 psychiatric hospital units, spread across the country. Some were complaints from a single young person about his or her treatment within a unit, often as part of a general complaint about treatment within the care system. These young people tended to have been 'known' to social services and the psychiatric service for many years. Most had been in and out of care and through a variety of 'care' placements. All had initially been the victims of some form of abuse. All our young people felt that this initial abuse was either ignored or soon forgotten, as they were 'labelled' due to their behavioural difficulties which were as a result of extreme behaviour problems, constant running away from care or behaviour perceived as overtly 'sexual'.

There were particular establishments about which we received many complaints, the worst in this respect being Hillend Adolescent Psychiatric Unit near St Albans. A total of 17 young people complained about the regime and their treatment there. The next worse was the unit attached to Bexley Psychiatric Hospital with 9 complaints. We have to say that in virtually all the cases we dealt with, the young people's complaints were rarely taken seriously. Where we did get a response, it was the usual one of 'malicious complaints' from a disturbed, or group of disturbed, young people. One psychiatrist wrote 'one must realise that in a group of very disturbed young people, this (malicious complaints) is not surprising'.

None of the young people felt they were believed and none felt their complaints were fairly or properly investigated. In one case a girl had been raped on several occasions (this was acknowledged by the unit) and they had reported it to the police, together with complaints by other girls, all under 16 years of age. The rapes had been carried out by a disturbed adult patient. Yet the unit could not explain why this man had access to the adolescent unit, nor would they accept any responsibility for the lack of supervision which had placed these young people at risk.

At Hill End, we received complaints from two young people who seem to have been sent there purely because they suffered from anorexia nervosa. Both had been committed under Mental Health Act legislation and had been kept locked up on secure wards. Their 'treatment' appears to

have been solely behavioural modification 'therapy' and use of sedative drugs. The use of drugs, particularly largactil and haraparadol, both as treatment and during restraints is a common and widespread practise. At Hill End, we also had many complaints from young people (supported by staff) that sedation was used as punishment. As an example, one young person, out of sheer boredom, set off the fire alarms. As she did not own up, all eight young people in her dormitory were sedated for 24 hours. Those that did not take it voluntarily were forcibly sedated.

Another common practise at Hill End and other units was that during forcible restraints, their trousers and undergarments were pulled down and injections administered in their buttocks or thighs, often violently. All young people felt humiliated and sexually assaulted by this treatment, particularly female young people, subjected to this treatment by male staff. They often complained of being 'groped' or 'touched up' by males in these situations. All the female young people who complained had been subjected to strip searches on occasion by male staff and about 60% of those had also been body searched. The most common excuse being searching for glass or other sharp objects with which young people could damage themselves. Yet most young people felt that the circumstances at the time of the search gave no rise to any real concern that young people had any such items. Generally, strip searching appears to be part of general routine procedures within units. For instance, young people being strip searched after visits by social workers because 'that is the rule.'

Another disturbing feature was the length of time young people had been on sedatives, most for many years. One 15 year-old had first been put on valium aged two. Another 17 year-old girl had been on largactil since the age of four. When we saw her, she was also taking tegretol and other drugs. She suffered from ulcers, kidney problems, anaemia and muscular spasms. Many seemed to be on extremely high doses, such as the young girl who appeared to be on 100 mg doses of largactil four times daily, plus sleeping pills. The general picture that emerged appears to indicate the indiscriminate use of largatil, valium, haraparadol and tegretol, as a substitute for real therapy for the abuse that was the initial cause of their problems. In all the cases we investigated, not one of the young people's social workers questioned the use of sedatives or drug therapy on their clients or saw it as their place to question this treatment.

Sexual abuse appears to be common-place in these establishments. 78% of females reported being sexually abused either by male staff or by other male patients. About 25% of boys reported sexual abuse by male staff. Many did not complain as they felt they would not be believed. Even we were shocked when one 13 year-old girl expressed surprise that we thought she should complain. Since an early age, she had been sexually abused by most male carers she had been in contact with: father; an uncle; a teacher; two different foster parents and care staff in her homes. The child saw nothing unusual in having sex with one of the male nurses in her unit – it was normal 'affection' to her.

