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RADIO 4

TRANSCRIPT OF “FILE ON 4” – “TRANSFORMING CARE – IS IT WORKING?”

CURRENT AFFAIRS GROUP

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PRODUCER: Rob Cave
EDITOR: Gail Champion

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“FILE ON 4”

Transmission: Tuesday 2nd October 2018

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Producer: Rob Cave

Reporter: Lucy Adams

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BETHANY: [SINGING] Don't worry about a thing, cos every little thing's gonna be all right

ADAMS: This is Bethany singing her favourite song to her dad on the phone.

BETHANY: [SINGING] Cos every little thing's gonna be all right ...

ADAMS: Bethany's 17 years old. But her life is very different to that of most teenagers. She lives in seclusion, locked in a room.

JEREMY: When I go to visit Beth, I walk down a series of corridors. Every 20 metres maybe there's another door that has to be unlocked and locked behind us. I walk down a corridor and there are big glass panels and I can see the other girls in the unit, and then turn into a very small corridor, again through, through more locked doors, and I see the seclusion room that Beth is currently being held in.

MUSIC

ADAMS: Jeremy is Bethany's dad. We're not using his surname.

JEREMY: And then turning to see Beth behind a big glass window, stood in a room that's no bigger than 10 feet by 12 feet. All there is in this room is a bed and a chair. The bed isn't a bed like you and I have - it's a foam mattress covered in thick plastic, and the chair is the same. Apart from that, there's nothing else. My contact with Beth, there is a metal door with a hatchway in the door that they feed Beth through. It's a hatchway of about 8" by 8". I kneel down on the floor and I talk to Beth through that hole in the door.

ADAMS: What he's describing is not a prison, it's a hospital – an assessment and treatment unit or ATU. After Panorama revealed appalling abuse at Winterbourne View, the UK Government promised an end to the use of such units for people capable of living in the community with support. But Bethany is still in a unit, and has been for 21 months. She's been in seclusion for almost all of that time. She's one of 250 children with learning disabilities and autism still living in ATUs and other mental health units in England. Bethany's story is not an easy one.

JEREMY: At the age of four, she'd been excluded sort of three or four times from school, and eventually someone suggested autism. And you find out that it, it's a lifelong condition, that it's not something that, that our daughter will grow out of. And the older Beth got, the worse her behaviours became.

ADAMS: Beth can be aggressive. Aged 11, she went into her first placement. But a succession of different places didn't work out. Her parents think none of them were suitably skilled or staffed to cope with her, and she was sectioned and moved to St Andrew's Hospital in Northamptonshire, where she is now.

ACTUALITY OF PHONE CALL

VOICE RECORDING: Thank you for calling St Andrew's Healthcare. We're sorry but all our operators

ADAMS: Even for her father to speak to Bethany on the phone is hard. The handset has to be held up to a speaker outside of her locked, glass-fronted room.

JEREMY: Can I have a quick chat with her, please? Hi Beth!

BETHANY: Hi.

JEREMY: How are you?

BETHANY: All right thanks, yeah.

JEREMY: Yeah, good stuff. What you been up to today?

BETHANY: Absolutely nothing, as normal. I've been sitting in a room with the door closed, hardly doing anything.

JEREMY: Have you had any school lessons today?

BETHANY: No. Could be better.

JEREMY: What would make it better?

BETHANY: If I wasn't where I was at the moment.

JEREMY: What do you mean, in seclusion or in St Andrew's?

BETHANY: Both really.

ADAMS: Assessments of Bethany dating back to June last year say St Andrew's Hospital cannot meet her needs and that she should be in a specialist setting in the community, where she can access the activities, animals and people that help to calm her. And although her parents desperately want her to be moved to a community placement, they don't get to make that decision.

Do you have any say over that, where she goes next?

JEREMY: No. Our views are sought, but that clearly is just a tick in the box paper exercise.

ADAMS: Once someone like Bethany's been detained under the Mental Health Act, it can be very difficult to remove them. After a period of time, that decision is mainly up to the psychiatrist or lead clinician. She was meant to be moved earlier this year. She was assessed and approved for a community placement, but the same day Walsall Council and the commissioning group changed its mind. The place was lost. Internal documents show that on several occasions the hospital has admitted Bethany has been kept in seclusion because of staff shortages. She spends all of her time locked in her room. Her father says she has only been allowed out on a handful of occasions since March. She's become clinically obese and more prone to hurting herself.

