THE JOYS AND CHALLENGES OF ADOPTIVE FAMILY LIFE: A SURVEY OF ADOPTIVE PARENTS IN THE YORKSHIRE AND HUMBERSIDE REGION

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Chapter 1 - Introduction and background to the study

This project reports on a study of children adopted from care in one region of England, but its findings are of relevance both across the UK and internationally. Where children are at risk of harm from their parents various state interventions to protect children may be employed, beginning with supporting parents to care for their children adequately. Where the possibility of children remaining at home has been ruled out, a range of other options may be considered including foster care, kinship care, and voluntary or non-voluntary adoption and the use of these different options varies across different countries (Thoburn, 2010). Few jurisdictions use adoption as a route out of care, the main ones that do being the USA, UK and Canada (Thoburn, 2010). However anxieties about a lack of stability and permanency for children who remain in care mean that other countries are now beginning to use or are considering using adoption for such children. For example, the New South Wales government in Australia (2017) is implementing *Their Futures Matter* to address the issue of permanency through return to birth parents, kinship care, guardianship or *open adoption*. In Germany, the government have funded the German Youth Institute (DJI) to set up a Research Center on Adoption (EFZA) to inform a review of adoption policies (https://www.dji.de/ueber-uns/projekte/projekte/expertise-und-forschungszentrum-adoption-efza.html). In the context of these international policy debates about adoption, it is vital to learn about the experiences and outcomes of adoption directly from adoptive families.

Where children are adopted from care this is in response to serious risks in their family environment. Exposure to early adversity such as abuse and neglect in childhood can have far reaching, long-term developmental consequences for children (Grotevant and McDermott, 2014; Rutter, 2005). Adoption can provide opportunities for children to achieve some recovery from the negative effects of early adversity, as Van IJzendoorn and Juffer (2006: 1240) point out,

> …adoptions are effective interventions in the developmental domains of physical growth, attachment security, cognitive development and school achievement, self-esteem and behavioural problems.

Such findings have prompted successive UK governments to see adoption as a positive outcome for children in care who cannot live with a parent or relative. Promoting adoption and tackling delay in the adoption process has been an increasingly dominant theme in adoption

policy within the coalition and subsequent Conservative governments (Department for Education (DfE) 2016a; 2013; 2011). As part of the adoption reform agenda, proposals were set out in 2015 to establish regional adoption agencies (DfE, 2015b). Concerns were highlighted about inefficiencies in the system due to the large number of adoption agencies (180 – most of which are local authorities (LAs) and 45 of which are voluntary adoption agencies, some working on a national scale) compared to the relatively small numbers of children being adopted (around 5000), and the fact that many agencies were operating on a very small scale (DfE, 2015b). A reluctance to make placements across agency boundaries, identified as a problem in some cases by Farmer *et al* (2010), was also cited by DfE as a source of delay for children. A desire to achieve economies of scale and more certainty in contracting of the provision of adoption support was a further argument put forward for setting up regional adoption agencies (RAAs) (DfE 2015b).

Keen to facilitate regionalisation, in 2015/2016 the government released £4.5 million as start-up funding for LAs willing to begin the regionalisation process early and the regionalisation policy document stated that the proposed Education and Adoption Bill would make regionalisation mandatory (DfE, 2015b). Round one of the 'Practice and Improvement Fund' opened in April 2016 to fund the first wave of RAAs with plans to go 'live' mid-2017 (Department for Education, 2016b). In 'Practice and Improvement Fund: Round 2; improving outcomes in a regionalised adoption system' (DfE, 2016b), improving access to voluntary adoption agencies (VAAs) and Adoption Support Agencies (ASA) expertise was also emphasised, as was increasing the use of early permanence planning, along with improved matching and adoption support. Support service provision is being underpinned by the Adoption Support Fund which has released £52 million since May 2017 with the Government set to increase the fund to £28 million in 2017/2018 (DfE, 2017) and yearly to 2020 (DfE, 2016b).

In response to this regionalisation agenda, the Yorkshire and Humberside region sought to become one of the first areas to form a regional adoption agency (RAA), building on a successful and established consortium. Made up of 15 local authority adoption agencies and several voluntary adoption and voluntary support agencies from the Yorkshire and Humber region, One Adoption is divided into three geographical areas. The proposed 'One Adoption Agency North and Humber' combines five adoption agencies: North Yorkshire County Council, City of York Council, East Riding Council, Hull City Council, and North East Lincolnshire Council[1]. The 'South Yorkshire One Adoption Agency' is currently four individual agencies

[1] North Lincolnshire was originally part of this grouping, but have now withdrawn.

which are in the process of combining: Barnsley Metropolitan Borough Council, Doncaster Children's Services Trust, Rotherham Metropolitan Borough Council and Sheffield City Council. These two new regional agencies are still in the process of reform and, at the time of writing, are yet to go live. One Adoption West Yorkshire went live on 3rd April 2017 and 5 local authority adoption agencies are now working together: Bradford, Leeds, Calderdale, Kirklees and Wakefield (One Adoption, 2017).

This newly formed RAA consists of recruitment and assessment teams responsible for recruiting, assessing and approving adopters, family finding teams with responsibility for the placement of children with a plan for adoption, and adoption support teams responsible for varied adoption support services for everyone affected by adoption. These three strands tie in with the Government's regionalisation strategy, outlined in 'Regionalising adoption' (Department for Education, 2015b), which seeks to tackle delay by improving recruitment, speeding up matching and improving adoption support services.

The RAA also seeks to promote the voice of adopters and adoptees in service provision (One Adoption, 2017) which is also emphasised in 'Regionalising adoption' (DfE 2015b: 38),

> Adopters are best placed to understand the needs of their children and their insight is invaluable in shaping the services they use. The views and experiences of adopted children and young people also need to be understood and taken into account.

As part of this drive to listen to adopters, the University of East Anglia were asked to survey adoptive parents from the region. This was to gain a detailed understanding of adopter experiences of the process of adoption and into adoptive family life, including availability and use of adoption support services. Another aim was to look at risk and protective factors in adopted children's lives pre-adoption and outcomes now. Although adoption can offer children stable and secure family life and the chance of developmental recovery, many children adopted from care will need ongoing support in a range of areas including children's mental and physical health and educational needs, and birth family contact and identity issues (Thomas, 2013, Neil *et al*, 2015; Selwyn *et al*, 2015). An acceptance that adoptive families may need ongoing support is now embedded in government policy and in practice, though the accessibility, appropriateness, availability and effectiveness of support services have all been called into question (Holmes *et al*, 2013; Pennington, 2012; Rushton & Monck, 2009). Through this survey it was hoped to add to the understanding of the support needs of adoptive families by gathering in-depth information across a range of areas of child functioning and family life

on a large enough scale to be able to understand more clearly what support is needed, and which children are most likely to need the most support.

The aims of the study will be further detailed in chapter 2 along with an outline of the sample and methodology. Chapter 3 gives a detailed look at the risk and protective factors in the children's lives before adoption including: the background of birth families and the difficulties they faced; prenatal drug and/or alcohol exposure; the quality and continuity of foster care; and the level of severity of any experiences of abuse and neglect. Chapter 4 explores the adopters' perspectives of adoption outcomes overall and their child's strengths and challenges in the domains of behaviour, emotional wellbeing, physical health and relationships. Adopters' experiences of their child's introduction to their family are reported in chapter 5 including views on the speed and quality of introductions, how well parents thought their child coped with the move, the role of foster carers and professionals during these transitions and contact with foster carers after the move.

Chapter 6 reports on findings from standardised measures of the emotional and psychological health of children using the Strengths and Difficulties Questionnaire (Goodman, 1997; 2001) and the Tarren-Sweeney Assessment Checklist for children in care (Tarren-Sweeney, 2014). The chapter also outlines findings on the diagnoses children have. Chapter 7 uses a latent factor structural equation modelling analysis to help us understand the links between early adversity and adoption outcomes. Education outcomes are reported in chapter 8 and include: experiences of schools; achievements; exclusions and special educational needs. Chapter 9 presents findings about adoptive parents including: motivations to adopt; initial preferences about the characteristics of children they wished to adopt and how these changed through the preparation and assessment process; expectations versus the reality of adoption; and the results from the standardised measure Parenting Stress Index (Abidin, 2012). Chapter 10 details experiences of the extent and type of birth family contact after adoption and variations in agency practices. Chapter 11 gives a detailed look at the availability and use of support services including adopter views of unmet need. This is followed by a conclusion and discussion in chapter 12 which gives key recommendations for policy and practice.

Chapter 2 - Method and Sample

2.1 Aims of the survey

The survey aimed to gather detailed information from a cross-section of adoptive parents about how they and their child were getting on after the adoption order had been made, to measure risk and protective factors that may affect children's development, and to gain an up-to-date picture of what services families had used, wanted or needed. There were several main questions the research hoped to answer:

- What risk and protective factors had children experienced prior to the adoption? (For example what types of maltreatment (if any) had they experienced, what problems had the birth parents had, and how many foster placements had children experienced prior to the adoption?).
- What factors led the respondents into adoption, and what were their expectations?
- How well did adopters feel they were prepared for and supported around the process of becoming an adoptive parent to their child?
- How well did adopters think their child was cared for in foster care and what contact with previous foster carers had taken place? How did adopters feel the transition of their child to their adoptive family was managed?
- How were the children getting on? What were their strengths and challenges? What diagnoses had children received, if any? How were children progressing in education?
- What was the nature and extent of post-adoption birth family contact experienced by the adoptive families? What were the challenges and benefits associated with contact, according to the adoptive parents?
- What types of support had the adoptive families accessed, and how helpful did they find this support? What support would they have liked to have been available?
- How did the outcomes for the child relate to factors such as child characteristics (age and gender), the child's pre and post placement experiences, and birth parent characteristics?

As this study involved a survey of adoptive parents, these questions were explored from the perspective of adoptive parents only, not those of their children, previous parents or carers or professionals, all who may have differing experiences and views.

2.2 Method

Data were collected through an online adoptive parent survey administered using Qualtrics software. The survey design was informed by consultation with adoptive parents and professionals. A combination of multiple choice, Likert scale and open textbox questions were included, covering the child's pre-placement history, parents' experiences of preparing to adopt, their child's transition to their family, their child's characteristics and difficulties, birth family contact, and support services received and wanted. In the section on adoption support, an adapted version of the client services receipt inventory (CSRI) (Beecham & Knapp, 1992; Byford and Fiander, 2007 and Holmes and McDermid, 2012) was used to gather information about parents' use of support services. 'Part 2' of the survey included versions of up to three standardised measures to be completed depending on the age of the target child:

- A measure of parenting stress: The Parenting Stress Index short form, for parents of children up to age 12 (Abidin, 2012).
- A measure of children's emotional and behavioural strengths and problems: The Strengths & Difficulties Questionnaire (SDQ) (Goodman, 1997), for ages 2-4 years, or 4-17 years.
- A mental health measure for children in care/adopted: The Tarren-Sweeney Assessment Checklists (short forms) for Children (age 5-10) and Adolescents (age 11-17) (Tarren-Sweeney, 2014).

The survey was piloted by 4 adoptive parents all of whom were telephoned, or met with in person, and asked to give detailed thoughts on the content and presentation of the survey. The study was granted ethical approval by the University of East Anglia and the University of Loughborough.

The survey focussed on one child per family, and respondents were asked to select their most recently adopted child (if a sibling group placed at the same time, they were asked to select the oldest of the group). Respondents had the opportunity to provide other key information in relation to other children at the end of the survey, if they so wished. The survey was set up to automatically skip questions that were not relevant to respondents based on their previous answers.

Eligible families were those with an adopted child under the age of 18 who had adopted their child from the Yorkshire and Humberside area, and/or who had been approved to adopt in this area, and/or who were living in this area. Fifteen local authorities and six voluntary agencies

in the Yorkshire and Humberside region publicised the survey. Typically, promotion involved agencies emailing the survey web-link to adoptive families for whom they had contact details, up to three times through the active period of the survey. Printed postcard sized invitations were also handed out at some events, support groups or therapy sessions. These methods of reaching families are likely to have favoured families who had adopted recently and those who had kept their contact details up to date (possibly because they had ongoing support). In order to attempt to reach a wider range of families, particularly those who may not be in touch with agencies, additional promotion occurred via a regional newsletter, some agency websites, Facebook and Twitter, and word of mouth.

The Qualtrics survey format is inevitably more attractive to those who are comfortable using computers and internet-based services. To avoid this possible bias, adoptive parents could request a paper copy of the questionnaire that they returned by post. Four parents responded in this way and their answers were entered into the online survey by the research team.

The survey was completed anonymously and data were collected between November 2016 and March 2017. All who completed the survey were asked if they were happy to provide their email for the sole purpose of being invited to take part in any future stages of the research. If agreement was given for this, a separate survey link automatically opened to collect contact details which could not be linked to a respondent's main survey answers.

Statistical packages SPSS and STATA were employed to complete quantitative analysis. Responses to the open-ended questions were entered into Nvivo software to complete an analysis of this qualitative data. This allowed us to organise comments into themes and to quantify how many adoptive parents shared the various views and experiences that these themes represented.

2.3 The sample of adoptive parents

A total of 319 adoptive parents filled in the survey at least up until a key question early on which asked how the adoption was faring. There was some drop out at later stages into the survey, and not all competed all questions, particularly open boxes which collected further or additional descriptive information. At least 237 adoptive parents (74%) completed most questions through to the end of Part 1 of the survey. Part 2 of the survey (containing standardised measures) was completed by 207 parents (65%).

Throughout this report, percentages are based on the number of parents who responded to each question. Although there was some drop out in later stages of the survey, there was also

rather more missing data in the earlier sections asking about the child's history. When asking adoptive parents about children's backgrounds (the characteristics of their birth parents, experiences of maltreatment), questions included the option for parents to say "unknown", and how many respondents used this option is reported in Chapter 3. But other respondents simply skipped the questions altogether; the reasons for this are unknown, but it is highly likely that in many cases the adoptive parents lacked information to answer the question. Therefore where data on children's' backgrounds are reported, the 'don't know' responses suggest a minimum amount of cases in which adoptive parents did not know information about the child's history, the true figure is likely to be higher. There were more missing data about children's birth fathers compared to birth mothers, a factor that was also noticeable in a survey of adopted children's backgrounds completed by social workers (Neil, 2000).

Respondents included 85% (n=268) adoptive mothers and 15% (n=48) adoptive fathers, with 17% (n=53) being from single parent households (n=45 single female households and n=8 single male households). Three-quarters (n=238, 76%) were parenting as part of a heterosexual couple and 7% (n=22) as part of a gay or lesbian couple. The vast majority of (n=217, 93%) were White British or Irish.

Most parents (88%, n=281) had adopted a child who was previously unknown to them; only n=2 parents knew their child from their professional or family network and n=36 (11%) were foster carer adopters (n=15 had been recruited as part of a 'foster to adopt' scheme). Most respondents (n=305, 96%) who completed the survey said that they were the main carer of their children.

Parents were asked for their household monthly net income; 216 parents answered this question (67%). Households were spread fairly evenly across the categories provided, as can be seen in Table 2.1 below. To put this into context, the UK average (median) household net disposable monthly household income for the year 2015-6 (£2084) is within the £1801 - £2400 category (Department of Work & Pensions, 2017). Most (81%) households placed themselves in this category or above, with 19% placing themselves in the categories below.

Table 2.1: Respondents' net household income per month

Household Income	%
under £600	1%
£601 - £1200	6%
£1201- £1800	12%
£1801 - £2400	16%
£2401 - £3000	18%
£3001 - £3600	17%
£3601 - £4200	10%
£4201 - £4800	9%
More than £4800	11%
Total	100%

Respondents included adoptive parents connected to all the local authorities and voluntary adoption agencies within the Yorkshire and Humber region:

- 82% of respondents said they were assessed by a local authority agency in the Yorkshire and Humber area (see Table 2.2)
- 83% of respondents said they adopted their child from a local authority in the Yorkshire and Humber area (see Table 2.3)
- 85% of respondents said they lived in the Yorkshire and Humber area (see Table 2.4)

A small number of respondents (<10) appeared not to fit any of the categories of currently living in, having been assessed by or having adopted their child from agencies in Yorkshire and Humber area. It is most likely that they were involved with one of these agencies for an older child who was not selected as the target child to be focussed on in the study. It is possible a small minority may have heard about the study via their network and decided to complete it even though they did not fit any of the categories for inclusion. Most of these parents did seem to have involvement (in relation to their target child) with a neighbouring agency or lived in a neighbouring county. These respondents were not excluded from the analysis.

2.4 The adoption agencies

The 15 LAs in the Yorkshire and Humber region are responsible for just over one tenth of looked after children in England (7,720 children were looked after in the region and 72,670 in England on March 31 2017). These 15 LAs vary very considerably in terms of their geographical size, population density and levels of deprivation and therefore numbers of children in care in each local authority vary widely, as do the rates of children looked after per 10,000 of the child population. For example on 31 March 2017 Leeds had 1,255 looked after children whilst North Lincolnshire had only 225. Hull had the highest rate of the child population

in care (124 per 10,000) and North Yorkshire the lowest (36 per 10,000). The numbers of children being adopted in each area also varies widely in absolute terms (e.g. in 2017, 80 were adopted from Leeds and just 10 each in York, East Riding and North Lincolnshire), in terms of the percentage of children adopted from care (e.g. in 2017 8% in East Riding but 30% in Barnsley), and from year to year (the current total of 17% being the lowest in the last 5 years). For the region as a whole, a somewhat higher percentage of the child population are looked after compared to England (67 vs 62 per 10,000), and amongst those looked after a slightly higher rate of children are adopted (14% vs 17%). Appendix 1 summaries key information about the 15 LAs and comparative data from England, drawing on data from the Department for Education (DfE 2017a).

In addition to the variations in agency size and use of adoption, agencies also differed according to their promotion of the survey, with some being more active and encouraging. It was not possible to calculate a response rate in terms of the percentage of parents contacted about the research who took part in the survey as it was not known how many parents each agency were able to contact. See below for a summary of information about what connection respondents had to different adoption agencies.

Numbers of respondents who stated they were assessed by each individual agency in the York and Humber area can be seen in Table 2.2 overleaf. This shows that the agencies with the largest numbers of adopters participating were Leeds, Calderdale, North Yorkshire and Hull, all of which had at least 30 respondents.

Table 2.3 overleaf shows the local authorities from which the children originated. Five parents did not complete this question, and some parents specified a voluntary agency which may have been an error on their part, or a direct placement of a voluntarily relinquished infant. The largest category was of children adopted from outside of the Yorkshire and Humberside region (n=52), and within the region the largest agencies again were Leeds, North Yorkshire, Hull, and Calderdale. One child had been adopted from abroad. For just over a quarter of the sample (n=81, 26%) the child's local authority was different from the agency who had assessed the adoptive parents - in other words it was an interagency placement (based on n=310).

Table 2.2: Frequency of answers to 'Which council / adoption agency carried out your adoption assessment?'

Council / adoption agency	Number of survey respondents
Sheffield	19
Rotherham	4
Doncaster	8
Barnsley	12
Leeds	33
Bradford	16
Kirklees	16
Calderdale	30
Wakefield	17
North Yorkshire	35
York	10
East Riding	12
Hull	30
North Lincolnshire	9
North East Lincolnshire	8
Barnardo's	10
SSAFA	1
After Adoption	3
Yorkshire Adoption agency	9
other UK LA	26
other UK VA	6
other non UK	1
Total	319

Table 2.3: Frequency of answers to 'Which council or adoption agency did you adopt your child from?'

Council/adoption agency	Frequency
Sheffield	21
Rotherham	3
Doncaster	9
Barnsley	14
Leeds	36
Bradford	20
Kirklees	12
Calderdale	24
Wakefield	18
North Yorkshire	28
York	10
East Riding	11
Hull	31
North Lincolnshire	9
North East Lincolnshire	12
Barnardo's	1
Yorkshire Adoption agency	1
other UK LA	52
other UK VA	1
other non UK	3
Missing data	5
Total	319

Table 2.4: Frequency of answers to 'Which council do you pay your council tax to?

Council/adoption agency	**Frequency**
Sheffield	23
Rotherham	2
Doncaster	5
Barnsley	14
Leeds	35
Bradford	21
Kirklees	18
Calderdale	26
Wakefield	24
North Yorkshire	14
York	29
East Riding	29
Hull	15
North Lincolnshire	9
North East Lincolnshire	4
Other UK LA	48
Missing data	3
Total	319

Table 2.4 (previous page) shows the numbers of parents living in each local authority in the Yorkshire and Humber region, with 15% of respondents living outside of this area. Within the Yorkshire and Humberside region, the areas where the largest numbers of respondents were currently living were Leeds, York, East Riding and Calderdale.

While the study was open to all adoptive parents who met the eligibility criteria, the method of self-selection is inevitably prone to bias. It cannot be known why some parents chose to take part in the study and others did not. It is possible that the study appealed more to certain types of adoptive parents, for example those who have had particularly difficult experiences, or those who feel strongly about the appropriateness of post-adoption services. From analysis of the findings, however, this does not seem to have been the case. Respondents reflected a broad range of different post adoption experiences, some positive and some negative. The diversity of their experiences are captured in this report.

2.5 The characteristics of the children

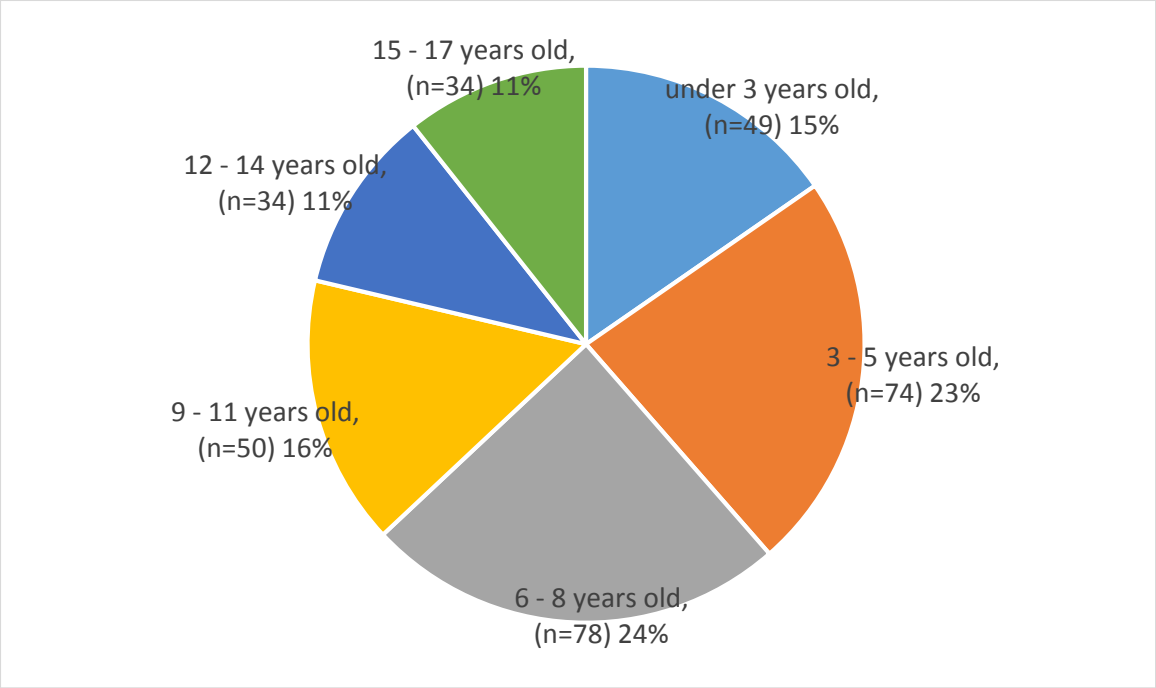
Responses to the survey were given in relation to 319 children, all of whom were selected according to the survey criteria of being the only or most recently adopted child in their family (or the oldest of a sibling group adopted together). The sample is representative of national adoption in terms of the child's gender. Just over half (n=165, 52%) of the 'target' children, were boys and 47% were girls (n=151). Three parents (1%) selected the option 'other' (no further details supplied). This is almost identical to recent national data reporting 51% of adopted children to be male, and 49% female (DfE, 2017b).

Nationally around 84% of adopted children are white (DfE, 2017b), and minority ethnicity children may be slightly under-represented in this survey. In the study sample 89% of children (n= 279) were White British or Irish and a further 3% were white of other origin (n=8). Of the remaining children most were of mixed heritage (n=21, 8%) with just 8 children being Black, Asian or 'other' (3%).

As presented in Figure 2.1, the children ranged from under 1 year old to 17 years old at the time of the survey, with 79% (n=251) being of preschool or primary school age (the mean and median age of children was 7 years old). The smaller numbers of children in the older age categories (only 21%, or 68, were twelve years old and over) may partly reflect the lower proportion of UK domestic adoptions at the time these teenagers were adopted (a significant increase in the use of adoption took place in 2011; children adopted from this time period would now be up to around 9-11 years old). It is also possible that adoptive parents of older

children and teenagers, particularly those not recently in need of support, may not have kept in touch with their local authority or adoption agency. Only adoptive parents whose current contact details on recruiter agency databases would have received recruitment emails and leaflets, although some additional parents may have heard about the survey through other routes such as social media.

Figure 2.1: Age of the children at the time of the survey



Nearly a third (32%, n = 106) of the target children were adopted with one or more sibling from their birth family and 70 children were placed *at the same time* as a sibling. Eleven children were part of sibling groups of 3 or 4 children adopted together.

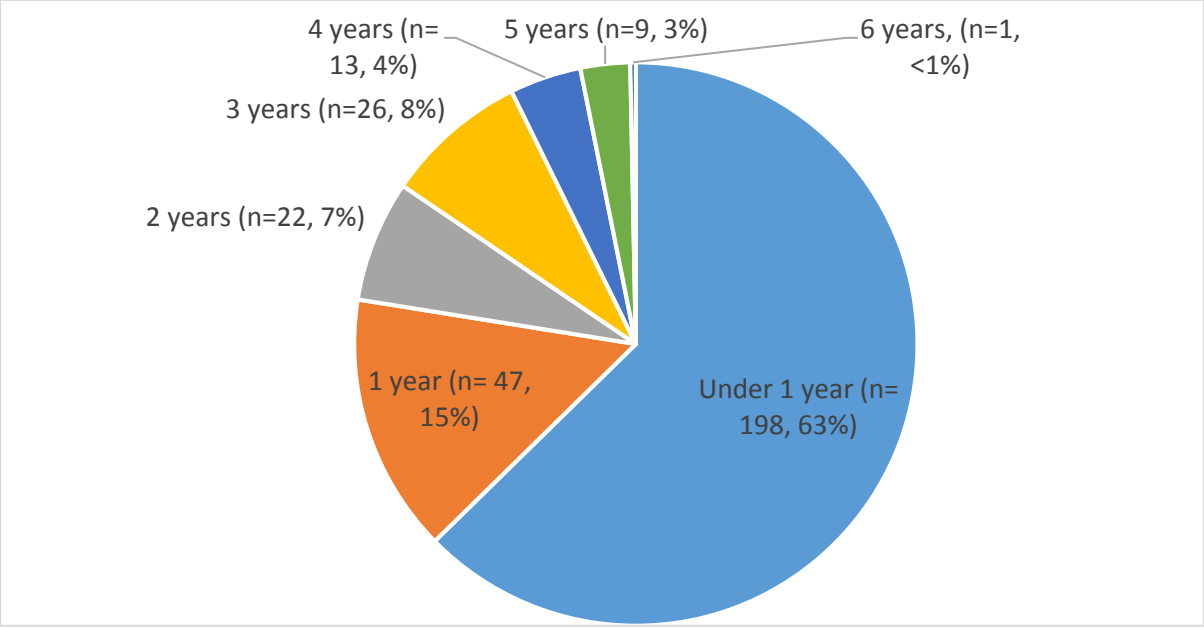
2.6 Coming into care

Parents were asked whether their child was relinquished by their birth parent(s) (i.e. it was the parent(s) who made a decision that they could not care for the child and this led to the adoption) or whether the adoption was planned by Children's Services for reasons related to child protection (the parents may or may not have consented to the adoption). All 319 parents answered this question and 10% (n=33) indicated that their child was relinquished by their parents. It is important to note that many children in this group did not fit the definition of a "straightforward" baby adoption e.g. a child given up by a young mother not yet ready to parent. As also identified in an earlier survey by Neil (2000), some parents who 'give up' children for

adoption do so in very complex circumstances, including situations where child protection procedures were in progress. For example one adopter in this survey explained that her child's birth parents had already had three children removed and adopted. For the other children (n=286, 90%) their adoption was planned by Children's Services for reasons related to child protection.

Parents were asked how old their child was they were moved into care (for the last time) from their birth family. The results are presented in Figure 2.2 below and this shows the very young age at care entry for most. Reponses ranged from birth to 6 years (n=316). The mean age at removal was 14 months and median 4 months. Nearly half of the children (n= 150, 47%) were removed from their birth family and came into care when they were under 3 months old. Around two thirds (n=198, 63%) were under 1 year old. However, 49 children (16%) were not removed from their birth family until they were over age three.

Figure 2.2: Age when the target child was removed from their birth family



2.7 Children's ages at placement

The age at which children were placed into their current adoptive family was calculated using the month and year of the child's birthdate, and the month and year of placement (exact dates were not asked for in the survey to preserve anonymity). Age at placement could be calculated for 299 children and it ranged from 0-11.5 years, with a mean of 28 months (SD= 23.9) and a median of 19.5 months.

Thirty percent of the sample were placed age 0-11 months (n= 91), though only 12 of these were placed shortly after birth (<1 month). About one quarter of children (n= 73, 24%) were placed when age 1 (12-23 months). Fourteen percent (n= 43, 14%) were age 2 (24-35 months) and the remainder (n= 93, 31%) were age 3 or older (36+ months).

It is difficult to directly compare the children in this sample to those adopted nationally in terms of age at placement, as Department for Education statistics focus on the age of the child *at adoption*, this being (at least in the most recent Adoption Leadership Board statistics, ALB 2017) an average of 9 months after placement. A further complication is that our sample is cross sectional rather than taken from just one year, and recent policy initiatives have focused on reducing delay in the adoption process. In 2016-17, the average age at adoption was 3 years and 4 months; this suggests an average age at placement of about 31 months – close to the figure of 28 months for children in this sample.

It was considered whether the age at placement of the children in the sample varied in terms of the child's age at the time of the survey. Age of placement in months was significantly positively correlated with age at the time of the survey (n=298, r_s= 0.37, p<0.001), in other words the older children were at the time of survey, the greater their age at placement tended to be.

Figure 2.3: The age at placement of children by age at time of survey.

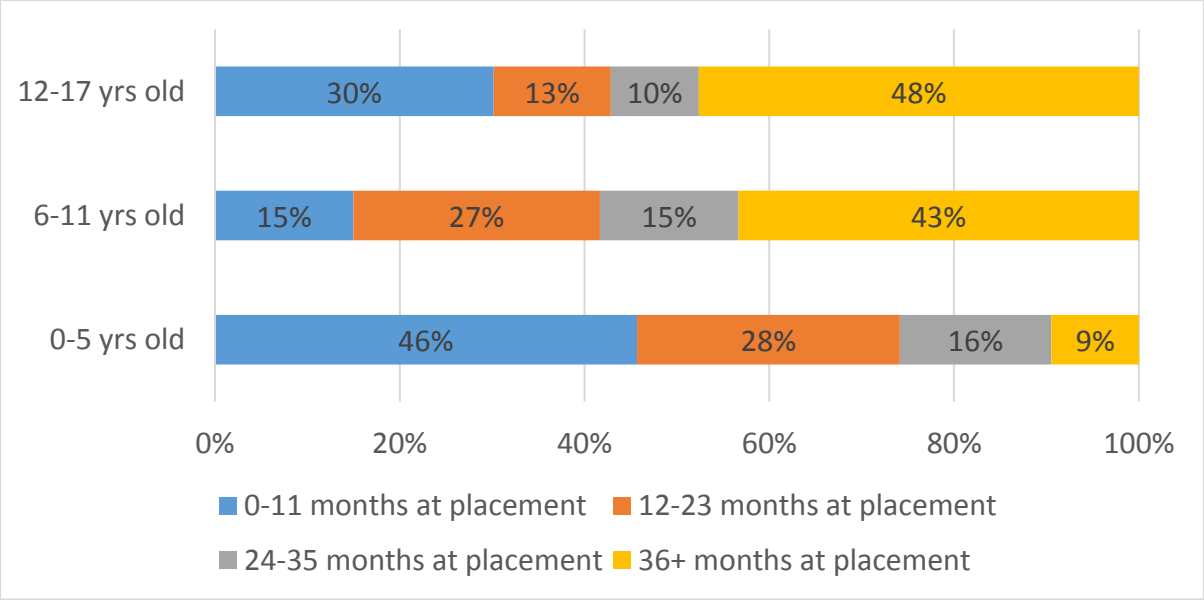


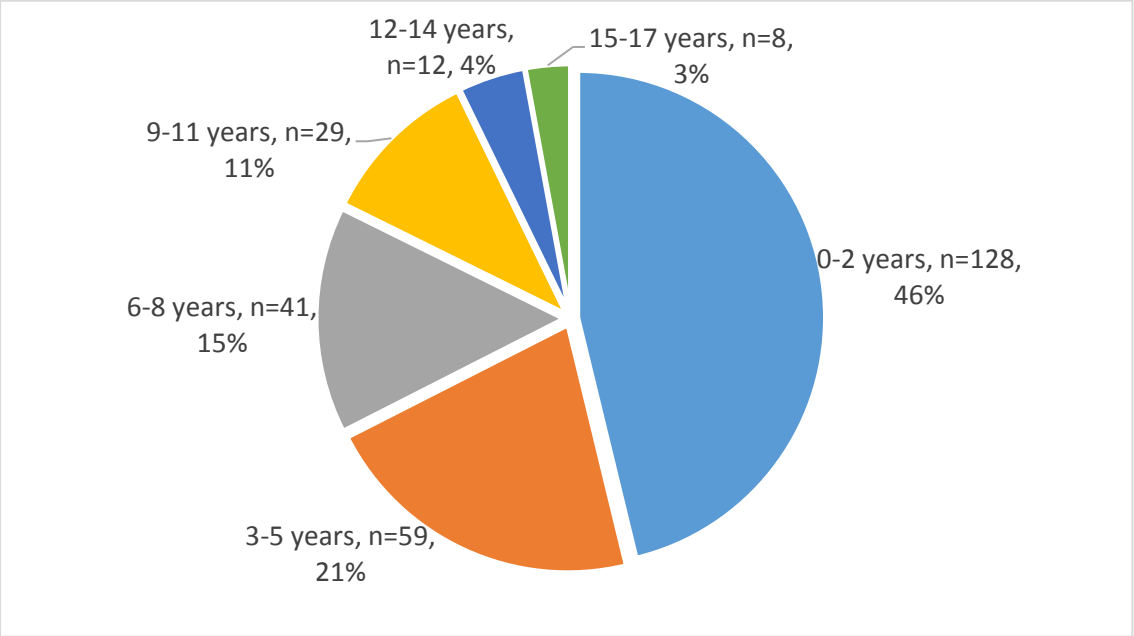
Figure 2.3 shows how age at placement varied for children in different age groups at the time of the survey. This shows that predominantly the differences are between the youngest

children (under 5s), almost half of whom were placed under age 1 and 74% under age 2, and the older two groups – where only about 1 in 4 were placed by age 2. There are a number of possible reasons why the younger age group contains more children placed at younger ages. To begin with there is the time lag between being placed and being adopted, which is likely to be ab at least 9 months. Hence this group of children who are currently under age 5 will have been placed up to the age of 4, but probably not beyond that age (as such children would not have been legally adopted by the time of the survey). Secondly, recent government policy changes have led to shorter court proceedings and greater availability of foster to adopt placements (ALB, 2017) and younger children may have benefited from these initiatives. Finally, with regard to older children agencies may have been able to reach more families of older *placed* children, as such families may have needed more support after adoption. It is important to bear in mind in a cross sectional survey that outcomes for children at different ages are not directly comparable.

2.8 Time since adoption

To find out how long children had been legally adopted at the time of the survey, the number of months between the date of the children's adoption and the date of completion of the survey was calculated (parents were asked for month and year only to preserve anonymity and the exact date was assumed to be the 15th of each month). The mean number of months since the adoption order was 4 years & 10 months (58 months), and median 42 months, n=277. Over two thirds of the children had been adopted less than 6 years prior to starting the survey (n=187, 68%) (see figure 2.4).

Figure 2.4: Number of years since the adoption order



2.9 Chapter summary

This chapter described the methods used to collect the data and reported demographics of the sample of adoptive parents who responded and some basic information about the adopted children who were the focus of the survey. Key points are summarised below.

- The survey aimed to gather detailed information from a cross-section of adoptive parents about how they and their child were getting on after the adoption order had been made, to measure risk and protective factors that may affect children's development, and to gain an up-to-date picture of what services families had used, wanted or needed.
- The survey was completed anonymously between November 2016 and March 2017. Most parents completed it online with a small number completing a paper version.
- A total of 319 adoptive parents completed some early key questions. There was some drop out at later stages and some missed questions. At least 237 adoptive parents completed most questions through to the end of Part 1 of the survey. Part 2 of the survey (containing standardised measures) was completed by 207 parents.
- Responses to the survey were given in relation to a target child, this being the only or most recently adopted child in their family (or the oldest of a sibling group adopted together).
- Respondents included 85% adoptive mothers and 15% adoptive fathers. Seventeen percent were single parent households and 8% were part of a gay or lesbian couple.

The vast majority of (93%) were White British or Irish. Most parents had adopted a child who was previously unknown to them (88%) the rest were foster carer adopters (12%)

- Fifty-two percent of the 'target' children were boys and 47% were girls; 89% were White British or Irish and 3% were white of other origin. Nearly a third (32%) of the target children were adopted with at least one birth sibling.
- Children ranged in age from 0-17 at the time of the survey and the average age was 7. The children's ages at placement ranged from 0-11 years, but most were adopted under age 5 - the average age at placement was 28 months. Age at placement and age at the time of the survey were correlated, younger children were placed at younger ages.
- The survey data represents a spread across time of families with an adoption connection to the Yorkshire and Humberside area; over two thirds of the children had been adopted less than 6 years prior to starting the survey.

Chapter 3 – The risk and protective factors in children's lives before adoption

3.1 Introduction

The average age that children from care were adopted in 2016/7 was 3 years and 4 months and a significant proportion of these children were adopted from care due to child abuse or neglect (DfE, 2017a). Although still near the beginning of their journey in life, many adopted children experience a number of adverse circumstances before being adopted, both prior to coming into care and sometimes within the care system. Early childhood adversity, especially maltreatment, has a long-term effect on children's development even after removal to a more favourable environment (van der Vegt *et al*., 2009; Rutter, 2005). This chapter is concerned with the prevalence and severity of children's difficult pre-adoption experiences, focusing on experiences in the birth family and the continuity of care experienced once removed from the birth family. Adoptive parents gave us information, if known, about: birth family background; prenatal exposure to drugs and alcohol; exposure to and the severity of various forms of abuse and neglect in the birth family; and the quality and continuity of foster care. Chapter 7 will explore the links between early adversity and child outcomes.

3.2 Birth family background

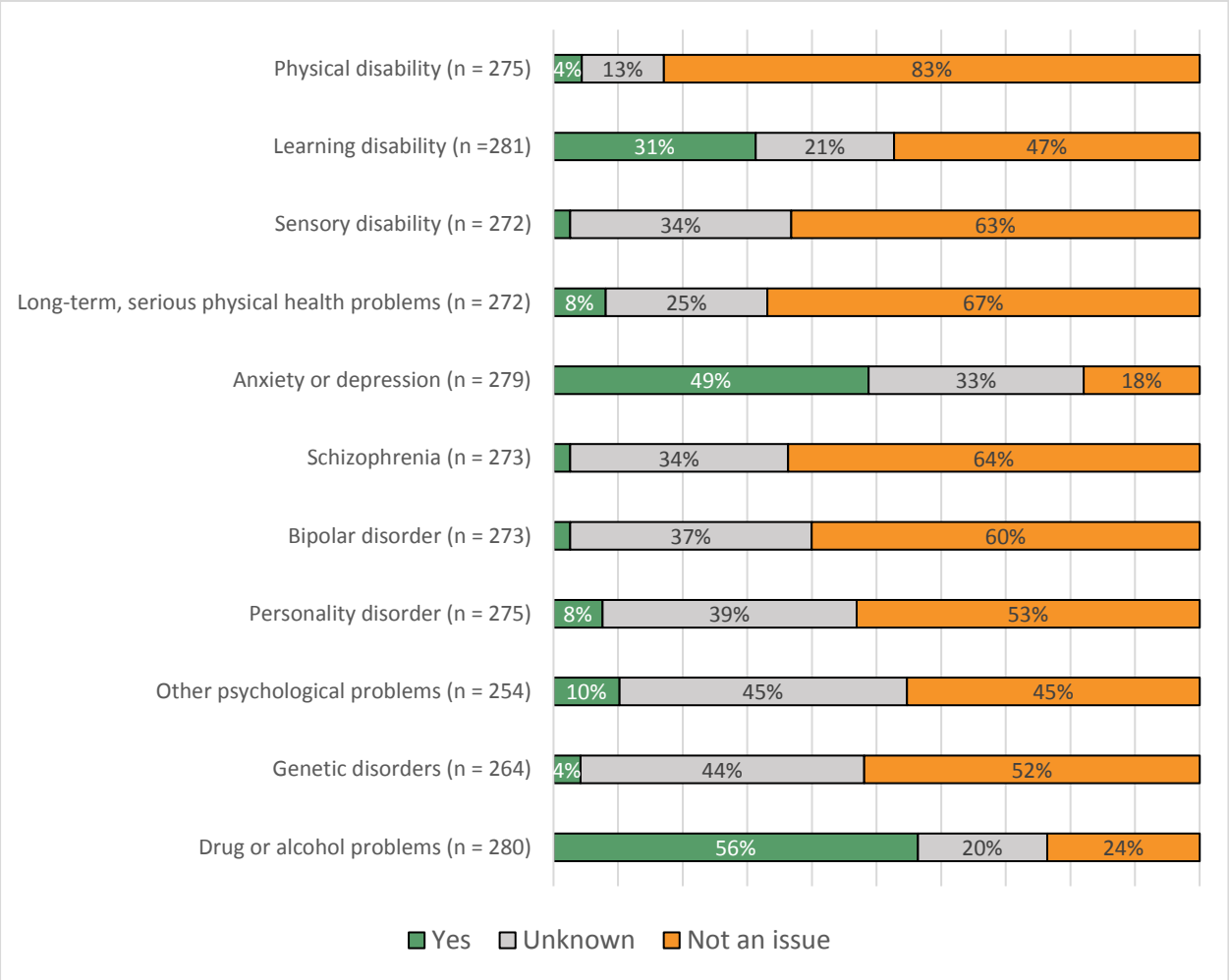
Adopters were asked if they knew anything about their child's birth mother and birth father. If they answered 'yes' they would then be directed to tell us about any significant genetic, disability, health or psychological problems that their child's birth mother and birth father had or has. Respondents were asked to tick *yes*, *unknown* or *not an issue* for the following problems: physical disability; learning disability; sensory disability; long term serious physical health problem; psychological problem related to general anxiety or depression; psychological problem – schizophrenia; psychological problem – bipolar disorder; personality disorder; psychological problem – other (specified in text box if possible); genetic disorders; drug or alcohol addiction/misuse; other (please specify). These questions were followed by a text box asking for further details on the problems specified and/or anything else significant that respondents wanted to tell us. Adopters were then asked to summarise, in a few sentences, why their child's birth parents could not (or chose not to) care for their child.

3.2.1 Birth mothers' backgrounds

The information that adoptive parents had about birth mothers paints a picture of mothers who had themselves experienced multiple adversities, both social and psychological,

often reaching back to their own early childhoods. This concurs strongly with reports of birth parents themselves (Neil *et al*., 2010) and reports of social workers (Neil *et al*., 2000). As can be seen in figure 3.1 below, the most common problems experienced by birth mothers were drug and alcohol problems (n=158, 56% of n=280) and depression or anxiety (n=136, 49% of n=279). Almost a third of 281 respondents (n=88, 31%) said that the birth mother of their adoptive child had a learning disability. Small numbers of birth mothers had physical disabilities (n=12, 4%), genetic disorders (n=11, 4%), sensory disabilities (n=7, 3%), bipolar disorder (n=7, 3%) and schizophrenia (n=7, 3%). Other psychological problems were given in 26 cases (10% of n=254) and descriptions included: stress and trauma after sexual abuse; being a victim of domestic violence; anger management issues and violence; phobias; hypochondria; Munchhausen Syndrome by proxy; and attachment issues. Twenty three people used the text box to tell us about other issues in the birth mother's background. These respondents specified issues such as heavy smoking in pregnancy, sexual abuse as a child, various physical health problems, ADHD and domestic violence.

Figure 3.1: Birth mothers' known significant genetic, disability, health or psychological problems as reported by adopters



Qualitative data about birth mothers showed a dominant theme was experiencing abuse themselves during childhood. Another recurring theme was birth mothers being victims of domestic violence and experiencing multiple intimate partners. The following quotes demonstrate some of these issues:

'I believe she came from an upbringing of abuse & neglect herself. Her sister committed suicide at a young age…'

'…trauma after physical and sexual abuse from her father. Lots of domestic violence from various partners… multiple pregnancies (13).'

'Birth mother was adopted herself and during teenage years disclosed abuse from her adoptive parent.'

'Birth mother was also affected by a chaotic abusive childhood with neglect and some foster care…'

'Subjected to emotional and physical neglect. Sexually abused by father, other family members and friends. Prostituted by father as a minor.'

'Very vulnerable adult originating from severe sexual abuse as a child.'

'Sexually abused by her father resulting in the birth of her first daughter.'