We were also shocked to find how little understanding these units actually had in dealing with sexual abuse victims. Self-mutilation appears to be seen solely as a symptom of low self-esteem or as attention-seeking behaviour. Even young girls who slashed their breasts or faces were diagnosed as such, with little thought to the cause of such extreme behaviour. In most cases we dealt with, we discovered undiagnosed sexual abuse and the resultant guilt and low self-esteem were the prime cause of such behaviour. But we are not doctors nor psychiatrists, so what price our credibility!

Disturbingly, in one case of an isolated complaint, we were convinced that the girl was part of an organised sexual abuse ring and used the unit as an 'escape' from this abuse. Although she had some difficulty in distinguishing reality, mainly due to the heavy sedation, there was enough in what she told us for us to recognise the only too familiar signs of such organised abuse. It is worth mentioning that we come across organised abuse and ritualistic abuse quite a lot and it has been increasing to a disturbing degree, particularly satanic ritualistic abuse. However, the unit concerned above seemed unaware of the problem and ridiculed our suggestion they should explore the issue with the girl. They said it was all sexual fantasy and the girl had a history of sexual promiscuity and overt sexual behaviour from a very young age. Nobody seemed to have bothered to find out why.

Most young people, we found, accepted being locked up as par for the course and rarely questioned why. They seemed to accept that staff decided it was for their own good. When we looked at how the young people got there, only a few were detained under Mental Health Act legislation. Most were 'voluntary' admissions, although few of the young people felt they had any real say in it or were consulted properly. None of the young people felt that any real, alternative therapy was even discussed and most felt 'persuaded' by social workers that it was 'for the best.' We came across a disturbing number of cases (67) in which 'voluntary' admission or a secure unit was the choice these young people faced. We came across one girl who, during psychotherapy at a secure unit placement, had disclosed sexual abuse to her therapist. A review decided on her transfer to an adolescent psychiatric unit (she was a Ward of Court). At the unit she was put on sedation. After four months she was transferred back to the secure unit. She had received no therapy other than drugs and three half-hour sessions with a psychiatrist. She reports that she was being restrained constantly and if she did not comply immediately, she was forcibly injected with haraparadol. The girl was physically abused and had been sexually assaulted by a male patient. She attempted to cut herself on several occasions, but this only led to her being kept heavily sedated for three days after. Eventually, her behaviour became so bad she was sent back to the secure unit, in a far worse state than when she had left it. She was still on largactil and tegretol months later.

Another girl, aged 16, had been constantly in and out of psychiatric units since being taken into care at the age of three, following sexual abuse. She had been on sedation for many years and, when we saw her, she was taking 350 mg largactil daily and tegretol. She first came to us for help because the adolescent psychiatric unit she was in had closed and she had been transferred to a closed adult ward, although she was then only 15 years-old. She had been sexually abused on a number of occasions and also been beaten up. She had spent a lot of time locked up in a secure unit. Although very disturbed, she was extremely intelligent and articulate. It seems that psychiatrists and psychologists could not cope with this and she had never received any real therapy. She was later transferred to a secure unit and then sent to a private adolescent unit.

Virtually every young person who complained was on long-term use of sedative drugs, mainly valium, largactil, tegretol, haraparadol or pharisadine. Many reported suffering serious side effects including inability to concentrate, muscle spasms, skin rashes, jaundice and, in one case, stomach ulcers. Most of the young people felt 'fucked-up' by the drugs and stopped taking them on release or transfer from the unit. None of the young people had received any counselling on the effects of long-term use of these drugs, or any therapy or support to help wean them off the drugs on their release. We are very concerned about the use of tegretol, which appears to be used as a 'mood inhibitor' as part of the 'behaviourist therapy' practised in many of these units. Even normal behaviour for adolescents is perceived as abnormal. Tegretol is used to inhibit emotions such as laughing, sadness and high spirits. Tegretol is also used in 'cocktails' with haraparadol and administered during physical restraints. Most young people felt very ill after this. Couple with the often extreme physical force and forcible injection during restraint, all the young people lived in a constant state of fear of 'the jab' and restraint.