JEREMY: I've talked about Beth having a flight or fight response. When she's locked in a seclusion cell, she can't do either of those, so she resorts to self-harm. In the last 18 months, she has found numerous ways to hurt herself. At the moment, she has the insides of a biro in her arm.

ADAMS: The inside of like a Bic biro?

JEREMY: Yes.

ADAMS: In her arm?

JEREMY: Mmm. It's been there for four weeks.

ADAMS: Why haven't they taken it out?

JEREMY: They deem it too dangerous at the moment for Beth to have staff go into the room.

ADAMS: St Andrew's Hospital told us there is a national shortage of community placements, and while the hospital provides care as best it can, it can't comment further on Bethany's case for reasons of patient confidentiality. Walsall

ADAMS cont: Council told us Bethany requires specialist mental health provision, so a community placement is currently not appropriate, and the complexity of her needs make it difficult to find a suitable alternative. But the heart of the problem is Bethany is still in an ATU, despite multiple assessments and experts saying she shouldn't be.

MUSIC

ADAMS: In 2011, ministers set out a new policy to move people like Bethany with learning disabilities and autism out of units and into the community. It was called Transforming Care.

LAMB: The whole aim of Transforming Care, which came in the aftermath of Winterbourne View, was to recognise that there are very many people who are held, often for years on end, and sometimes from childhood, in institutional care, who are perfectly able to live in the community with proper support.

ADAMS: Norman Lamb was the minister responsible for social care. At the time of Winterbourne View, he expressed shock, anger and dismay at what the BBC had uncovered, and vowed to end the practice of keeping people in unsuitable hospital settings. Yet many people like Bethany are still stuck, despite specific targets to get them out. In 2015, in a national policy document called Building the Right Support, NHS England and local authorities pledged to cut the number of people in ATUs by 35-50% by March 2019. But with just six months to go, it hasn't happened - the number of children in such units has instead more than doubled. The number of adults has fallen only slightly, from around 2,600 to around 2,400.

LAMB: It's a fundamental breach of people's human rights that so many people who are able to live in the community with support remain behind locked doors in institutions. I think that's wholly unacceptable.

ADAMS: The Department of Health and Social Care told us it's committed to the Transforming Care programme and will continue it beyond March 2019. It says since 2015, there have been around 5,500 people discharged into the community and over 410 in-patient beds decommissioned. But despite the thousands of people discharged,

ADAMS cont: the total number of people in units has gone down very little, which seems to confirm what we've been told by experts and families – that once released, people are often getting sent back in. Rob Greig is a former UK Government advisor. He was the National Director for Learning Disabilities. He blames the failure to get more people out of hospital squarely on a lack of community provision.

GREIG: The reason why it's gone wrong is that basically they had the wrong focus for Transforming Care and they organised it in the wrong way, so the focus should have been on developing the competence of local community services, because that's what let people down in the first place, that resulted them ending up in assessment and treatment beds. Instead, Transforming Care placed the focus on getting people out of the existing beds and closing the beds. And all that happened was that one person moved out and somebody else was ready to move in, because someone else had been let down by the community services not supporting them properly.

ADAMS: So things are getting worse, not better?

GREIG: I think if you talk to most people involved in the world of people with learning disabilities across the country, they will tell you that in the last few years things have gone backwards. The role of services is to support people to live a full life alongside everybody else. We know that's possible for everybody, no matter how complex their disability is, provided the right support is put in place.

ADAMS: Not only is hospital deemed the least appropriate setting for most, it's also generally more expensive. The price of keeping one person in an ATU is between £90,000 and half a million pounds a year. Figures from 2015 suggest the overall cost of in-patient units is £452 million a year. Half of that hospital provision is run by private providers. Experts say that means the Government can't order them to close down their beds.

GREIG: There is a business imperative for them to fill the beds. This is a market driven issue, which is really sad. People are at risk of becoming financial commodities of the system.

ADAMS: And there's an additional tension here too. Although community placements generally cost less, they have to be paid for, on the whole, from the social care budget. That means local councils, rather than the NHS. Rob Greig says that's the main obstacle to change.

GREIG: One of the things that has bedevilled this programme is, if you're a local authority, why would you voluntarily accept somebody back into your area who might cost you £100,000 or £200,000 a year when that money at the moment is being spent and incurred by the NHS?