Strong themes, in the qualitative data, of drug and alcohol abuse, depression/other mental health issues and learning disabilities echoed the quantitative data about birth mothers' backgrounds (see figure 3.1). Some of these issues were thought, by adopters, to be linked to maltreatment experienced in childhood.

'Birth mother had a complicated childhood. She disclosed sexual abuse. She had various psychological illnesses and had used drugs and drink heavily in the past. She spent some time in a children's home as a teenager. Had her first child aged 15. Has four other children; first two adopted, second two in and out of care.'

'Birth mother had mental health issues as a result of past experiences and excessive drinking/drug use… exposed to domestic violence by partner…'

Many birth mothers were reported to experience the cumulative effects of multiple problems.

'Birth mother is depressed due to the situation she is in. She has also used cocaine, cannabis and amphetamines whilst pregnant.'

'Birth mother suffered from depression. Unable to put the needs of her children before that of her relationships.'

'Prolific drug and alcohol use. Spent time in prison during pregnancy. Violence and abuse daily.'

'Birth mother has learning difficulties. It is not known whether this is genetic or whether she was unable to thrive due to the awful things she experienced as a child.'

'Drug use. Some evidence of learning disability - treat children like dolls.'

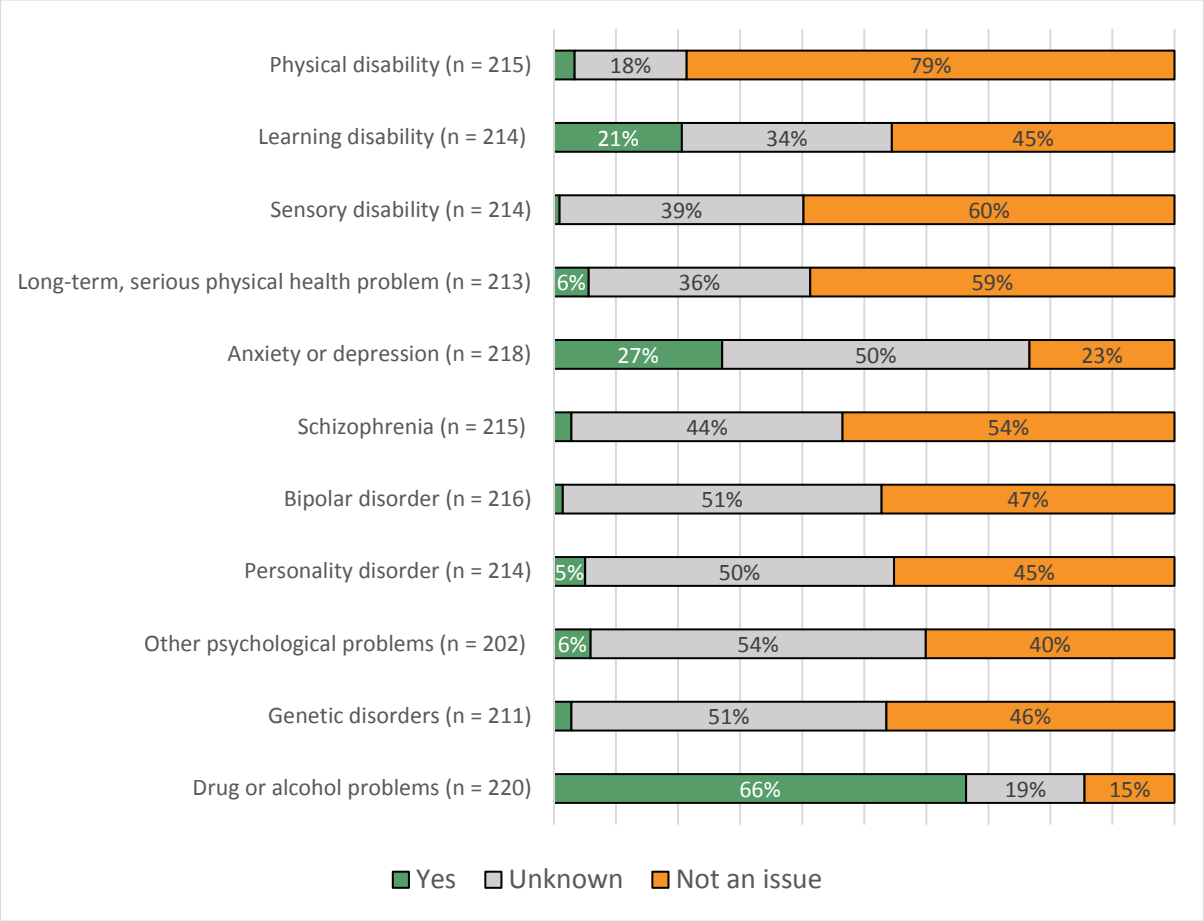
'Birth mother was in care herself due to sexual abuse from step brother and missed 2 years of schooling at least. Medical experts told us her learning difficulty was almost certainly environmental.'

3.2.2 Birth fathers' backgrounds

The adopters' responses to questions on birth fathers' backgrounds gave a similar picture of the cumulative effects of adversity.

As can be seen in figure 3.2 below, the three main problems experienced by birth fathers were the same as for birth mothers: drug or alcohol problems, anxiety and depression and learning disabilities. A larger proportion of birth fathers (n=146, 66%) experienced drug or alcohol problems compared to mothers (n= 158, 56%). Smaller proportions of birth fathers than birth mothers had learning disabilities, just over a fifth (n=45, 21%) of birth fathers compared to nearly a third of birth mothers (n=88, 31%). Just over a quarter of 218 birth fathers experienced anxiety or depression (n=59, 27%) compared to almost half of the 287 birth mothers (n=136, 49%). Figures for the other issues were similar. Other psychological problems were present in 12 of 202 cases (6%). Ten respondents gave details of other problems for birth fathers and five of these fathers were reported to be violent. ADHD, Autistic Spectrum Disorder, sexual offences and childhood neglect were also reported.

Figure 3.2: Birth fathers' known significant genetic, disability, health or psychological problems as reported by adopters



Respondents were given space to give further qualitative data about fathers or to add anything else they knew about their child's birth father. As reflected in the quantitative data (see figure 3.2), substance abuse problems were a dominant theme. These problems with drugs and/or alcohol were often mentioned alongside violent behaviour and mental health problems. These three issues frequently coexist and the cumulative effects can present significant risk factors for children (Brandon *et al*., 2010);

> *'Father left when my daughter was 6 months old – domestic violence was a real concern… Father died falling down the stairs in drink. He was a long term alcoholic.'*

> *'Drug and alcohol abuser. Heroin and cannabis. Domestic violence common. Time served in prison.'*

'Birth dad has ongoing mental health issues from a young age. He heard voices, self-harmed, was depressed, took cannabis and cocaine, was violent on many occasions to birth mum. He finally committed suicide whilst in prison for robbery.'

Some respondents told us that birth fathers had had difficult childhoods themselves;

'We know the birth father's own childhood was difficult. He was taken into care when he was young and lived for some of that time in residential care, which he cited as the happiest time, and he apparently doesn't want a relationship with his mother who was an alcoholic.'

Many respondents told us that criminal activity was a feature of birth fathers' lives;

'*Birth father was abusing drugs when my son was born and has served at least one prison sentence for drug related crime.'*

'Sexual offender, been in prison… had lots of previous relationships and previous children estranged from them.'

3.2.3 Adopter's understandings of why birth parents could not look after their child

Respondents were asked to briefly describe why their child's birth parents could not (or chose not to) care for their child. There were similar themes to those outlined above. These respondents related birth family difficulties directly to parenting, as shown in the examples below.

'They didn't know how to care for children. They couldn't look after themselves properly. Birth Mum at 17 was still a child herself when she conceived [my son]. *Birth Mum had a bad upbringing. Her Mum had children taken from her & put into care.'*

'Unable to provide love, safe environment, appropriate feeding, care, nurture. Unable to give boundaries. Birth parents displayed aggressive behaviour. Also drink/drugs.'

'Very unhealthy relationship including serious DV [domestic violence]. Youngest child was hurt in one incident. Also ongoing inability to provide basic care. Both children admitted to hospital with gastroenteritis, potentially could have been fatal. Decision that birth parents would not be able to parent properly, particularly whilst birth mother continued in unhealthy relationship.

In some cases adopters also mentioned birth parents' difficulties in working with professionals:

Psychology assessment concluded a lot of therapy for birth mother due to past trauma needed, she has never engaged with it properly.'

'They could not/chose not to look after him properly even with massive intervention and guidance from the local authority. Carers went in 5 days a week to improve conditions but birth parents ignored advice and suggested that there were no issues. They felt that their parenting method was fine despite being advised otherwise.'

Ten per cent (n=33) of children were relinquished by their birth parents and 11 adoptive parents gave us further details about the reasons for this. One reason that several adopters cited was that the birth mother and/or father were unable to manage *another* child:

'They were separated, the two siblings living with dad and grandparents, could not manage another child.'

'Birth mother is from [abroad] and had a two year old … Social services had become involved over concerns for the care of our daughter's older sister when she was a baby. Having returned to her first daughter's father [not the father of second child] birth mother did not feel able to provide a good standard of care for another child and made the decision to have her adopted at birth.'

Some birth parents had had multiple children removed prior to the relinquished child,

'The mother had had three other children adopted. The first, not with the same father, was taken away after a violent incident, I think at about 18 months. She was subsequently adopted. The following two children were taken at birth and the parents contested these, but unsuccessfully. When she let social services know about the pregnancy with our son she decided to relinquish him at birth and have no further contact…'

'Relinquished as BPs had already had 3 children removed and adopted and would have been unlikely to be assessed successfully to care for my child. BF claimed that he was too old and had too many health problems so wouldn't have been likely to be around for long…'

In these cases, the birth parents' young age was a factor,

'Birth mother had also been a looked after child, even though her biological parents were both alive. She was 20yrs at the time of his birth. Birth father was the youngest of 5 children & his parents were elderly & could not help to support him or our son.'

'Due to their age and attending university they felt unable to provide and care for my son.'

3.2.4 Changes in main carer while living with the birth family

Inevitably, as birth parents' problems escalate or at times of crisis, children may go to live with other birth family members. They may be transferred between separated birth parents or spend time with the extended family. Parents were asked if they knew how many changes of main carer their child had experienced while living in their birth family.

Whilst almost half of the respondents said that their child had experienced one or no changes in main carer in their child's birth family (n=153, 48% of n=317), over a quarter (n=91, 29%) had experienced two or more changes in carer. One child was reported to have experienced 15 changes of carer in the birth family and another respondent wrote '10+'. Textbox responses showed that, in some cases, responsibility for care could alternate between birth mum and birth dad,

'Birth Mum & Dad were main carers then experienced relationship difficulties so cared for children separately and when couldn't cope birth Grandma looked after [my child] *& Auntie looked after sibling….'*

Grandparents, aunts, uncles and step parents were among other people named as main carers for adopted children. One respondent wrote, *"Multiple male figures."* Another stated that, although their child had only had one foster carer, they had three different carers within the birth family and had, *"…moved round different addresses up to 10 times in the first 11 months."*

The problems faced by birth families can, at the very least, leave little energy for caring for children and, at worst, can create conditions in which children are at serious immediate risk. The quality of care that a child receives is greatly impacted upon by the cumulative effects of the serious issues (social and psychological) of their birth parents (Sidebottom et al, 2006). In addition, disruptions to the lives of children may be experienced as family members step in to try to provide substitute care. Poor quality care, disruptions in continuity and incidences of

maltreatment are all adverse experiences that are likely to have an impact on the long term health, emotional wellbeing and development of children (Felitti et al, 1998). Chapter 7 will look at the impact of adverse pre-adoption experiences on children's outcomes but here the findings on the prevalence and severity of pre-adoption maltreatment are presented.

3.3 The quality of care before children were placed for adoption

Adopters were asked what they knew about the quality of care their child experienced at any time before coming to live with them. The questionnaire listed 14 poor experiences with a short explanation for clarity and these explanations will be given with the findings in each section. The poor experiences were: exposure to excessive or dangerous drugs before birth; exposure to alcohol before birth; emotional/psychological abuse; physical abuse; sexual abuse involving contact; sexual abuse not involving contact; witness to domestic violence; singled out for rejection; medical neglect; nutritional neglect; emotional neglect; physical neglect; lack of supervision and guidance; and educational neglect. Parents were asked to estimate how significantly their child experienced each problem, if at all. Respondents were given the following guidance in order to help standardise responses:

- Code as *mild* situations where your child was removed quickly from a difficult situation, or suffered with quite a low level of the problem, possibly on and off with 'good enough' care in between
- Code as *significant* poor problems that went on for an extended period and/or which were very extreme (e.g. witnessing extreme violence; suffering very severe physical abuse causing extensive damage and/or pain)
- Code as *moderate* problems somewhere in between *mild* and *significant*.

Other response options were "likely experienced but unsure what level", "not experienced" and "don't know". There was also a text box for parents to add further comments.

3.3.1 Prenatal exposure to drugs and alcohol

The effects of exposure to drugs and alcohol in utero are varied; almost all of these substances cross the placenta and have some effect on the foetus (Behnke *et al*., 2013). In a summary of findings of prospective studies on prenatal drug exposure, Bandstra *et al*. (2010) found that prenatal cocaine exposure seemed to be associated with cognitive, neuro-behavioural and language function, particularly when considered alongside the caregiving environment which can moderate/mediate the effects. Opioid use in

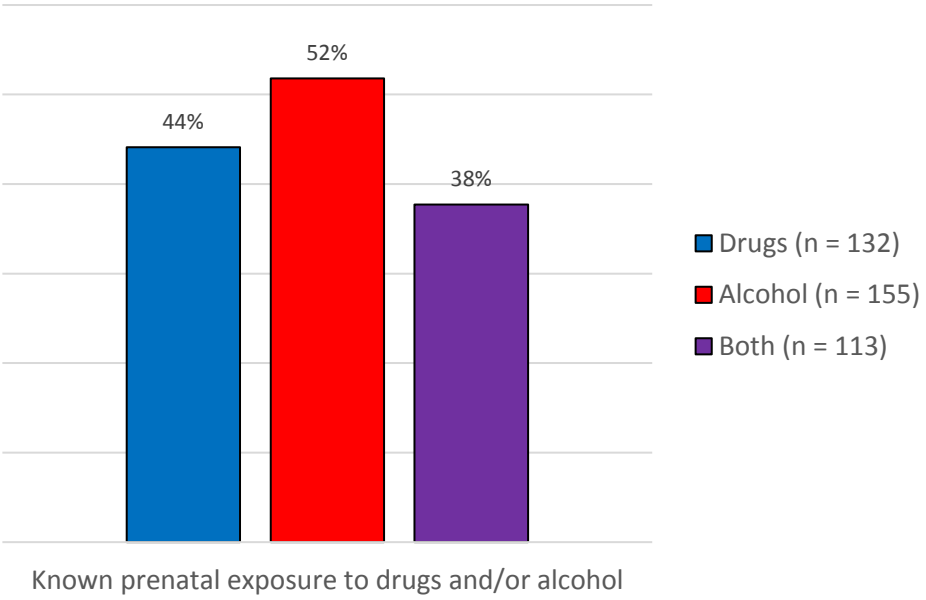
pregnancy can cause neonatal abstinence syndrome and neuro-behavioural deficits in infancy (Bandstra *et al*., 2010). Although most children who are exposed to alcohol in the womb do not develop foetal alcohol syndrome, excessive consumption is significantly associated with central nervous system abnormalities, growth restrictions and abnormal facial features (Kuehn *et al*., 2012). Even when other predictors of memory and learning are controlled for, prenatal alcohol and marijuana use have both been found to have a significant impact on memory and learning. Prenatal marijuana exposure is also associated with increased levels of impulsivity in children (Richardson *et al*., 2002). Our findings, presented in table 3.1 below, give the prevalence and severity of pre-birth exposure to drugs and alcohol. Chapter 7 looks at the effects of exposure on children's outcomes.

Table 3.1 below shows the data about the severity of children's exposure to toxic substances before birth. In total, 299 respondents answered these questions. Just over a quarter (n=79, 26%) did not know whether or not their child experienced prenatal exposure to drugs and the same proportion answered 'don't know' for prenatal alcohol exposure. A similar number stated that their child had not experienced drug exposure (n=88, 29%) and a smaller proportion, just over a fifth (n=65, 22%) of children, did not experience pre-birth alcohol exposure. However, 44% (n=132) said their child had experienced some level of drug exposure in utero and just over half (n=155, 52%) had experienced some level of alcohol exposure. Significant levels of exposure were slightly higher for drugs with 15% (n=46) at a significant level compared to 13% (n=38) for alcohol. Figure 3.3 below shows numbers of children known to have experienced drug exposure in the womb, those that have experienced alcohol exposure in the womb and those that have experienced both drugs and alcohol exposure. Thirty-eight percent of (n=113) said their child had experienced *both* alcohol *and* excessive and/or dangerous drug exposure before birth.

Table 3.1: Prevalence and severity of exposure to drugs and alcohol before birth

Severity level	Excessive or dangerous drugs before birth		Alcohol before birth	
	%	***n***	**%**	***n***
Experienced at a mild level	5.0	15	4.3	13
Experienced at a moderate level	7.4	22	10.0	30
Experienced at a significant level	15.4	46	12.7	38
Likely experienced but unsure what level	16.4	49	24.7	74
Total experienced	**44.2**	**132**	**51.7**	**155**
Not experienced	29.4	88	21.7	65
Don't know	26.4	79	26.4	79
Total respondents		299		299

Figure 3.3: Known prenatal exposure to drugs and/or alcohol as reported by adopters



3.3.2 Abuse

The survey included definitions of abuse/neglect that were partly based on definitions featured on the NSPCC website https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/). In the survey 'abuse', seen as the infliction of harm on another, was sub-divided into 6 different categories:

- ***Physical abuse*** *(*defined by the NSPCC as '*deliberately hurting a child causing injury'* https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/physical-abuse/)
- ***Emotional/psychological abuse*** *(*sometimes termed psychological abuse, and defined by the NSPCC as '*the ongoing emotional maltreatment of a child [that] can involve deliberately trying to scare or humiliate a child or isolating or ignoring them'.* https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/emotional-abuse/what-is-emotional-abuse/*)*
- ***Sexual abuse involving contact*** (defined by the NSPCC as when children '*are forced or persuaded to take part in sexual activities'.* The NSPCC distinguishes between sexual abuse with contact and sexual abuse without contact. Sexual abuse with contact includes sexual touching of the child, rape, or making a child touch someone else's genitals (https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/)
- ***Sexual abuse not involving contact*** (see above; for example encouraging a child to watch or hear sexual acts, grooming a child in preparation for abuse or allowing a child to be exposed to sexual activities by others)

- ***Witness to domestic violence*** (the NSPCC describes domestic abuse as '*any type of controlling, bullying, threatening or violent behaviour between people in a relationship'* and states that '*witnessing domestic abuse is child abuse'* https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/domestic-abuse/)
- ***Singled out for rejection*** (living in a household with other children but being the only one to receive harmful/neglectful treatment or experiencing it to a more severe extent to the other children (Rushton & Dance, 2005))

Witnessing domestic violence is now defined as a form of abuse in law meaning professionals need to act to safeguard children. The Adoption and Children Act 2002 section 120 changed the definition of 'harm' in section 31(9) of the Children Act 1989 to include, 'impairment suffered from seeing or hearing the ill-treatment of another' (Brammer, 2015). 'Singled out for rejection' (Rushton & Dance, 2005) is included with abuse as the child would be ignored and/or isolated and experience emotional abuse as a result.

Parents were asked what they knew about any abuse of their child at any time before coming to live with them (see appendix 2 for guidance given to help respondents define and categorise these types of abuse). As can be seen in table 3.2 below, in total, most parents (between 298 and 300 people) responded to these questions on types of abuse. Sexual abuse, with or without contact, had the highest proportions of people who either didn't know (both 19%) or who thought that their child had not experienced these types of abuse: (n=214, 72%) for sexual abuse with contact and (n= 211, 71%) for sexual abuse with contact. This, perhaps, reflects the fact that this is the most hidden form of abuse and that disclosure by children can often come much later as they get older (Cossar *et al*., 2013). Singled out for rejection was found to have similar figures to the two types of sexual abuse in terms of 'don't know' (n=51, 17%) and 'not experienced' responses (n=206, 69%). Only 14% (n=41) had experienced this at some level.

Table 3.2: Prevalence and severity of different types of abuse experienced at any time before adoption

Severity level	Type of abuse											
	Emotional		Physical		Sexual (contact)		Sexual (non-contact)		Witness to domestic violence		Singled out for rejection	
	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*
Mild	4.0	12	8.0	24	1.3	4	1.7	5	2.3	7	3.0	9
Moderate	8.0	24	5.3	16	0	0	0.3	1	10.1	30	1.3	4
Significant	18.1	54	6.0	18	2.8	9	2.3	7	22.5	67	4.7	14
Likely (level unsure)	8.4	25	10.0	30	4.7	15	5.4	16	12.1	36	4.7	14
Total experienced	**38.5**	**115**	**29.3**	**88**	**8.8**	**28**	**9.7**	**29**	**47.0**	**140**	**13.7**	**41**
Not experienced	45.2	135	55.3	166	71.6	214	70.8	211	41.9	125	69.1	206
Don't know	16.4	49	15.3	46	19.1	57	19.5	58	11.1	33	17.1	51
Total respondents		299		300		299		298		298		298

Witnessing domestic violence was common with almost half (n=140, 47%) of parents saying their child had experienced this at some level. Moreover, almost a quarter (n=67, 23%) said their child had experienced this at a significant level meaning that they suffered for an extended period of time and/or to an extreme level. Of the 299 people who responded to the emotional/psychological abuse question, 45% (n=135) said that their child had not experienced emotional abuse; a further 16% (n= 49) stated that they didn't know whether their child had experienced this type of abuse. Over a third of parents (n=115, 39%) thought that their child had experienced emotional abuse and for 18% (n= 54) this was rated as having occurred at a significant level. Physical abuse was

experienced by 29% (n=88) but with a much lower proportion of significant level exposure at just 6% (n=18).

3.3.3 Neglect

Neglect is defined by the NSPCC as '*the ongoing failure to meet a child's basic needs'* (https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/). Horwath (2007) identified six types of neglect which were distinguished in the survey:

- ***Medical neglect*** (failure to adequately care for a child's health and dentistry needs)
- ***Nutritional neglect*** (failure to provide a child with adequate calories or a healthy diet, leading to malnutrition or severe obesity at its most extreme)
- ***Emotional neglect*** (failure to respond to a child's basic emotional needs)
- ***Physical neglect*** (a failure to respond to a child's physical needs such as hygiene and adequate clothing)
- ***Supervisory neglect*** (lack of safe supervision, and at the extreme end, abandonment of a child)
- ***Educational neglect*** (failure to provide enough stimulation as well as issues around learning and school)

Parents were asked whether their child had experienced these forms of neglect, and to what level, at any time before their child came to live with them. Guidance was given to help respondents define and categorise these types of maltreatment and this can be seen in appendix 2.

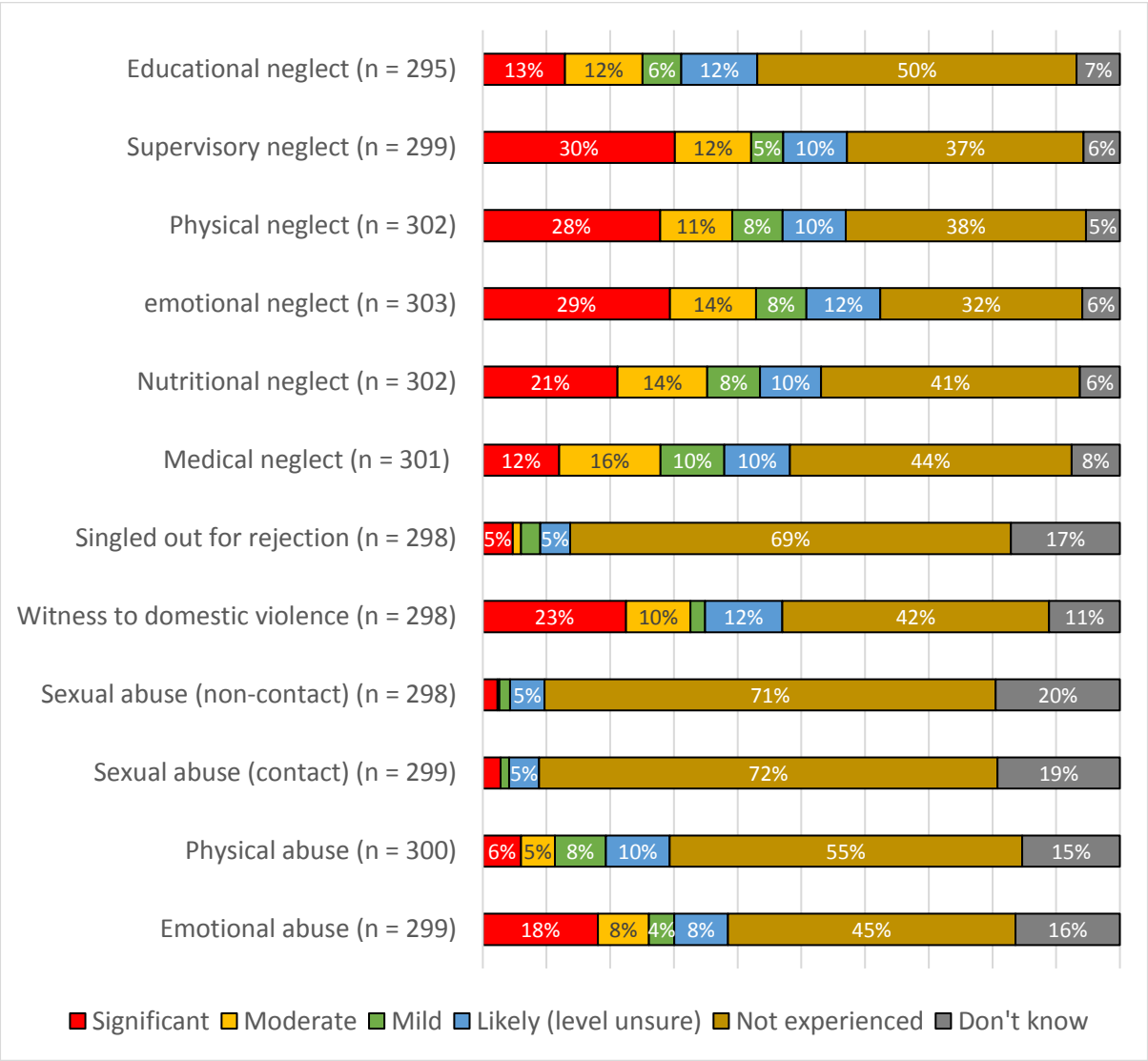
As can be seen in table 3.3 below, the most prevalent form of neglect was emotional, with 62% (n=189) of 303 respondents reporting that their child had experienced emotional neglect at some level. Nearly a third of the total had experienced emotional neglect to a significant level (n=89, 29%). Significant supervisory neglect was report by a similar proportion (n=90, 30%) and physical neglect and supervisory neglect had almost identical figures for experienced at any level at 57% (n=172 and n=171 respectively). Significant levels of neglect were lowest in the medical neglect and educational neglect categories with 12% (n=36) for medical and 13% (n=38) for educational.

Table 3.3: Prevalence and severity of different types of neglect experienced at any time before adoption

Severity level	Type of neglect											
	Medical		Nutritional		Emotional		Physical		Supervisory		Education	
	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*
Mild	10.0	30	8.3	25	7.9	24	7.9	24	5.0	15	6.1	18
Moderate	15.9	48	13.9	42	13.5	41	11.3	34	12.0	36	12.2	36
Significant	12.0	36	21.2	64	29.4	89	27.8	84	30.1	90	12.9	38
Likely (level unsure)	10.3	31	9.6	29	11.6	35	9.9	30	10.0	30	11.9	35
Total experienced	**48.2**	**145**	**53**	**160**	**62.4**	**189**	**56.9**	**172**	**57.1**	**171**	**43.1**	**127**
Not experienced	44.2	133	40.7	123	31.7	96	37.7	114	37.1	111	50.2	148
Don't know	7.6	23	6.3	19	5.9	18	5.3	16	5.7	17	6.8	20
Total respondents		301		302		303		302		299		295

Figure 3.4 below summaries parents' responses to the questions about abuse and neglect. As can be seen in the far left section, more parents did not know about forms of abuse compared to forms of neglect. All forms of neglect except educational and medical, had high figures for 'experienced at a significant level', as did 'witness to domestic violence'. Emotional neglect was the most prevalent form of maltreatment with the highest figures for 'experienced at a significant level'.

Figure 3.4: Prevalence and severity for all forms of maltreatment on the survey



3.3.4 The quality of care between living in the birth family and being placed for adoption

Good quality foster care that provides a safe, supportive and nurturing environment can act as a protective factor for children whose birth families cannot take care of them (Gilligan, 2001). Continuity of care, with as few placement moves as possible, is also important for children's future healthy development (Simmel et al, 2001). Adoptive parents were asked if they knew how many changes in main carer their child experienced before coming to live with them. They were asked to record numbers of main carers experienced in their child's birth family (reported earlier in the chapter), number of different foster carers and numbers of main carers in other families, if known. Respondents were given open text boxes to comment further on the nature of the care and any time spent in residential care or hospital (without

parents staying) as well so that a sense could be gained about whether their child experienced different unknown carers in these settings.

Most children had experienced 1 foster carer (n=180, 61%) and 6% (n=17 of 297) had no previous foster carers (i.e. placed directly with the family that adopted them). A quarter (n=73, 25%) had been in two foster homes. A small minority (n=27, 9%) had lived in three or more foster homes. Combining these last two categories, one third of children (34%, *n* = 100) had experienced two or more foster carers, the maximum number being 15. This respondent gave more information about multiple placements for their child; *"11 different foster care placements before being placed with us at the age of 9.5 months of age. The placements varied in length from 1 night to 4 months."*

In terms of the quality of foster care, many adoptive parents wrote about good foster care that they felt had provided children with positive developmental opportunities:

'Excellent care in foster care for 3 years after suffering extreme harm in birth family.'

'The foster carers for our child… were brilliant. They gave our child a great start in life and continue to be part of our support network.'

'Birth mum drank and had a violent relationship. Son was removed at 2 days, then was placed with foster family until 17 months. They were supportive and nurturing.'

Having a supportive and nurturing relationship prior to adoption can be viewed as a protective factor which could mitigate harm suffered in adverse birth family environments. Adopters were asked whether their child had experienced a supportive nurturing relationship before being placed in their adoptive family. Parents could tick *yes, no* or *don't know.* They were further asked, *"Who was the person (or were the people) that provided such a relationship? (E.g. foster carer, birth father, grandmother)"* and there was space for the respondent to type in an answer. Of the 308 respondents who answered this question, 69% (n=213) said that their child *did* experience a supportive nurturing relationship before coming to live with the adoptive parent. This was reported to be a foster carer or foster carers by the vast majority of respondents (n=212).

Several parents used the open boxes to comments on what they perceived to be poor quality foster care including lack of stimulation, neglect and lack of supervision:

'His time in foster care was not much better. When he arrived he was in shoes two sizes two small… he was in clothes way too big for him and his hair was shaved off as foster mum found it difficult to wash his hair. Nursery had reported that he regularly came with bite marks and scratches on his arms (while living in care).'

'She was treated like a doll with only a small space to sit in with little encouragement or opportunity to learn to crawl or move. They didn't like her to be messy so no opportunity to feed herself.'

'The foster carers failed to provide adequate supervision and another foster child pushed her down the stairs and she broke her leg.'

Whilst documented maltreatment in foster care is rare (Biehal, 2014), Meakings & Selwyn (2016) have reported that some adoptive parents had significant concerns about the quality of foster care their child's had experienced before adoption.

3.4 Chapter summary

This chapter reports the data gathered from adoptive parents about what had happened to their children before joining their adoptive families. This reveals the high levels of adversities children had experienced, which in over half of cases began with exposure to alcohol and/or drugs in the womb. Adoptive parents reported complex and long standing issues that had impacted on birth parents' capacity to look after the child, in many cases these going back to the parent's own childhood. Although high levels of often multiple pre-adoption adversities were reported by many adoptive parents, it should be noted that levels of prevalence and severity were found to be wide ranging between children. In chapter 7, the link between earlier adversity and outcomes for adopted children is examined through an index developed to take account of these variations in exposure to risk. For many children, being in care may have provided an opportunity for developmental recovery to begin; two-thirds of adopters felt that their child had experienced supportive and nurturing relationship with a foster carer. In other cases the child's time in care may have added to previous adversities through both a lack of stability and quality in foster care.

- **Birth family background:** The most common difficulties experienced by birth mothers and birth fathers were drug and/or alcohol problems (56% for mothers and 66% for fathers), anxiety and/or depression (49% and 27%) and learning difficulties (31% and

21%). Multiple adversities, both social and psychological, were experienced often as far back as birth parents' own early childhoods.

- **Quality of care before being placed for adoption:**
    - ***Prenatal exposure to drugs/alcohol*** – 44% of children had been exposed to excessive or dangerous drugs in the womb at varied levels of severity, 52% to alcohol and 38% to both. Since the effects of exposure to toxic substances in utero are varied, and can result in cognitive, neuro-behavioural and physical impairment, such high rates are concerning.
    - ***Abuse*** **–** The most prevalent form of abuse reported was witnessing domestic violence with almost half of 298 children experiencing this at some level (47%). Sexual abuse (with and without contact) was the least experienced form of abuse (72% of parents said their child had not experienced sexual abuse involving contact and 71% had not experienced non-contact sexual abuse). This may be a reflection of the fact that this is the most hidden form of abuse which children tend to disclose much later, as they get older (Cossar *et al*, 2013).
    - ***Neglect*** – Emotional neglect was the most common form of neglect experienced (62%). By and large, most forms of neglect were experienced at significant levels for a larger proportion of children than abuse (except for witnessing to domestic violence which was experienced by 47%). As such, an omission of care, as opposed to deliberate harm, is more widespread in our sample. This may indicate that, for more birth families, the cumulative effects of difficulties experienced caused preoccupation with their own needs, resulting in neglect, with less birth families intending to deliberately inflict harm on their children.
    - ***Quality and continuity of foster care*** – for some children their time in care provided the child with a stable and nurturing experience where developmental recovery could begin. Over two thirds of adopters (69%) reported that their child had experienced a supportive and nurturing relationship before coming to live with them and the vast majority said this relationship was with foster carer(s). Again for two thirds of the sample (67%) the child had lived with just one foster family, or, in a small number of cases, they had been adopted by their first foster family. But for other children further adversities may have been encountered within the care system. Just over a third of children (34%) had experienced two or more foster carers – so separation from caregivers (birth family and foster carers) was another area where children encountered

adversity. A minority of adopters expressed concerns about the quality of care their child had received in foster care.

Chapter 4 - Adoption outcomes overall: Adopter perspectives

4.1 Introduction

In this chapter adopter perspectives on how the adoption was faring overall are discussed. This was a key question in the survey and one which all respondents (n=319) answered. This chapter also reports adopter perspectives of their child's strengths and challenges in relation to ten areas of functioning: general behaviour in the home; behaviour outside the home; general physical health; emotional wellbeing; self-esteem; relationship with you; relationship with your partner (where applicable); relationship with siblings (if applicable); social interaction with adults outside the family; and making and maintaining friendships.

4.1 How was the adoption faring overall?

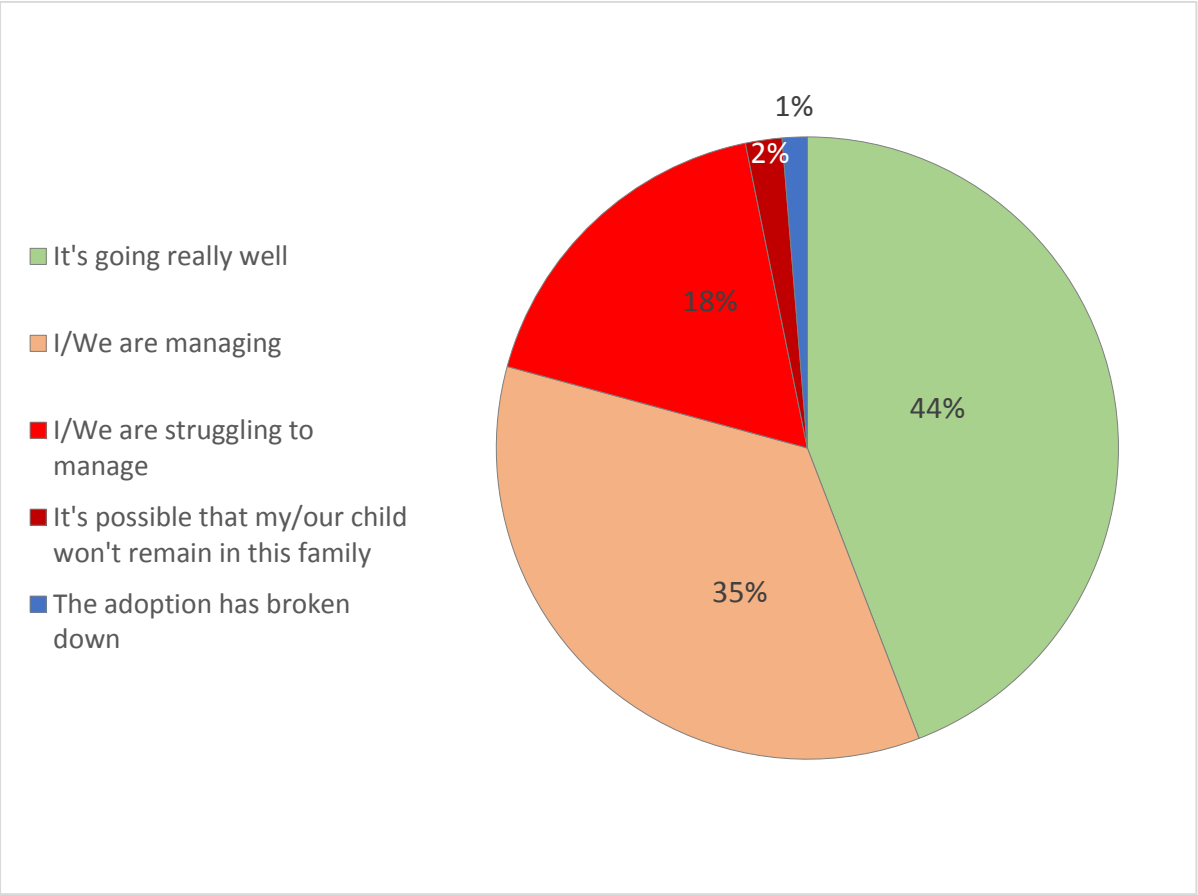
A question positioned early in the survey, adapted from Selwyn *et al*.'s (2014) research on adoption challenges and disruption, asked respondents to indicate how the adoption of their child was faring overall. A range of fixed responses was provided. There was also an open box giving the opportunity for further comment. This optional box helped to provide insight into how the respondents' were generally experiencing the parenting of their child, the various responses suggested that parents perceptions were influenced by a range of factors including the child's progress, the parents' abilities to cope with challenges, and their perceptions of the rewards of adoption (discussed further below). The fixed options were as follows:

- It's going really well
- There are challenges, but also rewards and overall I/we are managing
- Ongoing challenges and we are struggling to manage - but I/we are totally committed to keeping my/our child in this family
- Many challenges - it is possible that my/our child will not remain in this family
- The adoption of my/our child has broken down
- Other (please specify)

As shown in figure 4.1 below, 44% of most parents (n=141) said 'its going really well' and a further 35% (n=112) said 'there are challenges, but also rewards and we are managing'. On the one hand taking just the first category of 'it's going really well', only a minority of parents felt the adoption was currently very straightforward. But combining the first two categories 79% of parents could be described as feeling they were at least managing at the point of completing the survey, leaving 21% (n=66) experiencing quite serious difficulties. Eighteen percent of

parents (n=56) referred to their situation being one of 'ongoing challenges and we are struggling to manage', however they remain committed to their child remaining in their family. The adoption had broken down for 4 children in our study, and they were in care at the time of the survey completion. For 6 more children the adoption was in danger of breaking down. It is acknowledged that even in situations where adoptions "breakdown" and children re-enter care, in some cases parents remain committed to their children and continue to see them as part of their family even though they feel unable to look after the child within the family home (Selwyn *et al*, 2015).

Figure 4.1: Answers to the question: 'If possible, try to let us know how the adoption of your child is faring overall'



Parents could add additional comments alongside their overall rating of the adoption and these offer insights into the issues behind these overall ratings.

Some parents who rated the adoption as **'going really well'** indicted that everything had gone smoothly from the start and no problems had been encountered e.g. *"Totally brilliant and easy." "He's always been part of our family, he just fitted from day one"*. Other parents referred to challenges being no more than would be expected with a birth child:

'As with all adoptions, there have been some challenges, but we prefer not to label them as "problems" and consider that the challenges have not necessarily been any greater than those seen in birth families. As with all teenagers, there is resistance to parental guidance at times, and the fact that we are not her "real parents" is occasionally used as a weapon, but we think this is just an easy target and play it down. On the whole she is a happy, diligent, well behaved child who comes to talk to us when she has issues.'

Some parents who rated the adoption as 'going really well' referred to having overcome earlier issues:

'The first year our little boy was with us was particularly challenging but we were under no illusion as the adoption process prepared us for this. We continue to be open and honest and talk about his first family whenever he wants and feel although we have challenging times, this helps him deal with emotions as they arise.'

Some parent mentioned ongoing problems (for example, for their child in school) but these did not affect their overall view that the adoption was going well. Other parents felt that the adoption of the 'target' child was going really well, but they referred to problems with another child in the family: *"It is going really well with this child - much, much harder with her younger brother".*

When parents chose the option **'There are challenges, but also rewards and overall I/we are managing'** (for brevity, this group will be referred to as 'managing challenges') in the additional comments mostly parents referred to behaviour or developmental problems that the child was experiencing:

'Challenges with behaviour and sibling rivalry'

'Our daughter is hearing impaired and was assessed as being on the autistic spectrum two years ago. She sometimes struggles with her emotions and can get very distressed at changes in routines.'

Some parents using this category wanted to emphasise positives:

'She has learning difficulties that can make family life a challenge but she is a treasure too.'

'He is our son and loved because of who he is, not despite of his difficulties.'

'*The hard days are really, really hard but we love him so much, are so proud of him and want the best for him.'*

In this 'managing challenges' group some parents made comments similar to parents who had chosen 'going really well' e.g. referring to their child's challenges as being no more than would be expected, illustrating the different ways in which parents chose to answer the fixed response question.

'Any challenges are mostly related to her being a teenager, it's sometimes to separate the two things- is it because she has issues around being adopted or is it because of the pressure of being a teenager',

'normal tantrums for a two year old'.

The open responses of parents who said they were **'struggling to manage'**, or where the adoption was in '**danger of breaking down'** or had '**broken down'**, frequently mentioned child behaviour and developmental problems (We will refer to this combined group as 'struggling'). In several cases parents referred to their child's problems with anger, controlling behaviours and aggression towards others in the family:

'When first placed he would assault me to get control'

'She has attachment disorder, is angry a lot, can be controlling, has emotional dysregulation, lies, and can be aggressive to the other children'.

One parent however felt that the challenges she experienced mainly related to her bond with the child, something she had been trying to address *"I have struggled with my attachment but am starting to make progress".*

Two other studies have used a similar overall question about how adoptive parents perceived the adoption was working out. Selwyn *et al*. (2015)'s study used slightly different categories to ours. Their survey found that around two thirds of parents (66% in their local authority study of n=379 parents and 65% in their Adoption UK survey of n=310 parents) were in their 'going well' and 'highs and lows but mainly highs' categories. Around one fifth to a quarter (21% of their LA sample and 25% of the Adoption UK sample) in Selwyn *et al*.'s study placed themselves in the 'it is difficult' category – so slightly higher proportions to our 'ongoing challenges and we are struggling to manage' category (18% of our sample). For 13% (LA

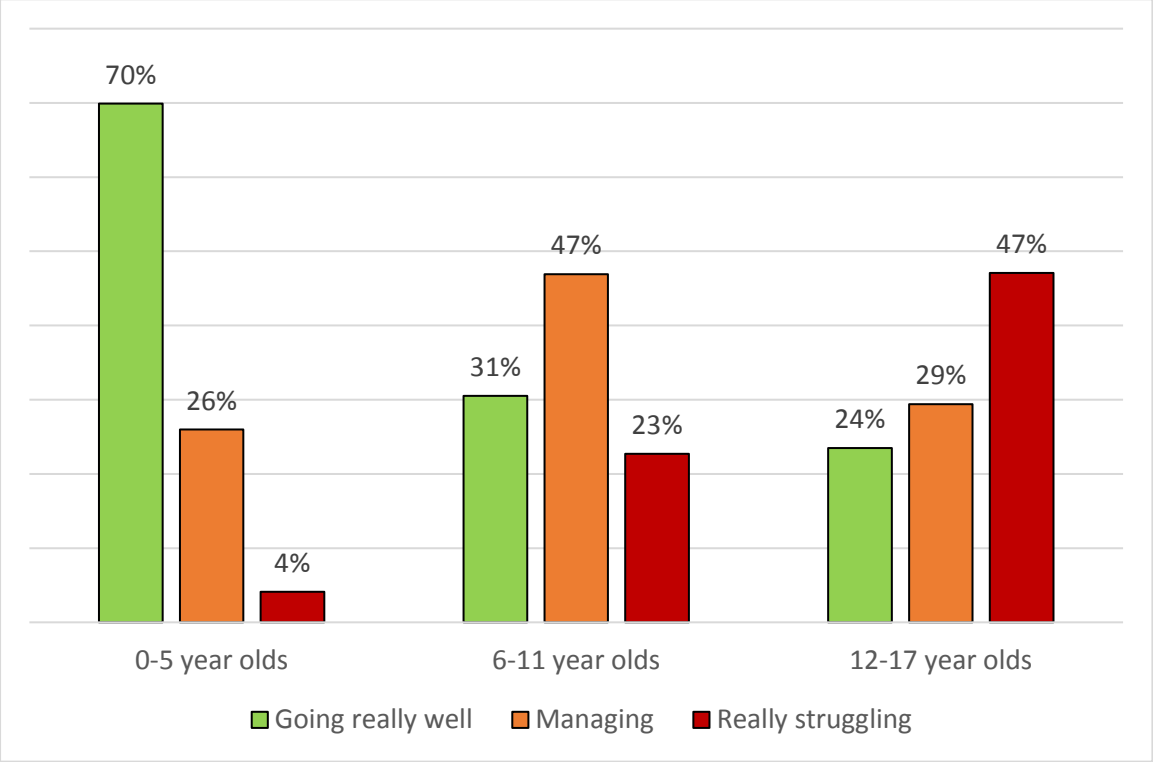
sample) and 9% (Adoption UK sample) the child was living apart from the family or the adoption had broken down. The rate of more difficult adoption situations (combining the 'it is difficult'/'struggling to manage' categories with the 'living apart'/disruption categories) was therefore higher in Selwyn *et al*. (2015)'s surveys (34% for both samples) than in ours (21%).