Young people were often left badly bruised and battered following restraint and virtually all those young people perceived these restraints as physical abuse. Three of the young people complaining had suffered broken arms during restraint and one young person had both shoulders dislocated when her arms were twisted violently up her back when she was restrained by four male staff members. The overuse and improper use of restrain and excessive violence during restraints was the most common complaint we received.

Strip searching and body searching appears to be a matter of routine procedure in all units. Many of the young people complained of being strip searched by persons of a different sex to them. 65% of complaints also concerned the use of sexist or racist abuse during restraint or strip searching. Many girls reported that staff made derogatory comments about the size of their breasts and all felt totally humiliated and degraded by this process. Yet most units, when challenged, denied body searches were ever used, and claimed that strip searches were only carried out in exceptional circumstances and were strictly supervised.

The over-whelming evidence is that this is patently not so. That strip searches and body searches are routine. Very few units had written guidelines, none explained these to young people and only one unit had proper complaints procedures. Most seemed to feel they had no need for complaints procedures as they had mental health tribunals and internal procedures which they considered sufficient. None of the units provided any guidance to young people on how the complain. Most young people were too frightened to complain. All said that previous experience had taught them that they would not be believed.

We were absolutely staggered, in preparing this report, to discover the extent of sexual abuse. Some 78% of complaints included sexual abuse. Whilst we realise that young people were coming to us to complain, the extent to which sexual abuse came up in complaints was surprising. It is worth noting that in only nine cases out of the 182 reported cases of sexual abuse, was that the MAIN cause of the initial complaint or referral. Very few young people wanted to complain officially about the sexual abuse as they did not think they would be believed.

Many of the young people, who were not held under Mental Health Act legislation, complained of being given brain scans or EEGs as a routine part of admission procedures, without their permission. As only a small percentage of young people appear to be admitted to these units with a diagnosed mental condition, we must question the use of these procedures as a routine part of admission without specific medical need.

As far as young people from the care system were concerned, they felt their admission to these units was to treat perceived behavioural problems. Very few felt that social workers, psychiatrists etc were really concerned about the abuse that young people had suffered, despite the fact the abuse was the cause of their problems. All felt they had not been listened to and had been labelled 'disturbed' or 'maladjusted' or 'psychotic' because it was easier for the system to deal with them. None of the young people felt they had received any real help or therapy in these units at all. In following up these young people, we found that most of them were discharged into prison, long-term psychiatric care or had disappeared onto the streets.

One final statistic concerning the young people we saw. 19 are now dead. Five committed suicide. Eleven died from drug overdoses. Two died from AIDS. One was killed in a crash in a stolen car. A number just disappeared 'on the run' and we never heard from them again. One 13 year old was living on the streets, being pimped along with five other girls under the age of 16, all on the run from care. As well as prostitution, all were being made to do sex videos and live sex shows. They were generally 'paid' by their pimps with drugs and given a little cash. Both their social services departments (two from the Midlands, two from London, one from Wales, one from Northern Ireland) and the police were informed by us. They did not seem interested or at all concerned. Incidentally, the youngest girl being pimped by this man had just turned 12 years of age and was on the run from an adolescent unit in the Midlands.

Quite a number of young people, who have left these types of institutions, were users of hard drugs, speed, coke, skag, crack and so on. Many told us they felt they now used drugs because they had become used to surviving on legitimate drugs throughout their childhoods and now needed drugs to survive. It was what they were used to. There seems to us a clear connection between legalised drugs, given as a substitute for therapy in these institutions, and a later reliance on hard drugs on the streets, or isolated in hostels or bedsits on release. We do not know of any research done in the area, but believe it would be valuable.

We are also extremely concerned at the number of 'street kids' we see who have either run away from these units or appear to have been abandoned after discharge. No one appears to be picking up on these young people and even many police and others we have spoken to have expressed concern as to the continuing vulnerability of these young people and the total lack of provision for them. Many we see survive by begging, although recent police operations against these young people has made even this means of survival difficult. None of the young people we know make anywhere near the huge sums it is claimed they make. The reality is they are barely surviving and often go cold and hungry.