ADAMS: So what incentive is there for the local authority financially to move them out?

GREIG: You've hit one of the key points on the head.

ADAMS: Surely people then in local authority positions would be saying to the NHS, okay, it's time now to give us the funding that you have for these people so we can move them back into the community. Surely overall their aim is to do the right thing by these people.

GREIG: The overwhelming majority of people who work in both local authorities and the NHS have the interests of people with disabilities at heart and want to do that. But when you're in a situation whereby the financial position of the authority does not allow you to take these steps forward, managers and practitioners in all public services at the moment are in an incredibly invidious position, that they are unable to do some of the things that they know in their hearts they should be doing, because of a combination of the financial pressures and the huge demands that are placed upon services at the moment to make change in a very difficult time.

ADAMS: Figures show in England around 665 people with learning disabilities and autism are still stuck in hospitals because of delayed discharge, having been assessed as no longer needing in-patient care. Other parts of the UK have similar policy aspirations, to move people with learning disabilities out of institutions. Each is at a slightly different stage, but all are struggling to achieve that goal. In Northern Ireland,

ADAMS cont: we were told the figure for delayed discharge is between 80 and 90 people, and in Scotland around 80. Wales says it isn't possible to give us a figure. Each country admits people with learning disabilities are often sent to in-patient units hundreds of miles from home. The Local Government Association, which speaks on behalf of councils, declined to do an interview. We asked if councils are standing in the way of the people moving out into the community. It says authorities are working hard to deliver and that there's work ongoing which is helping to change lives and prevent people being admitted. But it says there are still challenges in supporting the funding flows to councils and admits overall adult social services face a £3.5 billion funding gap by 2025. Margaret Flynn authored the Serious Case Review of Winterbourne View. She says she's frustrated by the lack of progress.

FLYNN: For good reason, this country embarked on long stay hospital closure programmes in the 70s and the 80s, and here we are, years later, finding that the number of people in in-patient units run by the independent sector is increasing, when Government policy is for the opposite to happen.

ADAMS: NHS figures show the average length of stay in England in ATUs is more than five years. It's not changed significantly since 2011.

FLYNN: Assessment shouldn't take many, many months. It can be done and completed and treatment should not exceed six months. And some people are being placed in these settings, where they will remain for many years.

ADAMS: But with the right care and support, even after lengthy stays in in-patient units, it is possible to transform people's lives.

ACTUALITY ON SPORTS PITCH

COACH: [SHOUTING] ... eyes on me ... just eyes on me. Going to change it a little bit. This time we're going to dribble it ...

ADAMS: Richard is proof of that. He lives in Milton Keynes. He's slight and quick to laugh. He's lived most of his life in hospital units. On his last stay, he was in for eight years.

We're inside a huge, domed polytunnel. It's the training ground for MK Dons, where Richard plays football once a week. There's people with a range of physical disabilities and learning disabilities having a lively kickabout.

COACH: Good touches, really close Richard, well done.

ADAMS: Every part of Richard's week is planned, mapped and supported by the charity Turning Point, who run his care plan in the community. The aim is to build a routine around the activities he enjoys.

RICHARD: I was born in Northampton. I'm aged 42, I'll be 43 in December. I like my football. I support Liverpool. My home team is MK Dons.

ADAMS: Back at his house, Richard tells me what it was like in the hospital. He says when he was in the most secure unit, he wasn't allowed out.

RICHARD: It was too noisy for me, hearing other people, the staff, the nurses, people kicking off. I keep saying to myself I want to go back to Milton Keynes.

ADAMS: So you kept saying, I want to get back to Milton Keynes?

RICHARD: Because it was a bit stressful.

ADAMS: Why was it stressful?

RICHARD: I didn't like it there. I talked to my doctor ... ups and downs ...

ADAMS: So this is your care plan. Oh, this is nice. And this is your daily task assessment for goals.

RICHARD: Mmm.

ADAMS: Travel independently to art group on a Tuesday.

RICHARD: Yeah, Tuesday afternoon.

ADAMS: It says at no time am I to be physically restrained. Did that happen quite a lot at hospital?

RICHARD: Yeah.

ADAMS: What's that like?

RICHARD: Worse. Worse. I didn't like it.

ADAMS: Did that start because you were feeling anxious?

RICHARD: Yeah, yeah, yeah.