The BBC/Adoption UK survey (2017) of n=2774 parents recruited from subscribers to Adoption UK's newsletter also contained a similar question about how the adoption was going overall. Twenty-seven percent categorised the adoption as 'fulfilling and stable' and 45% as 'challenging but stable'. The more negative categories of 'serious challenges impacting on wider family', 'at risk of disruption' and 'already disrupted' involved 28% of parents. It therefore appears that our survey picked up a greater proportion of parents where the adoption was going well, in comparison to these similar surveys. This may reflect the relatively young age group of children in our study, and/or samples of parents who participated in the other studies may differ in other ways e.g. proportions of those connected to support organisations such as Adoption UK may vary.

4.2 How well was the adoption going overall for children of different ages?

Parents' answers to the question about how well the adoption was going overall were broken down into different age groups (0-5, 6-11 and 12+). As can be seen in figure 4.2 below, parents of older children gave less positive ratings. For example, 70% of those with a child under six said the adoption was going really well (n=86), compared to 31% of those age 6-11 (n=39) and 24% in the 12-17 age bracket (n=16). A large proportion of parents with children in the 12-17 years old age category referred to themselves as 'struggling' (this included situations where the adoption had broken down). Forty seven per cent of this older age group were in this category (n=32), contrasted with 23% of 6-11 year olds (n=29) and just 4% (n=5) of a children age 5 years old and under.

Figure 4.2: How the adoption was faring according to age of the child at time of survey completion

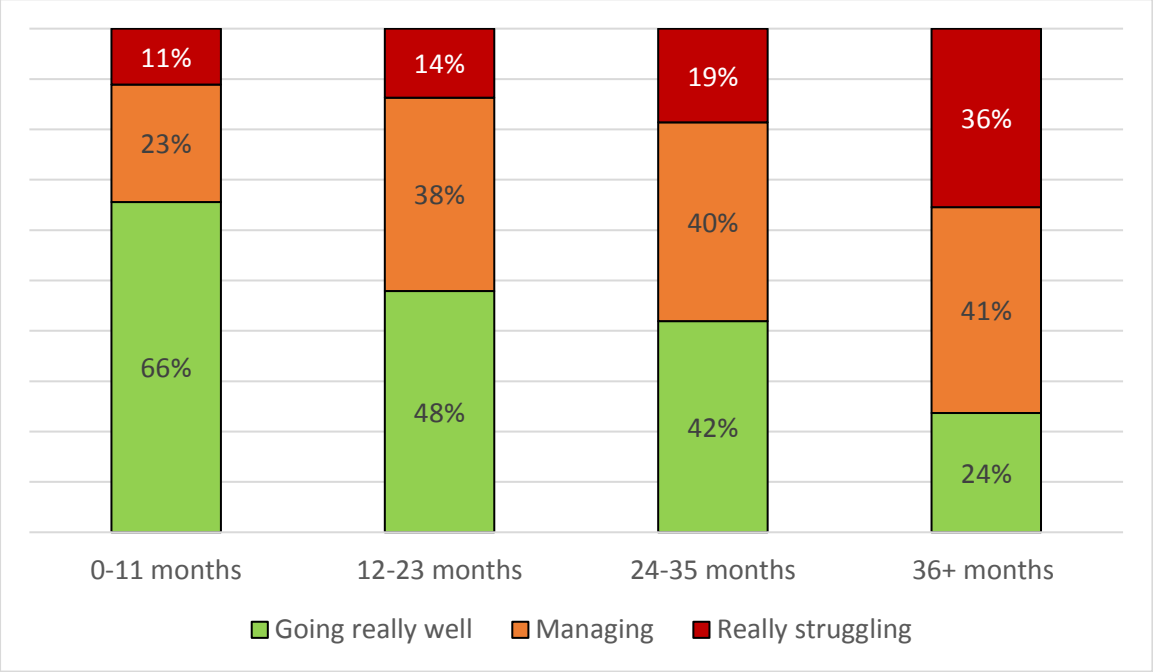


A number of explanations are possible for this link between the child's age and the parent's rating of the adoption in our survey. Firstly, as discussed in chapter 2, the age of placement of the children currently under five was much younger than the age of placement for those in the two older age groups. For the youngest group therefore (under 5s) these children may have experienced less pre-placement adversity (due to shorter time in either the birth family and/or the care system) and children in older age groups may have experienced more adversity. The higher levels of difficulty reported by parents of older children may also be because, at some distance from the adoption, agencies have been able to contact families where children have difficulties more easily than families who are managing well. But it may also be that the age of the child does have a direct effect – i.e. children's problems can increase as they get older. For example, it could be that some difficulties may be manageable with young children but become increasingly difficult as the children mature and children need to cope with the demands of the school environment. Some difficulties may also only be evident in later years, perhaps due to an interaction with teenage issues like identity challenges, the onset of puberty, and secondary school environments. Our analysis in chapter 7 provides a comprehensive analysis of factors affecting children's outcomes, and this shows

the relative effects of a range of different factors including the length of time the children spent with birth family, in care and with the adoptive family.

The child's age at placement, shown in figure 4.3 below, also appeared to be linked to the adoptive parent's overall ratings of the adoption, though it must be remembered that age at placement and age at time of the survey were correlated. When children were placed under age one, 11% (n=10) of parents described themselves as really struggling compared to 36% (n=33) of parents whose child was aged three or older at placement. Two thirds of parents of babies placed under one (n=59, 66%) described the adoption as going really well while just 24% (n=22) of parents whose child was placed with them at three years old or older were in this category. These findings reflect much research on adoption that age at placement affects outcomes for children (e.g. Selwyn *et al*., 2015), though the extent and timing of early adversity may be more important than age at placement *per se* (Howe, 1998).

Figure 4.3: How the adoption was faring for children according to age at placement

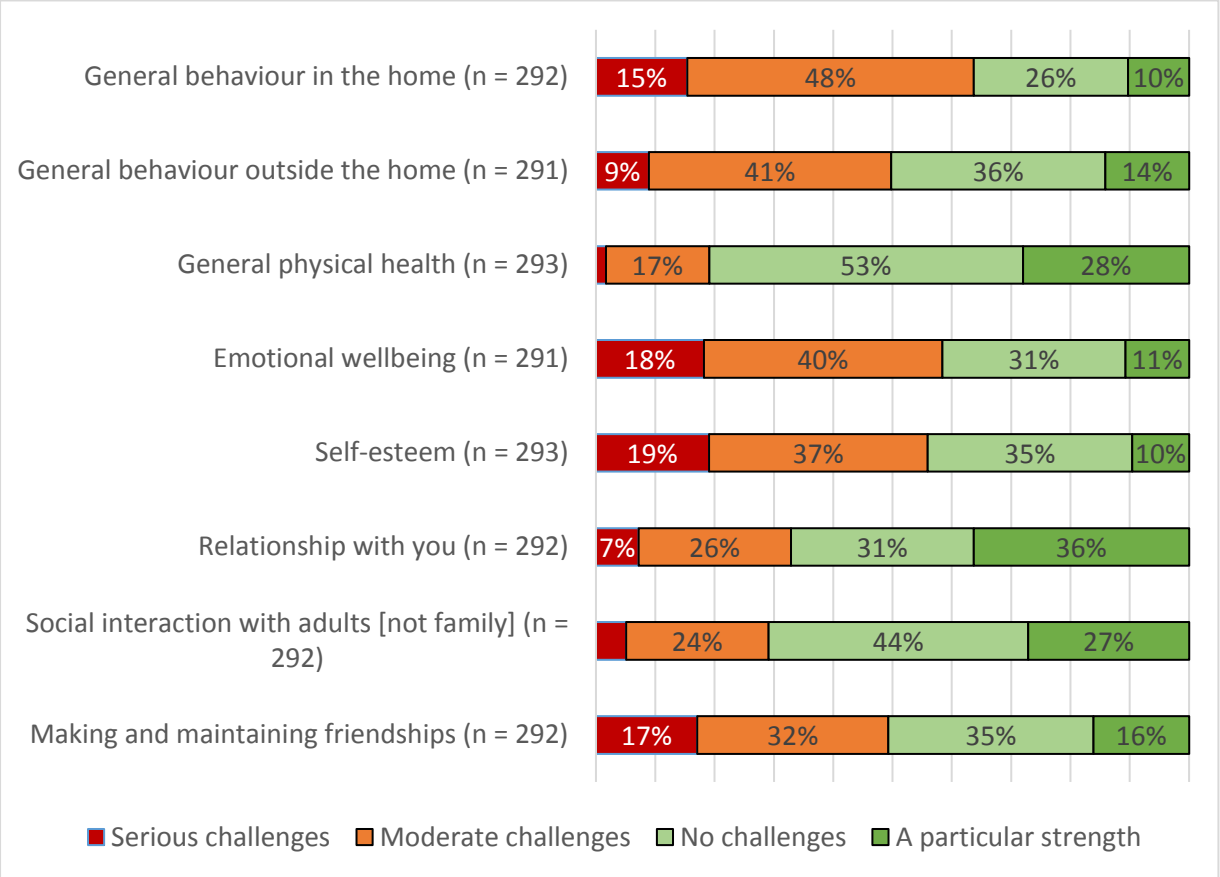


4.3 Children's strengths and challenges

Parents were asked to rate whether their child had challenges or particular strengths in 10 different areas of functioning: general behaviour in the home; behaviour outside the home; general physical health; emotional wellbeing; self-esteem; relationship with you; relationship with your partner (where applicable); relationship with siblings (if applicable); social interaction with adults outside the family; and making and maintaining friendships. Figure 4.4 shows how

parents answered these questions about their children's strengths and challenges. 'Relationship with your partner' and 'relationship to siblings' were not applicable in some cases so numbers of respondents were fewer (n=256 and n=217 respectively). Consequently these items were omitted from figure 4.4 below. Figure 4.4 shows that the areas where parents were most concerned about the child were 'general behaviour in the home', 'emotional wellbeing', and 'self-esteem'. Parents thought their children had fewest challenges in terms of physical health, 'social interactions with adults outside the family' and 'relationship with parent'. Relationships with the parent was the area where parents were most likely to perceive their child as having particular strengths.

Figure 4.4: The extent to which children showed challenges in areas of functioning and those where these areas were a particular strength



4.3.1 General behaviour in and out of the home

For 10% (n=30) of parents, their child's behaviour in the home was seen as a particular strength and 14% (n=41) of parents said behaviour outside of the home was a strength. However, serious or moderate challenges in behaviour at home were reported by just over two thirds of parents (64%, n=186) and half said their child had serious or moderate challenges in behaviour outside the home 50% (n=145).

Qualitative data gave us more detail on the behaviour problems experienced e.g. this parent told us about issues at home and in the community:

> *'Anger issues, low self-esteem, poor organisation, doesn't respond to any form of discipline. Steals money from me, smashes up the home, runs away, gets into trouble with the police…'*

Some parents had ideas about underlying causes of their child's behaviour, with this parent attributing difficulties to a mental health issue:

> *'Suffers from anxiety which can manifest as aggression and oppositional behaviour…'*

Another parent had invested considerable time and energy in trying to determine the reasons for difficult behaviour:

> *'As a self-taught therapeutic parent the daily challenges are vast. Understanding what is driving a behaviour at different times is difficult. It could be sensory, attachment or trauma related. Our son is demanding, rarely able to sustain themselves on their own and needs constant reassurance. He lives more or less permanently in an anxious state, never too far away from a fight response. Although he is 5, emotionally he is 2/3. We have fought inch by inch to get close to him and take care of him, reassuring him about safe touch. His outbursts are daily and a mix of predictable (around food or needing to wee) or random. It makes parenting exhausting.'*

4.3.2 General physical health

One of the highest percentages of particular strength ratings was in this domain with 28% (n=82) scoring physical health as a strength. Serious challenge ratings occurred in only 2% of cases (n=5).

Qualitative data provided further insight into the health challenges that parents perceived their children to have. Some issues, ranging in severity, seemed purely physical for example: asthma; a thyroid condition; kidney problems; a rare genetic condition requiting long term dietary management; squints. In several cases however parents' descriptions of their children's physical health problems suggested conditions that were at least in part overlapped with mental health difficulties or learning disabilities and which could be related to difficult

experiences earlier in life. For example parents mentioned problems such as global developmental delay, sensory issues, autism, and foetal alcohol spectrum disorder (FASD): *'She had a delay in all areas particularly speech and has no stranger danger awareness, over familiar, very happy and contented but can be stubborn and aggressive, has no self-awareness...'*

It is possible that that developmental delays may partly attributable to maltreatment in early life. Van Ijzendoorn and Juffer (2006: 1229) point out, *"Malnutrition and neglect in the first few months or years after birth may lead to impaired growth…"* Grotevant and McDermott (2014) argue that physical growth is hindered by excessive levels of stress hormones.

Seventeen per cent (n=51) stated that physical health was a moderate challenge. In the open comments box several parents mentioned FASD. This adopter attributed multiple issues to the disorder:

> *'FASD causing skin sensitivity, bowel problems, squint, development delay, speech and language delay, attention and concentration problems, severe behavioural issues, lack of social interaction with other children.'*

The following parent suspected their child had FASD and felt that a diagnosis would help her daughter:

> *'I believe that she is affected by FASD but there is no diagnosis at this time. The geneticist is looking into possible genetic issues that have led to her developmental delay and learning difficulties. If that shows nothing, we will look at seeing if we can pursue the FASD route as she could do with the right strategies. Struggles to do simple things like buttons and laces. Difficulties with understanding social cues and can often come across as blunt or clumsy in speaking to others as a result…'*

4.3.3 Emotional wellbeing and self-esteem

Parents perceived their child's emotional wellbeing and self-esteem to be a particular strength in around 10% of cases (n=31 for emotional wellbeing and n=28 for self-esteem). Figures for serious or moderate challenges were similar for both these items with emotional wellbeing at 58% (n=170) and self-esteem at 56% (n=164). Figure 4.4 above shows that after 'behaviour at home', 'emotional wellbeing' and then 'self-esteem' are the domains with the highest levels of moderate or serious challenge. Chapter 6 discusses the emotional and psychological

health of children in our study. The standardised measures used in the survey showed that a significant proportion of adopted children had difficulties in these areas. This reinforces the findings of other studies. In the Juffer *et al*. (2011) meta-analysis, adopted children tend to show higher rates of anxiety and depression, internalising problems that hinder emotional wellbeing and self-esteem. Along with externalising problems such as conduct issues, oppositional behaviour and aggression, internalising problems impact on peer relationships and social development (Grotevant and McDermott, 2014). Our findings on relationships will be reported in section 4.3.4.

Qualitative data provides an insight into the emotional wellbeing and self-esteem of the children in our sample. Some parents saw issues as not related to adoption, *"Usual teenager anxiety…"* while others clearly linked their child's emotional health to the separation and loss inherent in adoption:

> *'The main difficulty our child has is to overcome is the separation from his birth siblings and why they will remain in the foster home he grew up in and he did not stay there. He struggles also emotionally at times, being extremely sensitive to rejection, someone not liking him or not including him. Unexpected situations can throw him but mainly if I am not 100%, he will have a wobble and he would struggle significantly with his emotional state…'*

Improvement to emotional wellbeing following adoption is possible (van Izendoorn & Juffer, 2006) and appropriate support is crucial to help children deal with these issues, as this parent demonstrates,

> *'Our son difficulties are diminishing as he is having therapy… The main themes have been extreme non-compliance with us at home, outbursts of anger, anxiety when dealing with new situations/events, attachment issues with me and my husband. He has low self-esteem.'*

4.3.4 Children's relationships with adoptive parents, siblings, peers and other adults outside the family

'Relationship with you' was perceived by adopters as a strength for over a third of children (n=106, 36%). Relationships with siblings were seen as a strength for nearly a quarter of children 24% (n= 52) and social interaction with adults outside the family a strength for 27% (n=79). Seventy per cent (n=204) of children had at least one good relationship (defined as having no 'challenges' in that relationship) with at least one of their adoptive parents - and for

38% (n=110) the relationship with at least one of their adoptive parents was seen as a particular strength for the child. Two-thirds of parents (n=142, 66%) said their child had no challenges in their relationships with siblings – and for one quarter (n=52, 24%) the child's sibling relationships were seen as a particular strength.

However, around a third (n=106, 36%) of children were perceived to have serious or moderate challenges with their relationship with at least one of their adoptive parents (for n=27, 9%, there was a serious issue). Similarly about one third (n=75, 35%) said their child had challenges with sibling relationships and 29% (n=85) said there were challenges with their child's social interaction with adults outside their family. Serious or moderate challenges for the child with making and maintaining friendships were reported by almost half the parents (49%, n=144). The following quote sums up common themes found in the qualitative data around difficulties which make forming relationships difficult:

> *'Child struggles to understand how relationships work - struggles with empathy & understanding the feelings of others. Presents as difficult and disruptive when worried or frightened. Attempts to be in control to make themselves feel safe. Very competitive for attention or resources. Challenges decisions and struggles to trust adults... Struggles with sense of identity so tends to copy others.'*

Social and relationship problems can be related to other developmental difficulties such as behavioural problems and low levels of emotional wellbeing (Grotevant and McDermott, 2014; Juffer and Van IJzendoorn, 2006). For example, it is difficult to make friends with a peer when a child shows oppositional behaviour, aggression and conduct problems (externalising behaviour). This parent demonstrates this point,

> *'…very volatile behaviour, struggles with intimacy, low self-esteem, applies minimum effort to tasks, struggles to maintain friendships/relationships.'*

Emotional regulation and low self-esteem hindered relationship formation for some:

> *'Difficulties with emotional regulation. Difficulties sustaining and maintaining friendships with peer groups (gravitates towards younger children as easier to manage)... Has low self-esteem…'*

The inability to sustain relationships could be upsetting and compound the effects of emotional difficulties and feelings of low self-esteem:

'He struggles to maintain friendships with children his own age. Feels very emotionally upset when friendships break down. Desperate to be liked by friends & adults (particularly in school).'

4.4 Chapter summary

This chapter reported on adopter perspectives of adoption outcomes overall, focusing on the key question, 'How is the adoption faring?' which all 319 respondents answered. Parents were also asked to consider their child's strengths and challenges in domains of development including behaviour, physical health, emotional wellbeing and relationships. These findings showed large variations in terms of how well children progress after adoption and how well parents feel they are managing. About one in five families appeared to be in crisis and in need of immediate and extensive support. The majority of families (79%) had a predominantly positive view of adoption, but many of these families were managing challenges and were also in need of support particularly help for children with emotional and behavioural problems, educational problems, and developmental delays and disabilities. It was evident from parents' comments that support needs can fluctuate over time and improvements and deterioration are both possible. Chapter 9 explores the impact of adoption on adoptive parents including how expectations had changed over time and how initial expectations have matched up with the realities of adoptive family life. The next chapter looks at the psychological and emotional health of the children and gives us more insight into the challenges that families faced and the support they need.

Key findings from this chapter are summarised below.

- **How the adoption was faring:** A substantial minority of parents (44%) of parents said the adoption was 'going really well' (the 'going really well' group') and a further 35% said 'there are challenges, but also rewards and we are managing' (the 'managing challenges' group). Combining the first two categories 79% of parents could be described as feeling they were at least managing at the point of completing the survey. The remaining 21% were experiencing serious difficulties – the 'struggling' group (this includes 10 cases, 3%, where the adoption had broken down or was in serious danger of doing so). This is just a snapshot and should not be taken to mean that only a fifth of families need help and support; many of those that were 'managing challenges' needed or were already using services and some of these families, and possibly some

of those where the adoption was 'going really well' may need help at some point in the future.

- **How children's ages related to parents' perception of how the adoption is faring:** How well the adoption was going overall varied according to the age of the child at the time of the survey. Parents of older children gave less positive ratings; 70% of those with a child under six said the adoption was going really well (n= 86), compared to 31% of those age 6-11 (n=39) and 24% in the 12-17 age bracket (n=16). These differences for children in different age groups may be related to increasing challenges for adopted children as they get older, and or they may relate to differences between the age groups in the characteristics of families who responded to the survey.
- **Parents' perceptions of the challenges children present:** Around two-thirds of children were reported to have serious or moderate difficulties with their behaviour at home (n=186, 64%). Approximately half had serious or moderate difficulties with their emotional wellbeing (n=170, 58%), self-esteem (n=164, 56%), friendships n=144, (49%) and behaviour outside the home (n=145, 50%). Around a third had at least moderate challenges with their relationship with at least one parent (n=106, 36%).
- **Parents' perceptions of their children's strengths:** Over one third of parents felt their child's relationship with them was a particular strength (n=106, 36%) Seventy per cent (n= 204) of children had at least one good relationship with at least one of their adoptive parents (defined as no challenges or a particular strength).

Chapter 5 – Children's transitions to adoption

5.1 Introduction

When children are adopted they often move from foster carers to whom they have developed an attachment, to unfamiliar adoptive parents. Separation from attachment figures is very stressful for young children. If not handled sensitively, it can have a long term impact on children's development, in some cases threatening the success of the adoptive placement (Selwyn *et al*, 2015). Previous research has suggested that these transitions are not always focused on children's needs; a range of problems stem from the practical and emotional stresses inherent in this transfer of care and children's distress may be overlooked (Boswell & Cudmore, 2014). Adopted children have often experienced high levels of adversity, and reducing any additional risks is vital to offer children the best chance in their adoptive families. There is professional uncertainty around planning and supporting these transitions for example, how long should introductions last and should foster carers have contact with children? Current practice guidance doesn't deal sufficiently with these issues (Boswell & Cudmore, 2014; Swain, 2016).

Exploring parent's experiences of transitions was therefore a strong area of interest in the survey. The survey included a section about the process of the child moving to live with the adoptive family. The questions were focused around the transitions of children from foster care to adoption, and about contact with foster carers after the adoption. This chapter is based on the answers of up to 226 parents (71%). Not all parents answered this section of the questionnaire: some because they had dropped out of the survey by this stage, or because skip logic directed them away – e.g. if they collected their child from hospital after birth. Some other responses were excluded from analysis because the child had been adopted by their foster carers (in which case the transition into the family was often not planned). This chapter focuses therefore on the responses of parents in families where children had moved from a foster home to a planned adoptive placement.

5.2 How long did transitions from foster care to adoption take?

Parents were asked about how long it was from their first meeting with the child to the child moving in (i.e. length of introductions). Of the 214 parents who answered, the replies ranged from 2 days to 56 days (8 weeks). The median was 10 days and the mean 11.5 (SD=6.9). The majority of children (87%) moved in within two weeks of first meeting their adopters (see table 5.1 below). Only 12 children (5.6%) made the move over a period exceeding 3 weeks.

Table 5.1: The length of introductions

Length of introductions	n	%	Cumulative %
Up to one week (0-7 days)	63	29.4	29.4
Between 1-2 weeks (8-14 days)	123	57.5	86.9
Between 2-3 weeks (15-21 days)	16	7.5	94.4
Longer than three weeks (22 days or more)	12	5.6	100
Total	214	100	

5.2.1 Was the length of introductions linked to the child's age at placement?

Children who were moved over a shorter time period tended to be those who were younger. Of those children moved in up to 7 days, the mean age at placement was 20.8 months (SD=17.03; n=62). This compared to a mean age of 31.2 months for those moved between 8-14 days (SD = 22.6; n=112) and 41.4 months for those whose transition took place over two weeks (SD = 27.5; n=28). Half of babies aged under 12 months (50%) moved within one week. In comparison one quarter (24%) of those aged one or older moved within a week.

5.2.2 What were parents' views about the speed and quality of introductions?

Parents were asked whether they thought the length of the introductions period was 'about right'; 'too long'; or 'too short'; 222 parents answered this question. Three-quarters of parents thought that the length of introductions was about right (n=164, 74%). Where parents did not think the length of introductions was right, mostly they thought the process had taken too long rather than being not long enough. Nineteen percent (n=43) thought the introductions had taken too long whilst 7% (n=15) thought they had been too short.

The process of helping a child move from their foster home to an adoptive home can be stressful and difficult for children, foster carers and adoptive parents (Boswell & Cudmore, 2014, Lewis, 2018). The impending loss of the child may be hard for foster carers whose own feelings may detract from their focus on the child's needs (Boswell & Cudmore, 2014). Foster carers may find it hard to let go of their parenting role, or to support adoptive parents where they do not feel confident about the quality of the match (Pyman, 2007). Adoptive parents may feel they do not have sufficient information about the child's behaviour or care routines in the foster family (Selwyn *et al*, 2015). In some cases adoptive parents may have doubts about the quality of care the child has received in the foster home (Selwyn *et al*, 2015).

To explore adoptive parents' views about these aspects of the introductory period parents were asked to indicate their agreement/disagreement with four statements, shown in table 5.2 below. For each statement the available replies were *strongly agree*, *agree*, *neither agree nor disagree*, *disagree*, *strongly disagree*. Table 5.2 below shows how parents answered these questions (*strongly agree* and *slightly agree* have been combined in "agree", and *strongly disagree* and *slightly disagree* combined into "disagree".) All items were worded positively. In other words agreement with the item suggests the adoptive parents perceived that aspect of the transition to be positive.

Table 5.2: Parent's views about aspects of the handover from foster parents

	agree		disagree		neutral	
	n	%	*n*	%	*n*	%
The previous carer was fully focused on my child's needs during the move to my family (*N* = 224)	157	70.1	53	23.7	14	6.3
The previous carer was fully supportive towards me in the transition period (*N* = 226)	171	75.7	49	21.7	6	2.7
I was told all I needed to know about my child life in their previous household (*N* = 225)	162	72.0	55	24.4	8	3.6
I was confident about the previous carer's care of my child before they moved to my family (*N* = 225)	170	75.6	46	20.4	9	4.0

As table 5.2 shows, the majority of adoptive parents (70-76% depending on the item) perceived the transition to have been well supported in terms of the foster carer focusing on the child's needs, supporting them personally, and relevant information being passed on. Furthermore three quarters of adoptive parents were confident that the child was well cared for in the foster home.

In order to look at how often parents experienced difficulties with any aspect of the transition, a new variable was created. Where a parent had answered "strongly disagree" or "slightly disagree" with any one (or more) of the four positively worded questions, they were categorised as having found at least one aspect of the introduction period unsatisfactory. Eighty-three parents (37%) fell into this group, whilst 143 parents (63%) were positive (or at least neutral) about all of the four questions relating to introductions. Later in this chapter qualitative data illustrating how adoptive parents experienced the transition period are reported.

5.3 How well did parents think their child had coped with the move?

Parents were asked “overall how did your child find the process of moving to your household?’ Available responses were: *extremely difficult*; *somewhat difficult*; *neither easy nor difficult*; *somewhat easy*; *extremely easy*. Answers were provided in 224 cases where the child had a planned move from a different foster home to the adoptive family. Only a small number of parents thought that the move was extremely difficult for the child (n=16, 7%). Responses across the remaining four categories were very evenly split: 55 parents felt the child found the move ‘somewhat difficult’ (25%), 50 parents said the child found the move ‘neither easy nor difficult’ (22%), 52 parents thought the move was ‘somewhat easy’ for the child (23%) and almost the same number (n=51, 23%) thought the child found the move ‘extremely easy’.

The new binary variable was created to distinguish children who found the move “somewhat difficult” or “extremely difficult” (n=71), from children and the other three categories (n=153) (“neither easy nor difficult”; “somewhat easy”; “extremely easy”). This variable was used to look at differences according to the child’s age at placement, categorising children into three groups: <1 year, 1-2 years, 3 years or older. This showed that parents whose children were younger at placement, perceived their children as moving more easily than parents of children who were older at placement. Most parents whose children were placed under age 1 felt that the child had not found the move difficult (43 of 54, 80%). For parents whose children were aged 1 or 2 when they moved in, two-thirds (61 of 90, 68%) felt the child had moved easily, this proportion being the same for one year olds as two year olds. But of the 67 parents whose children who were 3 or older at placement, somewhat fewer children were perceived to have found the move easy (n=39, 58%).

These data could suggest that the older they are at placement, the more likely children are to find the move difficult. But it may also be the case that parents can more easily perceive the child’s difficulties when they are older - for example a 3 year old may be able to verbalise their difficulty with the move whereas for a baby any difficulty may be expressed in disruption to their daily functioning (for example eating or sleeping) which is possibly more difficult to attribute to the move alone.

Parent’s perceived difficulties for the child during introductions did not seem at all related to the speed of the introductions. The mean length of days over which transitions happened was virtually identical for all categories of response to the question about the child’s reaction to the move. This could be because other factors may be more important than the timescale for example how well adoptive parents and foster carers got on or how sensitively the move was

handled. It may also be that there was insufficient variability in the sample in terms of how transitions were handled, for example there were very few examples of children who had an extended period of getting to know adoptive parents before a more intense period of actually handing over care was attempted.

5.4 Key themes from adoptive parents about what went well, and what was difficult during transitions

In the section of the survey about transitions, there were three open boxes where parents could provide additional information about their experience of the child moving into their family. The first box asked about what went well for the parent and their child, the second box was about what did not go well, and the third box provided adopters with an opportunity to give advice or suggestions in relation to transitions.

These open boxes generated a significant amount of qualitative data; a brief analysis was carried out to identify key themes and messages. These are summarised below:

5.4.1 The role of foster carers during transitions

It was evident from many comments that how foster carers had managed the introductory period could make a crucial difference to how adoptive parents experienced this process, and how they felt their child experienced the transition. Positive practices included:

- Being welcoming, friendly, encouraging and approving with adoptive parents.
- Being willing to pass on detailed information about the child, their likes and dislikes, their routine, their character etc.
- Gaining information from adoptive parents in advance, so they could begin to prepare the child and introduce their new family, for example using photographs, videos etc.
- Willingness to stay near the adoptive family home if needed during introductions.
- Giving practical parenting advice, hints and tips

Where adoptive parents reported difficulties related to the foster family during the introductory period they included:

- Foster carers finding it hard to cope with their own feelings of loss and letting the child go. Some adoptive parents described very difficult situations where the move had been particularly abrupt (this could be both in terms of speed and also lack of contact with foster carers afterwards) and consequently very hard for the child.

- Not allowing adoptive parents to gradually spend time with the child alone - appearing possessive, controlling or intrusive.
- Where foster carers seemed ambivalent about the plan for adoption or the match, for example where they had wanted to adopt child themselves, or where they had negative or discriminatory views about the adopters for example about the child being be adopted by a same-sex couple.
- Not managing the presence of other people in their home during introductions for example neighbours, friends, extended family, cleaners or decorators.
- Not wanting to stick to the plan decided by the professionals (though several people also commented that it could be helpful for foster carers to be flexible about the plan when it was not working).

5.4.2 The role of professionals during introductions

The largest number of comments concerned adoptive parent's views of how social workers and other professionals had planned and supported introductions. Although the arrival of an adopted child in their family was a time of great joy, the introductions period was experienced as highly stressful and physically and emotionally exhausting by many parents. Good support from professionals was therefore crucial for many people in helping them cope. Positive practice included:

- Where social workers found a good balance between being reliable, responsive and available to adoptive parents without being intrusive
- Offering clear advice and contributing to careful planning of the transition, but at the same time listening to the views of adoptive parents and foster carers, and being willing to adjust the plan when it was not working. This seemed a particularly delicate balance for social workers to strike, as several adoptive parents also commented that social workers must be willing to resist changes to the plan when these were led by adults needs, not children's needs
- Being available outside of office hours during the introductions period in the early days of the placement - being contactable in the evenings and at weekends
- Recognising the highly emotional nature of introductions for adoptive parents, and being emotionally supportive through creating a safe space where adoptive parents could talk through their feelings: in the words of one adoptive parent, social workers should be "encouraging at all times, never critical"
- Offering emotional support to foster carers so that the adopters did not feel this was their responsibility.

- Offering practical help for example with arranging or paying for accommodation near the foster family home.
- Making as much information as possible available about the child, including bringing in the knowledge and expertise of others (for example through life appreciation days). Related to this, adoptive parents felt it was important for social workers to be honest about the child's background and behaviours.
- Being open to adoptive parents using their support networks through introductions for example facilitating the involvement of grandparents who could help look after an older adopted child whilst the new child was being placed.

Difficulties that adoptive parents reported around the role of professionals in introductions included:

- Where support was experienced as intrusive; some adopters argued that professionals should also allow them space to get to know the child. Professionals should be considerate about meetings e.g. some adopters did not like to have meetings involving large numbers of professionals in their house.
- Life story work, life story books and letters for later life were not completed in a timely fashion - this was a common complaint.
- Where the plan for introductions focussed around the availability of professionals in terms of holidays, sickness, college days etc. Several parents also complained about the difficulty in contacting social workers because of these reasons.
- Where there was a lack of continuity in personnel, particularly where the new social worker did not know the child.
- Several adoptive parents found professional advice to restrict their social contact in the early days of the placement to be unhelpful as it isolated them from their support systems.

5.4.3 Difficulties experienced by children during transitions

Comments from parents to these open questions also illuminated some of the difficulties that children could experience during the introductions. These are summarised below:

- Where the length of the introductory period is not right for the child. Some parents felt introductions had been too lengthy for their child, and that children had indicated their readiness to move at an earlier stage. Other parents however felt that the meetings

were too fast, and the child did not have time to adjust to the transition, and grieve the loss of their foster carers.

- The most difficult situations described were where the ending of the foster placement have been particularly abrupt and poorly handled, for example where foster carers found the ending so painful they wanted to get it over with quickly, and sometimes could not say goodbye. One parent said that their children felt as if they had been 'stolen' from the foster family
- Some parents said that their children found long car journeys difficult and disruptive to their care routines.
- Some children did not welcome visits from the social worker after placement. For some children such visits were unsettling because they associated their social worker with difficult events in their life.

5.5 How did parent's perceptions of the introductions relate to how well the adoption was working out?

Selwyn *et al* (2015) found that poorly managed transitions were often a feature of adoptions that disrupted or were in danger of disrupting. Associations between how adoptive parents reported the adoption was faring at the time of the survey, their reports of the child's difficulties with the transition, and their perceptions of the handover were explored. This analysis used the "adoption faring" groups reported in chapter 4: "going really well", "managing challenges" and "struggling" (this latter group combines the 'struggling to manage' with 'it is possible the child won't remain in the family' and 'adoption has broken down' categories). These data are reported in table 5.3 below. This shows that the more challenges parents reported in the adoption currently, the more likely they were to have reported that their child found the transition into their family difficult - over half of parents who were 'struggling' said that the child had found the transition difficult. A chi-square test showed that this association was statistically significant, meaning it is unlikely to have happened by chance.

Where parents reported at least one aspect of introductions as not satisfactory there was also a significant association how the adoption was working out overall at the time of the survey (see table 5.3). Of the parents in the 'struggling' group over half (56%) had reported problems with introductions. Proportions of parents reporting problems with introductions in the other two groups were lower (30% of those where the adoption was 'going really well' and 32% of those where there were challenges but parents were managing challenges).

Table 5.3 - Associations between parent's views of how the adoption was faring at the time of the survey, and their views of transitions (child's difficulties, and parent reported problems with introductions)

How is the adoption faring overall?	Child found transition somewhat or very difficult		Parent reported at least one aspect introductions not satisfactory	
	n	%	*n*	%
Going really well	16 of 94	17%	29 of 96	30%
Managing challenges	31 of 83	37%	27 of 83	32%
Struggling	24 of 47	51%	27 of 48	56%
Chi-square	$\chi^2 = 18.7$, df=2, p<.001		$\chi^2 = 11.1$, df=2, p<.01	

There are a number of possible explanations for these significant associations. It could be that poorly managed transitions and or high levels of child distress during the transition pose a risk factor in the long term. For children who have already experienced maltreatment, loss and separation, badly managed separation from the foster carer and introductions to the adoptive family could pose another risk - particularly the risk of children finding it hard to build new relationships in their adoptive family. It could also be that there are common underlying factors (such as older age at placement and attachment difficulties) that predict both long-term outcomes and difficult transitions. It might also be that adoptive parents may retrospectively label transitions as having been difficult when they encounter problems later on. Whatever the explanation for this association, these data do suggest that managing transitions carefully, and particularly making sure that children are helped to cope with the emotional strain of transitions, is an important area for practice and for reducing risks in adoptive placements.

5.6 Contact with foster carers after children had been placed for adoption

Adoptive parents were asked whether their child had had any contact with their previous foster carer after they had moved into the adoptive family. Responses showed that the child had some form of contact in three-quarters of cases (n=169, 75%).

An open text box was provided where parents were asked to talk about what type of contact they had had with the child's foster carers. These responses indicated a significant diversity in the nature and type of contact that families had experienced. The quality and consistency of these data were insufficient to attempt to categorise cases according to different types of contact, but the ways in which this contact varied are discussed below.

Contact varied in terms of whether it was direct (involving face-to-face meetings) or indirect (for example letters, phone calls, email, Facebook, FaceTime). The contact also varied in terms of whether it only happened once or for a short period (typically in the early days of the placement) or whether it was ongoing. In some cases there was a long gap (sometimes several years) with no contact and then contact was introduced again. Some parents reported that they had become family friends with the foster family and had reasonably regular ongoing contact in a range of ways.

Another variation in contact was to do with the timing in relation to the placement. A number of parents referred to delaying contact between the child and the foster carer for periods of time after placement, often for several weeks or months:

> '*We allowed him to see his foster carers so that he didn't worry or miss them - but only after 6 months'.*

Some parents referred specifically to advice from the agency to delay any face-to-face contact:

> *' [She] was desperate to see them for 6 months and the adoption team prevented this.'*

In other cases, the contact with the foster carer had been very soon after the placement:

> '*The foster carer brought child to my house, stayed overnight in hotel & visited him again next day.'*

We asked parents to say whether the plans for contact (or no contact) with the foster carer had been due to their own wishes, the agency's advice and plan, the foster carer's wishes, or the child's wishes. These categories were not mutually exclusive - parents could tick all that applied. Responses are shown in table 5.4 below.

Table 5.4: The views of adopters about who influenced the plan for contact with the foster carer

Was this contact (or lack of contact) due to…	*n*	% (based on *N* = 226)
Your wishes	130	57.5
Your agency's advice or plan	37	16.1
The foster carers wishes	95	42.0
Your child's wishes	53	23.5

The data above suggest that decisions about whether or not the child should have contact with their foster carer after adoption are often made between foster carers and adoptive parents; the majority of adoptive parents did not perceive the decision about foster carer contact to have been influenced by professionals. In about a quarter of cases parents perceived that they had been acting, at least in part, on the wishes of their child. This is not to say other parents were ignoring children's wishes - some children may have been too young to articulate their views about this matter. Given the highly emotional nature of introductions for adults and children, and the complex feelings that all can have about this type of contact, this is an area where more professional guidance or mediation would be helpful.

In the 174 cases where parents reported that some contact with the foster carer had taken place, they were asked on balance how positive this contact was for the child. Three quarters of parents (n=128, 74%) reported the contact had been positive (very positive n=98, 56%; slightly positive n=30, 17%). A small percentage of parents said the contact had been negative (very negative n=6, 3%; slightly negative n=7, 4%). The remaining parents thought the contact had been mixed or neutral (n= 33, 19%)

Parents were invited to provide more information about the child's experience of foster carer contact in an open box, and n=136 chose to provide this. Looking first at potential difficulties of the contact (where parents said the contact was mixed, neutral or negative), 39 people added some additional information, though the level of detail given varied. Issues described included:

- That the child did not appear to recognise or remember the foster carer
- That the contact with foster carers had affected their relationship with the child (three cases): *"initially contact was too much - prevented child from bonding to me – [he] always wanted to check with the foster carers."*

- That contact triggered difficult feelings or behaviour in the child, including feelings of loss (e.g. of the foster family, or of siblings they used to live with, or of a sense of permanent connection to the adoptive family*):"the latest birthday card unsettled my child brought about insecurities, we think it was a trigger for a couple of weeks of unsettled behaviour-perhaps reminding them that they had not always been part of our family"; "He was okay during the visit but very distressed and clingy afterwards - he did not understand why [the foster carer] had gone away again"; "it upsets her to talk about adoption… She wishes to have always been my daughter, seeing foster carers rakes up the past."*
- Difficult emotions for themselves or for the foster carer during the meeting: *"I felt nervous and not confident"; "[the foster carers] got a bit upset."*
- That the child was upset because the foster carers had not continued with contact: *"foster carers broke off contact before child was ready."*

Of the parents who described the impact of the contact on the child as being slightly or very positive, 97 parents wrote a comment in the open box. A number of themes emerged about why parents had felt this contact was beneficial:

- Parents emphasised the significance and value of the relationship their child had developed with the foster carer, and understood the benefits of continuing with this connection: *"he loves the foster carers"*. This emphasis on the importance of the relationship was made strongly by another parent who said *"please stop calling it contact - these are human relationships that should be maintained".* Most comments referred to the child's relationship with the foster carers, but some parents also mentioned the importance of the child's relationship with other children in the foster home.
- Linked to this notion of relationships, some parents argued that maintaining the foster carer relationship prevented their child from experiencing another loss, or having a sense of rejection: *"I didn't want them to suffer another total loss"; "it's important for my child… to know that he has not been forgotten by them."*
- Parents felt that the foster carer contact had eased the child's transition into their family and/or helped their relationship with their child: *"overall it has cemented him even more in our family", "it was massively important for him in settling with us… I can't say strongly enough how the inclusion of foster carers in our life is essential."*
- The contact was seen as helping the child to understand their life history: *"I think that it is helping her piece together her story"; "it helps him understand his timeline."*

- Some parents said that foster carers had supported them in their parenting of the child: *"they are equally supportive of me."*

5.7 Chapter summary

This chapter reported on 226 children's planned transitions from their preceding foster care placement to their adoptive family. The data reveal wide ranging experiences in terms of the quality of introductions, how well children cope with the transitions, the role of professionals and foster carers in the transition and the level of post-placement contact with the foster family. Overall the data suggest that this is an area where current practice would benefit from review as there were indications that poorly managed transitions were linked to poorer outcomes for children. Key findings are summarised below.

- **Length of introductions:** Time taken ranged from 2 days to 8 weeks with the majority (87%) moving within 2 weeks of first meeting their adopters. Younger children were more likely to be moved over a shorter timescale, half of babies aged under 12 months moved within a week compared to a quarter of children aged one year and older.
- **Parents' views of speed and quality of introductions:** Three quarters (73.9%) said the length was 'about right' and most of those that disagreed thought the introduction was too long (19%) rather than too short (6.8%). Most adoptive parents agreed the foster carer was focused on their child's needs during the move (70%). Three quarters (75.7%) felt the carer was fully supportive towards them too and the same proportion stated that they were confident about the care their child received in this foster home.
- **Parents' views on how well their children coped with the move:** One third of parents felt that their child found their transition 'extremely difficult' or 'somewhat' difficult', these difficulties being reported more often by parents of children who were older at placement. This could because parents might more easily perceive children's difficulties when they are older, i.e. able to verbalise. Difficulties were not associated with the speed of transitions suggesting other factors may be more important than timescales.
- **The role of foster carers during transitions:** How foster carers managed the introductory period could make a big difference to how adopters and the children experienced the process. Positive practice included: being welcoming, friendly and encouraging; being open about information on the child, their routines, likes/dislikes etc; and preparing the child in advance by giving them information about their new family. Difficulties included: foster carers finding it hard to cope with loss or being

possessive and controlling; foster carers not agreeing with the match; deviating from the plan (although flexibility was welcomed if the plan was not working).

- **The role of professionals during introductions:** Although the arrival of an adopted child in their family could be a time of great joy, the introductions period was experienced as stressful and physically and emotionally exhausting by many parents. Good support is needed and positive practice included: striking a balance between being available without being intrusive; flexible plans with changes based on the child's, not the adults', needs; offering emotional support to foster carers and adopters allowing them to fully express their feelings without a critical response; and making as much information available about the child as possible. Difficulties included: absence of life story work, letters for later life etc.; introduction focused around the availability of the professionals; and lack of continuity in professionals supporting the transition.
- **Difficulties experienced by children during transitions:** There were indications that transitions were not always focussed fully on children's needs. Length of introductions were sometimes too long or too short causing upset for children. Abrupt and poorly handled endings, for example due to foster carer's painful feelings, were difficult for some children. Sometimes, social work visits post-placement were unsettling.
- **The relationship between introductions and how well the adoption was going:** Of the parents who were 'struggling' with the adoption, over half (56%) had reported problems with at least one aspect of the introductions. In contrast, where the adoption was going really well a lower percentage (30%) reported problems with introductions.
- **Contact with foster carers after placement:** In three quarters of cases there was some kind of contact with foster carers either face-to-face or indirect (for example letters, phone calls, Facebook, emails). Sometimes this was for a short period post-placement and in some cases there was a long gap before contact was re-introduced. Decisions about the nature and frequency of contact were made between foster carers and parents, mostly without professional involvement. Three quarters said that the contact had been positive, 20% neutral/mixed and 8% negative. Reasons given for negative experiences included: triggering difficult feelings for the child; contact hindering the development of new attachments to adoptive parents; and upset when foster carers ceased contact. Positive experiences included: maintaining an important relationship that means a lot to their child and to minimise experiences of loss; helping the child with their life story and sense of continuity; and as a source of parenting support for the adoptive parent.