2. PRIVATE ADOLESCENT UNITS

We received complaints about five such units, three of which were run and administered by AMI plc, the American medical insurance company which now controls over 50% of the private medical market in the UK. The bulk of complaints concerned AMI's Langton House in Dorset. Both ourselves and other agencies had received many complaints in the past regarding this establishment, when it was known as 'Spyways' (see Appendix 2). This establishment calls itself an 'adolescent psychiatric unit'. It is registered as a nursing home. It advertises regularly in the social work press and aims specifically at social services departments as its main target group, with the use of highly dubious and emotive adverts (see Appendix 3). It takes clients from the age of 12 up to their early twenties in the following categories:

A) Mentally ill

B) Mentally handicapped

C) Physically handicapped

D) Difficult to place children from care

All young people live together and are subject to the same 'treatment regime'. The establishment is run strictly on American behavioural therapy lines, which were pioneered by AMI in the United States. Their methods are the subject of great controversy in the USA, not only among social work professionals and others, but with civil liberties groups. A recent America TV documentary highlighted the extreme brutality of regimes in some of their institutions, including one establishment where staff used cattle prods to control young people. Great concern has also been raised regarding 'the unrestricted use of drugs, including highly controversial ones', as the major part of therapy. The regime is based totally on a system of reward and punishment, everything has to be 'earned' by conforming to strict behaviour goals and young people are 'failed' for even the most minor breaches. AMI have imported many of those methods over here.

The complaints we received were as follows:

1. Young people were given brain scans/EEGs against their wishes and for no obvious beneficial reasons.

2. Young people were being given medication against their wishes and with little or no consultation with their social workers.

3. Young people were subjected to extreme violence during restraint, including having their heads banged against walls, kicked and punched, and dragged down corridors.

4. Allegations of sexual abuse and failure to protect young people from sexual abuse.

5. The use of humiliation, verbal abuse, racism and sexism as a means of control.

6. Male staff being present and taking part in the strip searching of girls, which is a routine procedure.

7. Forcible injection of haraparadol/tegretol cocktails as a punishment, as part of routine procedure.

8. Unlawful imprisonment as a means of control.

9. Young people were subjected to humiliating and degrading practises as part of the everyday ethos of the establishment.

10. No formal complaints procedure and the intimidation and victimisation of young people who do complain.

We will go into detail of these complaints and also try to look at the serious issues these raise regarding acceptable practice and the gross violation of young people's civil liberties and basic human rights.

A number of young people initially wrote to us asking for our help. We wrote back and later spoke to some of the young people by telephone, those that had 'earned' the privilege. The letters spoke of violent restraints and young people being degraded. They spoke of two blind boys covered with bruises. How a deaf girl was always 'failed for volume' – she did not realise she shouted because she was deaf. We were told of young people being locked up in a dark, small room. They also spoke of being locked up in an observation room, sometimes for days. They told of being given 'the jab' – forcible injections of haraparadol and tegretol, during restraints. Girls were forced to ask male staff for sanitary towels and were often laughed at. They were told to produce used ones before being issued with new ones and were made to 'prove' they were having periods, often to male staff, before they were allowed off swimming.

We had one written allegation that a girl was raped by one of the boys. She complained to staff but they just laughed. We were very shocked by this, as this girl was known to us. We submitted a complaint on her behalf to the local government ombudsman regarding serious abuse she had previously suffered in a local authority children's home. (Her complaint was later upheld by the ombudsman and she was awarded compensation). We were assured that she was in 'a regional establishment' and receiving the best of care.

We learned that young people were given brain scans and EEGs on admission. They lived in constant fear as they could be 'failed' for the smallest thing. Failure would result in a total loss of all privileges – letters, telephone calls, sweets etc. The letters spoke of verbal abuse from staff and how strip searching was a matter of routine, with male staff often present when this was done. We also received written allegations of sexual abuse and violence. All this was confirmed by other young people we spoke to, including ex-residents. Additionally, we were told:

1. Young people were given tegretol 'cocktails' if they exhibited any emotional behaviour, even normal emotional responses. Tegretol is used as a mood inhibitor.