ADAMS: Did being in hospital make you feel more anxious?

RICHARD: Yeah. Now I'm glad I'm out of it. I'm here at my nice house.

ADAMS: Richard's one of many people who have been successfully supported to move into the community. He no longer faces restraint. So how typical is his experience and just how safe are the thousands of others, like Bethany, still living in institutional care?

MUSIC

ADAMS: We wanted to get a better understanding of what life is like now in ATUs and other units, including how often restraint is used. But we were told up to date figures don't exist. After weeks of digging, however, we discovered the figures are

ADAMS cont: recorded, but they're not collated or published. We were able to obtain the technical codes under which they're held, and as a result NHS Digital was able to compile the data for us. I'm looking at it now. The information we've obtained is far more disturbing than we'd expected. In 2016, restraints were used 15,000 times, and that went up to more than 22,000 times in 2017. That, on average, is a use of restraint every half an hour. And all this at a time when the Government says the overall number of people in in-patient beds is supposedly falling. We asked Wales, Scotland and Northern Ireland for fully comparative figures, but were told it's not possible to provide them. We showed the English figures to Norman Lamb, the former Care Minister who, in 2014, introduced guidelines to reduce the use of force in hospitals.

LAMB: The bottom line is that I had wanted to see - and expected to see - a substantial decline in the use of restraint and that hasn't happened, and I think that's really shameful when we know that it's possible in very many cases to avoid the use of restraint at all, through a more sophisticated approach to people in in-patient settings.

ADAMS: Our investigation has also found face down or prone restraint - which should no longer be used, according to those Government guidelines - has also increased. In 2016, it was used more than 2,000 times. In 2017, that went up to more than 3,100 times.

LAMB: That is absolutely shocking. There's clear evidence that there is risk attached to the use of prone restraint and it's also extraordinarily demeaning, so there is a moral obligation on the system to achieve that.

ADAMS: Experts say autism and learning disabilities cannot be effectively treated with medication. And yet the figures we've obtained show that chemical restraint - which is essentially a dose of a sedative - was used more than 1,800 times in 2016, and more than 2,300 times in 2017. Seclusion - the state Bethany is in almost constantly - is also classed as a type of restraint. It was used more than 2,000 times in 2017 - an increase of 40% on the previous year.

Why, if anything, would the use of restraint be increasing?

LAMB: Well, my fear is that what we see across both mental health units and units with people with learning disability is that very often they are completely full up, often operating at above 100% - in other words, they may send a patient home for home leave and fill that bed whilst they're on home leave. So these are organisations operating sometimes under massive strain, sometimes having to make use of agency staff, sometimes understaffed, and in those circumstances there must be a heightened risk of violence, of the use of force.

ADAMS: We also took the figures to the Department of Health. It says work is underway to reduce the use of restrictive interventions and improve patient safety. It's also backing a private members bill which would force NHS trusts to increase transparency about restraint, including making police officers wear body cameras. The concern in using restraint though is not just the immediate danger it poses, especially in the case of prone restraint, but the lasting effect. Viv Cooper is the Chief Executive of the Challenging Behaviour Foundation and she has a son with learning disabilities.

COOPER: If you talk to some of the families and some people with learning disabilities who've been restrained, the impact on the individual of that restraint is significant and often lasting. I was with a mum the other day whose son was restrained for hours in an in-patient unit and physically held down and he's now out in the community thankfully and hasn't been restrained since he's been in the community, but he's constantly saying, 'Is anyone going to hold me down? Is anyone going to hold me down?' so there's a lasting traumatic impact on people of these sorts of practices.

ADAMS: The growing use of restraint is not the whole picture though. We've also obtained figures – again compiled by NHS Digital - which show that patient on patient assaults have almost trebled between 2016 and 2017, from 3,600 to more than 9,000. Figures for January to May this year suggest they're continuing to rise.

COOPER: We're putting people in in situations that are causing them distress and that are damaging them and that's entirely unacceptable.

ADAMS: One of the biggest concerns with Winterbourne View was that patient reports of assault had not been taken seriously or believed. There's worry in some areas this is still the case. We've also found, even when allegations are reported to different agencies, those responsible don't necessarily apologise or make changes. Experts say people in care homes and hospital units are still not as safe as they should be.

ACTUALITY IN CAR

ADAMS: Tell me a bit more about the garden, what we can see – it's a beautiful garden.