Chapter 6 - The emotional and psychological health of the children

6.1 Introduction

Outcomes for adopted children are highly varied (Rutter 2005). For some children, the effects of early adversities can present in the form of oppositional, aggressive (externalising) behaviour (Verhulst, 2000) and conflicts may surface quickly into the adoptive placement, go on for a long time and/or re-emerge after seeming resolution at times of acute stress (Cairns, 2008). There may be difficulties in forming attachment to adoptive parents expressed through mistrust and distance (Hodges *et al*., 2005) and insecure attachments may be visible through behavioural problems and hyperactivity (Quinton *et al*., 1998, cited in Quinton, 2012) as well as difficulties forming relationships with others (Howe, 2005). Early neglect can cause neurological damage resulting in cognitive impairment (Bauer *et al*., 2009). Maltreatment can also lead to internalising problems such as anxiety and depression (Juffer, 2006). The degrees of difficulties experienced often increases with age at placement (Rutter, 2005) as can adoption disruption rates (Barth and Berry, 1988; Selwyn *et al*., 2014). Whilst it is estimated that disruption rates of non-infant adoptions are low (Selwyn *et al*, 2015), a significant minority of intact families may struggle due to the child's behavioural and emotional difficulties (Rushton and Dance, 2006; Selwyn *et al*, 2015; Neil *et al*, 2015).

Whilst chapter 4 looked at adopter's perspectives on how their children were getting on and how the adoption was going overall, this chapter is concerned with the findings from standardised instruments used to measure the emotional and psychological health of children, as well as any diagnoses that the child has received. The survey used the Strengths and Difficulties Questionnaire (Goodman, 1997), typically used for children in the general population as well as at risk groups, and the Tarren-Sweeney Assessment Checklist, a specialised mental health measure for children in care (Tarren-Sweeney, 2014). The use of these measures serves to triangulate the self-report questions on adopted children's wellbeing with more objective, standardised measures used in clinical settings.

6.2 The Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a measure of emotional and behavioural strengths and problems for children and has two versions; one for children aged 2-4 and another for those in the 5-17 age bracket.[2]

Depending on the age bracket the child fell into, respondents were directed to complete the appropriate version of the SDQ for parents; the SDQ for 2-4 year olds was completed by 46 parents and the SDQ for 5-17 year olds was completed by 148 parents. Both versions are broadly similar with slightly different wording on a few items to reflect the age group. The questionnaire includes a mixture of positively and negatively worded statements (items) and respondents were asked to indicate their child's position on a three-point Likert scale [*not true* (0), *somewhat true* (1) or *certainly true* (2) for negatively worded statements and *not true* (2), *somewhat true* (1) or *certainly true* (0) for positive statements]. There are 25 items that span five subscales (with five items in each):

1. Emotional problems
2. Conduct problems
3. Hyperactivity/inattention
4. Peer relationship problems
5. Prosocial behaviour

6.2.1. Scoring the SDQ

This section details how the SDQ was scored. To just review the results, skip to section 6.2.3.

The 20 items in the first four subscales were summed to give a Total Difficulties score (range 0–40), with higher scores indicating greater difficulties (Goodman 1997, 2001). Two variables were created for each scale, one with the raw scores and one categorising the raw scores into bands reflecting the findings of a population-based UK survey (Goodman, 1997). The study on which the bands were based suggested slightly different population norms for the 2-4 year olds compared to the older children so the banding thresholds are not identical. The raw scores were firstly recoded into bands as follows:

[2] The SDQ is a brief, valid and reliable measure [internal consistency, Cronbach's alpha (a) = 0.73; cross-informant correlation, Pearson's correlation (r) = 0.34; test–retest stability after 4 to 6 months, a = 0.62] (Goodman, 2001) and is widely used to assess mental health in childhood.

- *close to average* (representing 80% of children in the general population in both age groups);
- *slightly raised* (representing 12% of 2-4 year olds and 10% of 5-17 year olds in the UK community sample);
- *high* (4% of 2-4 year olds and 5% of 5-17 year olds in the community sample);
- *very high* (4% of 2-4 year olds and 5% for the older group in the community sample).

A single variable was created with both age groups for both the total difficulties raw scores and the banded scores.

To identity children with difficulties within the clinical range a new variable was created recoding children whose scores were *close to average* or *slightly raised* as *below the clinical cut off*, and those whose scores were and *high* and *very high* as *above the clinical cut off*.

'Externalising' and 'internalising' scores were calculated giving a score for each in the range of 0 - 20. The externalising score is the sum of the conduct and hyperactivity scales and the internalising score the sum of the emotional and peer problems scales.

An 'impact score' was also calculated from additional questions in the second part of the measure. Respondents were asked whether, overall, they think their child had difficulties in one or more of the following areas: *emotions, concentration, behaviour* or *being able to get on with other people.* They were asked to tick one of these options: *no, yes-minor difficulties, yes-definite difficulties* or *yes-severe difficulties.* Respondents then chose how long the difficulties had been present – *less than a month, 1-5 months 6-12 months* or *over a year.* These responses to chronicity, and the final question in the section asking whether the difficulties put a burden on the family as a whole, are not included in the impact score. Both age groups were asked the same questions in the survey and were scored the same. The 5 questions used to generate the impact score gave respondents the option of ticking: *not at all* (scored as 0), *only a little* (also scored as 0), *quite a lot* (scored as 1) and *a great deal* (scored 2). The questions are:

1. Do the difficulties upset or distress your child?

Do the difficulties interfere with your child's everyday life in the following areas?

2. Home life
3. Friendships
4. Learning

5. Leisure activities

The sum of the scores for the 5 impact questions was calculated for each age group and then a variable was created to give the scores for each child. Two variables were created to show the clinical cut off for each age group. These variables were also combined to show whether each child was above or below the clinical cut off by recoding the measure's four-band categorization into a binary variable (*close to average* and *slightly raised* recoded as 0 meaning *below the clinical cut off* and *high* and *very high* as 1 – *above the clinical cut off*).

Prosocial behaviour – showing empathy, being kind towards others, being considerate and helping others, for example – may be beneficial for adopted children as a way to garner social support from others, strengthen relationships and bolster self-esteem and might help children with the social environment. As with the other subscales in the SDQ that were positively worded, respondents were asked to rate *not true* (scored as 0), *somewhat true* (1) and *certainly true* (2) to the following five statements:

- Considerate of other people's feelings
- Shares readily with other children
- Helpful if someone is hurt
- Kind to younger children
- Often volunteers to help

Answers to the five items within this subscale were added together to create raw scores for both age groups and these were combined in a single variable.

A four-band classification was originally used to code the answers. The lower the scores the less prosocial a child is and figures in brackets show the % of children in the general population scoring in each range:

- Raw scores of 8-10 were considered *close to average* and displaying prosocial behaviour (80%) and were coded as 1.
- A raw score of 7 was coded as 2 *slightly lowered* indicating lower than average prosocial behaviour (12% of the younger age group and 10% of the older in the general population).
- A raw score of 6 was coded as 3 *low* (4% 2-4 year olds and 5% 5-17 year olds).
- A raw score of 0-5 was coded as 4 *very low* (4% 2-4 year olds and 5% 5-17 year olds).

Impact scores were also recoded into a binary variable to reflect whether or not a child's impact score was clinically significant or not. Hence those whose scores were *close to average* were in one group, and those whose scores were *slightly lowered, low or very low* were combined in the clinically significant group.

6.2.3. Results of the SDQ

Table 6.1 below shows the results of the strengths and difficulties questionnaire for children aged 2 to 4 years reporting total difficulties, emotional symptoms, peer relationship problems, conduct problems, hyperactivity/inattention, internalising behaviour, internalising behaviour and impact.

Table 6.1: The results of the strengths and difficulties questionnaire 2-4 year olds

SDQ measure and subscales	Scoring	N	Range	Mean	SD	% scoring in clinical range
Total Difficulties	0 (low) – 40 (high)	46	0-28	8.96	5.57	13% (6)
Emotional Symptoms	0 (low) – 10 (high)	46	0-7	1.17	1.58	10.9% (5)
Peer Relationship Problems	0 (low) – 10 (high)	46	0-7	1.76	1.70	10.9% (5)
Conduct Problems	0 (low) – 10 (high)	46	0-7	2.33	1.80	10.9% (5)
Hyperactivity / Inattention	0 (low) – 10 (high)	46	0-10	3.70	2.41	10.9% (5)
Internalising	0 (low) – 20 (high)	46	0-11	2.93	2.65	N/A
Externalising	0 (low) – 20 (high)	46	0-17	6.02	3.73	N/A
Impact	0 (low) – 10 (high)	46	0-7	0.40	1.23	6.5% (3)
Prosocial	0 (low) - 10 (high)	46	1-10	7.43	2.07	37.0%* (17)

*i.e. scoring < 7 and therefore 'not prosocial'

Thirteen per cent of the 46 children for whom the SDQ (age 2-4) was completed scored in the clinical range for total difficulties on this measure (approximately 10% of a UK community samples scored at this level). This indicates a relative low level of total difficulties for this age group although slightly elevated compared to the general population. No one problem subscale stood out from any other; for each of the four subscales, almost 11% (n=5) of children scored in the clinical range (although these were not necessarily the same children. Externalising scores were higher than internalising scores. With a potential range of 0-20, the maximum externalising score was 17 compared to a maximum of 11 for internalising. The overall stress and impairment determined in the impact scores was in the clinical range for 6.5% (n=3) of 2-4 year olds. In terms of pro-social behaviour, this was where the largest number of children were scoring in the clinical range. Just over a third of children were below average in terms of pro-social behaviour suggesting this could be an area where problems could be picked up at an early stage and early intervention provided.

Table 6.2: The results of the strengths and difficulties questionnaire 5-17 year olds

SDQ measure and subscales	Scoring	N	Range	Mean	SD	% scoring in clinical range
Total Difficulties	0 (low) – 40 (high)	145	1-36	17.74	9.07	55.2% (80)
Emotional Symptoms	0 (low) – 10 (high)	149	0-10	3.85	2.89	40.3% (60)
Peer Relationship Problems	0 (low) – 10 (high)	147	0-10	3.63	2.59	34.7% (51)
Conduct Problems	0 (low) – 10 (high)	147	0-10	3.99	2.76	51.7% (76)
Hyperactivity / Inattention	0 (low) – 10 (high)	148	0-10	6.26	3.07	39.9% (59)
Internalising	0 (low) – 20 (high)	147	0-20	7.50	4.87	N/A
Externalising	0 (low) – 20 (high)	146	0-20	10.22	5.17	N/A
Impact	0 (low) – 10 (high)	147	0-10	3.2	2.98	62.8% (93)
Prosocial	0 (low) - 10 (high)	150	0-10	6.57	2.57	55.7% (82)*

*i.e. scoring < 7 and therefore ‘not prosocial’

Table 6.2 above presents the results of the SDQ for children aged 5 to 17 years. Of the 148 children for whom the SDQ for 5-17 year olds was completed, 55% (n=80) scored in the clinical range for total difficulties. This is significantly higher than the general population but similar to results reported in other studies of children in foster or adoptive homes. For example, Minnis *et al*. (2006) found 57% of 175 foster children (aged 5-17), were in the clinical range for total difficulties. National data published by Department for Education (DfE 2014a) show that of children (aged 5-16) who were looked after in 2014 36.7% scored in the clinical range. Biehal *et al.*'s (2010) longitudinal study of children who had entered care found 32% of children adopted by strangers scored in the clinical range, with the percentage rising to 50% of those who had an unstable care placement history.

In this survey, more children in older age ranges scored in the clinical range for total difficulties: 63% of 12-17 year old scored in the clinical range (n =43) compared with 49% of 5-7 year olds (n=53) and 55% of 8-11 year olds (n=49). The largest percentage of children in the clinical range was for conduct problems with just over half (n=76, 52%) of 5-17 year olds scoring in the clinical range for this subscale. Emotional problems and hyperactivity/inattention both had around 40% (n=60 and n=59 respectively) in the clinical range and 35% (n=51) of 5-17 year olds were in the clinical range for peer problems. Externalising behaviour average scores were higher than internalising average scores with 10.22 for the former and 7.5 for the latter. Just under half of children had good pro-social behaviour but for 55% their functioning in this area was below average.

Impact scores were also markedly higher for the 5-17 year old age range than for the 2-4 year olds with 63% (n=93) in the clinical range for impact in the older age group compared to 7% (n=3) for the younger children. (As a comparison, McCarthy *et al* (2003) found over half (41 out of 69, 59%) of looked after children aged 5-16 years from an English local authority had impact scores in the clinical range). It is important to remember that the 'problems' that some adopted children have may present challenges to other people, but *even more so* they are distressing to children themselves and they interfere with children's every day activities.

Across all ages (age 2-17, n=191), 86 children (44%) had total difficulty scores in the clinical range. In general, scores for the 5-17 year old children were much higher than for the 2-4 year olds. Because of the correlation in the sample of age at placements and age now, further investigation is warranted to fully understand this patterns of older children faring so much worse than younger children. A slightly higher proportion of boys had scores in the clinical range (43 of 91, 47%) compared to girls (41 of 98, 42%), and further analysis of results by sex will be undertaken in journal articles. A similar gender difference was also reported by

Department for Education (DfE 2014a) for SDQ scores of looked after children in England in 2014.

6.3 The Tarren-Sweeney Assessment Checklist for Children (ACC) and Adolescents (ACA)

The Tarren-Sweeney Assessment Checklist measures are carer self-report rating instruments with different versions for children aged 5-10 (with slight variations for boys and girls in terms of thresholds for clinical significance) and adolescents aged 11-17. The short form versions of these measures was used. These checklists were designed to measure difficulties, typically observed among children and adolescents in care, those adopted from care and children experiencing maltreatment in general, which were not sufficiently measured by mental health measures used for the general population (Tarren-Sweeney, 2014)[3].

6.3.1 Scoring the assessment checklists

Respondents were asked to complete either ACC or ACA (Short Form) questionnaire depending on the age of their child. One hundred and nineteen parents completed the child measure and 42 completed the adolescent measure. Respondents were asked to tick one of 3 responses (*not true, partly true* or *mostly true* for some statements and *did not occur, occurred once and occurred more than once* for others) to a range of statements describing children/adolescents' behaviour and feelings based on the last 4 to 6 months of their child's life. This gave scores for 9 clinical scales for the ACC and 6 scales for the ACA. Scores are combined for a total score.

Tarren-Sweeney (2014: 5) describes the significance of the nine ACC (child measure) scales, as outlined below:

- *Sexual behaviour:* measures age-inappropriate sexual behaviour.
- *Anxious-distrustful:* measures distrust and anxiety related to trauma.
- *Abnormal pain response:* measures a pattern of abnormal responses to physical hurt indicating insensitivity to pain or failure to communicate the pain.
- *Food maintenance behaviour:* measures excessive eating and food acquisition which is primarily triggered by acute stress.
- *Self-injury*: measures self-injurious behaviours.

[3] The internal reliability of the ACC short-form total score (44 items) is alpha = 0.92 (n = 347), while the internal reliability of the six short-form scales ranges from 0.67 to 0.84. For the ACA short-from, internal reliability of the total score (37 items) is alpha = 0.91 (n = 230), while the internal reliability of the six short-form scales ranges from 0.73 to 0.87 (Tarren-Sweeney, 2014: 113).

The remaining 4 scales measure a range of types of maladaptive interpersonal relatedness indicating attachment disorder behaviour and/or social difficulties related to attachment:

- *Pseudo-mature interpersonal behaviour:* describes a pattern of pseudo-maturity with role reversal tendencies,
- *Non-reciprocal interpersonal behaviour:* describes avoidant and emotionally withdrawn social behaviours with a lack of reciprocity. High scores indicate an extremely avoidant attachment pattern and/or inhibited form of reactive attachment disorder,
- *Indiscriminate interpersonal behaviour:* describes a pattern of indiscriminate overfriendliness. Resembling the disinhibited form of reactive attachment disorder, children display affection-seeking and attention-seeking behaviour.
- *Insecure interpersonal behaviour:* measures a range of emotional difficulties and social behaviours indicating felt insecurity. This insecurity is likely to be in the form of a trait (insecure attachment and temperament) and state (for example, a response to extreme stress such as impermanent care).

Tarren-Sweeney (2014: 7) describes the significance of the 6 subscales of the ACA (adolescent measure) as follows:

- *Non-reciprocal:* describes emotionally withdrawn, avoidant and non-reciprocal social behaviours. High scores indicate a severely avoidant-insecure attachment pattern and/or inhibited for of reactive attachment disorder.
- *Social instability:* describes a combination of unstable, attachment-related social relatedness difficulties and behavioural dysregulation. This scale incorporates the majority of items in the ACC Pseudomature and Indiscriminate scales.
- *Emotional dysregulation/distorted social cognition:* describes a pattern of highly dysregulated emotion and affective instability, coupled with distorted social cognitions (negative attributions, paranoid beliefs).
- *Dissociation/trauma symptoms:* measures a pattern of trauma-related dissociation and anxiety symptoms.
- *Food maintenance behaviour:* measures a pattern of excessive eating and food acquisition that seems to be triggered by acute stress.
- *Sexual behaviour:* measures age-inappropriate sexual behaviours indicating risk of self-harm.

The clinical range on this measure indicates scores which are highly predictive of psychiatric impairment. *Borderline* or *elevated* scores indicate a moderate likelihood of psychiatric

impairment which may warrant further monitoring, may have uncertain clinical meaning, may be maladaptive for some children and would not be considered normative for children generally (Tarren-Sweeney, 2014: 34).

The total score variables were coded into bands to reflect the thresholds for clinical significance with 0 representing *normal,* 1 *borderline* and 2 *clinical*. A similar process was undertaken to code the adolescent and children's totals, however the thresholds for boys and girls (age 5-10) differ slightly so codes were adjusted as necessary to reflect the gender of the child. A binary variable was created for each age group with 0 representing *below the clinical cut off* (combining *normal* and *borderline* into this category) and 1 as *above the critical cut off* (which was previously 2 *clinical*).

6.3.2. Results of the assessment checklists

Table 6.3 below shows the results of the Tarren-Sweeney Assessment Checklist for children aged 5-10 years. Almost half (n=57, 49%) scored in the 'clinical' range for total scores, and a further 11% (n=13) were in the borderline clinical range. The most significant subscale was *insecure* (containing statements such as; clingy, fears rejection by peers/carers, seems insecure and worries that something bad will happen to their carer), with 45% (n=53) of children scoring in the clinical range. The proportions of children in the clinical range for *pseudo-mature* (n=33), *non-reciprocal* (*n*=32), *anxious-distrustful* (n=33) and *indiscriminate* (n=35) were similar at around 30%. *Abnormal pain response* had the lowest percentage in the clinical range (9%, n=11), *sexual behaviour* was also relatively low (11%, n=13) as was *food maintenance behaviour* (14%, n=16). Tarren-Sweeney and Hazell (2006) found that around half of children (aged 4-9) in care show one or more forms of the attachment-related interpersonal behavioural difficulties (i.e. *insecure, pseudo-mature, non-reciprocal* and *indiscriminate*). Higher figures may be due to his sample consisting of children in foster and kinship care as opposed to those permanently placed with adopted families.

Table 6.3: The results of the Tarren-Sweeney Assessment Checklist for Children (ACC) 5-10 year olds

TS measure and subscales	Scoring	N[4]	Range	Mean	SD	% scoring in clinical range
Total Score	0 (low) - 88 (high)	116	0-52	16.96	14.04	49.1% (57)
Sexual Behaviour	0 (low) - 8(m) 10(f) (high)	117	0-6	0.39	1.21	11.1% (13)
Pseudo-mature	0 (low) - 10 (high)	118	0-9	2.36	2.48	28.0% (33)
Non-reciprocal	0 (low) - 12 (high)	117	0-9	2.27	2.60	27.4% (32)
Indiscriminate	0 (low) – 10 (high)	118	0-10	2.94	2.61	29.7% (35)
Insecure	0 (low) – 10 (high)	118	0-10	3.17	2.73	44.9% (53)
Anxious-distrustful	0 (low) – 12 (high)	117	0-9	1.91	2.30	28.2% (33)
Abnormal Pain Response	0 (low) – 8 (high)	117	0-8	1.21	2.01	9.4% (11)
Food Maintenance	0 (low) – 8 (high)	117	0-8	1.44	2.02	13.7% (16)
Self-injury	0 (low) – 8 (high)	117	0-8	1.31	2.26	18.8% (22)

Table 6.4 below presents the results of the Tarren-Sweeney Assessment Checklist for adolescents. Three-quarters (n=32, 76%) of adolescents' total scores were in the clinical range and a further 7% (n=3) were borderline. The subscale with the highest proportion in the clinical range was *emotional dysregulation/distorted social cognition* (n=37, 84%). Almost three quarters of adolescents scored in the clinical range for *non-reciprocal* (n=32, 73%) and n=30 adolescents had *social instability* scores in the clinical range (68%). Around a third of

[4] Numbers for sub-scales differ due to missing data meaning that not every subscale could be calculated for every child.

adolescents had clinically significant *dissociation and trauma symptoms* (n=14, 33%) but just three showed clinical significance for *sexual behaviour* (7%).

Table 6.4: The results of the Tarren-Sweeney Assessment Checklist for Adolescents (ACA) 11-17 year olds

TS subscales	Scoring	N	Range	Mean	SD	% scoring in clinical range
Total Score	0 (low) - 74 (high)	42	1-56	23.52	13.28	76.2% (32)
Non-reciprocal	0 (low) - 12 (high)	44	0-12	4.36	3.13	72.7% (32)
Social Instability	0 (low) - 16 (high)	44	0-13	6.16	3.46	68.2% (30)
Emotional Dysregulation / Distorted Social Cognition	0 (low) – 14 (high)	44	0-14	6.50	4.11	84.1% (37)
Dissociation / Trauma symptoms	0 (low) - 12 (high)	43	0-10	2.49	3.27	32.6% (14)
Food Maintenance	0 (low) – 10 (high)	44	0-10	3.75	3.19	27.3% (12)
Sexual Behaviour	0 (low) – 10 (high)	43	0-6	0.42	1.37	7.0% (3)

Combining results from the two versions of the Tarren-Sweeney measure, 89 out of 161 children had total scores in the clinical range. This is 55% of children across all age groups.

6.4 How did the standardised measures relate to parents' ratings of how the adoption was faring?

The standardised measures provide a mechanism to assess how the 'adoption faring' variable reflected the mental health difficulties of the children. The percentages of children with clinically significant difficulties within each of the 'adoption faring' groups were examined.

Table 6.5 shows the numbers of children (for whom the SDQ and Tarren-Sweeney Assessment Checklists were completed) with clinically significant total scores in each of the

three adoption faring groups. Looking first at the 'struggling' group, the vast majority of children had clinically significant scores on the SDQ (37 of 41, 90%) and on the assessment checklists (39 of 40, 98%). Of those in the 'managing challenges' group 44 of 72 (61%) of children had clinically significant difficulties on the SDQ and 42 of 65 (66%) were in the clinical range on the assessment checklist. In contrast, few children in the 'going really well' group had clinically significant problems (5 of 78 on the SDQ, 6%; 8 of 53 on the assessment checklist, 15%). The higher percentage of clinically significant scores on these measures in the 'struggling' group are comparable to scores found by Selwyn *et al* (2014) in relation to their '*challenging but at home'* group (82.4% in the clinical range on the SDQ) and '*left home following adoption breakdown*' group (97.1% in the clinical range on the SDQ).

Table 6.5: Clinically significant total scores on the SDQ and Tarren-Sweeney Assessment Checklists and how the adoption is faring overall

'How is the adoption faring?'	Number of children for whom the SDQ was completed	% clinically significant on the SDQ for total difficulties (both versions) (n = 191)	Number of children for whom the TS checklist was completed	% clinically significant on the TS assessment checklist (both versions) (n = 158)
'going really well'	78	6% (5)	53	15% (8)
'managing challenges'	72	61% (44)	65	65% (42)
'struggling'	41	90% (37)	40	98% (39)

Such high rates of clinically significant mental health problems in children whose parents have rated the adoption overall as 'struggling', indicates that parents should be listened to when they say they are struggling. Moreover, professionals need to be conscious of the fact that, the majority of parents who are 'managing challenges' are likely to be parenting a child with high levels of difficulties in the clinical range and appropriate support services will be needed. Without such services families may be extremely vulnerable to becoming 'struggling' at other times, but even more importantly their children are experiencing distress and disruption in their everyday lives. For those 'managing challenges', and even when parents think that everything is 'going really well', some children will still need help and support to help them deal with

significant mental health difficulties. Keeping the door open for parents to seek help when needed is vital. But the scale of difficulties that many adopted children experience suggests that early assessment and intervention is warranted and continued assessment and intervention where necessary should be available.

6.5 Diagnoses of developmental problems

A separate section of the survey asked parents to state if their child had ever had a diagnosis or treatment for a developmental problem (physical, sensory, mental health, emotional or behavioural). There was space for respondents to list (in their own terms) up to 7 problems, and add details of the professional who gave the diagnosis or treatment. This question was completed by 291 parents, with 36% (n=106) stating that their child had received some form of diagnosis or treatment. The various entries were recoded into categories of problems following the advice of a children's mental health specialist and DSM-5 (APA, 2013). Physical disorders were very varied and included apparently minor or short term issues. Mental health, emotional or behavioural issues and learning difficulties are the subjects of table 6.6 below.

Table 6.6: Children's diagnoses of mental health, emotional/behavioural issues & learning difficulties

Diagnosis	Children with diagnosis	
	%	n
Attachment Disorder	14	40
Autistic Spectrum Disorder/Asperger's Syndrome	5	15
Trauma	3	10
ADHD	3	10
Anxiety Disorder or OCD	3	10
Fœtal Alcohol Syndrome	2	7
Personality & Dissociative Disorder	1	3
Eating Disorder, Self-harm, Suicidal	1	3
Motor Disorder (Tics, Tourette's)	1	2
General/Other Behavioural, Emotional and Social Difficulties (BESD)*	4	13
Specific or General Learning Disability	6	17
Communication issues or delay (not with a Learning Disability)	3	9

*Includes: emotional dysregulation and behavioural issues/mental health problems/emotional difficulties diagnosed by therapists

Table 6.6 shows the range of diagnoses received and the percentage of the total number of respondents (n=288) whose children had received the diagnosis. Twenty nine per cent of children (n=83) had received at least one diagnosis of, or treatment for, a mental health, emotional or behavioural issue (autistic spectrum disorders, foetal alcohol spectrum disorders and attention deficit hyperactivity disorders were included here due to their association with emotional or behavioural difficulties). The most common issue, referred to in relation to over half (n=45, 55%) of these children, was of some type of attachment disorder or trauma related problem (or both). Fifteen children were said to have an autistic spectrum disorder, 10 children to have an attention deficit hyperactivity disorder and 7 to have a diagnosis or treatment for foetal alcohol spectrum disorder.

Additional comments by parents indicated that many children were struggling with emotional or behavioural difficulties but had not yet received a diagnosis and/or treatment – this is also indicated in how parents scored children on the two standardised measures where the percentage of children showing clinically significant mental health problems (44% on SDQ, 55% on Tarren-Sweeney checklists) exceeds the percentage with a diagnosis (28%) (see above).

> *'We are waiting for assessments for anxiety, dyspraxia, sensory processing disorder and speech therapy for stammering.'*

> *'She seems to react in extremes - e.g. regularly describes new children she's just met as her "best friend", and often reacts in an extreme way when asked to do something or not do something. She regularly tells us that she is no good at things. She doesn't have many close friends at school. She frequently lies about things. She often doesn't seem to learn from experiences – i.e. does the same things over again despite any intervention.'*

6.6 Chapter summary

This chapter reported on the emotional and psychological health of the adopted children in our survey through results of standardised measures of child/adolescent emotional and psychological wellbeing, as well as diagnoses that children had received. The findings suggest very high levels of difficulties overall that, in our sample, are particularly prevalent in older children/teenagers. The results are similar to the studies carried out by the Office of National Statistics on the mental health of young people, aged 5-17, looked after by local authorities (Meltzer, H. et al, 2003, Meltzer, H et al, 2004a and Meltzer et al, 2004b). These

studies found that 45% of looked after children in England, 45% of looked after children in Scotland and 49% of looked after children in Wales had a mental disorder. In the current study many children with clinically significant problems were yet to receive a diagnosis and parents expressed frustration about this in their comments.

- **The Strengths and Difficulties Questionnaire (SDQ):** Overall 44% of children had clinically significant difficulties on the SDQ total difficulties score. The SDQ for children aged 2-4 *total difficulties* scores in the clinical range (13%, *n* = 6) were only slightly elevated in comparison to the general population (10%). In contrast, clinically significant scores were much higher for 5-17 year olds (55%).
- **Clinically significant mental health difficulties (ACC and ACA):** On the Tarren-Sweeney Assessment Checklist for Children (ACC), almost half (49%) were in the clinical range for total score with the most significant subscale being *insecure* (45%). For adolescents (ACA) over three-quarters of children were in the clinical range for total score (76%) with *emotional dysregulation/distorted social cognition* showing the highest level of clinical significance by far (84%). Combining results for both age groups, 55% of children had problems in the clinical range.
- **Clinically significant difficulties and how the adoption is faring:** Total scores on both standardised measure mapped well onto the self-report data about how the adoption was faring overall (chapter 4). Of the 41 children whose families were 'struggling', the vast majority (90%) scored in the clinical range for total difficulties on the SDQ and almost all (98%) of the children had total scores in the clinical range on the Tarren-Sweeney assessment checklists.
- **Diagnoses of mental health problems:** Over a third of children (36%) had received some form of diagnoses or treatment. Twenty nine per cent of the children received a diagnosis of, or treatment for, a mental health, emotional or behavioural issue. Comparing data on diagnosis with data from the standardised measures suggests that many children's problems are undiagnosed and untreated.

Chapter 7 - Understanding links between early adversity and children's outcomes: a latent factor structural equation approach

(This chapter was co-written with Dr Marcello Morciano, Research Fellow, Health Economics Group, School of Medicine, Health Policy & Practice, University of East Anglia)

Analyzing research data and interpreting results can be complex and confusing. In many cases, empirical analyses may focus on a specific part of the 'broad story', as opposed to taking a wide range of factors into account . In this chapter the results of a statistical analysis (latent factor structural equation modelling) are presented. This analysis brings together a range of data described in previous chapters into one model with the overall aim of understanding children's outcomes. The links between children's experiences of maltreatment (reported in chapter 3) and children's progress in the adoptive home (reported in chapter 4) are explored whilst taking into account a range of other factors (such as other potential risks factors and demographic characteristics).

Links between early maltreatment, age at placement, and the developmental progress of adopted children are established (Rutter, 2005). But many factors in children's lives will overlap and correlate, making it difficult to understand which factors are most important in predicting outcomes. For example children who enter care at older ages will not just be older at placement, but are likely to have experienced greater exposure to maltreatment. They may stay longer in care and have more placement moves before being adopted. Is it their age at placement for adoption that matters most, their history of maltreatment, or their time in the care system? Adopted children may show an increase in emotional and behavioural problems in adolescence (Selwyn *et al* 2015, Neil *et al* 2015, Verhulst *et al*, 2000), so in a cross-sectional study such the current one it is important to take account of the child's age at the time of the survey. But in the current study age at placement is correlated with the child's age at the time of survey (see chapter 2), so it is important to consider both age and age at placement simultaneously. The statistical model used is able to manage complexities such as these by considering a range of factors at the same time.

7.1 Questions addressed in the analysis

In this chapter the following research questions are explored:

1. Are time spent in the birth family, pre-natal exposure to drugs and alcohol, and parental mental illness and/or learning disability associated with children's experience of maltreatment before adoption?
2. Is maltreatment experienced before entering care associated with children's later adverse outcomes (as reported by adoptive parents) in their adoptive families?
3. Are the child's sex, the length of time that children have stayed in the care system, or the number of placements, linked to later adverse outcomes in their adoptive families?
4. Is the child's greater distress in moving from their foster home to adoptive family associated with adverse outcomes later on?
5. Are the length of time in the adoptive family or the structure of the adoptive family (two parent vs single parent) associated with children's adverse outcomes?
6. Are there any direct associations between pre-natal drug and alcohol exposure and parental characteristics (learning disabilities, mental health problems) and children's adverse outcomes?

7.2 Method of analysis

The chosen approach to the statistical analysis was two-factor structural equation modelling. This method was chosen because of its ability to manage the limitations of the data, specifically measurement errors, correlations between variables and missing data. These data problem are explained below.

- *Measurement errors*: the data were all self-reported by adoptive parents, and may contain sizeable measurement errors. Measurement errors (the degree to which the reported value differs from its "true" value) might arise from different sources. For example, respondents, because of their different experiences, knowledge and attitudes, may interpret the meaning of the survey questions in different ways. Therefore, a response to a single item like "how is the adoption faring overall?" is a function of one's true attitude but also a function of other more transient factors such as the specific item wording, the respondent's mood, recent difficult experiences, or even random error.
- *Multicollinearity*. Many variables were highly correlated with each other (e.g. age at placement & age at time of survey; various types of maltreatment) and this is a serious issue in most of the traditional statistical methods employed for analysing them.
- *Missing data*: there were many variables where data were missing, particularly data about children's birth parents, and their experiences in the birth family (see chapter 3)

- these being missing either because the information was unknown to the adoptive parent, or because they had skipped the question.

The best approach therefore to work with this type of data is through an explicit statistical model that allows for the error prone nature of the indicators of maltreatment and outcomes, and which integrates the two key aspects of maltreatment and child outcomes at the child level in a comprehensive statistical framework: a two-latent factors structural equation model was employed. Traditional statistical approaches to data analysis specify models that are valid under specific conditions. For example, they assume measurement occurs without error. Latent factor structural equation modelling is is an increasingly popular multivariate technique for representing and estimating a set of relationships between variables which can be directly observed or latent constructs. This approach allows researchers to test the validity of hypothesized patterns of directional and nondirectional relationships among variables (MacCallum & Austin, 2000).

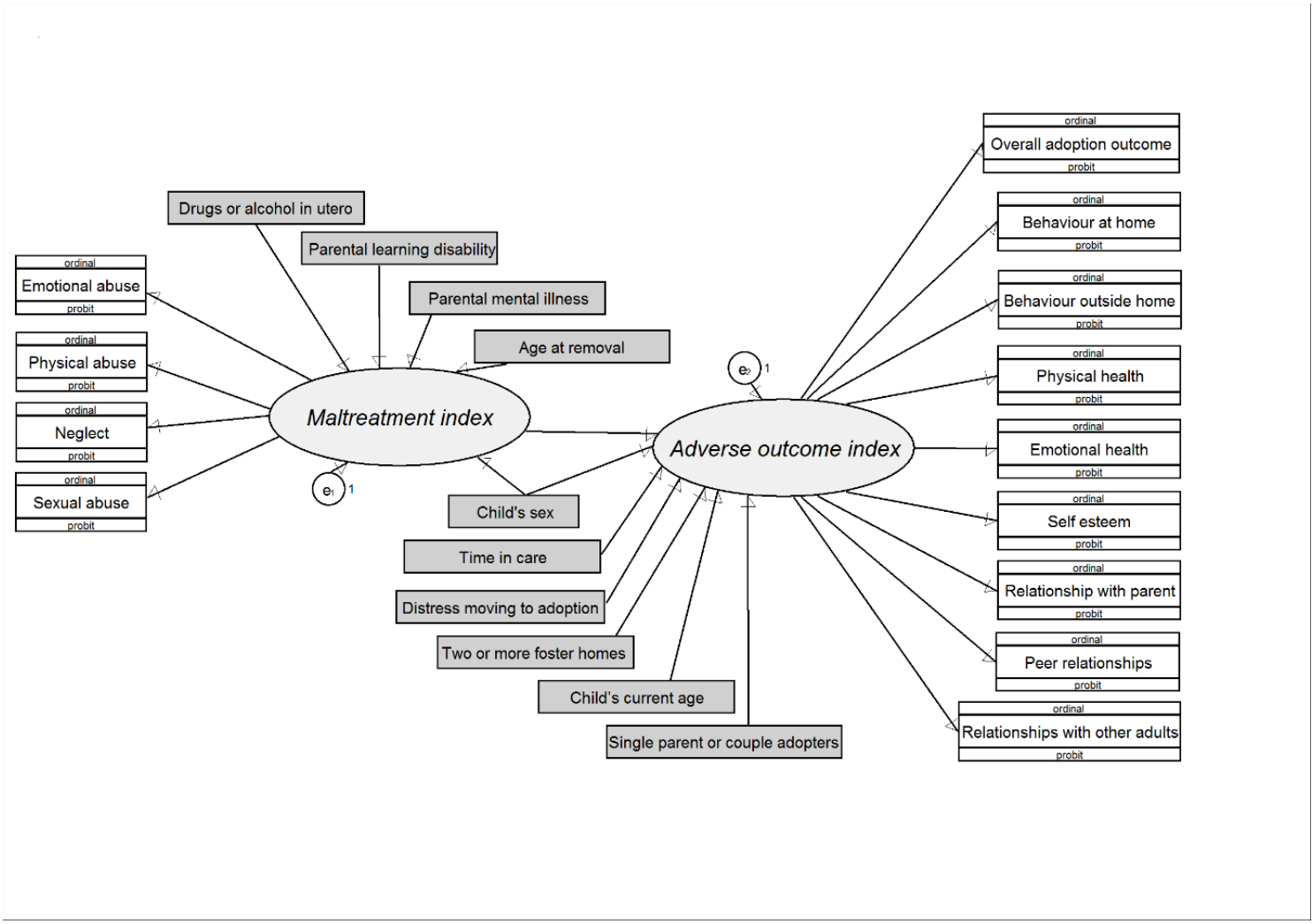
The outline of the model used is presented in figure 7.1. It comprises four different components that are being estimated simultaneously. These four components are described simply below, and in more detail in appendix 3.

1) *The measurement of maltreatment:* an index was created to estimate the range and severity of maltreatment suffered by children before adoption. This 'latent' (i.e. not directly measured) maltreatment variable is shown on the right side of Figure 7.1: the oval labelled 'maltreatment' stands for the latent maltreatment variable whereas the square boxes indicate the observed indicators of maltreatment (based on adoptive parent's reports of the child's history). Four different indicators of maltreatment are used in deriving the latent maltreatment index (physical abuse, emotional abuse, neglect, and sexual abuse). The index takes account of the presence/absence and severity of maltreatment; the four types of maltreatment were highly correlated (see appendix 3). Cronbach's α coefficient[5] was reasonably strong. The test scale for the 4 indicators of maltreatment was 0.8025

[5] Cronbach's alpha is a measure used to assess the reliability (internal consistency) of a set of indicators as a measure of the same concept/construct. Cronbach's α coefficients is a widely used way of measuring the strength of that consistency; α coefficient ranges from 0 to 1 and the higher the α coefficient, the more the items have shared covariance and probably measure the same underlying concept. Conventional thresholds recommend a minimum α value between 0.6-0.8, depending in the number of indicators. The results provide clear indication of high scale reliability.

2) *Factors influencing maltreatment*: Included in the model were a range of factors that may influence the likelihood of a child experiencing maltreatment, these factors being the child being exposed to drugs or alcohol in the womb, parental learning disability, parental mental illness, and the length of time the child was potentially exposed to maltreatment - indicated by the child's age at final removal into care. These factors are shown in the model on the right hand side, above the latent maltreatment index
3) *Measuring children's outcomes*: using a similar procedure as described above in (1) a latent outcome index was calculated through using adoptive parent's ratings of how well they perceived their child to be functioning in a range of areas, plus the parent's ratings of how well the adoption was faring overall. Note again that these indicators are highly correlated (see appendix 3, table A3.5) and it can therefore be assumed that an underlying "true" outcome (i.e. how the child is actually doing) causes the adoptive parents' responses to the outcome questions. Cronbach's α coefficient was very high, 0.9049.
4) *Factors influencing outcomes*: a model of the relationship between the child's outcomes and a set of factors, including the maltreatment index was proposed. In other words the analysis explores the extent to which the maltreatment index predicts the outcome index while simultaneously taking into account a range of other factors that may also affect outcomes (these including factors to do with the child's time in care, their current age, sex, and adoptive family variables).

Figure 7.1: Latent factor structural equation model: child maltreatment and adoption outcomes



7.3 Indicators of maltreatment

The indicators of maltreatment were developed using the data from the 12 of the 14 questions that parents were asked about the quality of care the child experienced before being placed in the adoptive family (two questions in this section on maltreatment - which focused on the child's exposure to drugs or alcohol before birth - were included in the analysis as a covariates- see below). The descriptive data relating to these 12 questions have already been presented in Chapter 3. To develop the indicators of maltreatment data were combined and recoded data as follows:

For each area of maltreatment, parents were asked estimate how significantly their child experienced the problem, if at all. Respondents could tick one of the following options and guidance was provided as to how to distinguish between "mild", "moderate" and "significant":

- Experienced at mild level
- Experienced at moderate level
- Experienced at significant level
- Likely experienced/unsure what level
- Don't know
- Not experienced

For 11 of the 12 areas of maltreatment, the data were recoded in order to assign a value to each of these responses so that higher numbers represented greater levels of maltreatment: 0 = not experienced; 1 = mild; 2 = likely[6]; 3 = moderate; 4 = significant; (.) = missing data or "don't know".

The data for *singled out for rejection* were converted as follows:

- 0 = Not known to have experienced (encompassing the previous codes 'don't know' and 'not experienced')
- 1 = yes (encompassing the previous codes 'mild', 'likely', 'moderate' and severe')

[6] The decision to rate 'likely experienced/level unknown' as between 'mild' and 'moderate' was taken in order to be able to include children where maltreatment was known but details of the level were missing. Scoring this between 'mild and 'moderate' is an estimate based on the assumption that more significant examples of maltreatment might be more visible and therefore likely to be known.

This different approach was taken with “singled out for rejection” because this type of maltreatment (the preferential rejection or scapegoating of one child in the family) was considered to be an indicator of emotional abuse that was specifically directed towards one child, rather than a different type of emotional abuse per se. So, for example, two children (in two different families) might have experienced similar types and levels of verbal abuse, but whilst one child may have been treated similarly to his or her siblings, the other child was the only one of their siblings to receive this treatment. The second child would score more highly than the first because although the verbal abuse is at the same level, is likely to have a more serious effect because of the preferential rejection (Rushton & Dance, 2005).

The reasons for reducing the variables about maltreatment from 12 dimensions to 4 were firstly to reduce the complexity of the model (to allow the system to achieve convergence). Secondly it enabled a greater number of children to be included as cases could still be included even where some data were missing (a child could be included in the analysis providing the parent had answered at least one of the questions about each of the four main types of maltreatment).

7.3.1 Neglect

This new variable was created by merging all available data from 5 recoded variables: *emotional neglect, physical neglect, lack of supervision, medical neglect* and *nutritional neglect.* All these types of maltreatment are included in the definition of ‘neglect’ used by the NSPCC (citing from Horwath, 2007). How the parent had rated each of the individual areas of neglect was examined, and the highest score on any one of the subscales was used as the score for neglect. If data were missing for one or more of the subscales, the overall score for neglect was still calculated using the highest score from remaining subscales. For example if data were missing about whether the child had experienced medical and nutritional neglect, but they had experienced moderate emotional and physical neglect and significant lack of supervision, then their score for neglect would be 4 – ‘significant’. Scores on this variable range from 0 to 4.

7.3.2 Emotional abuse

This new variable was created by merging responses to 3 variables: *emotional/psychological abuse, witness to domestic violence* and *singled out for rejection*. The decision to merge these three factors under ‘emotional abuse’ was based on NSPCC definitions (citing HM Government, 2015). The NSPCC describes domestic abuse as causing serious harm to children and that witnessing domestic abuse is child abuse, justifying its inclusion in this

variable as a form of emotional abuse. *Singled out for rejection* i.e. living in a household with other children but being the only one to receive harmful/neglectful treatment or experiencing it to a more severe extent to the other children, was included as an indicator of greater severity of abuse (see above – 7.3)

The data for *emotional/psychological abuse* and *witness to domestic violence* were first merged so that each case was given the highest score on either of these variables. If the child had a score of one for "singled out for rejection" (indicating they had experienced this) then this was added to their highest score on the other two variables. Hence the scale for the emotional abuse variable ranged from 0 (not experienced) through to 5 (only achieved if the highest score on emotional abuse and/or witness to domestic violence was 4 AND the child was singled out for rejection.)

7.3.3 Sexual Abuse

This new variable was created by merging data from *sexual abuse involving contact* and *sexual abuse not involving contact*. The NSPCC defines both these types under the umbrella of sexual abuse which informed the decision to merge the variables. The data for these two variables were then merged taking the highest rating over both as the score for the new variable; range of scores on this variable was 0 to 4.

7.3.4 Physical Abuse

The data for this variable were not merged with any other data but were drawn from the single question about physical abuse. The range of possible scores on this variable was 0 to 4.

7.4 Outcome indicators

The outcome indicators used in the model were adoptive parents' reports of the adoption overall, and their child's progress in seven different areas of development. Data from the standardised measures of children or parenting stress were not included in the model because of non-random missing data: these questionnaires could only be completed by parents with children of a certain age (see chapters 6 and 9).

7.4.1 How was the adoption faring overall?

As reported in chapter 4, parents were asked how the adoption of their child was faring overall. This variable was recoded as follows: 1 = going really well, 2 = managing challenges, and 3 = struggling (combining three options on the original survey).