2. All young people were given drugs, either occasional or on long-term use. These included valium, largactil, haraparadol, tegretol and others. Many young people said they refused to sign the medical treatment permission slips on admission and medication was administered against their will.

3. On admission, a 12 year-old blind boy urinated on the floor because no one would show him where the toilets were. Staff restrained him violently and rubbed his nose in the urine. He was told this would happen every time he did it.

4. Two young people witnessed the same child being violently restrained by staff. One was banging his head against a wall and he was dragged off to a 'quiet room' with blood pouring from his head.

5. Young people were 'jabbed' for no reason at all. Staff made sure that they were sedated in this way, both as a punishment and a warning.

6. None of the staff had any training in paediatric psychiatric nursing. The restraint and physical control techniques were those taught to prison and police riot control officers. This was later confirmed to us by AMI who admitted it was the Home Office approved course.

7. Young people had to go to the office to be issued with two sheets of toilet paper before using the toilet.

8. Staff referred to mentally handicapped children as 'subbies'. A common punishment for failing was being made to eat your meals at the same table as the 'subbies'.

9. A number of young people were given experimental drug cocktails, which gave them severe side-effects. They described these as 'muscles feeling loose. You felt cold inside and could not open your eyes. Sometimes your neck goes rigid and your muscles cramp up'. They also complained of stomach cramps, vomiting, lack of ability to concentrate and dizziness. One of the drugs had a name like parsatron (their spelling).

10. One girl had her arm broken during restraint.

11. Staff threw bricks at two young people who were trying to run off.

12. One girl was indecently assaulted by a male member of staff.

We continued to receive a constant string of complaints. We also had a young person visit the office quite independently of all this, who had been discharged some months previously and who wanted to complain. We contacted both the East Dorset Health Authority and the police. We also wrote to the Social Services Departments of all the young people who had complained (see appendices). The Area Health Authority held a short, secret Inquiry and at no time approached us or asked us to give evidence, despite having agreed that NAYPIC could represent the young people and that they could have NAYPIC representatives present when interviewed. This never happened. When we went to visit the young people we were thrown out by the officer-in-charge and denied access. Having finally, after three months, obtained the permission of all the young people's social workers, and arranged a date to visit, it was cancelled by the officer-in-charge because he had 'another meeting'. The following day, he wrote refusing to let us see the young people concerned.

In a letter to the Department of Education, AMI in response to allegations claimed:

1. Brain scans were given if they considered it necessary and EEGs were routinely used as part of the admission procedure. They claimed young people could refuse.

2. Medication was prescribed by 'medical staff' and could be refused by young people, unless it was 'necessary for their health' or they were detained under the Mental Health Act 1983. AMI had previously claimed that medication was prescribed by the young people's GP.

3. That all allegations were vigorously investigated 'where appropriate' by the registering authority. In fact, Langton House is registered as a nursing home. It is not registered as a school, a community home with education (CHE), a psychiatric unit, nor as a children's home.

4. That they denied all allegations.

5. Strip searches took place with male staff present. They justified this on grounds of reasonable cause for suspicion.

6. They claim they only use a 'time-out' room. No mention is made of the two 'observation' rooms.

7. They claim there is no intentional humiliation of young people. They say 'the issue of sanitary provision had to be controlled to prevent misuse'.

In short, AMI either deny allegations or justify their 'regime' as reasonable and appropriate treatment, given the type of young people they deal with. As usual, the complaints are either malicious or because 'psychological problems impair reasoning or interpretive skills'. They also claim they have a complaints procedure (pinned to a notice board in a hallway) and that young people can complain to a 'committee of visitors' or the Mental Health Act Commission. Given that these 'rights' are not explained to young people in an understandable way, they have no access to independent advice or representation and were, in fact, denied access to NAYPIC, we must question the validity of this claim.