I went to meet Sarah and James. Their son Danny isn't in a hospital unit; he's in a care home, because they were told that was the safest place for him. These are not their real names as we have to protect Danny's identity, and these are not their own voices.

SARAH: Danny is a young man. He is gregarious and outgoing and enthusiastic about life. He loves animals - especially horses - and sport, and he can tell you the names of everybody in the English cricket team. Everything makes him laugh. He has the sense of fun and naivety that that most of us lose, so he's not cynical, he's not jaded - he just enjoys his life.

ADAMS: Danny seemed happy in the private care home in East Sussex where he was living. But suddenly that changed. He claimed he was sexually assaulted by another young person, who we will call Tom.

SARAH: We had a phone call three years ago from the home where he lives to say that he'd confided in someone that he had been abused by another resident. The police were involved and they interviewed him, and the police officer told us that he had interviewed Tom previously in connection with an allegation of a sexual nature. And that changed everything for us, because we knew then that it had been known that there was a risk, that the safeguarding authorities had known that there was history there. That changed the perspective completely because we felt that they could have done something. They could have mitigated the risk and they clearly hadn't done so.

ADAMS: Tell me, when the police spoke to you that day, after they'd done the interview with your son, what did they tell you about the detail of the allegation? If it's not too difficult to talk about.

SARAH: They classed what happened to Danny in the same category as rape. We learned that it had been happening probably for two years. It was one of the first times I have seen Danny's dad cry.

ADAMS: Danny was meant to be receiving constant one to one care, but his parents say that wasn't always happening. Despite the police taking the allegations seriously, Danny and Tom remained in the same care home, in rooms that were next to each other, for several months. The police investigated, but Danny's parents didn't feel it would be fair to ask him to give evidence in court. Then there was a safeguarding review, but Sarah and James were unhappy with the result.

SARAH: So at that point we decided to go to the local government Ombudsman. They investigated for well over a year. At the end of that, they concluded that there had been fault in the way in which the local authority had handled the situation. They ordered them to apologise to Danny, they ordered a payment of compensation and they made recommendations about some of the procedures that needed changing. Danny's world is a very simple world and something had happened to him, something wrong had happened and he thought there would be a consequence and someone should say sorry.

ADAMS: But that didn't happen. East Sussex County Council, which is responsible for safeguarding in the care home in question, contested the draft decision of the Ombudsman and asked for it to be reviewed. Danny and his parents were astonished when the final decision was different.

JAMES: The new case officer acting as the Ombudsman reviewed the whole case, and in the space of two weeks, they issued a revised draft report, which changed the decision 180 degrees, and made a statement that there was no fault on the part of the local authority and safeguarding.

SARAH: And that was that.

ADAMS: Tom has been moved to a new placement, but Danny's parents feel that lessons haven't been learnt in terms of how to protect those round him. Sarah and James believe Danny is now safe. But Danny feels he's not been treated fairly.

ACTUALITY WITH LETTER

ADAMS: This is a handwritten note Danny has sent me and my producer. It says, 'Please could you just get the council to say sorry. I was right. They were wrong.'

East Sussex County Council told us it takes all safeguarding concerns extremely seriously and investigates them thoroughly. It says the Ombudsman independently investigated the family's complaint and found no fault in how the council carried out the safeguarding inquiry. The local authority Ombudsman told us it offers both parties in all cases the chance to challenge the final decision. Since Winterbourne View, safeguarding processes should have been improved, so where allegations are made, agencies should know to investigate thoroughly and prevent future mistakes. But Margaret Flynn says the culture still hasn't changed.

FLYNN: In spite of what should be a system that appears robust, we know it's not. We know that abuses occur, we know that local authorities may not be informed of these, even though services themselves are primarily responsible and accountable for the practices that are revealed either by individual patients and families or by inspectors or visitors.

ADAMS: You're involved in safeguarding reviews. Once a review is done, is there a compulsion on the agencies involved to act upon that?

FLYNN: Very typically, recommendations arise from a review, the host safeguarding board will follow through on those recommendations and in fact, very typically an action plan will be drafted. But it has to be said the urgency that surrounds the creation of a review is rarely paralleled with a follow-up. In fact, there's a lamentable lack of follow-up and even interest in what's happened since.

ADAMS: So are reviews seen as a sort of way of parking things?

FLYNN: I think cynics would say so.