7.4.2 Child behaviour, wellbeing and relationships

Parents were asked about their child's behaviour, wellbeing and relationships (see chapter 4). They were asked to indicate whether their child showed strengths or challenges in 10 different areas: *general behaviour in the home, general behaviour outside the home, general physical health, emotional wellbeing, self-esteem, relationship with themselves (i.e. the parent completing the survey), relationship with the respondent's partner (if applicable), sibling relationships (if applicable), social interaction with adults outside the family* and *making and maintaining friendships*. Eight of these areas were included in the adverse outcome index: *relationship with the respondent's partner,* and *sibling relationships*, were not included in the model because these questions did not apply in all cases. Respondents could tick one of four options and these were assigned scores as follows: *serious challenges (3), moderate challenges (2), no challenges (1)* and *a particular strength (0).*

7.5 Covariates

The number of covariates that could be included in the model was again determined by the sample size, and issues of multicollinearity. Multicollinearity arises when there may be two or more covariates that are closely correlated. This could mean that is difficult to distinguish the individual effects of both variables.

7.5.1 Covariates included when modelling the maltreatment index:

The child's sex: in some studies girls have been found to demonstrate more resilient outcomes after exposure to adverse early experiences compared to boys (Rutter, 2000). Hence was important to include gender as a covariate to examine whether there were significant differences between boys and girls.

Exposure to drugs or alcohol in utero: prenatal toxic exposure could influence the likelihood of maltreatment in two ways: exposure in the womb may affect a child's behaviour and functioning in ways that pose challenges to their caregivers and/or maternal drug and alcohol problems may compromise parenting capacity (Stanley *et al*, 2010). Although parents were asked whether their child had been exposed to drugs/alcohol at a mild, moderate, significant or unknown level, data were recoded to distinguish those children who were *known* to have been exposed *at any level* to drugs/alcohol from those where this was *not known*. This approach was taken because there was a lot of missing data about this type of exposure, and in reality it is often impossible for social workers let alone adoptive parents to realistically know the level of exposure. A variable was generated that took the value of 0 if it was *not known*

that the child had experienced exposure to either drugs or alcohol, and 1 = known exposure to either drugs or alcohol or both.

Learning disability of birth parents: a variable capturing the presence of learning disability of the birth parents was included. This variable was included in the analysis as learning disability can be linked to a lack of parenting capacity (Stanley *et al*, 2010). All available data about the birth mother and the birth father was examined. This variable took the value of 0 where neither parent was known to have a learning disability, 1 = where one parent was known to have a learning disability, and 2 = both birth parents were known to have a learning disability.

Serious mental illness of birth parents*:* a variable for the presence of bipolar disorder and/or schizophrenia in birth parents was included. This was because the severity and nature of these mental illnesses can negatively affect parenting capacity (Stanley *et al*, 2010). As with *parental learning disability*, this variable was scored as 0 (neither parent known to have these mental illnesses), 1 = one parent is known to have this type of mental illness, 2 = both parents are known to have this type of mental illness.

The age of the child when finally removed from the birth family*:* the length of time the child was exposed to the birth family environment was taken into account. Since this might involve some form of exposure to neglect/maltreatment captured by the indicators (even if intermittent because the child may have spent periods of time being well cared for with relatives or in the care system), this variable is likely to approximately capture the extent (in terms of length of time) of the child's exposure to an adverse environment. To account for potential non-linearities in the relationship between the length of time the child was exposed to the birth-parent environment and the maltreatment index, five different dummy indicators were defined, with cut-offs for the age of the child set at 3,5,11,17 and 23 months old. The reference category was therefore a child that was removed from the birthparents after 23 months.

7.5.2 Factors included in modelling the outcome index:

Time in foster family*:* this variable represents the time the child spent in care (following their final removal from the birth family) in one or more foster homes. These data were not collected but were approximated by subtracting age at placement from age at final removal from birth family. For children adopted by their foster carers (including early permanency placements), this represents the time in a different foster home rather than the time spent in their current

family on a foster placement (e.g. if a child had been adopted by foster carers they had been living with since leaving their birth family, time in foster care would be 0). This approach was chosen because although children adopted by foster carers may have (legally speaking) been "in foster care", from the child's point of view they had been living continuously in the same family. Even though this may have not been a legally secure placement, it is qualitatively different to living in a completely different family as the child has continuity of relationships and environment and does not experience separation. To allow for non-linearities, two binary variables were generated: the first took the value of 1 if the child spent less than 12 months in care; the second took the value of 1 if the child spent between 12 and 24 months in care. The reference category was therefore a child that spent more than 24 months (two years) in care (not with the family who adopted them).

Difficult transition*:* a binary indicator was generated from the question *'Overall, how did your child find the process of moving to your household?'* (see chapter 5). Possible responses were: extremely difficult; somewhat difficult; neither easy nor difficult; somewhat easy; and extremely easy. In order to identify children who had a noticeably difficult move 'extremely difficult' and 'somewhat difficult' were recoded as 'yes' (1) and the other categories of response as 'no' (0). This was included as previous resach by Selwyn et al (2015) found poorly managed transitions to be associated with adoption in difficulty.

Number of foster homes*:* this variable was included because changes in caregiving environments/caregiving relationships are likely to be stressful, particularly for small children (Gilligan, 2001; Simmel et al, 2001). Adoptive parents were asked how many changes of main caregiver children had experienced whilst in foster care (excluding short periods of respite care). There were two open boxes allowing parents to add more detail about this. These data were used to code the number of different foster homes children had lived in before moving to their adoptive family. Where adopters had previously fostered the child this was not counted as a foster placement. From the number of placements a binary variable was used taking the value of 0 if the child had no or one previous foster home and 1 if the child had had two or more foster homes before moving to their current family, hence identifying children who had more disruptive experiences in the care system.

Adoptive family –single or dual parenting: parents were asked: which of the following best describes you (and your partner): single female household (1); single male household (2); one male and one female household (3); two male household (4); or two female household (5). From that question a binary variable was generated which took the value of 1 if the parent was single and 0 otherwise. This was to explore whether family structure (one or two parent family)

might affect adoption outcomes. Previous research suggests it does not, despite the fact that single carers often adopt more difficult children than couples (Brodzinsky & Pinderhughes, 2005).

Child's length of time in the adoptive family: In the general population, higher rates of mental health disorders have been found for adolescents compared to younger children (Meltzer *et al*, 2000). This same pattern has been found for *adopted* adolescents (Selwyn *et al*, 2015, Neil *et al*, 2015) and adoption may be a particularly difficult time for adopted teenagers because complex identity issues come to the fore (Brodzinsky, 2011). Hence it was important in the analysis to take account of the child age at the time of the survey, as older children would be expected to show slightly worse outcomes compared to younger children.

Because the analysis looks at the child's age at the time of the survey controlling for the child's age at placement, this variable is also a proxy for the length of time they have been in their adoptive family. As children settle into their adoptive families and the length of time they have experienced continuous good care grows, some improvement in children's development might be expected. The longitudinal English and Romanian Adoption study has charted the development across multiple domains of children adopted after experiencing early deprivation and has drawn a complex picture of developmental catch up over time. For example by adulthood the adopted children had caught up with their non-adopted peers in terms of cognitive development and they improved in terms of disinhibited social engagement. But in other areas of development (inattention and emotional problems) problems increased in adolescence or adulthood (Sonuga-Barke *et al*, 2017). Tarren-Sweeney's longitudinal study of the mental health of children in care found no overall group difference in children's mental health scores from middle childhood to adolescence, though for *individual* children stability, improvement or deterioration were all possible outcomes (Tarren-Sweeney, 2017).

7.6 Descriptive statistics

The descriptive statistics for all the variables described above (indicators of maltreatment, outcome indicators, and covariates) are all reported in appendix 3; tables A3.1 to A3.5. This also includes the pairwise correlation coefficients between maltreatment factors (table A3.4), and between outcome factors (table A3.5). The high magnitude of the correlation coefficients and their significance level support the use of a latent factor approach.

In terms of the four types of maltreatment, neglect was most prevalent with 59% of children having experienced this at a moderate or significant level. Almost half of children (47%) had

experienced moderate to very severe emotional abuse. In contrast physical abuse was less commonly experienced (18% physical abuse at moderate or significant levels) and only 4% of children were reported to have experienced moderate or significant sexual abuse. All four types of maltreatment were significantly correlated with each other at the 5% level or higher, with the highest correlations being between emotional abuse and neglect.

In terms of outcome indicators, as reported in chapter 5, the areas where parents reported adverse outcomes for their child it was mostly in terms of their behaviour in the home, and their emotional well-being with fewer concerns being shown about the child's physical health, relationships with the adoptive parents, and social interaction with adults outside the home. Significant correlations at the 5% level or better were found between the overall 'adoption faring' variable and all the eight other outcome indicators. Parent's ratings of the child's physical health correlated least well with the other outcome variables, although correlations were still significant.

In terms of the descriptive statistics relating to the covariates that are reported in appendix 3, these show that over half of children (54%) were reported to have been exposed to harmful levels of drugs or alcohol in utero. Almost one third of children (31%) had at least one parent with a learning difficulty. In contrast just 5% of children had at least one parent known to have a bipolar or schizophrenic disorder. In terms of age at removal, almost half of the children (48%) were removed from home in the youngest age band (under three months), but over one in five children (22%) were not finally removed until they were two years or older. The descriptive statistics also show that one third of children (33%) had lived with two or more different foster families before moving to their adoptive family.

In terms of time spent in foster care, for almost half of the sample (46%) this period of time between leaving the birth family and moving to the adoptive family lasted less than 12 months. For one third of children (34%) the time in care was between one and two years, and 13% of children had waited more than two years in foster care before moving in with their adoptive family. For about 7% of the sample, time spent in foster care was not reported. Children's sex and ages at the time of the survey are as reported in chapter 2, with 75% of the sample being aged 10 or under.

7.7 Estimated results

7.7.1 Factor loadings

The extent to which the different types of maltreatment influenced the latent maltreatment index was examined. The results are reported in detail in appendix 3 – Figure A3.1. In brief, these showed that all types of abuse had a significant positive effect in determining the overall level of the maltreatment index, but the most significant factors were emotional abuse and neglect. In other words, children who experienced these types of maltreatment had particularly higher levels/severity of maltreatment overall.

When looking at how parents' ratings of outcomes in the different areas loaded onto the adverse outcomes index, again all factor loadings were also highly significant. These data are reported in appendix 3 – Figure A3.2. They show that there are some indicators that are more relevant than others in determining the latent outcome index. The highest correlations with the outcome index are found for emotional wellbeing, self-esteem and general behaviour at home. The overall indicator "adoption faring" was also significantly well correlated with the adverse outcome index. These variables may have higher correlations with the outcome index because of their global nature. For example where a child has problems with relationships or behaviour, a parent may be quite likely to view this is also being an emotional problem for the child, or something that affects their self-esteem. On the other hand, the indicator of physical health and of the social interaction with adults outside the adoptive family are the least sensitive. Qualitative data from parents about children's health problems indicated a very broad range of childhood illnesses, many of which seemed quite distinct from emotional and behavioural problems. Maltreatment may have consequences for a child's physical health, but 'catch up' in terms of physical health may be more rapid and complete compared to psychological health (Rutter & the ERA team, 1998). With regard to behaviour outside the home, this domain of development may be less relevant to children's overall functioning for younger children compared to behaviour in the home. As many children in this sample were of preschool or infant primary school age, this may explain why this domain of development seems less influential.

7.7.2 Factors affecting maltreatment and children's outcomes

Below in Table 7.1 estimates of the structural parameters (i.e. the estimation of the nature and size of relationships between different variables) are presented. The first column of Table 7.1 provides estimated coefficients for the *maltreatment* index – the factors that influence the child's experience of maltreatment.

The latent maltreatment index significantly increases with the length of time the child was exposed to the birth family. Note that the effect is not linear: children that were removed from the birth parents when under 3 months have, as expected, significantly lower maltreatment index scores than those removed when aged 17 months or above. This group may stand out in particular as it contains a large number of children removed either at birth or within their first month of life - sometimes with children spending at least some of this time in hospital, so the length of exposure to the birth family environment was very minimal. It may also be that where significant risks in the home are identified at very early stage in a child's life, families may receive high levels of support or supervision. Children removed from the birth family in all groups up until 18 months of age experienced less severe maltreatment compared to children who remained in the birth family for two years or longer.

The maltreatment index was significantly higher for those children exposed to drugs and/or alcohol in utero. The maltreatment index was also higher for those children with birth parents affected by major psychiatric problems and learning disabilities. The effect, however, was significant at 5% level for learning difficulties only. Psychiatric problems were not associated significantly, when controlling for exposure to alcohol/drugs.

Column 2 of Table 7.1 provides estimated coefficients for the *adverse outcome* index. As expected, the latent adverse outcome index is significantly higher (i.e. worse) for those children with high value of the maltreatment index.

There was evidence that the time that children stayed in the care system (time in foster care) was negatively linked to the outcomes observed, all other factors being equal. Those children who stayed in the care system (in a different family to the one that adopted them) for less than 12 months had, on average, better outcomes than those who spent a longer period in care. Beyond the period of 12 months however there were no significant effects of time in care.

Children who had two or more foster placements before being placed with their adoptive family had significantly poorer outcomes compared to the group of children who had just one foster placement, or who were placed directly with their adoptive parents.

It should be also noted that, controlling for other characteristics, the length of time in the adoptive family (which is strongly linked to age) had no significant influence on the latent outcome. This concurs with some other studies which show no overall effect (e.g. Goemans *et al*, 2015, Tarren-Sweeney 2017). It is important to remember that for individual children change may occur over time, but within the sample as a whole some children may improve,

while others deteriorate - these effects cancelling each other out when looking at the group as a whole.

Those children who experienced the move to adopters as difficult were more likely to have poorer outcomes, when all other factors were taken into account. As discussed in chapter 5, children who are older at placement and who have experienced more maltreatment may be more at risk of a difficult transition - and these underlying factors may link to poor outcomes. However in this analysis these other factors are held constant, suggesting that a distressing transition may in itself be a risk factor for children's later development.

No significant differences between boys and girls were found either in terms of the latent maltreatment index or the adverse outcome index.

Finally, in line with previous research, it appeared that family structure did not have a significant effect in determining outcomes: the coefficient associated with being a single parent is –in fact- small in magnitude and not statistically significant.

Table 7.1: Factors affecting the maltreatment and outcome indexes

VARIABLES	Maltreatment equation	Outcome equation
Latent maltreatment		0.175***
Prenatal toxic exposure to drugs, alcohol in utero	0.330**	
Birth parents with Learning Disabilities	0.240**	
Birth parents with Bipolar disorders/Schizophrenia	0.214	
Removed from birth parents when under 3 months old	-2.273***	
Removed from birth parents when 3-5 months old	-0.875**	
Removed from birth parents when 6-11 months old	-0.786***	
Removed from birth parents when 12-17 months old	-0.612**	
Removed from birth parents when 18-23 months old	-0.217	
Female	0.035	-0.071
Time spent in foster care less than 12 months		-0.314*
Time spent in foster care 12- 24 months		-0.128
Length of time in adoptive family		0.02
Child found move to adopters difficult		0.581***
Two or more foster homes before moving		0.283**
Adoptive family single parenting		-0.02
Observations	327	
Log-Likelihood	-3608.306	
Degrees of freedom	73	
AIC	7362.611	
BIC	7639.279	

Notes: Robust standard errors. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

7.8 Estimating the association of other factors with children's outcomes (Post-estimation analysis)

7.8.1 Sensitivity analysis[7]

The analysis explored whether *exposure to drugs or alcohol in utero*, *learning disability of birth parents and serious mental illness of birth parents* also had a direct effect in determining children's outcomes (i.e. not just through the increased risk of maltreatment)[8]. This was particularly of interest because of the relatively large numbers of children removed at or shortly after birth. E*xposure to drugs or alcohol in utero and learning disability of birth parents* in particular were found to exert a positive and significant effect in determining the adverse outcome index at 5% and 1% levels respectively. On the other hand, the effect of mental illness of the birth parents was not significant at conventional levels. In other words, those children exposed to drugs or alcohol in utero and those with birth parents affected by learning disability were more likely to have worse outcomes, holding fixed all other factors.[9]

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[7] To test the robustness of our findings, we ran a series of robustness checks and modification of the main specification reported in Figure 7.1. Conventional model selection procedures (AIC and BIC criterion) suggest that the specification in place is the best-fitting model, in particular when accounting for model complexity much more heavily. However, results of these sensitivity checks are important because they help to test some hypothesis

[8] For this specification, goodness-of-fit statistics provided mixed results: the Akaike Information Criterion (AIC: 7357.199) is slightly better that the one obtained for the main specification but the Bayesian information criterion (BIC: 7645.236) is slightly higher (worse) because the model is more complex.

[9] We also checked formally whether the gap in terms of outcomes between children exposed to drugs or alcohol in utero or with parents with learning disabilities or mental health problems and those who do not have such factors in their background widens as they grow up. This might be the case if certain difficulties (for example learning difficulties) are more measurable or apparent at older ages, or if difficulties such as learning delay or foetal alcohol spectrum disorders begin to cause secondary problems (such as problems adjusting to the school environment). We tested this by introducing interaction effects of the birth-parents binary variables with age of the child. This specification fits the data slightly less well (AIC: 7362.898; BIC: 7662.305), in particular because of the added complexity. We found no strong significant evidence to support the proposition that the gap in outcome is widening with child age in our data, but this is an area where further research is warranted before firm conclusions can be made.

We also ran sensitivity tests to see whether the latent child's outcome is significantly affected by the loss of an adoptive parent (through parental separation, divorce or death), and whether the child was

7.9 Chapter summary

Variables characterising the adoption process are potentially affected by a number of important problems. These include measurement error, correlation with other observed variables, systematic errors such as poor recall by respondents, inaccuracies in reporting and missing values. Standard approaches generally ignore the first two problems, assume that the third does not happen and either remove cases with missing values or to impute missing values from observations of other respondents. They also tend to focus on bivariate correlations rather than developing more advanced statistical models that could provide more robust evidence to inform the public debate and influence professional practice.

Latent factor structural equation modelling is a flexible approach that enables the testing of hypotheses about both measurement (how well observed indicators serve as a measurement instrument for the underlying latent construct/s) and structural relations (how latent construct/s are related to each other and with a set of observed variables believed to be important determinants or consequences of the latent constructs) simultaneously and within a single framework. The main limitation of the analysis is that there is one informant for all data - the adoptive parent. As parents are reporting on both historical factors in the child's life, and the child's current outcome, there is a possibility that parents whose children are thriving may interpret or rate historical factors as being more benign compared to when children are doing poorly. However to reduce this *justification bias* as far as possible by detailed descriptions of maltreatment were provided, and descriptions defining the level of severity. It is typical in adoption research that there is missing data about children's backgrounds, as often not all available information is known to social workers (or even birth parents), and background information may not be reliably passed on to adoptive parents. However this model deals with missing data by using other information pertaining to individual cases, and information about other cases in the sample to estimate values.

The results of the analysis suggest that in order to improve outcomes for adopted children it is important to reduce pre-placement adversity at various stages of the child's life: pre-birth, whilst at home with their birth family, and during their time in the care system. Where children do move from foster care to their adoptive family it is important to plan and support these moves carefully.

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placed with a birth sibling. Including these variables however caused convergence problems and little improvement of the model goodness-of-fit statistics at the costs of increasing model complexity.

The identification of factors affecting children outcomes could be used in practice to help plan to meet the future support needs of children being placed for adoption. Although the presence or absence of certain risk factors does not automatically determine that the child will or will not have problems, where high levels of adverse experiences are known careful attention must be paid to assessing children's development, considering the provision of preventative/early intervention services, and helping adoptive parents to understand early indicators that future support services are required.

The findings about factors that did not affect children's outcomes are also important, particularly at the stage of recruiting and preparing adoptive parents. Outcomes were no better or worse for couples versus single parents. This suggests that when matching children with a prospective adoptive family structure per se should not be strong consideration - the focus should be on the capacity of the parent or parents to meet the child's individual needs and couples should not automatically be assumed to offer more than single parents. Views of either professionals or prospective adoptive parents that boys are likely to present more future challenges than girls could be challenged as this research did not find any significant differences in outcomes according to the child's sex.

The key findings from the analysis are summarised below:

- Children experienced significantly higher levels of maltreatment where they had been exposed to drugs or alcohol in utero, where one or both of their birth parents had a learning disability, and where they had stayed longer in the birth family environment.
- Children's outcomes at the time of the survey as reported by adoptive parents were affected by range of factors each of which were significant when controlling for all other factors. Factors associated with poorer outcomes were as follows:
    - higher levels of maltreatment
    - children showing moderate or high levels of distress when moved from the foster carer to the adoptive family
    - children spending more than 12 months in care
    - children having two or more foster homes before moving to their adoptive family
    - children who had been exposed to drugs or alcohol in utero
    - children whose birth parents had a learning disability
- children's outcomes were not significantly affected by:
    - sex of child
    - structure of the adoptive family (single parent versus couple)

- parental mental illness (birth parents)
- length of time in the adoptive family

Chapter 8 – Outcomes: Education

8.1 Introduction

Many adopted children, affected by early trauma and neglect, will experience additional challenges in their learning and interactions with peers and teachers in school (Adoption UK 2014). National statistics show that attainment for both looked after children and children in need is much lower than for non-looked after children (DfE, 2018). Adopted children's' school performance and language abilities can be poorer, and adopted children are at higher risk of developing learning problems (Van Izendoorn *et al*, 2005). Children spend a large proportion of their lives in school, and how school systems and the teachers work with and support adopted children can have a significant impact on their wider emotional and social wellbeing, as well as affecting their ability to reach their academic potential.

In 2014 the UK government showed acknowledgment of the disadvantages of adopted children and extended the Pupil Premium eligibility to include all children adopted from care in England. This extra educational funding, set up to narrow the attainment gap between disadvantaged pupils and their peers, provides £1,900 to help support each child each year. Virtual school heads have the responsibility of ensuring that this money is spent on the children for whom it is provided and they need to demonstrate how this funding is improving outcomes. Further support was given in 2015, specifically in the Yorkshire and Humber area when the Department for Education awarded a grant to PAC-UK and the Yorkshire & Humber Adoption Consortium to support families and develop capacities of schools and local authorities to better meet the educational needs of adopted and other permanently placed children.

The survey included a separate section covering education, with skip logic presenting questions to those who confirmed that their child was of school age. In addition, questions related specifically to support in school were included in the support section (see chapter 11). Observation of the data showed that some of these respondents were parents of 3-4 year olds who were still in nursery or day care. In order to ensure results applied to school and educational experiences (as opposed to the huge variation in day care settings), only responses relating to the 201 children of reception age and over were included in the analysis here.

8.2 Types of school attended by children

Parents were asked to indicate the type of school their child was currently attending. As shown in Table 8.1 below, the vast majority were a day pupil in a state school (n=161, 80%; a few were a day pupil in a private school (n=9, 5%). Six were in a further or higher education college. Two children were boarding, one of these in a private school. Twelve children (6%) were either

in a special unit within a state school or a special school for pupils with extra needs. Three children were being home schooled by choice. Three children were in Pupil Referral Unit (PRU) or similar. Five young people were not attending any form of education[10].

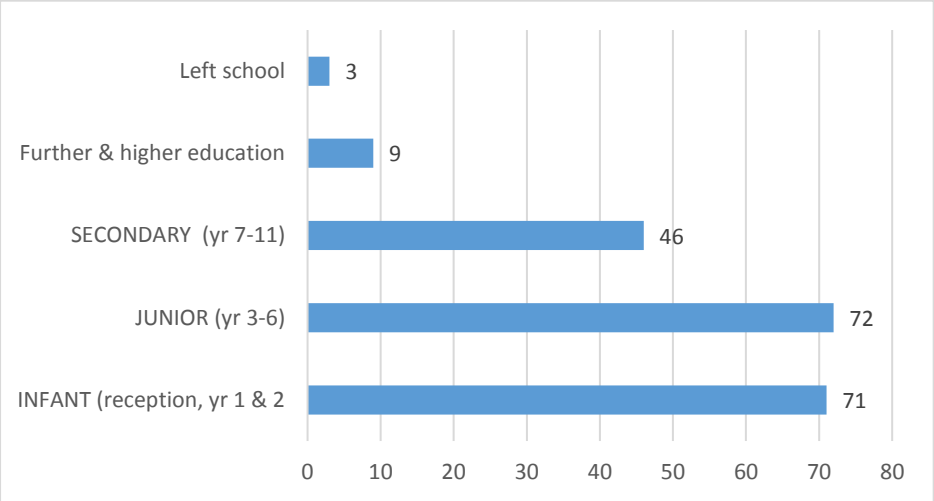
Table 8.1: Distribution of the children across different types of educational provision

Type of school	Number of children
State school or nursery school - day pupil	161 (80%)
State school - boarding pupil	1 (0.5%)
Special school for pupils with extra needs	8 (4%)
Special unit for pupils with extra needs within a state school	4 (2%)
Independent or private school- day pupil	9 (5%)
Independent or private school- boarding pupil	1 (0.5%)
Sixth form college/college of further education	5 (2.5%)
Home educated/flexi education	3 (1.5%)
Pupil Referral Unit / Pupil Re-integration Unit / Alternative Provision (AP)	3 (1.5%)
Children's hospital school	1 (0.5%)
Not attending any form of education	5 (2.5%)

As shown in figure 8.1, reflecting the greater proportion of children focussed on in the survey who were in the younger age groups, the majority (n=143, 71%) of school age children were being educated in year groups in the primary range, with an almost equal spread between in infant school year groups and junior school year groups. Twenty three per cent (n=46) were in secondary school year groups and a small proportion (n=12, 6%) were beyond secondary school (all these figures include home educated children).

[10] Two had left school (one working as an apprentice, for the other we have no information). One young person was a school refuser – on roll at a PRU but not attending. Another was awaiting the local authority to arrange his future education (his parent had removed him from two education provisions due to his mental health and the lack of support he was receiving). For another (17 year old) who was out of education, no information was provided.

Figure 8.1: The education stage of children



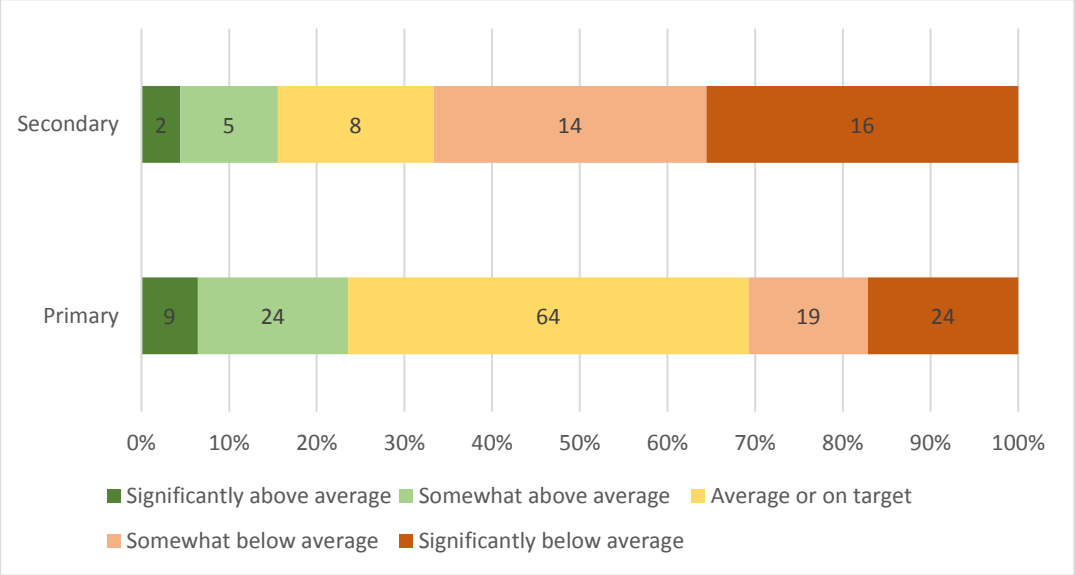
8.3 Current achievement

Parents were asked to describe their child's school performance in both core academic subjects (such as maths, english, science, humanities), and other subjects (such as music, drama, art, physical education). Parents (n=196) rated their children according to whether they were felt to be '*significantly above average'*, '*somewhat above average'*, '*average or on target'*, *somewhat below average'*, or '*significantly below average'*. Combining the two above and below average groups:

- 40% (n=78) scored their child as '*significantly* or '*somewhat'* below average,
- 38% (n=75) thought their child's achievement was '*average'*
- 22% (n= 43) chose either '*significantly* or '*somewhat'* above average.

As shown in figure 8.2 below, whilst two-thirds parents of primary school pupils thought their child's achievement in core subjects was at least average, only a third of secondary school children in the sample were said to be average or above in core subjects (the figures in 8.2 exclude the small number of children who were above year 11).

Figure 8.2: Parents ratings of child's achievement in core academic subjects: primary and secondary comparison

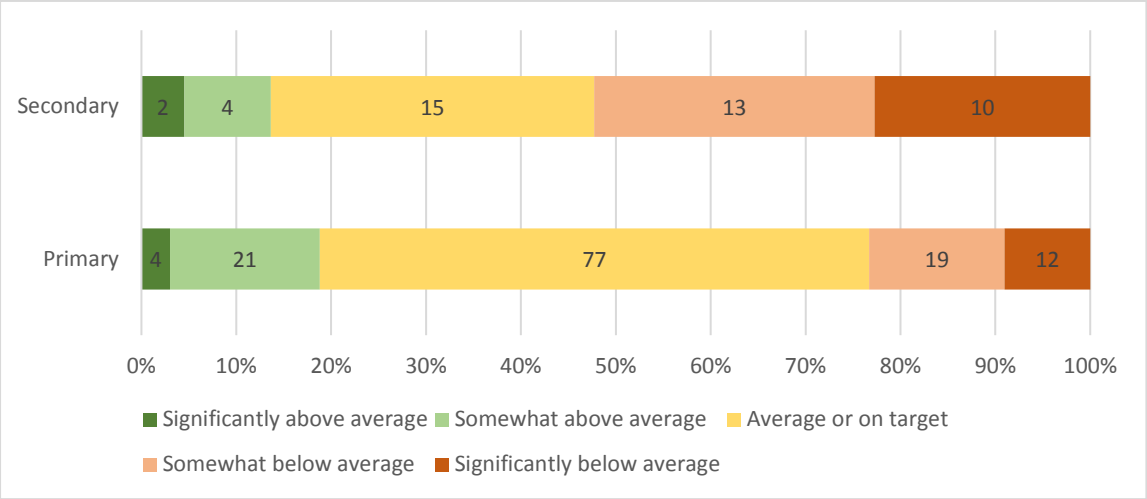


Parents of 188 primary and secondary school pupils rated their child's achievement in other (non-core) school subjects, such as music, drama, art, physical education:

- 31% (n=59) scored their child as '*significantly* or '*somewhat*' below average,
- 51% (n=95) as '*average'*
- 18% (n= 34) as '*significantly* or '*somewhat'* above average.

Overall, a slightly higher proportion of parents thought their child was at least average in non-core subjects compared to core subjects (core = 60%; non-core = 69%). As shown in figure 8.3 below, again there were differences between primary and secondary school age children. Most children in primary school were scored as average or above (102 out of 133, 77%). A smaller proportion of secondary school children in the sample were said to be average or above (21 out of 44, 48%).

Figure 8.3: Parents ratings of child's achievement in non-core academic subjects: primary and secondary comparison



8.4 Children with special education plans

Nearly 1 in 5 (n=38, 19%) of the 201 children of school age in our sample had an Education, Health and Care (EHC) plan (or the earlier versions of a Statement of Educational Needs or a Learning Difficulty Assessment). Four additional children were currently being assessed for one, and two parents explained they were pushing for an assessment but had encountered blocks to the process. Eleven of the children with an EHC plan were attending either a special unit within a state school or a special school for pupils with extra needs. Twenty-two children were day pupils in a state school, with the remaining children being out of education or in special alternative facilities. The proportion of adopted children in this sample with an EHC plan is much higher than for all pupils in England, where the percentage reported in 2017 is 2.8% (DfE, 2017b) and more similar to looked after children and children in need where the percentages reported in 2017 are 26.7% and 20.6% respectively (DfE, 2018)

For core subjects, children with special education plans 73% (27 of 37) were performing below average, 16% (n=6) were on target and 11% (n=4) were above average. Of the 38 children with a special education plan, in many cases it seemed that children's problems were wider than just in the educational field. For example in terms of how these 38 parents rated the adoption overall only 3 parents (8%) rated the adoption as 'going really well'. Half of parents felt they were 'managing challenges' (n=19, 50%) but 42% (n=16) were 'really struggling'. The proportion of parents in this subsample that rated themselves as 'really struggling' was twice that of the total sample (42% compared to 21%).

The picture of these children with special educational needs having quite complex difficulties is further illustrated looking at what parents also told us about their children's developmental problems. Most parents (n=36, 92%) of the 38 children in this subsample replied 'yes' in answer to a question which asked if their child had been diagnosed with or treated for a developmental problem. The vast majority of these children (n=34, 87%) were said to have a diagnosis related to emotional or behavioural problems (including Autistic Spectrum Disorder or Foetal Alcohol Syndrome). Forty one per cent (n=16) had a diagnosis of learning disabilities. Amongst all pupils nationally, the biggest category of need for children with an EHC plan was autistic spectrum disorders (27%) (DfE, 2017b)

8.5 Exclusions

Twenty one (11%) children had received a fixed term exclusion in the last year (there were no permanent exclusions). This is over twice as high as the national rate, where the overall rate of fixed period or permanent exclusions was just over 4% (across state-funded primary, secondary and special schools) in 2015/16 (DfE, 2017b). The proportion of exclusions rose to 22% (10 out of 45) when looking at those of secondary school age (again this is over double the national rate in state-funded secondary schools, where the number of exclusions in 2015/16 was 9%). Thirteen of these children who had received an exclusion were identified with special educational needs (EHC/SEN), similar to the national picture where pupils with identified special educational needs accounted for almost half of all permanent exclusions and fixed period exclusions.

For half (n=10) of the children who had been given fixed term exclusions no alternative education provision was given during the fixed term exclusion, a further three parents referred to work being sent home or electronic learning being offered. Two had time in a PRU or inclusion room and all others included no clear information on alternative provision, although one stated '*very little'*. Qualitative data, obtained from an open question which asked parents to provide more information on their child's key challenges in relation to school, showed that many of the children who had experienced an exclusion had difficulties which meant they struggled to cope in the school environment. Common issues were:

- Difficulties with conforming and following rules, '*My child finds the rules at school really hard, especially positive discipline, as he thinks of himself as an adult.*'
- Anxiety and stress made worse by the busy school environment, '*Cannot cope with school environment. Too loud, too busy, too regimented. Doesn't feel safe.*'

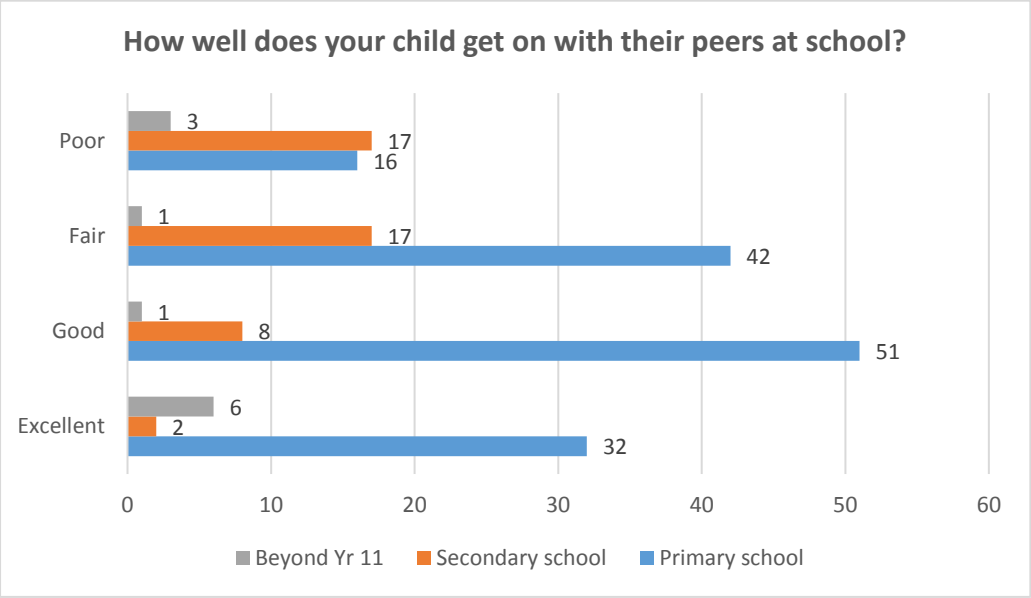
- Issues related to attention and concentration, '*Struggles to focus on work. Easily distracted and disengaged.*'
- Lack of self-esteem/pride in success, '*Lack of resilience, reinforces how rubbish she feels…*'
- Limited understanding of instruction and organisational skills, '*[He] usually doesn't know what he is supposed to be doing, won't have right equipment (lost 4 PE kits between Sept and Dec!). Has difficulty understanding instructions so frequently does something different to what he is supposed to and then gets annoyed when pointed out?'*

Some parents thought that the school's lack of understanding of their child's adoption related issues made things more difficult for their children.

8.6 Peer relationships

Parents were asked to rate how well their child got on with their peers at school, selecting answers from '*excellent'*, '*good'*, '*fair'* and '*poor'*. This question was answered by 196 parents. Most school age children (n= 160, 82%) were thought by parents to get on at least reasonably well with their peers, (scoring '*fair'*, '*good'* or '*excellent'* with regard to their relationships). As can be seen in figure 8.4 below, the proportion raised to 89% (125 out of 141) when separating out primary school age children but dropped to 61% (27 out of 44) when looking at pupils in secondary school only. Over a third of secondary school children (n=17, 39%) were said to have '*poor'* relationships with peers, compared to 11% (n=16) of primary school pupils. Results showed considerable diversity amongst the sample: 23% (n=10) of secondary school and 59% (n=83) of primary school pupils had '*good'* or '*excellent'* relationships with peers. Of the children with special education plans whose parents answered this question (n= 37), 62% (n=23) said that their child's relationship with peers was either '*fair'*, '*good'* or '*excellent'* and 38% (n=14) answered poor.

Figure 8.4: Parent's perceptions of the quality of adopted children's peer relationships



Qualitative data, collected from responses to a question which asked parents to add further information about their child's relationships with peers at school, revealed that many children struggled with social skills. One hundred and thirty-six parents provided extra information and for over half these parents their text showed how friendships were a key difficulty for their child. Some children found understanding friendships difficult:

'Plays with others but has no significant friends no understanding on how to make these or why she should care.'

Some children found *maintaining* friendships difficult:

'He annoys them. He can make friends easily but not maintain meaningful relationships. His peer usually find him annoying and try to avoid him.'

'Friendly and quick to make friends but can't sustain them.'

Several parents felt that their child's difficulties with friendships were largely a factor of their developmental age being lower than their peers at school,

'[Girl's name] gets on better with children younger than herself. She has friends at school who understand her 'different' ways but the age gap is widening fast.'

'He is below his age socially and emotionally which can cause obstacles with his peers.'

Difficulties communicating with others, or understanding other's communication and emotion could also be a barrier to friendships,

'He still struggles to form lasting friendships which may relate to his delayed sentence formation and so inability to hold conversations.'

'Not being able to understand other people's emotions can cause problems for him.'

Some parents noted how peers seemed to avoid their child because of their child's inappropriate responses to others. Such behaviours included kissing or attacking others, wanting to control them or over–reacting to incidents:

'…she does not have any friends and frequently has difficult interactions with children during playtimes / lunchtimes. Sometimes hits / hurts other children. Sometimes kisses other children.'

'He is a popular boy but can be 'too physical' at times. He will react to provocation and prefers to 'sort it out' himself rather than tell a teacher (which is what he's been told to do).'

'Over reacts to incidents/comments/difficulties, is hyper-vigilant, low self-esteem, and cannot 'let go'.'

'Makes friends, but his need to control others makes him volatile if they don't co-operate.'

A few parents mentioned how their child gravitates to others with issues:

'Peer relationships are very difficult. Gravitates towards other vulnerable children and has unhealthy fascination with their life stories.'

'He seems to gravitate to negative peers and then gets into trouble.'

The child's tendency to get bullied was also raised by some parents, because they were so keen to be liked or easily triggered emotionally,

'She is easily bullied, because she is very small and immature compared to her contemporaries. She wants to be loved, so can be easily led astray.

'Has difficulty as so keen to be liked tends to be exploited by others.'

Other issues experienced by some children, possibly stemming from attachment problems, were an over possessiveness of friends and difficulty coping with the loss of friends,

'[She] has had difficulties with friendships being very intense and difficulties when friends moves away.'

'She is too clingy and overbearing sometimes. She gets incredibly upset if her best friends don't want to play with her.'

A couple of parents highlighted how a school's approach to their child made a difference to their child's experience of friendships – made apparent when they moved school,

'[Peer relationships have] improved recently, has struggled previously to such an extent we had to move schools. Now in a much better school who have worked hard to help her with her additional needs.'

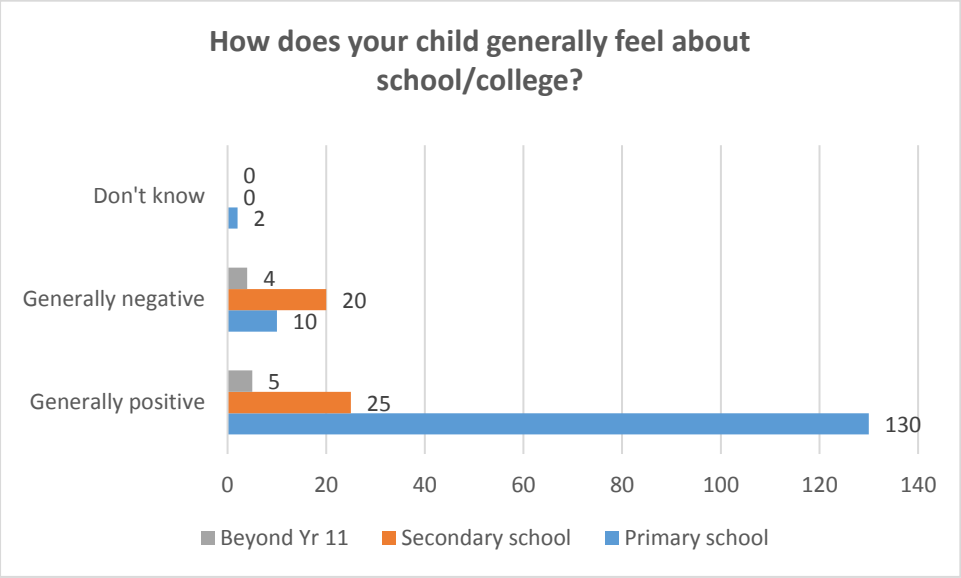
Of course many children raised in birth families have issues with friendships throughout school. One parent pointed out how difficulties with friendships was a 'normal' issue for girls of her daughter's age and therefore not necessarily related to their adoption:

'There were some issues in year 6 which appears to be a regular occurrence in girls.'

8.7 General experiences of school

Parents were asked to rate how well their child generally feels about nursery/school/college, selecting answers from 'generally positive', 'generally negative' and 'don't know'. Most (160 of 196, 82%) parents thought their child generally felt positive about school. However, as can be seen in figure 8.5 below, the proportions were quite different when comparing children at different levels of education. The vast majority (130 of 142, 92%) of primary school age children were thought to generally feel positive about school but only 56% (25 of 45) of secondary school age pupils thought to generally feel positive about school. The proportion of children thought to feel positive about school was also lower for those with an EHC plan, SEN or Learning Disability Assessment (22 of 35, 63%).

Figure 8.5: Positive and negative feelings about school overall



Parents were asked, in an open question, to explain further what their child's key challenges were in relation to school. One hundred and sixty eight people provided answers in response, although some included text to state that their child was doing well in school and had no significant problems, or no more problems than any other 'typical' child at school.

A range of issues were referred to when discussing significant challenges faced by their child. One of the most common issues was difficulties with attention and listening,

'His inability to concentrate on one tasks for more than 5 minutes without the need to move off and do other stuff. He can only really engage with the curriculum with one-to-one adult support…'

'Her attention span - she is very easily distracted by noises, other people and spends time helping others rather than focussing on doing her own work.'

Specific learning issues were also raised by many parents,

'Learning, she can recall one day but next day it's like she's never seen it. Maths is completely alien to her, has struggled understanding any abstract concepts (e.g 7 +0 will produce a range of guesses). Reading is significantly delayed, but made some progress as can do most three letter words on sight now. Her learning issues seem similar to those with FASD.'

Some parents referred to the negative effect that the systems of authority within a school, and the way 'inappropriate' behaviour is dealt with, had on their child:

'…seems to have a compulsion to do the thing she has just been told not to, takes everything personally, i.e. Hates teacher if disciplined, feels things are unfair etc.'

'Regulating his emotions and believing that he is good. He is routinely on "red" and sent to the head's office and this creates a vicious circle as his behaviour becomes very difficult when he is shamed.'

'My child finds the rules at school really hard, especially positive discipline, as he thinks of himself as an adult.'

Several children were said to struggle with the overall school environment – stating factors such as the noise, number of people, changes in routine, overstimulation, and constant pressure to do well,

'Cannot cope with school environment. Too loud, too busy, too regimented. Doesn't feel safe.'

'Can't remember where to be or what to take. Hasn't eaten at lunch for 5 days as cannot cope with crowded dining hall.'

'Becomes over stimulated in busy situations, now in a small school with a small class size. Has a full time one to one, due to overstimulation which brings on behavioural issues. He can then be very unpredictable and run off or hit.'

Other common issues raised were the child's emotional and social problems, poor self-esteem, and poor understanding of instruction and organisational skills. Some parents additionally noted how support given and strategies used by their child greatly helped them:

'He struggles to sit and concentrate and chewing is his coping mechanism when he is sitting and concentrating in some lessons - writing/English. He has chew buddies and clickers which really help him.'