We took up these complaints and the professional, ethical and social work issues arising from these complaints with the Area Health Authority (our letter attached as appendix). Their response was a point blank refusal to discuss these issues with us. Another disturbing feature that has emerged from current complaints was that reports on young people were manipulated by Langton House staff purely to justify continued placement there. Young people told us that the reports often said they were either on a higher or lower 'level' than they really were, with a recommendation for continued placement there. AMI refused to discuss with us the cost of placements at Langton. However, one referring local authority told us they were paying £55,000 per year for a placement there. Clearly there is a great financial incentive for wanting to ensure placements of young people at Langton House lasted as long as possible.

The issue that disturbed us most of all was the placement of physically handicapped young people in this establishment. We cannot accept, under any circumstances at all, that behaviourist therapy is an acceptable treatment for a physical handicap. Given they also accept mentally handicapped young people, with a low mental age, we noted on our visit that there were no play or recreational facilities in the grounds. We only saw young people herded into a small tennis court for 'exercise'. There seemed no room for any unstructured play necessary for children and young adults. In looking through a window at the side of the house, we saw a number of young people just sitting under tables. Other young people told us this was commonplace and, again, there were no structured play facilities for learning and toys were not allowed.

In looking at the ethical and professional ethos behind the regime at Langton House, we became increasingly disturbed at the lack of even basic human rights for the young people there. The 'therapy' consisted of the use of fear. Young people lived in a constant state of fear. Fear of being jabbed or sedated. Fear of being 'failed' and losing points. This, in turn, led to the loss of even the most basic 'privileges', such as food, exercise and fresh air. There appeared to be no standard of what was an acceptable level of 'normal' behaviour against which young people were judged. Being 'failed' was a matter for individual judgement on the part of staff and appeared to depend much on their own moods or prejudices.

Coupled with the practice of 'failing' was the deliberate use of humiliation and degradation as another 'therapy'. As staff are taught these techniques on the Home Office course for restraint, we can only assume this was part of the philosophy of the establishment. In addition, looking at the daily living of young people, this philosophy could be clearly seen. Young people being issued with only two sheets of toilet paper; girls having to produce 'used' sanitary towels before getting clean ones; girls forced to ask male staff members for sanitary towels; the use of the term 'subbies'; staff using their professional knowledge to intimidate young people. Indeed, we witnessed the way one young girl was reduced to a crying, nervous wreck by the deputy. The girl was absolutely terrified of what would happen to her when we left. Given that many of these young people were victims of appalling abuse that had led to their placement at Langton House and that, in common with most such young people, they had a pretty poor self-image and low self-esteem, to further humiliate and degrade them in this way is beyond belief. We can find no justification at all for such brutal and inhumane treatment – it is certainly not therapy.

If the yardstick for basic human rights can be measured by the United Nations Convention on the Rights of the Child, then Langton House violates virtually every article in the Charter in respect of young people in its care. Article 39 of the UN Charter states 'parties shall take all appropriate measure to promote the physical and psychological recovery and social re-integration of a child victim of any form of neglect, exploitation or abuse; torture or any form of cruel, inhuman or degrading treatment or punishment. Such recovery and re-integration shall take place in an environment which fosters the health, self-respect and dignity of the child.

It is also clear from documentation around the time of the previous inquiry (when Langton House was called Spyways), and from recent correspondence, that the practices and regimes at Langton House are known to, and have been approved by, the Area Health Authority in East Dorset, the Social Services Inspectorate, the Department of Health and East Dorset Social Services. The issues of basic human rights, civil liberties, the setting of standards and regulatory functions should and must be a matter for parliament and public debate. We are concerned too

that, in their response to our complaints, AMI sent the Area Health Authority copies of their policy on care, restraint, strip searching and so on. We note all these 'policy' documents were dated 21st May 1990, over three months after we submitted our complaints. We find it strange that after all these years, AMI only produce a policy AFTER complaints are made and that the Area Health Authority, the Social Services Inspectorate and the DHS accept this as 'proof' that AMI has been operating properly.

As stated previously, AMI operates Langton House as a registered nursing home. They call themselves an adolescent psychiatric unit yet are not registered as such with the DHS. They take children of school age and allegedly provide 'education' but are not registered as a school, or community home with education (CHE), with the DES. They provide 52 week 'care' for children but are not registered as a children's home and, despite taking handicapped children, are not registered as such with social services or the Department of Health. They operate a secure provision, the so-called 'operation room', but are not registered as a secure unit. Indeed, they cannot under existing legislation operate such a provision.