ADAMS: Of course, the regulator, the Care Quality Commission, also has a role to play. It told us where a sexual assault is reported, it takes immediate action. But there's concern the CQC isn't fully aware of what's going on in hospital units. Take the extent of the use of restraint, for example – something it's partly responsible for monitoring. When we shared the figures we'd obtained with the regulator on restraint, it said it was under the impression these figures weren't recorded. It did say, though, that it had highlighted concerns about the high use of restrictive interventions in some in-patient services in its State of Care report last year. We also provided the regulator with our new figures on patient on patient physical assaults. They said they'd started or taken enforcement action in 108 such cases in the past two and a half years. Their data covers slightly different time periods to that of NHS Digital and looks at cases where action has been taken. But this still doesn't fully explain the stark contrast to the data we obtained from NHS Digital, which refers to thousands and thousands of physical assaults. The CQC says it will now investigate as a result of what we've told them. It told us providers have a statutory duty to tell it about serious incidents and abuse and that it will be reviewing our data to explore whether there are any discrepancies in the information reported to it. If so, it will take appropriate action. Their reassurances don't fully satisfy Margaret Flynn.

FLYNN: They can only take action when they know that events have occurred. They're not there every day and I think their reports have the caveats, 'On the day we visited' or 'On the days we visited this is what we found.' Families would say, 'Why aren't you visiting in the evenings, at weekends? Why aren't you doing unannounced visits, most particularly in services where people have so little power?'

ADAMS: So you are saying that the regulator is not protecting people, the sort of local authority is not necessarily doing it and nor can the families?

FLYNN: The families would struggle to do so, yes.

ADAMS: So who is protecting them?

FLYNN: I think it's really difficult to answer that, and isn't that a shocking statement?

MUSIC

ADAMS: The CQC told us although its inspections are periodic, it uses intelligence to monitor and assess. It says providers have a statutory duty to inform it of safeguarding concerns and that it benchmarks providers in order to flag inconsistencies. It says where there are safeguarding concerns, these are passed back to the relevant council to investigate.

MUSIC

ADAMS: Earlier this summer, NHS England announced £76.5 million of investment into the Transforming Care programme, to move people with learning disabilities out of hospital. It says an extra £53 million is being transferred from the decommissioning of specialist in-patient beds across the coming year to local health organisations to support community-based initiatives. But experts warn unless the funding is properly pooled between local government and the NHS, the same problems will continue – without robust scrutiny. And many believe the thousands of people still stuck in hospital settings will continue to be left without proper protection and without a voice. Norman Lamb is frustrated that people with learning disabilities are still being forgotten.

LAMB: It's a totally hidden problem. That is the problem, in a nutshell, that unless you have experience of a family member or a friend who's in this situation, this will be a complete closed book to you, you won't have any knowledge of what's going on. But we have a responsibility, in a civilised society, to treat everyone as equal citizens, and it is intolerable for people with learning disability and people with autism to be locked up in this day and age, often breaching their human rights, when they are capable of living with support in the community.

ADAMS: For many, Transforming Care has made all the difference. Richard has moved into his own home with one to one support. His life has been transformed. The point made by experts is that it can work and agencies should be able to make it work for everyone. But for those like Bethany, there's just a locked room and still no return to the things she loves. Her father Jeremy finds it almost unbearable to think of how much more she could be doing.

JEREMY: I've got brilliant memories of taking Beth to a circus in Blackpool, where we just had a stunning day. Beth, Beth loves the circus, there's just something about clowns and trapeze artists, and she dreams of being in a circus one day.

ADAMS: But today and tonight, she's effectively in a cell.

JEREMY: It's horrific, because every three months we go to a meeting at the hospital and everyone talks about how terrible it is and how difficult it must be for you as parents, [MUSIC] but nothing changes. Bethany's still locked away like a, like a criminal.

ACTUALITY OF PHONE CALL, BETHANY SINGING

ADAMS: This is Bethany back on the phone with her dad. They can talk about her having a life outside her room. But for now they can't make it happen.

JEREMY: What would it mean to you if you went somewhere else?

BETHANY: If I went somewhere else, it would mean a lot, but it just has to be safe and secure and then I'd be okay there. I'd feel a lot happier. A lot more myself.

JEREMY: What if it was a community place that was secure as well?

BETHANY: I would still feel safe as long as the right people support me. [SINGS]