In contrast other parents felt that the schools or particular teachers' lack of understanding of their child's adoption related or learning issues made things more difficult for their children,

'Anxiety, insecure, doesn't understand relationships, lack of resilience, reinforces how rubbish she feels, too many changes in routine/ unreliable structure, staff who don't understand'

'As typical with education, an extremely poor understanding and a failure to address the needs of the child. Misuse of Pupil Premium plus having next to no impact for the child.'

'Some challenges interacting with staff who don't always understand her emotional and social needs.'

As the last quote demonstrates, knowledge and understanding of individual children's needs and difficulties is a crucial part of improving their school experience. Seven children (including four who had been excluded at one point) had lengthy period of time away from school due to their inability to cope with it or because of the schools lack of understanding of, or ability to respond appropriately to their adoption related issues. A few refused to go to school, or had been withdrawn by their parents:

'Began school refusing in year 5 anxiety became so bad had to home ed year 6.'

'Six months withdrawn from secondary school due to their lack of understanding re Attachment Disorder Anxiety and the effects of being bullied on adopted child.'

For a couple of children, even with a high level of support, time away from school was supported by professionals:

'Had to remove her from mainstream school as unable to cope even with school and CAHMS support (done in agreement with school and CAHMS).'

The issues that adopted can children face, such as attachment problems, cognitive developmental delay, emotional issues, conduct problems, attention deficits and inappropriate behaviour need to be understood and carefully managed by schools. Some parents spoke of constant battles to make sure that their child is supported in school (for further details on support for adopted children in school see chapter 11):

'We've had to fight and fight for school to use the PP in the right way and we're still fighting. The girls are bright but behind … and the school just does not get what it means to help them catch up, or how much pressure we're under at home on all the other stuff and have/little no time to do the school's job for them.'

'They need focused support educationally and we're having to push hard for this - as if we didn't have enough on. When she was at her most angry, the school were clueless on how to deal and left her very unboundaried - I had to write the behavioural plan for them. They're a caring team, but they just don't get it.'

Some contrasted different schools and teachers, showing how the right support, attitude and environment could help improve things for their child:

'The first choice of secondary school we made for our children was a disaster, it led to both going into crisis and sent the family into crisis. This school had a very rigid behaviour system where there seemed to be no flexibility to meet needs of the individual and little understanding of the problems and challenges facing children with attachment issues. Since moving schools things a bit better.'

'He has anxiety problems and sleep problems relating to his trauma and was not able to go to school as others - he had tuition in the children's home and then in the pupil referral unit. The virtual head has been brilliant at developing a personal education program.'

8.8 Chapter summary

This chapter reported on the experiences of school for the adopted children in our survey. Going to school was enjoyed by most children, at least in the primary school years, and some adopted children were doing really well in school. But compared to the general population adopted children were showing many more difficulties in school. Difficulties varied from child to child but problems with attention, behaviour, emotions and developmental disabilities were common and many parents felt that the school systems or environments were not well adapted to their child's needs. The 2014 extension of the Pupil Premium eligibility in England to include all children adopted from care demonstrates the government's recognition of the difficulties adopted children can face. This section of our survey demonstrates a need for the system of virtual heads to ensure that Pupil Premium funds are having an impact on the education of adopted children. It also gives weight to the argument that schools need to work towards becoming 'adoption friendly' with specialist training for staff about the difficulties that many of

these children face. Additionally projects like the Yorkshire and Humber PAC-UK, looking at the best way of supporting adoptive families and developing the capacities of schools and local authorities to better meet the educational needs of adopted and other permanently placed children, are important steps towards greater understanding of issues in schools.

Key findings were as follows:

- **Peer relationships at school:** Most school age children (83%) were said to get on at least reasonably well with peers, though children in secondary school had more problems with this than those in primary school. But for children experiencing problems in school, difficulties with peers were often part of the overall picture. Problems with peer relationship were thought by parents to relate to children being of lower developmental age to peers, difficulties understanding how relationships work and poor social skills leading to other children avoiding them.
- **Plans for special education needs:** Nearly 1 in 5 (19%) of the 201 children of school age in the sample had an Education, Health and Care (EHC) plan (or the earlier versions of a Statement of Educational Needs or a Learning Difficulty Assessment). Many of these children had difficulties that spanned a range of areas – not just school.
- **Plans for special education needs and mental health problems:** The vast majority of the children with special education plans had a mental health diagnosis (87%) and 41% had a learning disability.
- **Fixed term exclusions:** Of the 201 children in the total sample, 11% had received at least one fixed term exclusion in the last year. This is over twice as high as the national rate (4% in 2015/16). Over half of those that had been excluded had a special education plan.
- **Problems in secondary school**: Problems related to education were much more common for children in secondary school than for those in primary school. This may reflect differences in the profiles of older versus younger children in our sample. It may however also indicate the secondary school environment is less responsive to the complex needs that some adopted children have.

Chapter 9 – Outcomes: The impact of adoption on adoptive parents

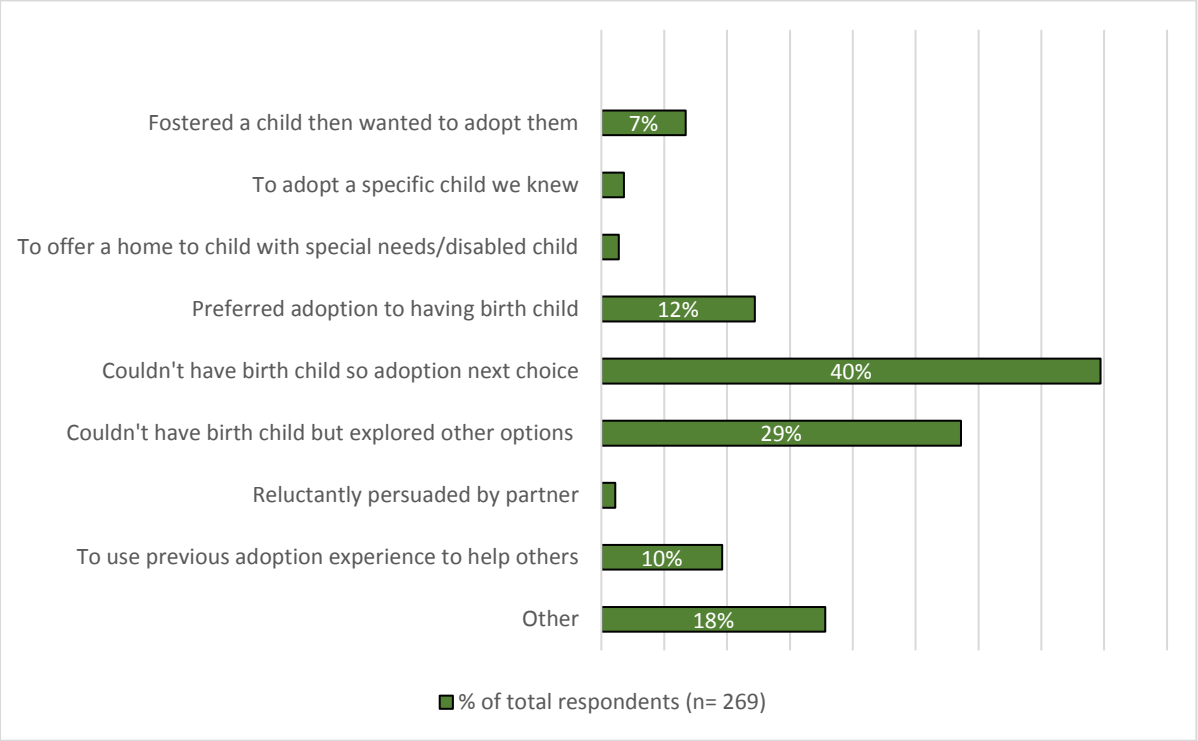
9.1 Introduction

This chapter reports on findings exploring the experiences and feelings of adoptive parents from early on in the process of adoption, through the matching and placement phase and on to experiences of adoptive parenthood. Parents were asked about their motivations to adopt, whether their preferences for the kinds of children they wanted to adopt had changed during the process and whether their expectations of family life had matched up with the reality. Pre-placement experiences of receiving support and information were also gathered. A standardised measure, the Parenting Stress Index (PSI), which assesses child characteristics, parent characteristics, the family context and life stress events, was also used to gain an objective measure of the impact of adoption on adoptive parents.

9.2 Motivation to adopt

We asked respondents what led them into adopting their child. Respondents could tick all responses that applied. The possible responses can be seen in figure 9.1 below.

Figure 9.1: Parent's motivations to adopt (percentages who chose each option)



Not all respondents completed this section of the survey (n= 269). The majority of respondents ticked one option although some gave more than one response reflecting the complex nature of motivation for some. Previous research (e.g. Ward, 2011) suggests that although infertility

is a significant part of many people's motivation to adopt, other factors come into play such as the desire to help a child with complex needs. There were a number of cases where respondents had ticked 'other' and gone on to outline difficulty conceiving biologically, for example due to secondary infertility (being unable to have further children after having a biological child) or repeated miscarriages, when they had not ticked either of the responses about being unable to have a biological child. A binary variable was created to distinguish the parents who had mentioned difficulties in achieving parenthood by birth from those who had not mentioned this as a motivation. Parents who had chosen either of the options including 'couldn't have a birth child' and any parents who had mentioned difficulties with infertility or miscarriage in the comments were coded in one group, and all other parents in a second group. This then gave us a variable which told us whether or not adopters had been motivated to proceed with adoption due to difficulties having a biological child.

The majority of the 269 respondents (n=193, 72%) had indicated that the inability to have a birth child was at least some part of their motivation to adopt. As can be seen in figure 9.1 above, some of these adopters moved quickly to adoption (n=107, 40%) whilst others exhausted other possibilities before concluding that adoption was the only way they could have a child (n=77, 29%). The remainder of those that had problems having a birth child had not ticked either of these options but indicated motivation due to these difficulties in the text. A preference for adoption over having a biological child was expressed by 12% (n=33). A similar proportion (n=26, 10%) had personal experience of adoption and wanted to use the experience to help others and 1% (n=4) wanted to offer a home to a disabled child or a child with considerable needs. A small proportion of adopters were motivated to adopt through fostering a child and then wanting to make them a permanent part of their family (n=18, 7%), five people adopted a child they already knew (2%) and three people were persuaded by a partner (1%).

As infertility and difficulties having a child biologically are such a significant part of the majority of adopters' initial motivations, many families may start their adoption journey looking for a child as close in characteristics to the baby they could not have (Ward, 2011; Bausch, 2006; Geen *et al*., 2004). However, contemporary adoption practice aims to achieve permanence and stability for looked after children. Many of these children are labelled *hard to place* i.e. older children, those with physical or learning disabilities, children from black and minority ethnic backgrounds, sibling groups and children with long-term medical needs (Farmer and Dance, 2015). Thus, the reality of the types of children available, and the complexity of their needs, may come as a shock to prospective adopters and/or necessitate a period of reflection

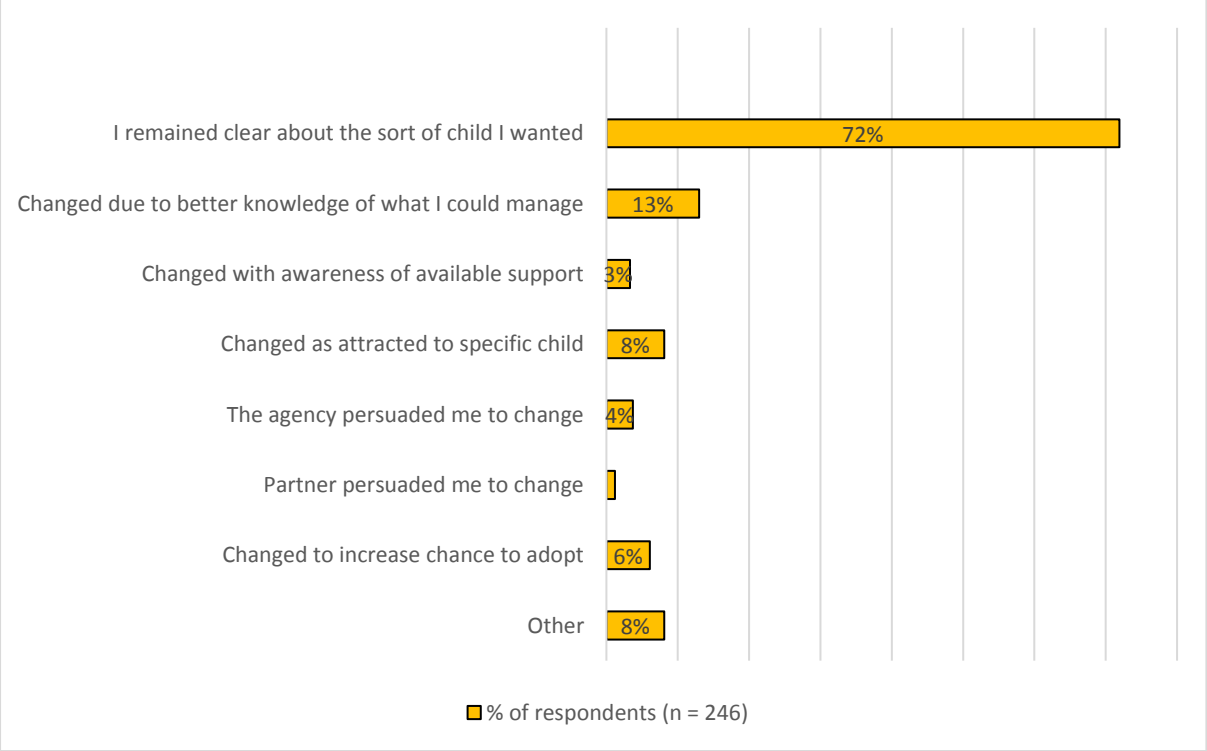
and adjustment (Hoffman, 2013; Dance, Neil & Rogers, 2017). As such, the preparation and assessment phase of adoption is key to helping prospective adopters to consider adopting children from care. Initial motivations and preferences need to be 'stretched' in order to help preferences match up to the realities of the children available for adoption (Dance *et al*, 2017).

9.3 Had adoptive parents views about the characteristics of the child they would like to adopt been changed during the adoption process?

Previous research has suggested that it is important that adoptive parents have realistic expectations of adoption and the needs of the child they are adopting; although prospective adopters may need to adjust their initial ideas, their 'preferences' should not be 'stretched' too far in terms of the what type of child they feel they can parent (Barth & Berry, 1988; Farmer & Dance, 2015).

Parents were asked whether, at the time they were matched with their child, they felt they changed their initial preferences regarding the sort of child they wanted to parent. They could tick all that applied and the responses can be seen in figure 9.2 below. In total, 246 adopters answered this question. Most respondents ticked only one option but some chose more than one, perhaps due to the interplay of several factors on their motivations and preferences.

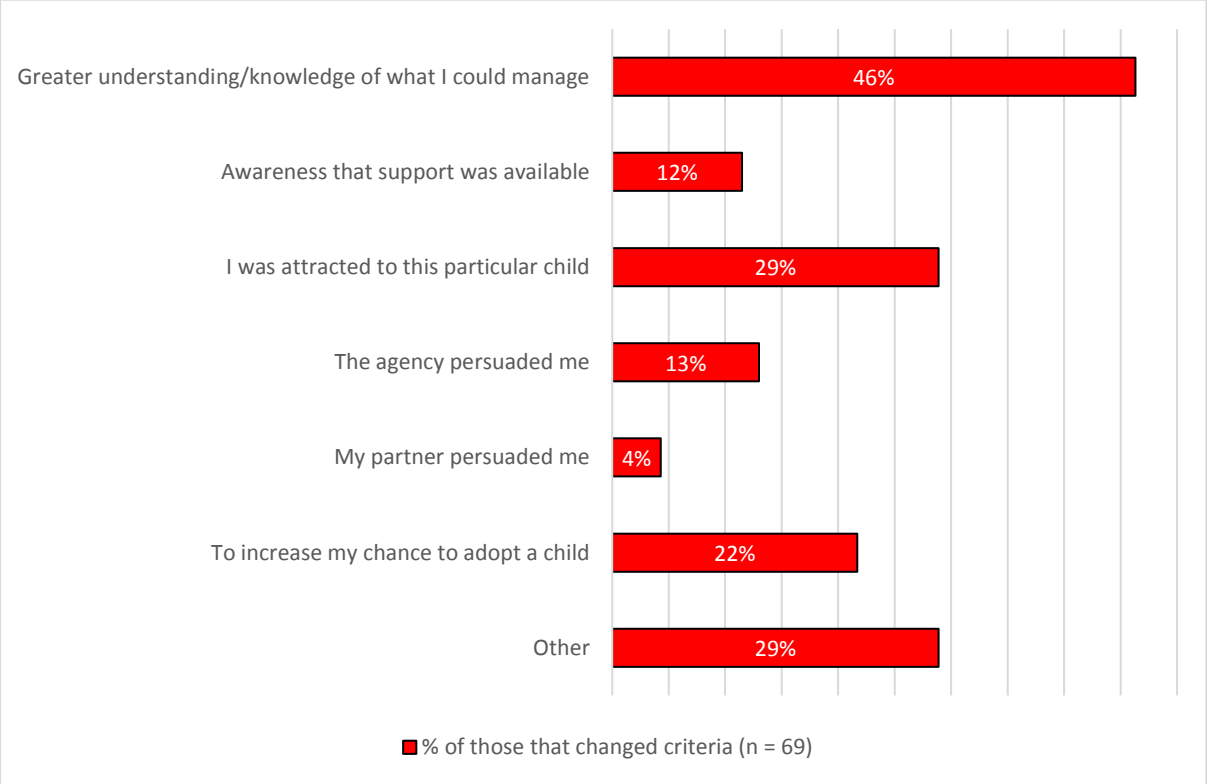
Figure 9.2: Changes in initial preferences at matching stage



As shown in figure 9.2, nearly three quarters of adopters who answered this question (n=177, 72%) said that they remained clear about what sort of child they wanted and could parent. The bulk of those that changed preferences did so because of better knowledge and understanding of what they could manage (n=32, 13%) or because of attraction to a particular child that they might not have considered hypothetically (n=20, 8%).

The data displayed in figure 9.3 below shows that of the 28% (n=69) who changed preferences, almost half (n=32, 46%, n=32) had done so because of greater knowledge or understanding of what they could manage as the process progressed. Four of the adopters who cited knowledge as a catalyst for changing preferences also stated that their preferences changed as awareness of available support grew. There were 8 in total (12% of people who changed preferences) who changed criteria on the basis of support available. A significant proportion of people who changed preferences did so because they were attracted to a particular child (n=20, 29%) demonstrating the effects of 'chemistry' and getting to know children in the round, as opposed to deciding on a list of characteristics perceived as deficits, in broadening prospective adoptive parents' perceptions (Beaumont, 2017; Cousins, 2003). As one adopter commented, *"I changed when I saw my daughter's profile – I was looking for a younger child, but I felt a connection to my daughter."*

Figure 9.3: Reasons for changing initial preferences at matching stage by percentage



In other cases, the reasons why parents had changed their preferences were less positive. Nearly a quarter of the 69 respondents (n=15, 22%) felt the need to expand criteria to increase their chances of adoption and 13% (n=9) were persuaded by the adoption agency to change criteria. Some parents specifically mentioned feeling misled by the agency about the needs of their children:

> *'We were completely misled about their challenges so ended up not where we intended at all'*

> *'Our son was not as described - but very hostile and violent - we found this once we had him with us…'*

Another parent felt emotional pressure to take a sibling group when they wanted one child,

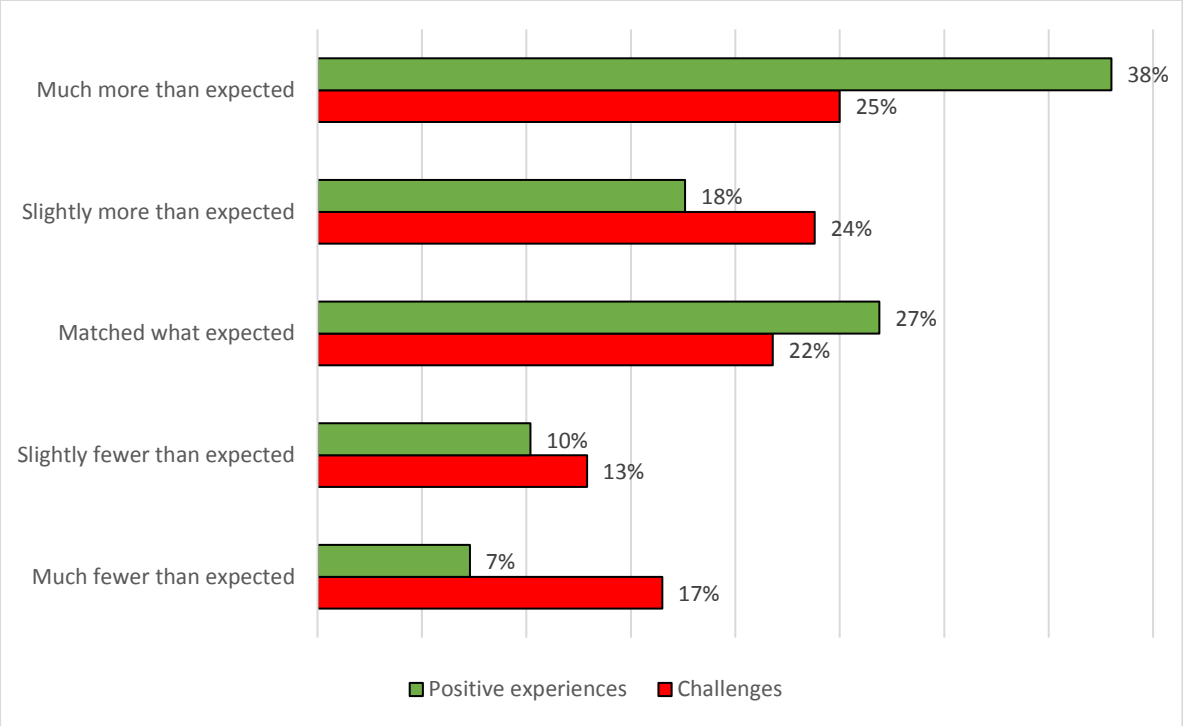
> *'I was very clear throughout the assessment that I did not want to adopt siblings as I felt more than one child at a time would be too much. However, our agency shared info about our daughter when she was 12 months old and her brother was two weeks old. It was extremely difficult to say 'no' to the prospect of such young children given I couldn't have children biologically.'*

A poor match between the parent's hopes and expectations and the child needs can cause problems later in the adoption (Farmer & Dance, 2015). To explore this in the sample parents who had changed their preferences were compared with those who had not in terms of whether or not they were "struggling" in the adoption overall. Of the parents who had changed their preferences, 29% were in the 'struggling' group in terms of how the adoption was faring overall. In comparison, where parents had stuck to their criteria 17% felt they were struggling. A chi-squared test was used to examine whether there was any association between whether or not parents had changed their preferences and the parent overall rating of the adoption ('struggling' versus 'managing challenges' or 'going really well'). This showed a significant association ($X^2 = 4.4$, df= 1, $p<0.5$). Our data show that most parents who changed their criteria did nevertheless feel the adoption was going OK, but as reported above there were a variety of circumstances in which parents changed their criteria – some more positive than others. Where parents feel under pressure to change their criteria risks may be highest. It is also possible that, with hindsight, parents whose children have run into difficulties might feel that the child they adopted was different from the one they originally wanted whereas parents who are managing challenges might feel that they got the child they wanted from the outset.

9.4 Pre-placement expectations versus the reality of adoption

As Cousins (2003) points out, stating preferences in the adoption process is based on hypothetical scenarios as opposed to decisions based on experiences of real children. Expectations of what adopting a child will be like are also formed on a hypothetical basis prior to matching. In the period between when a match is proposed and first meeting the child, adoptive parents gain more knowledge of the child they have been matched with on paper and inevitably begin to form expectations of what family life with that specific child will bring. Parents were asked "How far would you say the expectations that you had about your child before placement have matched reality?" They were also asked about challenges and positive experiences choosing, for each, one option from a 5 point Likert scale: *much fewer than expected, slightly fewer than expected, matched what expected, slightly more than expected* and *much more than expected.* A total of n=248 adopters answered the question about how the challenges matched reality and n=245 for how positive experiences matched reality.

Figure 9.4: How adopters' expectations of rewards and challenges pre-placement have matched reality



The picture that emerges from these data is that adoption is often more rewarding *and* more challenging than expected, a finding likely to be true of parenting in other types of family. The majority of adoptive parents reported the adoption to be rewarding. As shown in figure 9.4 above, over half of adoptive parents who completed this question (n=136, 56%) felt that they had experienced more rewards than they expected to prior to the adoption. For 38% (n=93) of parents the rewards were **much** more than they expected prior to the adoption. Overall

therefore 83% of parents felt that the adoption was as rewarding or more rewarding than they expected whilst fewer than expected rewards were experienced by 17% (n=43) of adopters.

Around half of parents (n=121, 49%) felt that the adoption had been more challenging than they expected. For 25% (n=62), the challenges were **much** more than they expected prior to the adoption. Fewer than expected challenges were experienced by 29% (n=73) meaning that for 71% (n=135) the adoption was as challenging as or more challenging than expected.

Taking account of how parents answered both of the questions (challenges and rewards) three groups were identified (n=243) as follows:

- More rewards, fewer or matched challenges (n= 122, 50%)
- More challenges, fewer or matched rewards (n= 30%)
- Greater challenges, greater rewards (n=47, 19%)

More rewards, fewer or matched challenges

For half of parents (n=122, 50%), the adoption was more rewarding than they hoped and at the same time less challenging (or no more challenging than expected). Many parents added additional comments to explain their answers about rewards and challenges. Some simply talked about their child's positive qualities or the joy the child had brought into their life:

> *Adopting our son is bar nothing the best thing that ever happened in my life. My husband says the same thing. He is such a life enhancer, and we could not imagine life without him. I can honestly say I never felt love or commitment like this.*

For some parents, the positives of adoption included feeling competent as parents and enjoying their child making progress:

> *Seeing child making positive developments / changes is a brilliant feeling, whether her improvements are academic, social, or simply manners etc, knowing I have a hand in these developments makes me feel great as a parent*

Other parents referred to anticipating challenges but these not materialising:

> *We expected our son's attention span to be very short and for his behaviour to be more challenging for a longer amount of time. We had realistically low expectations of him academically, from the evidence we were given, but now we think he'll be fine.*

Our child has been amazing in every way. I expected him to be more challenging in many areas, especially emotionally and with his behaviour. We obviously had our moments but …once he has been able to attach to us, I feel he turned a corner.

Several parents mentioned that they felt their preparation had focused on potential negatives, but their reality was more positive:

We expected 'worst case scenario' from having been through the adoption training days, and we expected to have more challenging times than we have had. As I have said - we haven't been through anything out of the ordinary.

I was told to expect a life of challenges and possible FAS but I have not had any bad experiences

It was clear however that for some parents having realistic expectations and good information during the preparation stage was important. Other parents mentioned positive experiences of professional support either at the stage of preparing to adopt or after adoption:

Because of the training we received, we have dealt with the challenges much better than expected.

We received much more support than we ever expected

Getting the full facts of my son's care and previous care.

In summary where adoptive parents experienced adoption as predominantly positive, and somewhat better than expected, this seems explained by a combination of factors including the child's good progress, parents having realistic expectations shaped by having received good preparation and information about their child, and relevant and effective support being available.

More challenges, fewer or matched rewards

Just under a third of parents (n=74, 30%) had found the adoption more challenging whilst the rewards were fewer or matched with expectations. The vast majority of open comments referred to children's difficulties. Some parents mentioned these in a non-specific way for example referring to *'long term needs'* or *'complex problems'.* Many parents mentioned issues

with children's behaviour, including in nine cases aggressive or violent behaviour towards parents:

> *Our son's violence - that has included pulling knives, punching to cause nose bleeds etc. has been particularly challenging.'*

Other parents mentioned attachment problems:

> *The attachment issues are draining and wearing, it feels as if despite all reassurances it's never enough and she will never feel secure.*

Some comments mentioned the child's emotional problems or feelings about being adopted/their birth family:

> *Managing my child's anxiety (and possible depression) and resulting meltdowns*

> *We have a lot of struggles with him trying to get to grips with his birth family history and if we are his 'real parents'. He can be very angry and blames us.*

Developmental delay or learning problems were also referred to by some.

Some parents felt that they had not been well prepared for the realities of adopting child. For one or two people it was not so much the child's particular difficulties that they felt underprepared for, but the demands of parenting generally:

> *I have found parenting a challenge after working full time and being childless for a long time it was a huge change that was unsettling and has taken some time to resettle into new family orientated routines.*

For most however it was the challenges their child presented over and above general parenting that they struggled with. Some parents who had adopted very young children felt that the child's young age at placement had proved a misleading indicator of future issues:

> *We expected this child to be 'normal' as he was removed at birth. This has not been the case - he has huge issues.*

The following parent felt that a lack of information about attachment meant their expectations were unrealistic:

We had little preparation, and nothing taught to us about attachment theory in 2000. We naively thought at 3 months, she would have very few additional challenges to bringing up a birth child!

Many parents expressed the view that they could and should have been better informed about their child's history, development or likely future issues, in some cases feeling that information that was available had not been passed on:

'We were not given accurate information about the boys' level of difficulties, particularly within their relationships'

'We expected they'd been in a generally positive foster placement that had significantly brought them on, as we'd been told. It turns out it wasn't…'

'His violent behaviour was very much played down in his profile report and described as "minor" and "in the past". When we were experiencing some of the extreme behaviours that were not mentioned in the profile report, we eventually found out that he had done this previously. It would have been better for us to know everything in advance so we could have been better prepared.'

The final recurring theme amongst this group of parents was that they had found accessing services for their child (education being mentioned often here) much harder than expected. In some cases, the responses (or lack of) of others were seen as the main area of challenge:

'Negotiating the education system for a child with additional needs has been more stressful and time consuming than I could ever have imagined.'

'The challenges have not come from my child - who would be expected to pose challenges given his past - the challenges have come from accessing services, ghastly court proceedings…'

Parents who found adoption more rewarding <u>and</u> more challenging than expected.

For 19% of parents (n = 47) *both* rewards and challenges were greater than expected. In some cases parents just talked about the challenges in their comments. These generally related to children's difficulties, though some of the more severe behavioural difficulties described by parents in the previous group (such as very aggressive behaviours) were absent. Most comments by parents in this group however described both joys and challenges. In some

cases the balance between these two had altered over the years as children's needs changed or because of reductions or increases in support or insight:

> *'We had many years with little problems. Transition into teenage years has brought more problems.'*

> *'Once I discovered that FASD existed and realised how my child fitted the profile, techniques from that have really helped to make life less stressful.'*

> *'Challenges were totally unexpected and there was no common sense you could apply to the behaviours which was why [adoption agency] specialist advice was so beneficial. Such lovely children - can't believe they're not ours by birth - sense of humour, sense of fun are all so similar to ours'*

But for many people the joys and challenges were intertwined across time, the ups and downs of family life being described by more than one person as a 'rollercoaster'. The joys of connecting with the child emotionally and enjoying his or her character countered the difficulties:

> *'This wasn't what I thought it would be - he will be dependent on me for considerably longer than I anticipated - but I wouldn't have it any other way at this point - or rather things could be easier but I love him and accept him for who he is.'*

> *'Initially I had stated that I didn't want an autistic child but [my daughter] has been assessed as on the spectrum and so it is something we are learning to deal with as she is loved so much and we want to do our best for her. Even though there are day to day challenges, we also have had many, many amazing experiences due to [her] delightful character and love of life'.*

Interestingly, several parents referred to the joys of adoption as *stemming from* the challenges – they gained a sense of reward in being able to help their child and see them make progress despite all their difficulties.

> *'How difficult behaviour can make you feel totally inadequate. How you can love another person more than anything or anyone else in the world. How little steps of progress can feel like you have both won an Olympic medal.'*

*'Becoming a parent in general has been more challenging that I expected….**[But]** the joy he has brought and to watch his development and see the happy little boy he is now is the most positive experience I have ever had*.'

9.5 Parents' experiences of adoption preparation

Understanding factors that influence outcomes for children is complex and it is difficult to determine the precise influence of various factors due to the complex interplay of these as well as individual variations in reactivity to stressors (Howe, 1998; Rutter, 2005). This makes for a highly challenging task for professionals in terms of adequately preparing parents for the challenges their child might face in the future. It is also likely to be challenging for parents to understand and anticipate their children's needs, especially when they lack information about the child's background.

Although most parents felt that they had been well prepared for *adoption in general*, with 77% of parents (n = 201) feeling that they had been prepared at least moderately well, somewhat fewer parents felt prepared for *their particular child* (n=164 of 259, 63%, felt they had been prepared at least moderately well).

Adopters were asked about the extent to which they were told **all relevant information** about their child's history and development or whether they felt there were gaps in this information (parents could specify 'lots of significant gaps', 'some significant gaps' or 'slight gaps') and 263 respondents answered the question. Overall, only a minority of parents felt that they had all relevant information about their child (n=101, 38%). Eleven percent (n=28) said there were 'lots of significant gaps', 20% (n=52) specified 'some significant gaps' and 31% 'slight gaps' (n=82).

Parents were then asked whether the gaps were because the information was 'not known' by the agency 'or 'held back'. Two thirds of parents who felt there were information gaps thought this was because the local authority did not have the information (n= 103, 68%) but one third of parents felt it was 'held back' (n=49, 32%):

'I was naïve but just very unprepared beforehand. I think I was misled. I just wish the adoption team had been more honest beforehand.'

Parents were given an open box in which they could say more about the gaps in information about their child. These comments revealed a wide range of types of information that adoptive

parents felt was missing. Common areas where adopters felt information was lacking were as follows:

- the birth father, even knowing his identity
- background, behaviours or medical history of birth parents.
- the child's exposure to drugs or alcohol in utero
- the child's exposure to neglect or abuse
- the child's medical history
- the child's development/behaviour
- the child's movements in the care system
- information about the child's siblings or other birth family members
- a lack of family photographs

These gaps in information had left some parents facing challenges they had not anticipated or prepared for:

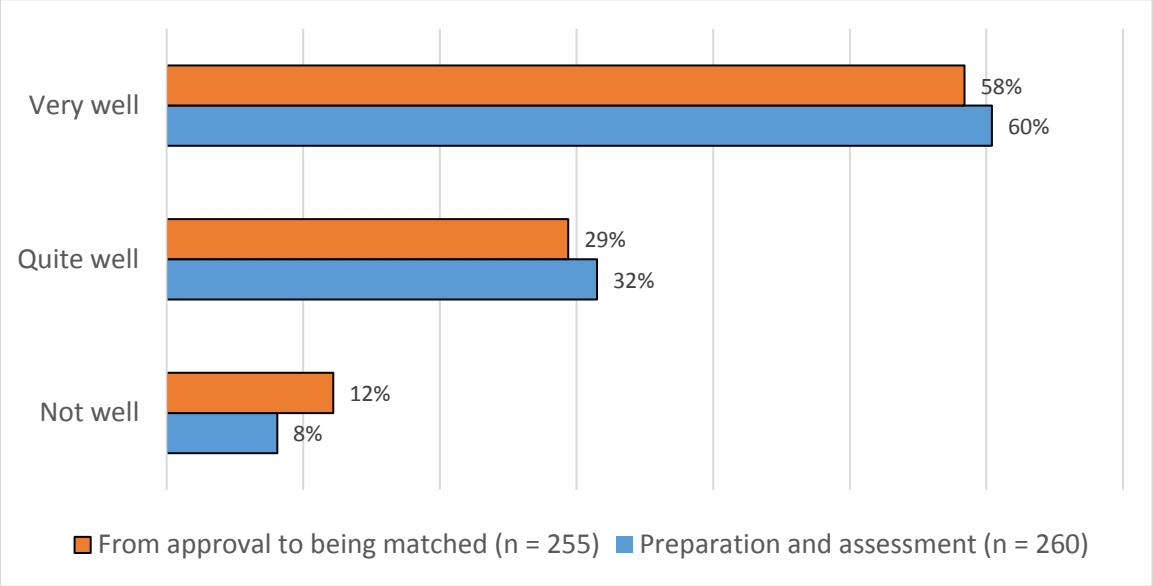
> *'[It's] challenging taking on children with therapeutic needs which have not been assessed by the authorities, left to find out the hard way what is needed to support them.'*

Several adopters described how over time they had been able to piece together more information about the child through a variety of means including pressing social services for more information, meeting birth family members or carers of siblings, through the foster carer, through access to the child's medical records, through the child's life story book or life story work.

As can be seen in figure 9.5 below, the majority of respondents felt very well supported in the preparation and assessment phase (n=157, 60%) and from approval to matching (n=149, 58%). This slightly lower rate of satisfaction in the post approval period could be due to a number of reasons including delays waiting to be matched or less frequent and less in-depth contact with social workers:

> *'I found the waiting between being approved and matched very challenging'.*

Figure 9.5: How well adopters felt supported in different stages of the adoption process



Parents could provide more information in an open box about **what the agency had done well in the period before their child was placed with them;** n=169 added comments in this box, almost all making positive comments.

Whilst several comments were non-specific such as *"the adoption social worker was brilliant"; "our social worker was very supportive",* where more detail was given key themes were apparent.

Adopters seemed to value particularly **good communication**. This could include for example the worker keeping them informed of the progress of their application:

> *'Kept us constantly informed as to what stage we were at - provided clear timetable'*

Staying in in touch during the waiting period was also seen as a positive:

> *'Kept in regular touch, second time round we were more aware of how very hard this period was going to be.'*

Other parents referred to the worker's availability and willingness to be contacted when queries or worries arose:

'Fantastic SW who contacted us regularly and always made us feel we could contact them/her at any time during this part of the process'

Another aspect of communication was, as discussed in section 9.4, the importance of **passing on all relevant information about the child**. What seemed particularly helpful for some was the work that the social worker did in *helping them to make sense* of this information and to make an informed decision about the match. In some cases this had involved workers connecting adopters to others who had relevant expertise or pointing them to useful training or reading:

'Kept us fully informed of any information relating to the child. Kept us informed of the process. Ensured we met with all key individuals associated with the child and ensured we had all information that was available. Arranged for me to attend a course on how to involve siblings in the adoption process.'

'Good provision of courses, reading material. I also had access to our child's paediatrician to discuss medical assessment.'

'Good at providing training on attachment disorder'

Parents also valued the expertise of workers, referring to both professional knowledge and experience and personal knowledge/life experience:

'We had a very experienced social worker who took time to get to know us as a couple and we felt we could be brutally honest with her. She wanted the adoption to work and she knew her job well.'

'Loved our SW … She has real life experience not just parroting books and text. She really understood what the reality of parenting is like. She came into SW later in life after having her own children.'

A second open box asked adoptive parents for further information about **what the agency did not do well prior to the child's placement**. Comments were added by 132 parents, although in about 30 cases the comments were saying that there had been no problems. The three main issues highlighted by parents who specified problems were:

Delays in the process. Some parents commented about the length of time the assessment, approval and matching process took overall:

> *'The time taken between appointments - It dragged on SO long'*

> *'The process was very long and drawn out. We waited six months from our initial assessment until going on a preparation course. We then waited another six months to be allocated a social worker to start the home study. The whole process took three and a half years to meet our son*'

Others referred to specific problems that delayed certain parts of the process such as problems with medical reports, or uncertainty about plans for children. Several adopters felt that their agency was not active enough in seeking a match, and they had to push things forward themselves to avoid delay. In a couple of cases adopters mentioned short but very stressful delays, for example one parent said that because of a missing signature on a key form they had to wait several hours on the day the first meeting with the child was scheduled.

Changes of social worker. A common complaint was about changes in social worker, these occurring for a variety of reasons. The changes of staff were experienced as unhelpful by some because they could cause delays. Other parents felt they had to start to get to know a new person having already been through that process:

> *'One difficulty was that our social worker left soon after we were approved as adopters. Although our new social worker was lovely she didn't really know us and our journey and it took time to build a new relationship.'*

Inadequate information or preparation regarding the child's issues. Comments here were similar to those cited above where parents felt that relevant information about their child was missing, had been withheld, and/or that they were not fully prepared to understand the relevance of the child's background on future development:

> *'I feel we were not prepared for what lay ahead it was mainly about children who had suffered major abuse and nothing about children who may have experienced things pre-birth.'*

Other problems mentioned by smaller numbers of parents included:

- a lack of support in managing relationships with foster carers/the child move from the foster home (see also chapter 5);
- a lack of understanding and support with the emotional strains of going through the approval/matching process;
- being unsupportive of the adopters application for approval (including, in a couple of cases, being unsupportive of same sex couples)
- inaccuracies or problems in paperwork in some cases involving the accidental disclosure of confidential information.

9.6 The Parenting Stress Index (PSI)

The PSI was completed by over half (n=171, 54%) of respondents. This measure has been validated for parents of children age from 4 months to 12 years old, so some respondents with a child outside of this age group would not have seen these questions. Also, this was the last section in the survey and some respondents with children within the relevant age group had dropped out by this stage.

The measure has three subscales which can identify different areas of stresses: personal parental distress, stresses derived from the parent's interaction with the child and stresses that result from the child's behavioural characteristics. A total stress score can be obtained as a sum of these three subscales.

As can be seen in table 9.1, 17% (n=29) scored in the clinical range for total stress. Four more parents (2%) were high – close to clinical level. It is recommended that parents scoring at these level are referred for closer diagnostic study and professional assistance (Abidin, 2012). The total stress score indicates stresses reported form all three sub-domains.

Table 9.1: Results of the Parenting Stress Index questionnaire

PSI measure and subscales	Scoring	N	Range	Mean	SD	% scoring in clinical range
Total Stress	36 (low) - 180 (high)	171	37-152	83.60	29.05	17.0% (29)
Parental Distress subscale	12 (low) – 60 (high)	174	12-54	28.71	9.99	13.2% (23)
Parent-Child Dysfunctional Interaction subscale	12 (low) – 60 (high)	174	12-57	25.49	10.12	19.0% (33)
Difficult Child subscale	12 (low) – 60 (high)	173	12-60	29.63	11.61	23.1% (40)

Twenty three per cent (n = 40) of parents scored in the clinical range on the Difficult Child subscale. This takes into account the behavioural characterises of children that make them either difficult or easy to manage, both factors connected to temperament but also learned behaviour such as defiance or non-compliance. The parent will have difficulty managing the child's behaviour, setting limits and gaining the child's cooperation.

Thirteen per cent (n=23) of parents who completed the measure scored in the clinical range on the Parental Distress subscale, which determines the level of distress a parent is experiencing in their role as a parent. It is related to a low level of parent competence, feeling restricted in life, having little social support, depression, and conflict with the other parent. The focus of professional services working with a parent with high levels of this type of stress should be interventions designed to assist the parent in their personal adjustment, and therapeutic services to strengthen the parent's self-esteem and sense of personal competence (Abidin, 2012).

As shown in table 9.2 below, the percentages of parents scoring in the clinical range on the PSI (total stress) were higher for children of older ages (within the limited age range of 0-12).

Table 9.2: Clinical significance of Parenting Stress Index according to child's age at time of survey

Age Now	Parenting Stress Index Clinical Significance				
	Low	Normal	High	Clinically Significant	Total (*n*)
0-3 years	31% (14)	64% (29)	0% (0)	4% (2)	45
4-6 years	14% (6)	70% (30)	2% (1)	14% (6)	43
7-9 years	18% (9)	63% (32)	2% (1)	18% (9)	51
10-12 years	13% (4)	44% (14)	6% (2)	38% (12)	32

Table 9.3 shows clinically significant PSI total scores according to age at placement. This shows that parents of older placed children had the highest levels of stress, though the differences were less marked compared to child's age at time of the survey.

Table 9.3: Clinical significance of Parenting Stress Index according to age at placement

Age at Placement	Parenting Stress Index Clinical Significance				
	Low	Normal	High	Clinically Significant	Total (*n*)
0-11 months	28% (15)	59% (32)	2% (1)	11% (6)	54
12-23 months	17% (6)	67% (24)	3% (1)	14% (5)	36
24-35 months	11% (3)	70% (19)	0% (0)	19% (5)	27
36+ months	17% (8)	54% (26)	4% (2)	25% (12)	50

9.7 Chapter summary

This chapter reported findings exploring the experiences and feelings of adoptive parents from the beginning of the adoption process, through the matching and placement phase, and on to adoptive parenthood. Data were collected about motivations for adoption, preferences for the kinds of children adopters want to parent and whether, how and why these changed over time and whether earlier expectations of adoptive family life matched up with the reality. For parents of children up to the age of 12, the impact of adoption on the parent was measured using the Parenting Stress Index (PSI).

The overall picture that emerges is that how happy adopters were feeling about their lives as an adoptive parent was related not just to the good progress or difficulties their child was experiencing, but also to the extent to which adoptive parents felt prepared for any difficulties, and the support they had been able to obtain to help manage such difficulties. As seen in

many places in this report, the importance of adoptive parents having as much information as possible about their children prior to adoption emerged as an important theme. Adoptive parents expressed many positive opinions of the support they had received from social workers throughout their preparation and assessment process, and good communication and information was a vital part of this. Some adopters had widened their criteria when agreeing to the match with their child, and in many cases this had worked out well. But problems in the adoption were more prevalent amongst this group who had 'stretched' their preferences. Key findings are summarised below:

- **Motivation to adopt:** Almost three quarters of parents (72%) stated that inability to have a birth child led them to adoption. A preference for adoption over having a birth child was expressed by 12% and 7% decided to adopt a child they were fostering. Some of our respondents ticked more than one option, reflecting findings in other research (e.g. Ward, 2011) that other factors come into play and reasons for wanting to adopt can be complex.
- **Preferences:** Seventy two percent of 246 adopters, at the matching stage, did not change their preferences for the types of children they wanted to adopt. Of the 28% who changed preferences almost half (46%) did so as a result of greater understanding of the skills and capabilities needed to parent the types of children waiting for adoption. Twenty parents (29%) changed preferences because they were attracted to a particular child, demonstrating the effects of chemistry and getting to know children in the round. Thirty five per cent of adopters expanded their criteria to either increase their chances of adoption or because the agency persuaded them. This runs the risk of adopters not being as fully prepared for the challenges as they might otherwise have been.
- **How stretching of preferences related to how the adoption was faring:** There was a significant association between preference change and ratings of how the adoption was faring overall at the time of the survey. This suggests it is important that adopters are supported to be realistic about children's characteristics and needs and that they are not unduly pressured to adopt children where they do not feel confident about meeting the child's needs. 'Preference stretching' needs to be carefully managed and based on preparation to increase knowledge and skills as opposed to led by the needs of the agencies.
- **Preparation for, and expectations of, adoption:** Although 77% felt at least moderately prepared for adoption in general, a lower figure felt at least moderately prepared for their particular child (63%). About half of parents found the adoption more

rewarding and no more challenging than expected; 30% experienced more challenges and matched or fewer rewards compared to expectations; 19% found the adoption more challenging *and* more rewarding than they hoped.