In short, Langton House is a dumping ground for the most vulnerable and difficult-to-place young people. To condone such practices, in violation of the United Nations Charter and the European Convention, exposes the hypocrisy of the United Kingdom's government as a signatory to both. Clearly, basic human rights are only seen by the United Kingdom's government as applying to other counties.

Langton House was not the only AMI establishment we have received complaints about. We received similar complaints from other young people of physical violence, over use of violent restraints, the use of the 'jab', use and over use of sedatives and sexual abuse, at other establishments. These other establishments also seem to operate along the same lines of fear, humiliation and degradation as therapy.

Appendix

Use of drug 'cocktails' for sedation and restraint

The complaints we received from young people raised questions not only about the types of drugs used in homemade 'cocktails' at Langton House, but also serious ethical and moral questions about the methods of prescribing, usage, monitoring, inspection and regulation. Aside from largactil, valium and temazepam, which are generally recognised as having a therapeutic value as a sedative over a limited period, we question the use of other drugs, not specifically designed for use as sedatives. We understand the use of largactil, valium and temazepam thoughout the NHS as sedatives, but the use and time period are now strictly monitored by GPs.

There were a number of other drugs in common use at Langton House. In particular, tegretol and haraparadol. It is common practise for both these drugs to be given to many of the young people at Langton up to four times daily. Most of the young people who complained to us were the subject of Care Orders and had not been admitted under Mental Health Act legislation. We question both AMI's authority to prescribe these drugs and also their use as a sedative 'jab' during restraints. Neither the officer-in-charge nor any of his staff are qualified medical practitioners and cannot prescribe medication. Many of the young people refused to sign the 'Medical Permission' slips on admission and we question the use of 'open-ended' prescriptions authorised by non-resident doctors employed by AMI on an ad-hoc 'as required' basis which allows Langton House staff to determine how, when and how much drugs young people get.

We checked with a number of well-known and reputable psychiatric departments at major London hospitals, as well as the Institute of Psychiatry and an independent consultant in chemistry. Tegretol is an anti-convulsion drug used to treat epilepsy and other neuro-disfunction disorders. It is generally administered in tablet form. It can also act, as one of its side-effects, as a mood inhibitor and, for this reason, its dosage and use is rigidly controlled. All the professionals we have talked to have expressed concern at any use of tegretol as a mood inhibitor or as a general tranquiliser, particularly on young people. We discovered that tegretol was being mixed with haraparadol and largactil into a 'cocktail' and would be administered to young people

by injection during restraint. Young people have told us that such sedation was often given as a result of 'failing' (according to AMI's peculiar brand of behavioural therapy), for laughing, crying or expressing any extremes of emotion. Even normal, youthful high spirits was deemed 'failing'. As far as we can tell, the only purpose for using mood inhibitor drugs is for control. No doubt, having a group of 'zombies' was much more administratively convenient and ensured maximum control with fairly minimal staffing levels and maximised profit.

We question also the use of haraparadol, both as a restraint and in its long-term use on young people, many of whom had been on high dosages for long periods of time. This drug is well-known for producing dystonic reaction in patients and many of the young people reported a severe or extreme reaction to this drug.

Having taken advice, as far as we can ascertain, the position of Langton House under Common Law, as regards the forcible injection of sedatives during restraint, is that this could be construed as a criminal assault. AMI claim justification for forcible injection of sedation, under Common Law, on the grounds of:

1. Saving life

2. Relief of acute distress

There may well be some justification for sedating a violent or very disturbed young person on grounds of relief or acute distress. However, Langton House staff use a 'mood inhibitor' drug, not a recognised sedative, which cannot be said to meet either of these two requirements. Further, young people have said that these restraints were often conducted on a random basis to ensure that all young people were regularly restrained, as part of the behaviourist regime at Langton House. If this is the case, then young people's complaints of criminal assault are justified.