- **Information on the child available to adopters:** Only a minority of parents felt they were given all relevant information about their child (38%) and almost a third (30%, *n* = 80) felt that there were significant gaps in information about their child's pre-placement history. Information was sometimes felt to be missing as social workers did not know it, but in some cases adopters felt facts had been held back from them or proper assessments had not been carried out.
- **Standardised measure – The Parenting Stress Index (PSI):** Over half of the total sample (*n* = 171) completed the PSI for parents of children aged from 4 months to 12 years old. Seventeen per cent of parents were in the clinical range for total stress. Scores on this measure were significantly positively correlated with the child's current age at the time of completing the measure ($r = 0.378$, $n = 171$, $p<0.01$). Thirty eight per cent of parents of 10 – 12 year olds had clinically significant stress levels compared to 4% of parents of children age 3 and under. This measure was not completed by parents of teenagers.

Chapter 10 – Contact with birth relatives

10.1 Introduction

Most adoptions in recent years have had at least an initial plan to retain some level of contact with the birth family. After adoption, mediated letter contact ('letterbox') is the predominant form of contact for adopted children, though a minority of children will have direct (face-to-face) contact with parents, grandparents or siblings (Neil, 2000). Contact can have benefits for adoptive parents, children and birth families, but the quality and sustainability are important in understanding when and how contact might be positive (Neil *et al*, 2015). Although letterbox contact is very common, it is often not sustained over time as both birth family members and adoptive parents can experience challenges in communicating in this way. Direct contact potentially poses more risks, but where such contact is planned carefully and supported in a way that is appropriate for each case, level of satisfaction with this contact can be very high - particularly contact with siblings and grandparents (Neil *et al* 2011; Neil *et al* 2015). Previous studies have concluded that there is no one type of contact that is best for all children - decisions should be made on a case-by-case basis assessing the needs, wishes and capacities of all involved (Neil & Howe, 2004; Neil *et al*, 2015). Regardless of whether or what type of birth family contact can be set up, it is however important for all adopted children that their understanding of birth family connections and heritage is recognised, valued and promoted by the adoptive parents; all adoptive parents need to be "communicatively open" about adoption with their children (Brodzinsky, 2005).

Due to the complexity of contact arrangements – likely to be extremely varied in frequency and type and involve combinations of different types of relatives – it was decided that details on respondents' post adoption contact experienced to date would be gathered via an open box. The open question did not ask about *plans* for contact – only *actual* contact that had occurred with birth siblings, birth parents and other adult birth relatives (previous studies have concluded that plans for contact often do not materialise as originally intended, Neil et al, 2015). It is possible that some parents may have had 'one off' meetings with birth family members *prior* to the adoption – these were not covered in the survey. Further questions in this section asked parents to rate contact according to how it had been for their child and themselves, to give details on what ways, if any, it has been positive for their child to have contact and to note the key difficulties, if any, with the contact. Finally parents were asked for their general views on contact, and suggestions for agencies/other parents. Information about the arrangements for their child's post adoption contact with birth relatives were provided by 255 adoptive parents.

10.2 The extent and type of contact experienced

Adoptive parents were asked to tick a box to say whether they had ever had:

- contact with birth siblings
- contact with birth parents
- contact with other adult birth relatives
- no contact with any birth relatives

Where contact had occurred, adoptive parents were asked to write more details about the arrangements in an open box. Forty-nine (19%) of the 255 parents indicated that there had been no post adoption contact with any birth family member including siblings. All others had experienced some type of contact, spanning a wide variety of arrangements with different birth relatives. This included indirect contact via letterbox (one or two way), telephone, internet, direct face-to-face meetings or a combination of different types of communication. The contact had often changed over the years; sometimes contact increased or decreased in frequency or changed, the change initiated by the adopters, birth parents or child. For example sometimes face-to-face contact began at different stages into the adoption prompted by a child needs; sometimes replies to adopters' correspondence stopped or started.

When contact was with an adult from the birth family this typically involved a birth parent, although 28% (n=72) of all families had contact with an extended adult birth family member (e.g. grandparents, aunts & uncles). Some parents were involved in maintaining contact with different people within large families, for example one spoke of writing to nine siblings as well as to birth parents, another wrote to a birth mother, birth father, an uncle and a paternal grandparent.

All answers to questions on contact were considered before categorising answers into contact type, to ensure there was as much information as possible to aid accuracy. Contact was coded separately for birth siblings, birth parents (we did not distinguish between mothers and fathers) and other adult birth family members. Contact was coded according to whether there had been:

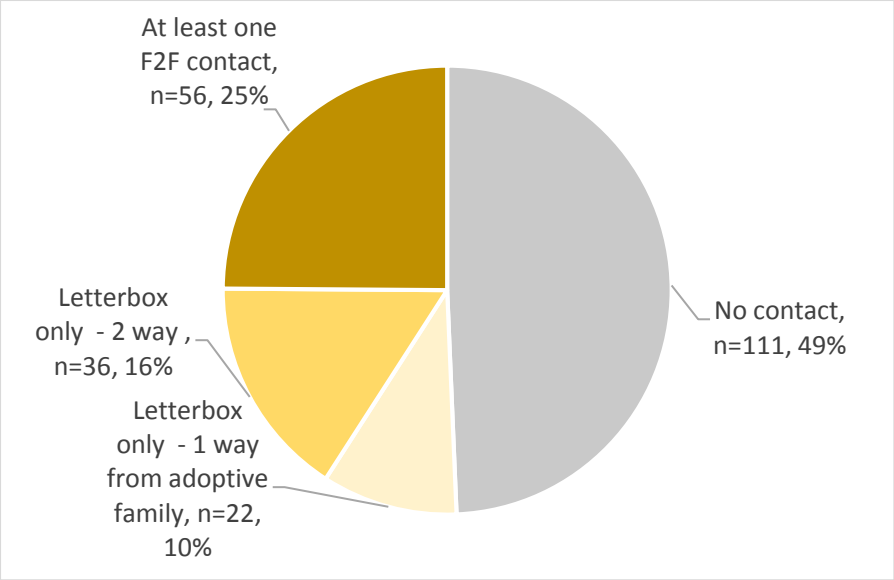
- One way letterbox contact from the adoptive family to the birth family only (even though it was clear from some answers that there had been a *plan* for 2 way contact)
- Two way letterbox correspondence between parties at some point (in some cases this was sporadic or had stopped)

- One or more face-to-face meetings between the child and birth family members after the adoption order (often with letterbox contact or other types of contact as well)

10.3 Types of contact with siblings

Most parents who answered questions on contact had stated earlier in the survey that they knew of half or full birth siblings of their child who were living outside of their family (225 of the 255 families). Figure 10.1 below shows the proportion of families (based on n=225) who had experienced each type of contact with a sibling at some point since the adoption.

Figure 10.1: Contact with birth siblings living in other families



Of the children with siblings, almost half, 111 (49%) had experienced no contact with any of these siblings. In a further 22 cases (10%) there had been contact but this had only ever involved one way letterbox from the adoptive family. Therefore 59% of families with birth siblings living elsewhere either had no contact with them, or had never heard anything back from them.

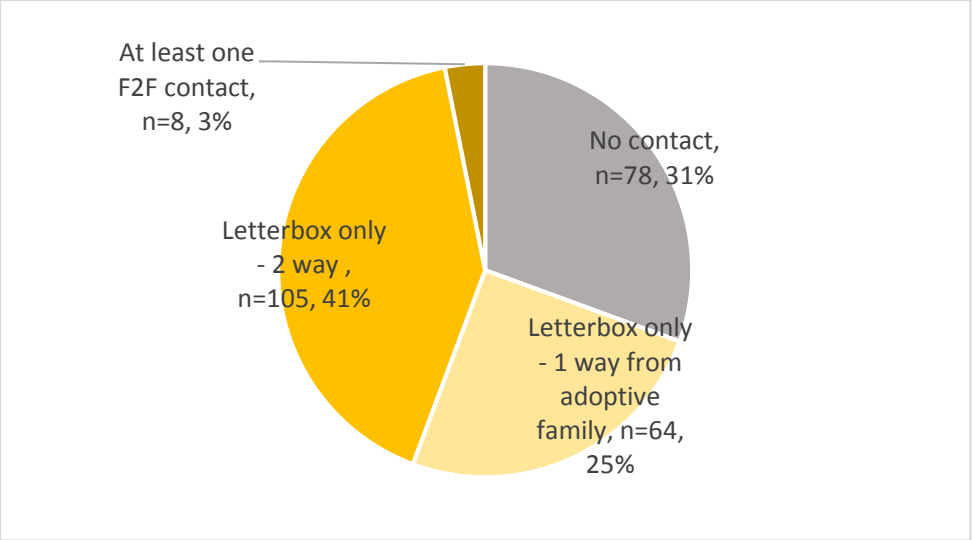
Ninety-two families (41%) had experienced either two way letterbox or face-to-face contact with siblings. Face-to-face contact with siblings was more common for older children, with 50% of 12 to 17 year olds (n=46), 24% of 6-11 year olds (n=99) and 11% of preschool children (n=80) having had at least one face-to-face contact with a sibling. In most cases the contact, especially when direct contact, seemed to have continued over time and been positive for the child and for the adoptive parent (see 10.9 and 10.10 below). In 9 cases the contact had

stopped at the time of the survey (2 cases with letterbox contact and 7 cases with face-to-face contact).

10.4 Contact arrangements with birth parents

Figure 10.2 below shows the number of families who had experienced each type of contact with one or both of their child's birth parents at some point since the adoption. Just under a third (31%, 78 out of 255) of families had not had any contact at all with birth parents. In the vast majority of cases where contact had occurred with a birth parent it had been letterbox contact. However for 64 (25%) of families the letterbox contact had only ever been one way from the adoptive families. Therefore over half (56%) of the families either had no contact with, or had never received information from, their child's birth parents. Seven adoptive families who had only ever had one way contact had eventually stopped sending information - primarily due to no reply (11% of all those with one way contact).

Figure 10.2: Types of contact with birth parent(s)



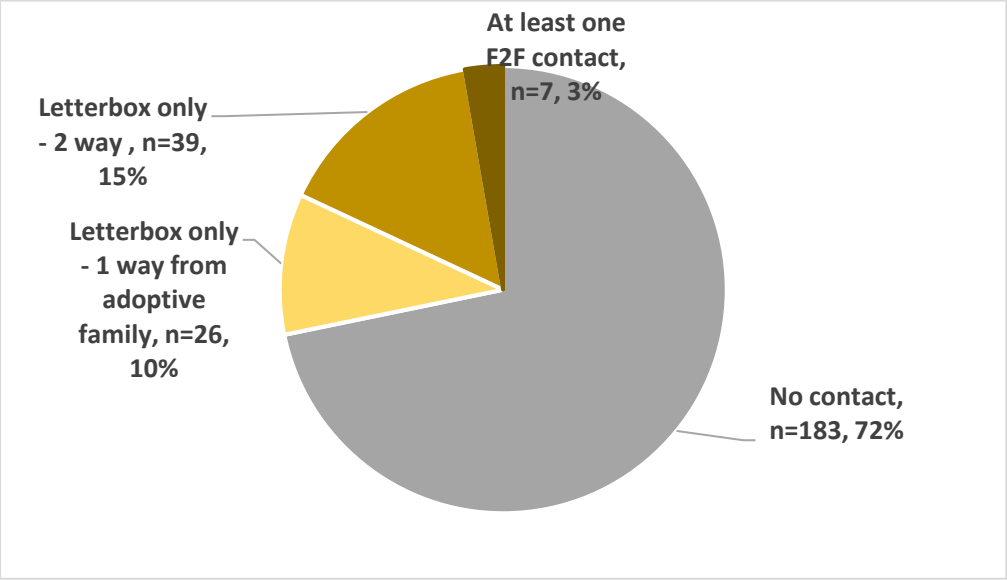
One hundred and five (41%) adopters had experienced two way letterbox contact receiving at least one letter or card from birth parents, however this was not always regular or ongoing. In a number of cases with two way letterbox (28%, 29 out of 105) it was stated that at least one party who had been sending letters had stopped doing so. In most cases this was because the birth parent had stopped corresponding (21 cases); in 7 cases *both* the adoptive family and the birth parents had stopped corresponding and in 1 case the adoptive family had stopped corresponding and requested that anything from the birth family was retained by the agency. In other cases where the letter contact seemed to be ongoing, it could be sporadic.

A small minority (8 families, 3%) had experienced at least one face-to-face contact with birth parent/s. All but 2 of these young people were in the older (12-17 year old) age group. Three families had experienced a one off face-to-face meeting and five families had experienced more than one meeting (with one of these families no longer having any meetings, and four appearing to be ongoing arrangements).

10.5 Contact with adult birth relatives (other than parents)

Figure 10.3 below shows the number of families who had experienced each type of contact with other adult birth relatives of their child at least at some point since the adoption. It was uncommon for adoptive families to have had contact with other adult birth relatives (other than parents). When it had taken place, it involved a variety of family members including grandparents, great grandparents, aunts, and (in one case) foster parents of the birth mother. Less than a third (n=72, 28%) had experienced any type of contact with non-parent adult birth relatives. Within this group, 26 families (10%) had only ever sent letters with nothing received in return (and in three cases they had stopped sending at the time of the survey).

Figure 10.3: Types of contact with other adult birth relatives



Only 46 families (18%) had experienced contact which involved a two way interaction with non-parent adult relatives. Thirty-nine (15%) had at some point experienced two way letterbox contact with the birth relative (in four cases one or more party had stopped corresponding by the time of the survey). Seven families had experienced some face-to-face contact – five of these had experienced a one-off meeting and three had ongoing face-to-face contact at the

time of the survey. Four of the young people who experienced face-to-face contact were in the older (12-17 year old) age group and one was of preschool age.

The majority of families, (n= 209, 82%) had either experienced no contact with, or had received no information back from other adult birth relatives. This could be seen as a missed opportunity as previous research into contact (Neil *et al*, 2011; Neil *et al*, 2015) has shown that contact with such family members can often be supportive and helpful to children and adoptive parents. It is likely to involve less complications and difficult dynamics than contact with birth parents and potentially easier integration of such relatives into the extended family network.

10.6 Agency variations in contact across place and time

Contact plans can vary according to the agency placing the child (Neil, 2000). Hence it was considered whether there were any differences in the proportion of families having contact between individual local authorities, possibly indicating different attitudes towards or resources available to support contact. Numbers of responses associated with each agency within the Yorkshire and Humber area were too small to enable meaningful statistical comparisons between them. Descriptive statistics are presented for six agencies (child's placing agency) for whom there were at least 15 families answering the contact questions, focusing on birth parent contact and sibling contact.

Table 10.1 below shows the number of families having each type of contact with birth parents according to the child's home local authority. Across these agencies about a third of children had had no contact (this figure being slightly higher in North Yorkshire, and slightly lower in Hull). Where there were more apparent differences between agencies was in terms of the proportion of adoptive families having experienced either two way letterbox contact or at least one face-to-face meeting with birth parents; this ranged from 29% (in Leeds) to 73% (in Bradford).

Table 10.1: Number of families having each type of contact with birth parents according to the agency the child was adopted from

Local Authority	Number of families having no contact	Number of families where contact had been 1 way from the adoptive family only	Number of families where contact had involved 2 way letterbox or at least 1 face-to-face contact
Sheffield (n=17)	6 (35%)	4 (24%)	7 (41%)
Leeds (n=28)	10 (36%)	10 (36%)	8 (29%)
Bradford (n=15)	4 (27%)	0	11 (73%)
Calderdale (n=20)	7 (35%)	5 (25%)	8 (40%)
Nth Yorks (n=22)	10 (46%)	5 (23%)	7 (32%)
Hull (n=24)	6 (25%)	6 (25%)	12 (50%)

Differences were less apparent when comparing the proportions of contact with siblings (see Table 10.2 below). Across the 6 agencies around half of families had no contact (the figure being slightly higher in North Yorkshire and lower in Leeds), and around one-third to half of families had either two way letterbox contact or at least one face-to-face meeting with siblings (with Bradford again having the highest proportion of this contact at 54%)

Table 10.2: Number of families having each type of contact with siblings according to the agency their child was adopted from*

Local Authority	Number of families having no contact	Number of families where contact had been 1 way from the adoptive family only	Number of families where contact had involved 2 way letterbox or at least 1 face-to-face contact
Sheffield (n=16)	7 (44%)	1 (6%)	8 (50%)
Leeds (n=23)	9 (39%)	2 (9%)	12 (52%)
Bradford (n=13)	6 (46%)	0 (0%)	7 (54%)
Calderdale (n=19)	11 (58%)	2 (11%)	6 (32%)
Nth Yorks (n=20)	13 (65%)	0 (0%)	7 (35%)
Hull (n=20)	13 (45%)	5 (25%)	6 (30%)

***** *families with siblings only included in this table*

In order to explore whether contact practices may have changed across time, families who had adopted their child within the last five years were compared with those whose child had been adopted more than five years ago. These data are presented in table 10.3. This shows that slightly higher proportions of families who adopted six or more years ago had had reciprocal contact with siblings or birth parents (47% with siblings, 55% with parents) compared to those who had recently adopted (37% with sibling, 43% with parents). Whilst this could reflect changing contact plans, it's also possible that for more recent adoptions that contact had not begun yet, and/or that for more distant adoptions contact has been initiated at a later stage - possibly as children's awareness and interest in their birth family has grown.

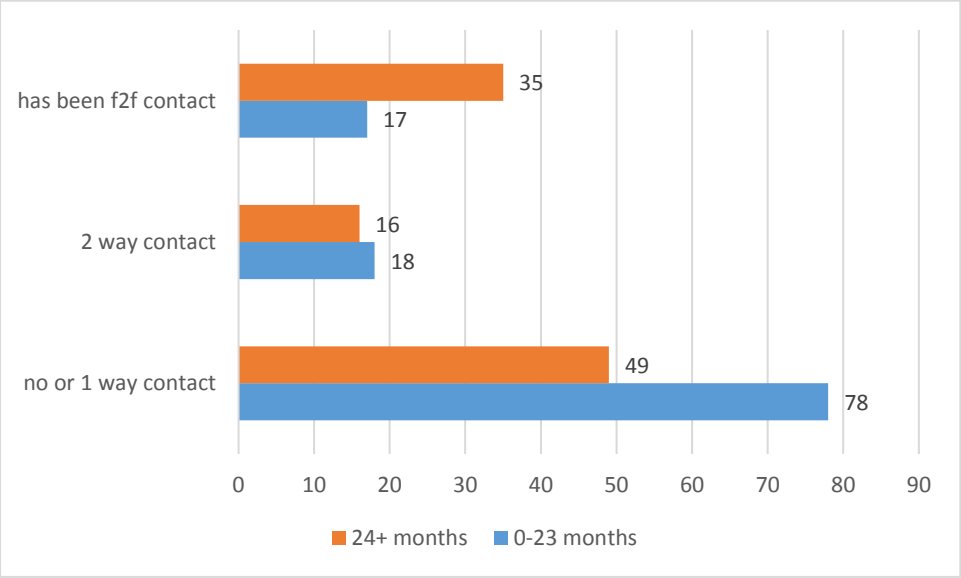
Table 10.3: Proportion of families where contact with a relative had involved 2 way letterbox or at least 1 face-to-face meeting, in relation to time since the adoption order

Time since the adoption order	with siblings (n= 198)	With birth parents (n= 224)	With extended family members (n= 224)
up to 5 years (n=141, 123 with siblings)	46 (37%)	61 (43%)	26 (18%)
6 or more years (n= 83, 75 with siblings)	35 (47%)	46 (55%)	16 (19%)

10.7 Contact type and age at placement

There were indications that older placed children were more likely to have face-to-face contact and less likely to have no or only one way contact compared to younger placed children (based on just children with birth siblings, n = 213). Thirty-five per cent (n = 35) of children placed age 2 or older were having face-to-face sibling contact whereas only 15% (n = 17) of children placed under 2 years old had such contact. Slightly less than half of children (49%, n = 49) placed when over 2 years were having no contact/one way contact with birth siblings, whereas over two thirds (69%, n = 78) of those placed under 2 years old were having no contact/one way contact with birth siblings (see figure 10.4).

Figure 10.4: Contact with birth siblings: children placed under 2 vs. age 2+



Similar differences between older and younger placed children can be seen when looking at contact with birth parents (n= 242). Under half (n=50, 45%) of children placed when over two years were having no contact/one way contact with birth parents, whereas nearly two thirds (n=82, 63%) of those placed under 2 years old were having no contact or only one way contact with birth parents (see figure 10.5). The same pattern is seen with extended family (adult birth relative) contact: 76% (n=85) of children placed when over 2 years were having no contact/one way contact with other adult birth relatives, whereas nearly all (87%, *n* = 113) of those placed under 2 years old were having no contact or only one way contact with other adult birth relatives (see figure 10.6). Face-to-face contact with birth parents and other adult birth relatives was extremely uncommon for both older and younger placed children.

Figure 10.5: Contact with birth parents according to age at placement

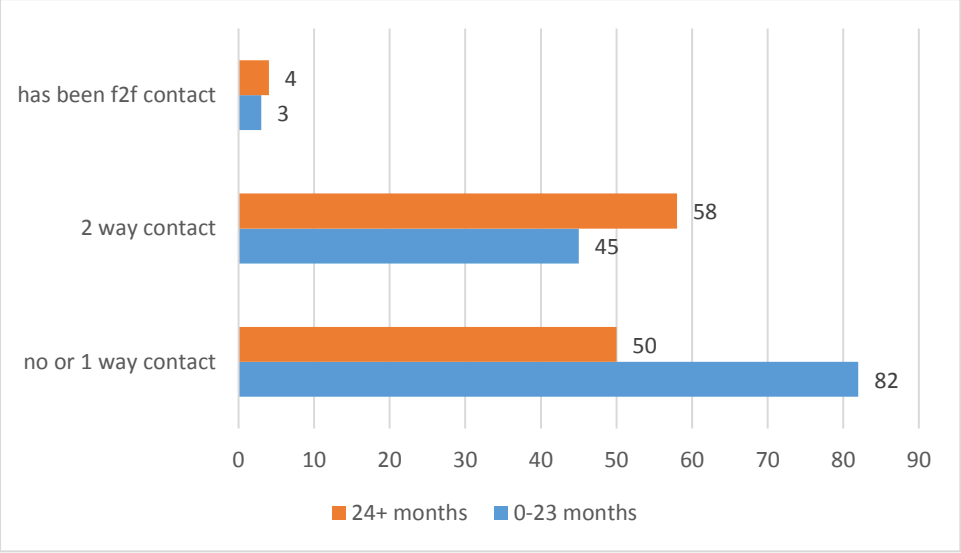
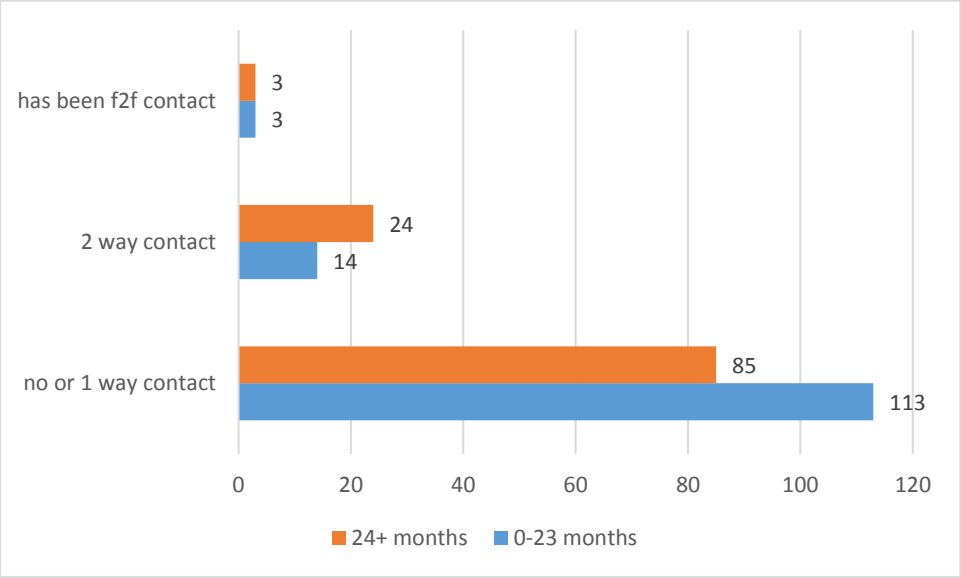


Figure 10.6: Contact with other adult birth relatives according to age at placement



10.8 Experiences of parents having no contact with or no replies from birth family members.

As indicated above, some families (n=49, 19%) had experienced no contact with any birth relatives. Many of the children with no contact were still young (84% were 11 years or younger) and for some of their parents the lack of contact was not viewed as an issue. For example, one parent felt it not particularly relevant as their 8 year old child had no memory of the birth family. Another parent of a 5 year old explained that they:

> '…*don't really want to get bogged down in her family issues. We may need to as she gets older but our families are complicated enough at the moment for her*'.

However often there was no contact with particular relatives when very much wanted by adoptive parents. This included contact with siblings adopted in other adoptive and foster families – some parents stated that other adoptive families had refused contact, or that no one had helped initiate it. Even when there were letterbox contact arrangements in place it was common for families to have received no replies from the carers of birth siblings or from birth parents/other relatives in response to their own letters, including letters penned by the adopted young people themselves. In most cases, adopters did not seem to know the reason for the non-response - they simply just received nothing.

Respondents were asked to rate how birth family contact had been for them and their child (separately), using the reply options: 'extremely negative, 'somewhat negative',

'mixed/neutral', 'somewhat positive', and 'extremely positive'. Results from parents who had experienced either no or only one way letterbox from themselves to the birth relative were separated out for analysis, though these questions were answered mostly by those with one-way letterbox rather than those having no contact at all. As can be seen in tables 10.4 and 10.5 below, those parents who did provide an answer tended to feel that having no contact (or one way letterbox) was either neutral/mixed or negative for their child and themselves with only very few considering it to be positive ('extremely negative' and 'somewhat negative' were combined into 'negative'; 'somewhat positive', and 'extremely positive' were combined into 'positive').

Table 10.4: Parents rating of contact for their child: No or only one way contact with family members

	Negative	Mixed/neutral	Positive
No/one way contact with siblings (n=19)	5 (26%)	13 (68 %)	1 (5%)
No/one way contact with birth parents (n=47)	18 (38%)	27 (58%)	2 (4%)
No/one way contact with extended family members (n=19)	5 (26%)	13 (68 %)	1 (5%)

Table 10.5: Parents rating of contact for themselves: No or only one way contact with family members

	Negative	Mixed/neutral	Positive
No/one way contact with siblings (n=19)	6 (32%)	11 (58 %)	2 (11%)
No/one way contact with birth parents (n=49)	22 (45%)	23 (47%)	4 (8%)
No/one way contact with extended family members (n=20)	8 (40%)	11 (55%)	1 (5%)

Many parents reflected how receiving no response from birth family members without an explanation was difficult to explain to their child. Some assumed that the parents or other relatives were '*not bothered'*. A lack of response had led to some children struggling with the lack of basic information (such as what their birthparents looked like and whether or not they had siblings). It also in many cases caused anger, upset, confusion, worry and feelings of rejection. Letterbox was in some cases eventually stopped by parents because they had received nothing in return. They felt it made their own letter writing appear futile. Even if an active decision was not made to stop, it could be easy to let letterbox drift when there was no response from relatives or reminders from agencies.

However some parents were committed to keeping the contact going even if nothing was received in return or when there were difficulties with the contact. Empathy with the child's long term needs and the birth relative's feelings seemed to encourage people to keep contact going and maintain a link:

'…If I had lost my kids as they did I would want to know that they were doing well'

'It doesn't take much to write a letter once a year. We are doing it for our son as he may be curious and have questions later in life.'

Several parents felt that keeping the link open could have benefits in the long term; one parent noted how they kept writing despite no response, and a letter from a birth parent suddenly appeared after some years had passed. Some parents felt that a danger with stopping contact was that a link to the birth family was closed would be much harder to open if desired in the future. In some cases a lack of contact when wanted had led to children hunting for information via their own methods including social media, a pattern also observed in Neil et al's (2015) longitudinal study.

'So little information about them has led to our daughter trying to trace them on Facebook'

A few parents were frustrated that their agency was not helping to start or maintain contact. Occasionally letters seemed to have been lost by agencies or at least not sent on. There was also a comment that agency systems could make things more difficult. One family stopped receiving a response after the agency changed their system to require birth parents to contact agencies to confirm their address each year. Other respondents did refer to help given from agencies to maintain contact, with examples of proactively seeking out, and reminding

relatives, or supporting a birth relative to respond. One respondent also referred to a foster carer helping to start contact between the adoptive family and birth siblings in their care.

10.9 How did families experience two-way letterbox contact?

Data from parents who had experienced two-way letters at some point were next selected out to explore overall ratings of the contact. As shown in tables 10.6 and 10.7 below, most parents who had experienced this two-way letterbox felt it was a neutral/mixed experience for their child. For themselves, respondents chose a greater mix of responses, with more indicating it had a positive experience but also more indicating it had been a negative experience. Only a minority felt letterbox was mostly positive for themselves or their child, echoing findings in Neil's previous study and highlighting how complex letterbox can be (Neil 2004)

Table 10.6: Parents rating of contact for their child: Two way letterbox contact with family members

	Negative	Mixed/neutral	Positive
Contact with siblings (n=28)	3 (11%)	18 (64%)	7 (25%)
Contact with birth parents (n=85)	23 (27%)	54 (64%)	8 (9%)
Contact with extended family members (n=31)	4 (13%)	20 (65 %)	7 (23%)

Table 10.7: Parents rating of contact for themselves: Two way letterbox contact with family members

	Negative	Mixed/neutral	Positive
Contact with siblings (n=29)	5 (17%)	14 (48%)	10 (35%)
Contact with birth parents (n=96)	39 (41%)	40 (42%)	17 (18%)
Contact with extended family members (n=35)	7 (20%)	16 (46%)	12 (34%)

Many cases included in the '2 way contact' category involved sporadic replies from the birth family or replies that had stopped early into the adoption. Replies from birth relatives were usually wanted by adopters. Letters were appreciated when they:

- Provided information about their child's background, how their child came to be adopted and how family members were getting on
- Provided previously unknown details of fathers and other relatives
- Helped the child to feel that their birth relatives were interested in them and cared about them

Parents often expressed dissatisfaction with what were seen as 'inappropriate' letters, particularly when referring to those sent by birth parents. Issues referred to by adoptive parents included:

- Birth parents describing themselves as 'mum' or 'dad' or as the 'real' parents
- Including their address
- Letters which were perceived as being 'emotive', 'offensive' or 'incoherent'
- Letters including information/photos of relatives unknown to the child
- Letters suggesting the child could see them when they turned 16 or stating 'come and find us when you are old enough'
- Sending the wrong age card for a birthday
- Letters that arrived irregularly/sporadically
- Letters which did not provide wanted information

'Offensive comments from birth parents…Due to [parents] learning disabilities [the letters are] fairly incoherent and not appropriate letters to share with the children.'

'*I will not allow someone to reject my child over and over again by not sending a letter. Or only send one when they want to…'*

Receiving letters that were upsetting or seen as inappropriate sometimes resulted in adoptive parents stopping contact. However there were instances of initially problematic contact changing to become more positive after a period of time had passed,

'Birth mother was initially extremely aggressive and hostile but now sends good appropriate letters for letterbox contact and thanked me for agreeing to do letterbox contact… [she]

now writes a letter to my daughter and a letter to me. I look forward to writing to her and receiving her letters...'

A few parents shared that it was hard to write letters. Some struggled with the knowledge that the parents had caused harm to their child,

> *'I find it hard to write jolly letters about the children to someone who I know in all likelihood would have caused significant harm to them'.*

Another felt their letters appeared boastful,

> '*I felt we were bragging about what we had been doing with him, taking him abroad and thoroughly spoiling him.'*

Another struggled with the yearly reminder that the child had another family,

> *'That he is also someone else's son, which is not very nice considering that he is ours.'*

It was acknowledged by some that more feedback would be helpful from the people they were writing to. These opinions of adoptive parents about contact and their feelings about birth relatives may reflect real differences in how birth parents manage the contact, e.g. whether they feel positive about the adoption, resigned to it or are still angry (Neil, 2006). But they may also reflect differences in how adoptive parents feel about birth family, and how 'communicatively open' they are (Neil, 2007).

There were examples of where letters had been helped by a face-to-face meeting with the relevant birth family member at an early stage, building empathy with their situation and helping establish a relationship,

> *'My husband and I met birth mum on one occasion for an hour...The face-to-face contact between us (no child) and birth mum was positive as it helped dispel some myths we had about her and made you realise she was just someone who made some bad mistakes in her life and was paying the ultimate price with the loss of her children...'*

It was not always known whether the child was involved in the letterbox contact as the responses did not always make this clear. However in many cases it was apparent that the

child was *not* involved, and this was sometimes explained to be because the child was '*too young'* or that the letters were *'inappropriate'* or sporadic. Children of a variety of ages (including teenagers) were not aware that letters were being received from the birth family.

In other cases parents explained that children (including pre-school children) were involved in the letter exchange even if in a limited way. Letters from birth relatives were read to them, and they signed or suggested things to go into the outgoing letters. Sometimes the child just knew the letters came, and they were kept safe for them if they ever wanted to see them. For these families there will be no need to suddenly announce the information in the future, and risk a young person feeling that things have been kept hidden from them.

One parent with letterbox contact spoke of how they would have liked face-to-face contact instead as this would have been more meaningful for their child but it was not seen as 'appropriate' by the adoption team,

> *'At this age letter contact means nothing to our daughter, so direct contact would have meant a lot more to her. We want her to know as much as possible about her birth family so that it is just a normal aspect of her life and doesn't become a big romanticised question for her… We are pleased to get anything she might send as we think it will mean a lot to her down the line.'*

10.10 How did families experience face-to-face contact?

Ratings of contact by respondents who had experienced face-to-face contact were also selected out of the data and scores can be seen in tables 10.8 and 10.9 below. Families who had experienced face-to-face contact with siblings mostly experienced it to be positive for their child and themselves. With regard to parents and other adult relatives, results presented a greater mix of responses. Contact with parents had more often been a negative experience and contact with other adult relatives had more often been positive (however note that numbers of those having face-to-face contact with adults are small so it is inappropriate to draw any firm conclusions).

Table 10.8: Parents rating of contact for their child: Face to face contact with family members

	Negative	Mixed/neutral	Positive
Contact with siblings (n=53)	3 (6%)	9 (17%)	41 (77%)
Contact with birth parents (n=8)	5	1	2
Contact with extended family members (n=5)	1	2	2

Table 10.9: Parents rating of contact for themselves: Face to face contact with family members

	Negative	Mixed/neutral	Positive
Contact with siblings (n=53)	3 (6%)	8 (15%)	42 (79%)
Contact with birth parents (n=8)	5	1	2
Contact with extended family members (n=6)	1	3	2

Sibling face-to-face contact was felt to be positive for most families who completed the rating scale (77% positive for children, and 79% positive for parents). In open boxes many parents described positive experiences with siblings having close bonds and adoptive parents of siblings receiving support from each other or becoming friends. The contact had often evolved to increase or become more natural and open, prompted by adoptive parents. It could include more frequent visits, sleepovers, and shared holidays and celebrations. This was particularly common with sibling contact where the children seemed to get on well,

'Her sibling stays with us overnight every few weeks. He is free to visit us as often as he wishes to… we wanted to increase contact between the siblings and promote their bond as much as we could.' (Parent of 7 year old)'

In three cases however the face-to-face contact with siblings was felt to be negative for the adoptive family and in two of these cases it had been paused or stopped by parents. One referred to the sibling's adoptive mother requesting a break in contact after the respondent's child disclosed information that upset his sister and she required counselling. Another respondent stopped contact after the early years as their own son was 'really unsettled' after visits. A couple of parents stopped or struggled with contact as the older siblings were in contact with birth parents (one sibling passed the adopters' phone number on to her birth mother and she phoned her).

Face-to-face contact with a birth parent or other adult birth relative was rare. Only 13 families had experienced such contact (6 with a birth parent, 5 with other adult relatives and 2 with both a birth parent and other relatives). In the small number cases where face-to-face contact was occurring it nearly always occurred following proactive action by adoptive parents or young people rather than having been established from the beginning. A few parents initiated this form of contact because they felt their child needed to see their parent/relative, that the relative themselves would benefit, or because it seemed easier than letterbox and there seemed no reason not to see the person. There were examples of face-to-face contact being initiated for children of a variety of ages, including pre-school and middle childhood, as well as young teenagers. Contact which had generally been initiated by *parents* in this way tended to be seen as positive for all. One parent referred to the face-to-face contact they initiated with her sons' birth parents, which started when her eldest was 5 years old, as,

'*Incredibly positive. We're 100% sure that, without it, our eldest would have developed emotional and behavioural problems [when it started] … it was like a switch had been flicked and he was okay. It was a remarkable transformation.'*

Another noted how,

'Grandmother is a positive influence and loves our child.'

One parent referred to having to work proactively and flexibly to deal with difficulties with contact to improve it for all parties, for example arranging the contact during school holidays so that the children have time to process it before and after, and choosing natural enjoyable

venues. They stressed the importance of working *"flexibly and with empathy"* towards parents, who can behave unpredictably and struggle to keep to time and dates. Their approach was,

> '*… to play the long game; to appreciate the value of contact (or even the potential value) and gradually build relationships. It's helpful to think of birth family as like in-laws, or a different branch of the family that you've been (re)united with… We're committed to creating happy, shared memories because that's what sustains relationships.'*

Some contact coded as face-to-face included cases where a young person took their own independent action, often without their adoptive parents' knowledge, to track down their birth family (usually parents) on social media. This usually resulted in mixed and negative experiences. For example a 14 year old who sought out his birth parents became,

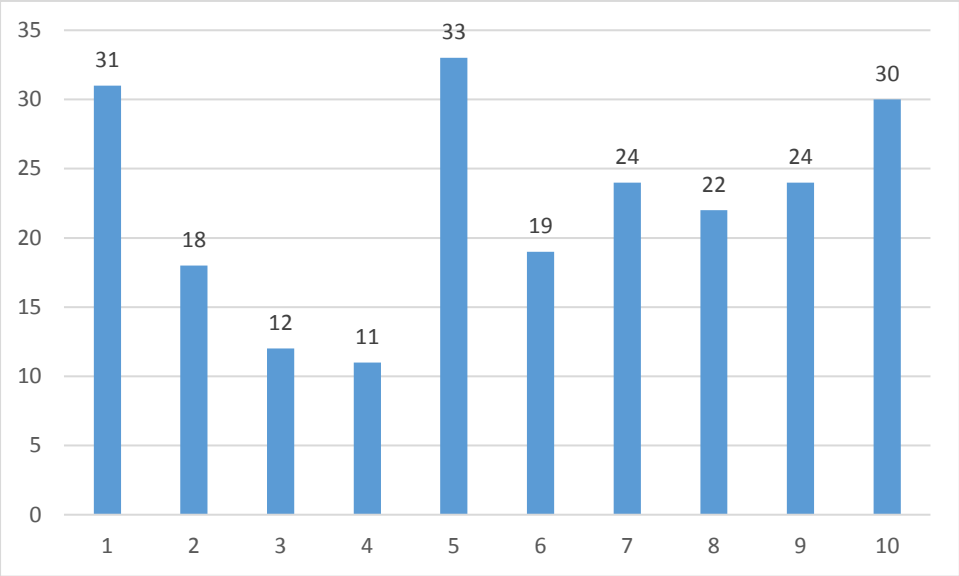
> '…*unsettled… he acknowledged they are like strangers. But not knowing how they were was something he couldn't cope with. One parent has moved on, stopped the drugs, had another family and is trying to make amends with my son. The other parent hasn't changed and is a negative influence on my son. The whole situation has put a strain on our relationship.'*

One face-to-face contact that was planned to be regular from the beginning (in a distant relative adoption) was apparently stopped at the birth mother request as she found it "*too hard and emotional to say goodbye."* This was also coded as a negative experience by the respondent.

10.11 Adopters' views on the value of contact

We asked parents to indicate how *important* they thought it was for their child to have contact with their birth family, using a 10 point rating scale. This question was answered by n=224 parents and very mixed views regarding contact and its value in the lives of their children were revealed. As shown figure 10.7 below, almost the same number chose the extreme end of '*not at all important*' (n=31) to those who stated it was '*very important'* (n=30). Nearly a third (n=72, 32%) chose a score of 4 or under indicating they felt that it was not particularly important. Just under half (n=100, 45%) chose a score of 7 or over, indicating a feeling that it was to some extent important. Nearly a quarter (n=52, 23%) remained in the middle choosing a score of either 5 or 6.

Figure 10.7: Answers to the question 'How important do you think it is for your child to have some kind of contact with their birth relatives' (1 = not at all important and 10 = very important)'



Many parents (n=202) gave further detail on their views of contact in the open response box provided. As expected from the quantitative picture above, answers varied considerably. Some expressed negative views about contact including statements that is was a, "…*pointless exercise"*, for, "*the benefit of birth parents only"* and that it, "*not always healthy or in the child's best interests to know*." One parent disliked the annual *"…reminder of adoption*."

Some answers indicated that many seemed unsure what they should do regarding contact and whether their child should be involved, or whether they should be allowed, "…*to move on and forget [their] early life experiences."* Some felt there was lack of relevant research and information available to aid them with making informed decisions regarding contact in particular situations.

Contrastingly other adoptive parents seemed very committed to keeping up contact with the birth family and clear of their reasons for doing so. They referred to the importance of contact to help with their child's future questions and long term identity needs, as a vehicle through which they could support their child gradually through their journey of self-exploration and to avoid future shocks and discoveries via social media,

'With social media, I'd encourage adoptive families to build relationships before the teenage years so that finding birth family is all a bit ho-hum by the time puberty rages. Our children

need to feel that their identity with us is integrated with their birth identity - they are not separate but part of the whole. They need to know that we can accept and embrace their histories as part of who they are now. This feeds into openness to ask questions and talk about their birth family as part of processing their early experiences and coming to terms with early trauma.'

10.12 Adoptive parents' recommendations for practice

Parents were given an opportunity to provide advice or suggestions to improve contact between adoptive parents/children and the child's birth family. One hundred and seventeen people responded to this open question. A number of suggestions emerged for agencies including:

- Provide support to track down relatives and establish contact when it was not taking place, or when there were no replies from the other party.
- Provide greater support to encourage sibling contact. Do not assume adopters/carers will be proactive e.g. *"We are too stressed and busy day to day to get on top of it. It would be better for us if his independent reviewing officer just directed the social worker to plan two dates a year, venue etc. and then we could just come along to it."*
- If contact cannot be established, try to at least provide some knowledge on the reasons for lack of contact and up to date information on family members.
- Advise and support birth family members to keep to agreements, to understand the contact, to write beneficial, age appropriate letters, and to sign them appropriately. Consider the use of a pro forma to complete by birth relatives, to help them send more appropriate information about themselves.
- Check letters, and let parents know that their letters had been received, sent on and received by the other party.
- Consider other types of contact such as video letters and audio recordings.
- More encouragement to consider promoting face-to-face contact (especially with siblings) despite the anxieties it may provoke in adopters.
- More sharing between workers involved with different children from the same family.

Some advice given applied to adoptive families and contained a mixture of suggestions. Many encouraged and promoted contact however some placed less value on the continuation of contact, leading to some contradictory advice. Those who had made contact work positively for themselves and their child suggested:

- Carry on sending letters even if not getting anything back and save letters, keeping in mind what your child may need to know In the future, and keeping your own feelings separate. Don't keep letters secret from your child but don't make a big deal about them.
- Try to meet birth family,

  'It answers a lot of questions that you can't get from reading reports. We found it also helped to quell any concerns we had about ill feeling towards us and we also came away knowing that she would not be any kind of threat to our new family. We honestly feel that if our paths should cross at any time, that she wouldn't approach the children, she might make eye contact with us, but would walk on past. That was invaluable to you.'
- Respond to your child's needs and wishes in a flexible manner, such as arranging extra contacts or moving to more open contact – perhaps trying one meeting and revising as necessary.

10.13 Chapter summary

This survey explored the perspectives of adoptive parents about the contact they and their children had had with children's birth relatives. Few children were having any direct contact with birth relatives, especially with birth parents. In contrast letterbox contact with parents was the most usual plan. Parents were generally positive about contact with siblings, though the majority of adopted children were losing contact with all of their siblings, sometimes despite the wishes of children and their adoptive parents to stay in touch. Adoptive parents had differing views on contact and its value in the adopted child's life, but the overall picture is one of contact being an area where adoptive parents experience a number of anxieties, challenges and where they are often dissatisfied either with the contact itself, or with the support from the adoption agency around contact. As well as the adoptive parents own ambivalence about contact, many adopters reported that birth family members had not been able to keep up planned contact, a finding echoed in other studies (e.g. Smith & Logan, 2004; Neil *et al*, 2015). This raises important questions about whether the way that contact is currently conceived of and managed is working effectively for children, birth relatives and adoptive parents.

Specific findings are summarised below.

- The survey showed families to have a diverse range of contact, however letterbox contact was by far the most common plan for contact with birth parents. The inclusion of the extended birth family in contact plans was not common.
- Levels of face-to-face contact with birth family members were low: 25% (of children with siblings elsewhere) had some face-to-face sibling contact. Just 3% of children had experienced face-to-face contact with a birth parents and 3% with a grandparents or other adult extended family member.
- In terms of differences in contact planning there were indications in the data that more contact was taking place for children who were aged 2 or over at placement, for those who had been adopted more than 5 years ago, and those who were adopted from certain local authorities.
- Where birth siblings had been placed in other families, most parents were keen for some type of contact with them, and were usually not satisfied if it was not occurring. Face-to-face contact with siblings was positive for the majority of families where it occurred.
- There were examples of very positive letterbox and face-to-face contact with adults from the birth family, but also many examples of families struggling to see the role of the contact in their child's life, to explain the contact (or lack of contact) to their child and be motivated to continue with their contact plan. However nearly all adoptive parents wanted at least up to date *information* about their child's birth family.
- A key issue with letterbox contact was the lack of or sporadic replies from birth family members suggesting birth relatives may need help and reminders to understand how contact can help their child, to know what type of information is wanted. Adoptive parents could not always see a long term benefit to contact and struggled to explain sporadic or lack of replies to their child in a way that helps them not to feel rejected.
- In the small number cases where face-to-face contact was occurring with adult relatives it nearly always occurred following proactive action by adoptive parents or young people rather than having been established from the beginning. A few parents initiated this form of contact because they felt their child would benefit, and in these cases it tended to be positive for all.
- There were a few cases where a young person took their own independent action, often without their adoptive parents' knowledge, to track down their birth family on social media. This resulted in mixed and negative experiences.

Chapter 11 - Support services

(This chapter was co-written with Dr Lisa Holmes and Clare Lushey; at the time of the study both were based at the Centre for Child and Family Research, Loughborough University)

11.1 Introduction

As discussed in chapter 6, significant proportions of adopted children experience emotional, behavioural and mental health difficulties. As such, timely and appropriate interventions are needed to ensure the wellbeing of the children and their families. This chapter explores adoptive parents' experiences of using or trying to obtain adoption support services and draws on both quantitative data from the section of the questionnaire based on the adapted version of the client services receipt inventory (CSRI) (Beecham & Knapp, 1992; Byford and Fiander, 2007 and Holmes and McDermid, 2012) and qualitative data provided by adoptive parents in open boxes.

11.2 The Adoption Support Fund (ASF)

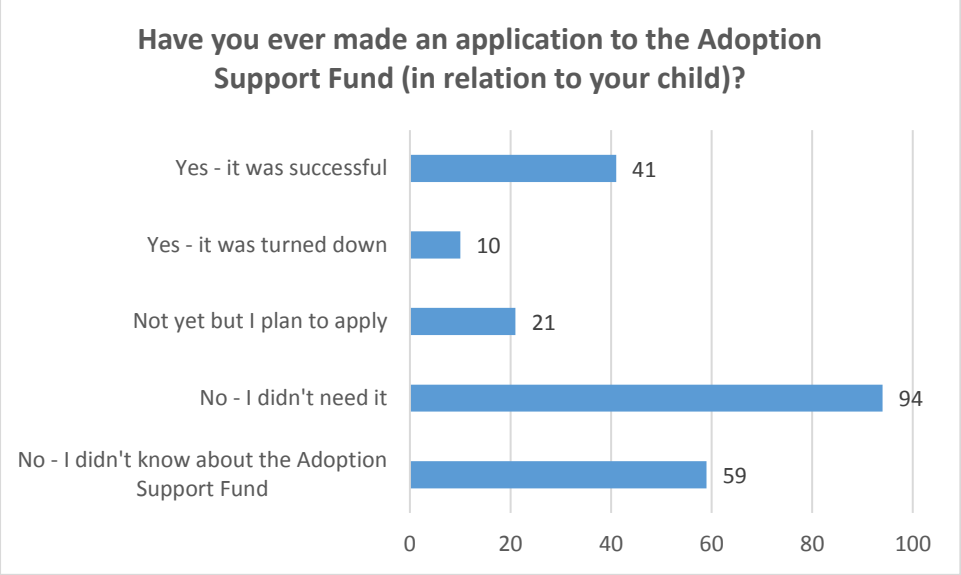
In 2013, the Department for Education (DfE) set out proposals to recruit more adopters and improve the support available to adoptive families ('*Further Action on Adoption: Finding more loving homes').* Recognising that many families had struggled to obtain therapeutic support following adoption, investment was made into a national Adoption Support Fund (ASF). Since 1 May 2015 adopters throughout the UK have been able to apply for this funding via the local authority where they are resident. In October 2016, the DfE announced that demand for the Adoption Support Fund was over twice the level forecast and despite increasing funding by an extra £2 million, it had been forced to take action to limit access to the fund. Despite this investment many families still experience issues or delays in accessing financial support for much needed services, including through the ASF (King et al, 2017).

The survey asked parents to indicate if they had ever made an application to the Adoption Support Fund. News of the ASF clearly had not spread to all adopters, as just over a quarter of parents (n=59, 26%) had not heard of it. Nine of these parents had indicated elsewhere on the survey that they had experienced a lot of difficulties with the adoption so it is possible that this may have been a help to them.

As can be seen in figure 11.1, 51 parents had applied for the funds (23% of those who answered this question) however 10 of these parents – approximately 1 in 5 of all applications

– had been turned down. The most common reasons given were that the cost of the requested service was too high, or the parents were told that they earned too much money (this is interesting as the ASF is not means tested). For those with successful applications, the ASF had primarily funded therapy and Theraplay courses. Some had so far received enough funding for assessments only. A small number had received help to attend conferences and training and one referred to receiving respite support. Further information about adopters' experiences of accessing the adoption support fund is reported in section 11.4.3.

Figure 11.1: Number of applications for, and awareness of, the Adoption Support Fund



11.3 Quantitative data on support services

Parents were asked to record information about services received in relation to their adopted child, length of service provision and frequency of use, and who paid for the support they received. Analysis for this report focused on:

- The 10 most used services within the last 12 months;
- 10 most used services received in the past;
- 10 most frequently wanted services, but never received;
- How long and how often adopted children and their families used the 10 most used post adoption service in the last 12 months; and
- Whether the costs of the services detailed in the survey were met by the adopter's local authority, covered by the Adoption Support Fund (ASF), paid for by the adopters (or their family/friends) or whether no cost was incurred, plus the top five services paid for by local authorities and adopters (or their family/friends).

Two hundred and forty-five (77%) parents out of 319 reported that their adopted child had received a professional intervention or received help/input from services detailed in the survey. This is similar to Selwyn and colleagues (2014) study that found that 83% of adoptive parents had received some form of post adoption support but much higher than Pennington's (2012) study that found only 47% had received support post adoption.

11.3.1 Ten most frequently used services within the last 12 months

The most frequently used service, in the last 12 months, was social events for adopted children and/or their families with 85 adopters stating that they had used this service within this timeframe. This was followed by support groups for adopters and special needs support/Special Educational Needs Co-ordinator (SENCO) with 134 (67 for each service) adopters identifying these services. Similar to Lushey and colleagues' (2017) study, general advice and information, parenting classes, and pastoral support were also in the top 10 most used services in the last 12 months. Five of the 10 most frequently used services in the last 12 months were adoption specific and all but one were low level support services, i.e. support groups, social events, and online services. Only one of the services could be considered a higher tier service, that is, play therapies with 36 adopters using this service within the last 12 months. This is similar to Bonin and colleagues (2013) who also found that therapeutic services were not cited as much as lower level support such as support groups, whereas Lushey *et al* (2017) and Pennington (2012) found that the most accessed services ranged from high to lower tier services. See table 11.1 below for further information.

Table 11.1: Ten most frequently used services within the last 12 months

Services	Number of adopters
Social events for adopted young people/ families	85
Support groups for adopters	67
Special needs support/SENCO	67
General adoptive parenting advice and support	58
Peer/social & emotional group support within a school setting	48
Adoption parenting classes/training	47
Online chat groups/forums of adopters	44
Mentor/pastoral worker	39
Play therapies	36
Online chat groups/ forums for parents of children with disabilities	34

11.3.2 Ten most frequently used services in the past

The service most frequently used in the past, was the same as the most frequently used within the last 12 months, this being social events for adopted children and/or their families, with 66 adopters stating they had used this service in the past. This was followed closely by adoption and parenting classes (63 adopters), and general adoption parenting advice and support (59 adopters). Six out of the ten most frequently used services in the past were also in the top 10 used in the past 12 months. See table 11.2 for further details.

Table 11.2: Ten most frequently used services in the past

Services	Number of adopters
Social events for adopted young people/ families	66
Adoption parenting classes/ training	63
General adoptive parenting advice and support	59
Support groups for adopters	51
Life story work	49
Play therapies	41
Support groups for adopted children/young people	28
Speech and Language therapy	26
Peer/social & emotional group support within a school setting	25
Educational Psychologist	24

11.3.3 Ten services most frequently wanted but never received

The most frequently wanted service by adopters that they never received was life story work, with 31 adopters reporting that they would have liked this service. This was followed by therapeutic parenting training (21 adopters). See table 11.3 for the 10 most frequently cited services that adoptive parents wanted but did not receive. Many of the ten services most frequently wanted but not received were less accessible and more expensive therapeutic services.

Table 11.3: Ten most frequently wanted services that adopters never received

Services	Number of adopters
Life story work	31
Therapeutic parenting training (e.g. Dyadic Developmental Psychotherapy, Nurturing Attachments, AdOpt)	21
Psychological support	18
Support around contact with birth family	18
Counselling	16
Holiday clubs/activities for children with disabilities	14
Conduct problem therapies (e.g. Non-Violent Resistance, Multisytemic Therapy, Break4Change)	13
Cognitive and behaviour therapies (e.g. CBT, Eye Movement Desensitisation and Reprocessing Therapy, Dialectical Behaviour Therapy)	13
Therapeutic camps or respite	13
Family therapy	13

11.3.4 Length of time and regularity of service use for the ten most used post adoption services, in the last 12 months

Adopters were asked to provide details on how long (e.g. one month) they had been accessing the services they reported they had used in the last 12 months and also how often (e.g. weekly) they used these services.

Regularity of service use varied and ranged from daily to occasionally throughout the course of a year, or for some adopters they accessed the service as a one off event. The services that were used most often (i.e. daily) were those that were easy to access, (e.g. because they were online or within a school setting), such as: online chat groups or forums of adopters and special needs support and/or support from a Special Educational Needs Co-ordinator (SENCO) (the latter was also accessed frequently on a weekly basis). Those accessed on a weekly basis were varied and included: peer/social and emotional group support in a school setting, support from a mentor or pastoral worker, play therapies (e.g. Theraplay, Filial therapy and SafeBase), and online chat groups or forums for parents of children with specific disabilities/issues. Two services were most commonly accessed on a monthly basis and they

were support groups for adopters and general adoptive parenting advice and support. All other services were generally accessed mostly just a few times a year or on one occasion only (i.e. it was a one off session/event). This included adoption parenting classes/training and social events for adopted young people and their families. See table A4.1 in appendix 4 for further details.

Support from services tended to be for between 7 to 12 months and this included the following six services: social events for adopted young people and families, support groups for adopters, special needs support and/or support from a Special Educational Needs Co-ordinator (SENCO), general adoptive parenting advice and support, online chat groups or forums of adopters, and support from a mentor or pastoral worker. Play therapies (e.g. Theraplay, Filial therapy & SafeBase) and peer/social and emotional group support within a school setting were accessed for between two and six months. Adoption parenting classes were most often a one off event. Access to online chat groups or forums for parents of children with specific disabilities/issues was varied. See table A4.2 in appendix 4 for further details.

11.3.5 Funding sources for all post adoption support services accessed within the last 12 months

Adopters were asked to state how the post adoption services they had accessed, within the last 12 months, were paid for. Most of the services in the list of the top 10 accessed in the last 12 months would have been free to parents. In the main parents thought that ultimately most services had been funded by local authorities (n=785) – this encompassing both adoption specific services like support groups or social events as well as SENCO services. This was followed by there either being no cost (this means the adopters did not think there was a cost to the service) or where the adopters did not know who had funded the service (n=325) (many of these services may also have been provided by local authorities, but being free to parents the 'funding' may not have been visible). The remaining services were paid for by the adopters or their family and friends (n =109), or the Adoption Support Fund (ASF) (n = 88). Funding sources are broken down further below. Please note adopters were allowed to select more than one funder.

For adoption specific services such as support around contact with family, support groups and online forums for adopters the majority of these services were paid for by the adopter's local authority (n = 400). See table 11.4 below for further details.

Table 11.4: Adoption specific services by funding source

Service	Self/family or friends	ASF	LA	No cost/don't know
General adoptive parenting advice	3	4	59	26
Adoption parenting classes	9	7	65	14
Support around contact with birth family	1	1	28	4
Online chat groups or forums of adopters	8	0	6	39
Support groups for adopted children/young people	3	3	30	7
Social events for adopted young people/adoptive families	7	6	106	16
Life story work	3	4	42	5
Support groups for adopters	9	2	64	20
Total	43	27	400	131

Similar to adoption specific services, therapeutic and counselling services were also in the main provided by the adopter's local authority (n=152), however a large number (n=56) were also funded by the ASF. The ASF is to help adoptive families access support following adoption, through paying for therapeutic support (DfE, 2015). However, although the ASF is for intended for therapeutic support, information provided by adopters in this study suggests it might have been used to fund other types of services including adoption specific services, educational services, and universal services. See table 11.5 below.

Table 11.5: Therapeutic/counselling services by funding source

Service	Self/family or friends	ASF	LA	No cost/don't know
Counselling	5	4	14	3
Play therapies		15	45	3
Therapeutic parenting training	2	13	14	0
Conduct problem therapies	3	4	6	1
Cognitive and behaviour therapies	2	6	7	1
Educational Psychologist	1	2	17	11
Therapeutic camps or respite	0	1	3	1
Psychological support	1	3	11	2
Psychiatric support	1	0	6	2
Medication for emotional/behavioural or psychiatric problems	0	0	6	4
Individual psychotherapy	1	1	3	0
Family therapy	4	6	13	2
Occupational therapy	0	1	7	2
Total	22	56	152	32

Similar to adoption specific and therapeutic services, educational services and health services were mainly seen by adopters as having been funded by the local authority (n = 98 and n = 67 respectively). See tables 11.6 and 11.7 below for a further breakdown of funding sources. However, although adopters reported that in the main their local authority paid for health and mental health interventions it is likely that some of these costs were covered by the NHS.

Table 11.6: Educational support by funding source

Service	Self/family or friends	ASF	LA	No cost/don't know
Virtual School Team	0	1	8	3
Education Welfare officer	0	0	4	4
Special needs support/SENCO	3	1	45	23
Peer/social & emotional group support within a school setting (e.g. nurture groups)	1	0	37	23
Hospital education	0	0	4	1
Total	4	2	98	54

Table 11.7: Health interventions by funding source

Service	Self/family or friends	ASF	LA	No cost/don't know
Eating disorders support	0	0	1	2
Continence services	0	0	4	1
Physiotherapy	1	0	2	3
Speech and Language therapy	0	0	30	7
Paediatrician	0	0	19	12
Community Nurse	0	0	0	3
Sleep clinic/services	0	0	4	0
Enuresis clinic	0	0	7	3
Total	1	0	67	31

Unlike the services listed above in the main adopters reported that there was no cost for the disability or universal services they received or that they did not know who had paid for the services. See tables 11.8 and 11.9 below for further details.

Table 11.8: Disability services

Service	Self/family or friends	ASF	LA	No cost/don't know
Online chat groups or forums for parents of children with specific disabilities/issues	3	0	1	19
Short break services for disabled children	2	0	4	0
Support groups for parents of children with specific disabilities/issues	1	0	4	7
Youth clubs for children with disabilities	6	0	7	0
Support for disabilities or specific issues with health & development	0	0	0	0
Total	12	0	16	26

Table 11.9: Universal services by funding source

Service	Self/family or friends	ASF	LA	No cost/don't know
Support groups for parents (not adoption specific)	1	0	4	7
General parenting advice and support (not for adopters)	2	0	4	8
Mentor/pastoral worker	0	2	28	10
Universal parenting classes/training	3	0	6	3
Online chat groups or forums of parents (not adoption specific)	2	0	3	16
Holiday clubs /activities	19	1	4	2
Advocacy service	0	0	3	1
Total	27	3	52	47

The costs of the five services most frequently paid for by local authorities and the five most frequently paid for by adopter (or their family/friends) were not that dissimilar. In addition, many were adoption specific. See tables 11.10 and 11.11 for further details.

Table 11.10: Top five[11] services most frequently paid for by local authorities

Top five services frequently paid for by local authorities	Frequency (identified by an adopter)
Social events for adopted young people/adoptive families	106
Adoption parenting classes	65
Support groups for adopters	64
General adoptive parenting advice and support	59
Special needs support/SENCO	45
Play therapies (e.g. Theraplay, Filial therapy & SafeBase)-	45

Table 11.11: Top five services most frequently paid for by adopters or their family/friends

Top five services frequently paid for by adopters	Frequency (identified by an adopter)
Holiday clubs and activities	19
Support groups for adopters	9
Adoption parenting classes/training	9
Online chat groups or forums of adopters	8
Youth clubs for children with disabilities	6

11.4 Adoptive parents' comments on experiences of receiving/not receiving support

Additional questions in the survey gave parents an opportunity to provide further detail on their experience of support services. They were asked to elaborate on what they had found most helpful, not helpful, whether they had experienced and delays or difficulties in accessing services and whether they had any unmet needs in relation to their child. Finally they were asked to make suggestions for the improvement of services for adoptive families and their children. Parents' responses to these questions illustrated a wide spectrum of experiences of support across the positive to negative continuum. Some parents had not experienced any delays or difficulties in accessing support e.g.

[11] Special need support/SENCO and play therapies were joint fifth.

'No [delays experienced] - any assessment and treatment has been prompt and professional.'

However others felt they had to battle for all support received, or were left on their own without help they felt they needed,

'The support for adopters is totally lacking. I had to pursue and took a very active role in seeking solutions. There was little to nothing useful available. This is a massive failure. How come foster carers get ongoing support & respite and adopters get nothing routinely. It's madness - kids with the same problems.'

11.4.1 Support from adoption teams and social workers

There were many positive comments from parents involved with a variety of local authorities and voluntary agencies in the Yorkshire and Humber area. Adoption social workers were particularly valued when they were:

- Supportive ('*someone to talk to about anything, gave us confidence in our parenting, and provided a friend in a time of need')*
- Understanding ('*so nice talk to someone who immediately 'gets' everything')*
- Trustworthy, and will listen without judgement ('*I've had an experienced social worker who knows me so I can be honest to say I am struggling and how bad it has got. When things get really tough I know parents are concerned they might have their children removed so don't tell support workers the reality of living with traumatised children who are violent and angry. The trusting relationship is everything')*
- Quick to respond ('*they immediately put me on a mailing list for info, training, events etc. and informed me of drop in sessions in my area but because I had a problem there and then she said the next one was too long to wait so within 20 minutes someone phoned and gave me a helpful consultation leaving her number in case I required further assistance')*
- Available when required to help in a crisis ('*Social worker's support was available at the end of a phone, and visits happened within a few hours of help being requested'* and *'My agency have been on call. They have a 24hr phone line for issues. There is always someone there who can listen and advise')*
- Informative on services available ('*support sessions with advice and services, [and they] come to tell everyone what is available to them')*
- Had expert knowledge on key issues ('*She had so much knowledge and training around attachment and developmental trauma'*)

- Proactive *('She's got us interim support with Early Help Hub to help our son with his anger issues…She's also helped with liaising with the school to help there and to identify attachment issues he has which display as 'disruptive and naughty' behaviour. And helping the school to deal with these issues from the angle of an adoptive child. She also recommended us to Chrysalis who assessed our son as needing therapeutic help which we have still to get').*
- Committed to help *('Although it has been a slow process, the children's social worker and the local authority seem committed to providing the therapeutic support the children need')*

However adoption teams were also frequently mentioned in answer to questions which invited parents to discuss difficulties with accessing support. Differences between workers within the same teams and between local authorities in adjoining areas were highlighted by parents. Sometimes the same parents were able to contrast different approaches by neighbouring departments or social workers in the same team that they had been in contact with.

A few parents referred to disorganised departments and administration issues which could lead to one being lost to the system,

'Because of retirement and staff shortages, we were lost to support services for several years after the adoption order. Someone eventually found us again and we were invited to adoption days out, but as my daughters had made good friends, I thought it could be counter- productive to introduce them to other adopted children en masse…'

'Overall [our] Council have been very unhelpful and disorganised. We have to constantly chase things and each time we do we find it is a different member of staff dealing with our issue…'

One frustrating problem experienced by some parents was simply not being told information by their agency,

'Did not know about help - had to sort out & investigate myself.'

'[I] was completely unaware that any of the previous support/help was available.'

Many comments in answer to the question asking about experiences of delays referred to workers in adoption teams not returning calls, not taking action or not making important decisions expediently:

'We are still waiting for [our] Council to decide on whether we can get funding from them or not.'

'8 weeks to see a SW from local authority to get assessed for adoption support fund.'

'I have asked for help with my son's behaviour and this has not happened. I approached the council in September 2016 and have been seen once in January 2017 but heard nothing since.'

There were several specific references to failure to complete key tasks of writing 'later life letters' and carrying out life story work for adopted children (these were in response to questions on unmet needs and delay). Some families had been waiting years for these to be provided,

'[Our local authority] have yet to do the life story work we have asked regularly for 3 yrs'

'We still have not seen let alone agreed our child's Life Story workbook, we have now been waiting 6 months from our adoption order being granted…Social Services should have handed everything over to us, including this, his later in life letter and baby photos 14 days after the order being granted…'

Several parents expressed how the response of their local authority to their request for help left them feeling that there were simply no appropriate services available to help them when in need,

'Huge issues ... social services just assess. Most services are apparently not available.'

'Wanted support for hypervigilant hyperactive child and was given photocopies.'

A few parents expressed their great distress in finding that their request for help led to them feeling they were being blamed for their child's issues, or their case being dealt within child protection departments,

'We asked for support from after adoption but were told if we pushed for the support our child would be put on the at risk register. When we pushed the only way they said we could get help was if we said the adoption was in danger of breaking down so we were left to struggle on our own.'

'I have put in a lot of time, work and effort putting myself in very personally awkward situations to try all to help…I feel as if social services think it is your fault.'

Areas of help particularly (requested from local adoption support teams) which remained unmet were help with dealing with every day behaviour and respite care. Eight parents specifically mentioned respite as an unmet need. In one case this was not for the parent to have breaks from the demands of day to day parenting but for one of their children to have time away from her 'extremely demanding' brother. Some families felt they were at breaking point, and although they understood the huge cost of respite, they felt it was in some situations necessary to keep a family together,

'My initial support network is no longer available…When my son kicks off, I have nowhere else he can go. I have regular 1 night a week over night respite which is great. But my adoption worker applied a year ago for short term foster care - e.g. 3 days a week. We were turned down. Our case was deemed not bad enough. But when he becomes so stressed and angry I struggle to cope and he needs somewhere or someone else to go to in order to give time or space to calm.'

'As a single parent I never have a break so would appreciate some respite just maybe once a year, and I have heard about a scheme which helps with finance towards a holiday for my son and myself but have no idea where to access this.'

11.4.2 Peer support

When given an opportunity to provide further detail on support that they had found particularly helpful, by far the most commonly mentioned area of help received was support from peers. This was obtained in variety of ways including adopter support groups, baby and toddler or play groups for adoptive parents, online chat groups (such as Adoption UK forums, Twitter and blogs), family celebration days, family fun days or training courses where they were able to meet with others experiencing similar challenges. Many parents mentioned friendship groups established with other families where people could chat via WhatsApp daily, meet

weekly, or meet socially monthly for evenings out without the children. People felt they received moral and emotional support from those who truly understood their experience,

'I have found the informal support of other parents via twitter, AUK forums and from reading blogs to be extremely helpful. ... I find the peer support from other people walking the same path as us vital - without people who understand where I am it would be so much harder.'

'The friendship group made through Theraplay which has now expanded to about 20 families has been a lifeline. We chat via WhatsApp daily, meet weekly, meet socially monthly for evenings out without the children. My husband and I have also just started a toddler group aimed at adoptive families. Peer support has been the most helpful thing for us.'

A few parents mentioned that they found it hard to access peer support or meet with adopters in a similar position to them. For example some parents worked or had busy lives and many activities arranged by the local authorities were not at convenient times.

'I like to go to meet up with other families but they are not available at good times for my family.'

It is important to note that support from other adoptive parents was not universally appreciated. At least three adopters felt that their experience did not correspond to those of other adoptive parents in the support groups offered:

'I did attend a support group meeting once, but quickly decided that certainly at the time, this had no benefits to our family. I found that a lot of the parents blamed everything on adoption, and that a lot of the situations they were labelling as problems were no different to those experienced by birth families. A few did need the extra support, and I thought it important to leave them the space.'

Another parent found it frustrating that her support group contained no parents at her stage in the adoption process,

'Local adoption self-help group. I found this frustrating and felt it was not for me. I suppose it was because there was no one there at my stage but were all waiting to adopt.'

11.4.3 Accessing the Adoption Support Fund (ASF)

The Adoption Support Fund was mentioned by several families when asked to comment on any delays experienced in connection with support requirements. Many families experienced delays in accessing services as a result of waiting for ASF applications to be completed and then hearing confirmation that their application had been approved (a typical wait was for 3 to 6 months for the latter). This meant that the fund was unsuitable for crisis intervention or could be inaccessible at times it was most needed:

> *'…my adoption support has been an absolute joke - I was advised it was sorted in October 2016 it is now Feb 2017 I still do not have confirmation of funds - I will be paying privately for support.'*

> *'...We had a meeting with social worker in June 2016 where decision was made for …an application for funding via Adoption Support Fund…When [social worker] was finally ready to make applications, the ASF cap came into effect meaning we could no longer be referred to [support provider] as the proposed assessment would exceed the cap. We are still waiting for progress re alternative routes for assessment and help (Dec 2016).'*

Some families blamed their wait on social services or social worker's inactivity or staff changes rather than issues directly connected to the fund administration itself, which led to much frustration with families keen for help to start. Additionally (as in the case above) the introduction of the cap, or 'fair access limit' of £5,000 per child was raised in connection with delay. This 'cap' means that local authorities have to share the cost of support over and above that limit; further delays can result as local authorities have to then process internal applications for in house funding to meet the additional costs,

> *'The therapy is a far greater cost than can be provided by the ASF. The Council have been asked to help but they haven't made a decision despite it being requested 4 months ago.'*

In addition to the delays associated with the ASF, other dissatisfactions with the ASF were referred to. One parent commented on restrictions for how the money could be used,

> *'Problem with adoption support fund is that you are supposed to know what you need in order to ask for it. I'm a parent not a psychologist I don't know what he needs! I would like respite for me, I would like suitable mentoring for him but that isn't available through ASF.'*

'I was assessed & it was found out that I suffer from secondary trauma. However help for this cannot be supported through the Adoption Support Fund! Even though if I have a breakdown it could jeopardise the whole adoption.'

Another parent was concerned with the difficulty of getting funding approval for all her children so that work was not started with one without knowing they would get support for the others. A couple of others had issues with the requirement that they would have to go via social services to access the fund, and due to bad experiences this was a barrier for them,

'Will never apply for ASF, even though need it - as WILL NOT EVER try to access support via social services ever again. And to apply for ASF, you have to go via social services.'

'I am aware of adoption support fund, but we have never been told how to apply or if it would be if benefit to us. We no longer have a named social worker and it can feel a bit like you have failed asking for help.'

The funding cap has also meant that some required therapy simply cannot be accessed, or is not provided for long enough,

'Sensory needs funding is about to stop due to ASF funding limits but the need is still there and needs to be met.'

Suggestions for improvement regarding ASF were to introduce a system whereby the children who need more funding get priority, or that funding is staggered so that increasingly higher need bands are eligible to get higher levels of funding,

'The cap on the limit to funding will probably help many children, but the children needing the most help get absolutely no help with this new funding cap.'

11.4.4 Therapy and emotional support

Therapeutic support was by far the most common area mentioned when parents were asked to consider needs of their child that had so far been unmet in terms of support, or whether they had experienced any delays or difficulties in accessing services. One key issue attached to accessing such therapy was the difficulty in obtaining funding for therapeutic help. As seen above, the capped ASF was not always able to match the required cost or length of work, and

any local authority money needed as an alternative to or in addition to ASF was tied up with financial year restrictions and short term restricted budgets.

Therapeutic services, especially via Child and Adolescent Mental Health Services (CAMHS), were the by far the most common support service referred to in relation to the question on delays. Many parents referred to frustratingly long waiting times from referral to initial assessment,

'Waiting a year for psychotherapy from CAMHS and her anxiety is getting much worse.'

'Waiting for CAMHS, over 9 months from original crisis point.'

Long waits could also mean that services were no longer appropriate when finally accessed, as needs had changed over the time waiting,

'…not being able to access CAMHS services as quickly as we needed to. By the time we actually received appointments, the issues had changed & we needed different types of help & support.'

'…because of the time it took for application to ASF for funds… our child's needs had changed and Theraplay, although a lovely experience, was not really appropriate.'

Many respondents expressed frustration that, after a lengthy wait, support offered was either inappropriate to their child's needs, not effective, or that they would have to travel too far to obtain the service,

'Waiting 9 months to get to CAMHS to be told yes child has significant problems but only intervention available is CBT [Cognitive Behavioural Therapy] *which does not work with children on autistic spectrum!'*

'Theraplay offered to us but would of meant our daughter travelling 3 hours in total to receive it.'

'CAMHS gives useful advice, but most of it does not produce results as such. 3 years on and my child's behaviour has not improved/ changed.'

Eligibility thresholds for CAMHS also caused significant frustration for some parents, who were then left without the help they felt they needed,

> *'Our daughter feels that she needs some support for mental health issues. After visiting the GP it was deemed that she was not bad enough to have a referral to CAMHS. She has some anger issues and feels let down.'*

> *'CAMHS has refused the referral, despite [my son] threatening suicide several times and self-harming.'*

A couple of parents expressed frustration at limited and inadequate assessments to determine the child's eligibility for therapy,

> *'I asked for CAMHS through GP…The referral session involved me with my daughter present, so it was impossible to talk freely about the issues… There was no discussion re attachment issues or support with that and referral closed.'*

However, a small proportion of adopters had positive things to say about CAMHS,

> *'CAMHS has been accessed for 2 years weekly VERY helpful.'*

> *'CAHMS* – [worker] *has been fantastic in supporting us as parents. The only person who has been on our side in the last two years.'*

Other adopters praised support received from a range of other third sector service providers including Barnardo's attachment and play therapy, therapy sessions with Chrysalis, Art therapy, multi systemic therapy and a *Parenting-Back-To-Front* package at Family Futures,

Some parents were not seeking intensive therapy or mental health support for their child but just needed help more generally around emotional issues or specific behavioural issues and had struggled to find this support:

> *'I would love for them both to have some general counselling around adoption, grief, and loss, but can't imagine it would be available where we live…'*

> *'Emotional support no one can seem to find what can tap in to my child's thoughts.'*

'I would like help with building empathy and compassion but don't know where to go for this.'

11.4.5 Education

There were many positive comments about good support from schools, especially in relation to SENCOs and pastoral teams,

'The SENCO has been worth her weight in gold - fantastic, as were the current school staff'

'Peer support group at school. In reception they operate a buddy system, this has helped her settle at school. School counselling and a nurse are on hand too if needed. They fully support our child in her adoption understanding.'

'Our school is very helpful and supportive… They are understanding and work with us for the best outcome.'

However several comments made in answer to questions about unmet needs or difficulties with support referred to the school environment (see also chapter 8). One key area frequently raised was schools failure to appreciate the emotional impact of adopted children's early lives, along with a general lack of understanding of attachment difficulties,

'I feel school still doesn't appreciate the impact of my daughter's early life and can't help her emotionally.'

'I just wish the education system educated themselves on attachment and the difficulties looked after or previously looked after children have to deal with.'

Some parents also referred to schools not using Pupil Premium effectively to support a child's individual needs as an adopted child. A couple of parents did not think their child was entitled to pupil premium. There were comments that Pupil Premium can often be just lumped in one pot for all children and used generally rather than specifically, causing an individual child's particular requirements to be missed,

'Trying to get support from Secondary School via Pupil Premium … had a meeting at the beginning of term but nothing yet - this money should be ring fenced for the adopted

children and not just go into the schools pot to be spent on other children; unless you fight for their rights they get overlooked - it is EXHAUSTING!!!'

Issues around obtaining or getting adequate support for a Statement of Special Educational Needs (SEN)/Learning Difficulty Assessment (LDA) or Education, Health and Care Plan (EHCP) were also referred to several times,

'Initial assessment for Statement of SEN (became EHCP 1 year ago) was refused but I fought it (added 3 months to process) and had no issues once they assessed my child - immediately offered high level of 1:1 support funding but it took the school 3 years to get to that stage.'

Some parents felt that it would have been useful for children to have more help to catch up with their peers and a more flexible curriculum to meet different needs:

'He could have real sports prowess- gymnastics etc… it would have been great to have nurtured these- rather than just banging the formal SATS curricula.'

11.4.6 Health, special needs and disability services

Another area mentioned by several parents when discussing difficulties in obtaining support was around assessment for special needs. There were some parents who had to wait 18-24 months for autism assessments, and others who were not able to access a FASD assessment at all,

'It is frustrating that we cannot get any FASD assessment...'

'22 month wait for CAMHS Autism assessment to start!'

'Always waiting. ADOS [autism spectrum disorders assessment] has taken 2 years'

Obtaining a diagnosis for children with a complex combination of issues was particularly difficult,

'Child is complex and lots of overlapping issues... Difficult to diagnose with her [we had delays with]…sensory integration, disassociation, trauma, Dyslexia and Dyspraxia assessments.'

Speech and language and enuresis services were specifically mentioned by a few people as area where delays were experienced,

'It took a long time for our GP to be convinced to refer our daughter to the enuresis clinic.'

11.5 Themes across service areas

11.5.1 The quality of the professional relationship

As many of the quotes referring to good post adoption support workers demonstrate, a positive experience of professional relationships went a long way to help adopters feel supported in times of need. Indeed, many adopters were positive about experiences when they felt that they had a good relationship with professionals involved in their care who took the time to know the family as individuals,

'If you can form a relationship with good key people from key services e.g. CAMHS, education and post adoption it is massively helpful.'

This relationship was vital to build the trust needed for adopters to feel comfortable asking for help as this adopter points out,

'...when I've had an experienced social worker who knows me so I can be honest to say I am struggling and how bad it has got. When things get really tough I know parents are concerned they might have their children removed so don't tell support workers the reality of living with traumatised children who are violent and angry. The trusting relationship is everything.'

However, this fear of triggering child safeguarding enquiries, through admitting that the family was struggling, meant that, worryingly, some families did not ask for help.

11.5.2 Professionalism, competence and expert knowledge

For busy parents adapting to a new and challenging role, encounters with professionals who were organised and competent was highly valued. Some parents described how disorganised departments, poor administration and late or missed appointments by social workers could add further demands on their lives and impact on a child's routine,

'[Our] Council have been very unhelpful and disorganised. We have to constantly chase things and each time we do we find it is a different member of staff dealing with our issue.'

Having trained and competent social workers who truly understand the complex needs of adopted children and families was valued. This was necessary for workers from all social work departments including child protection teams,

'Child protection social workers need an understanding of adoption issues. They see things in black and white, and had no idea of attachment disorder or developmental delay. Or the behaviours and the shame from the child's point of view.'

The importance of competence and expert knowledge with regard to therapists was also raised in comments,

'The play therapy was a disaster. Our local authority only uses one provider and they failed to build up any rapport with our son.'

The impact of every professional entering the lives of a child who has experienced much loss and separation was highlighted by one parent, who explained that her daughter had

'*an issue with people entering her life and then suddenly leaving'.*

11.5.3 Avoidance of a 'one size fits all' approach

Whilst many parents felt that the impact of adoption and early harm on children was not recognised often enough (e.g. *'Inexperienced workers who just don't get how different adopted children are and how usual ideas do not help.')* other parents felt frustration with a culture that seemed to 'blame' everything on adoption. They saw their problems as similar to those of other parents in non-adoptive families.

'Overall I found the approach of support services to be negative and focussed on the differences with adopted children with little thought about the common themes of parenting and childhood and the things which make our children 'just children' I disengaged from adoption support services at an early point as I found it incongruous with my views and experience.'

A number of parents also raised the problem of professionals treating their child and family as just another adopted child/adoptive family without recognition of their unique trajectories and differences,

> *'She was lovely to us but I didn't feel we could talk about my child as my child with her background and apply what I had learned to her rather than what 'adopted children are like'….'*

A balanced approach appeared to be one that could acknowledge the child's background and adoptive status and be constantly alert to possible ramifications of such experiences but without a blinkered focus upon a set adoption pathway in their life. In many ways this echoes Brodzinsky's characterisation (developed from early ideas by Kirk in the mid-1960s) of different approaches to the dilemmas encountered by the adoptive family. Brodzinsky explained how a healthy management of these dilemmas involved an *acknowledgement of difference* as opposed to *rejection of difference* or *insistence of difference* (cited in Brodzinsky, 1987). Where the difference adoption makes is excessively emphasised it may wrongly become the key explanation for dysfunctional behaviour in the child or the whole family system, the adopted child may be alienated from their adoptive family, problems are blamed on the biological parents and the child's genetic inheritance, individual differences ignored and general parenting issues not dealt with. Where the difference adoption makes is rejected, opportunities to work on crucial factors that may promote healthy adjustment are missed.

11.6 Summary

This chapter reported the data gathered from adoptive parents about support services received, length of service provision and frequency of use, and who paid for the support they received. Additional questions in the survey gave parents an opportunity to provide further detail on their experience of support services. They were asked to elaborate on what they had found most helpful, not helpful, whether they had experienced and delays or difficulties in accessing services and whether there were any unmet needs in relation to their child. Finally they were asked to make suggestions for the improvement of services for adoptive families and their children. The survey also collected information about their knowledge of and applications to the Adoption Support Fund.

- Just over a quarter of parents had not heard of the ASF. Just under a quarter of parents *had* applied for the funds however approximately 1 in 5 of the applications had been turned down. For those with successful applications, the ASF had

primarily funded therapy and Theraplay courses. Others had so far received only enough funding for assessments or help to attend conferences and training and respite support.

- Regardless of funding source, the most frequently used services in the last 12 months were: social events for adopted children and/or their families; support groups for adopters; special needs support/Special Educational Needs Co-ordinator (SENCO); general advice and information, adoption parenting classes and training, online support from adopters, pastoral support, peer/social & emotional group support within schools and play therapies.
- Some of the above services were also included in the 10 most frequently used services in the past, with the addition of life story work, speech and language therapy and educational psychology.
- The most frequently wanted services by adopters that they never received were: life story work, therapeutic parenting training, psychological support, support around contact with birth family, counselling, holiday clubs/activities for children with disabilities, conduct problem therapies, cognitive and behaviour therapies, therapeutic camps or respite and family therapy.
- In relation to their general experience of support, responses showed a wide spectrum of experiences of support across the positive to negative continuum. Some parents had not experienced any delays or difficulties in accessing support, however others felt they had to battle for all support received, or were left on their own without help they felt they needed.
- Adoption social workers were particularly valued when they were supportive, understanding, trustworthy, listened without judgement, quick to respond, available when required to help in a crisis, informative on services available, had expert knowledge on key issues, proactive and committed to help.
- When given an opportunity to provide further detail on support that they had found particularly helpful, by far the most commonly mentioned area of help received was support from peers.
- It was common for delays and difficulties in accessing support to be referred to in relation to therapeutic services (especially via Child and Adolescent Mental Health Services), life story work and the Adoption Support Fund.
- The was variable satisfaction with support from education and health services
- Families varied widely both in terms of the child's support needs but also the extent to which parents felt adoption issues were relevant in explaining any difficulties.
- Overall parents valued professionals they felt that could trust and who were professional.

Chapter 12 – Summary and Conclusions

12.1 Introduction

The main aim of this research project was to learn about the joys and challenges of adoption from the point of view of adoptive parents and to inform the provision of adoption support services. Three hundred and nineteen adoptive parents participated in an online survey - most were married heterosexual couples but single parents (17%) and gay and lesbian couples (8%) were also included. The survey was predominately completed by mothers (85%), and 93% of respondents were white British or Irish. Survey questions were focused on one child in the adoptive family (the most recently adopted child, or the oldest of the most recently adopted sibling group (for the 33% of families who had adopted siblings).

At the time of the survey the children ranged in age from 0 to 17 (with the mean and median ages being 7 years); just over one in five of the children (21%) were of secondary school age. This survey was commissioned by Barnardo's on behalf of Yorkshire and Humber consortium, order to inform the development of new regional adoption agencies in this area, and almost all families who took part had a connection to that part of the country. The findings of the study however are likely to be of use to adoption service providers beyond this region. The profiles of families who took part are similar to the profiles of families who have adopted nationally in terms of child gender and age at placement but the proportion of ethnic minority children (8%) was lower than reported across England in the last year (17%) (DfE, 2017a).

In this final chapter the strengths and limitations of the research and the key learning points from the study will be reviewed and the implications for adoption policy and practice will be discussed.

12.2 Strengths and limitations of the research.

The strengths of this study are that in-depth data (qualitative and quantitative) have been collected from a cross-section of 319 adoptive parents with connections to one geographical area whose characteristics are broadly similar to the characteristics of families adopting children from care across England. In terms of in depth adoption surveys, this constitutes a large sample. The design of the survey was informed through consultation with adoptive parents and professionals. Data collected has included information about children's experiences prior to adoption as well as their outcomes in the present day (measured by adoptive parent report and parent completed standardised measures), allowing the children's progress to be considered in the light of their histories. The relatively large sample size has allowed us to explore statistically the relationships between children's outcomes and a range of other factors, providing some understanding of which children do well and why. Adoptive

parents were generous in sharing their views in the open questions, allowing understanding of the experiences and processes behind the descriptive statistics reported. Extensive data has been collected about families' service use, and experiences of using services as well as their ideas about where further support is needed. The cross-sectional nature of the survey has allowed us to explore the experiences of parents with children right across the age range.

The limitations of the study are that all the data are collected from only one perspective - that of the adoptive parent. The views of adopted children, birth relatives, and professionals are not included. Neither are experiences represented of prospective adopters who had experienced a disruption before the adoption order. In terms of reporting on children's backgrounds, adoptive parents did not always have full information available and the child's history. Parents may interpreted children's histories in the light of their current functioning e.g. rating the severity of maltreatment as more severe when children had problems in the present day or vice versa.

Although the study collected information about children aged 0-17 and the different findings for those of different ages are reported, the children of different ages at the time of the survey differed in other ways as well. Most notably, children under age 6 tended to be younger at placement than older children. Agencies may have lost contact with many adopters with teenage children, except where current support was being provided. Findings for teenagers in this study may therefore over represent 'difficult' cases whilst the youngest age groups may over represent 'easy' cases. The sample also underrepresents the experiences of adoptive parents/children from black and minority ethnic backgrounds.

Although extensive data were collected from adoptive parents about service use, it was not possible to calculate individual costs of service use for families. This was because useful data about the costs of several services were not available. There are numerous problems in deriving comprehensive data about the frequency and duration of service receipt, and previous studies have documented that child level service receipt data for use in cost calculation can is notoriously difficult to capture (McDermid, 2008).

12.3 Review of research questions

12.3.1. What risk and protective factors had children experienced prior to the adoption?

Chapters 2, 3 and 7 discussed the risk and protective factors in children's lives before adoption. These data highlighted the complex and long-standing disadvantages and problems that adopters believed were experienced by the birth parents of their children. Many birth parents were described as having experienced abuse and neglect in their own backgrounds, and in adulthood birth parents were known to have high levels of personal and interpersonal

difficulties affecting parenting capacity such as substance misuse, mental health problems, learning difficulties and troubled and often violent relationships. Data about the social and financial disadvantages faced by birth parents were not systematically collected in this study, but levels of such adversities experienced by parents are also likely to be very high and may also have negatively affected parenting capacity (Neil et al, 2010).

Almost all children had been adopted from the care system and the threshold of having experienced or been likely to experience significant harm had therefore been established. The most prevalent form of abuse experienced by children was exposure to domestic violence (47%), and the most common type of neglect was emotional neglect (62%). The extent of harm experienced by children varied. Almost half (47%) of adopted children had been removed from their birth families (because of the likelihood of significant harm) and entered care when they were under three months old. Over a third of children (37%) had been at home for at least a year. Even where children had been removed at birth, a significant proportion were believed to have been exposed to high levels of alcohol in utero (52%) or to dangerous drugs (44%).

Chapter 7 reported the results of a latent factor structural equation modelling analysis. A latent factor indicating the levels of children's exposure to different forms of maltreatment was created, and the extent to which different factors predicted children's maltreatment was explored. As expected, levels of maltreatment were significantly and strongly related to the age at which children were removed from their birth parents; the longer children were at home the higher the overall severity of their maltreatment. Children who had been exposed to drugs or alcohol in utero and those whose parents had learning difficulties also experienced significantly higher levels of maltreatment. A direct impact of parental substance misuse and learning disability on parenting capacity could be one explanation for this. It may also be that parents with learning disabilities or substance misuse problems may have been disproportionally affected by other issues such as poor relationships, poverty or lack of social support and these factors may have affected their parenting. It is also possible that babies' behaviours and heath may have been affected by exposure to substances in the womb, making them more challenging to parent.

Once children had entered care, two thirds of them experienced stable care either in one foster home (60%) or were placed directly with the family who later adopted them (6%). But for a third of children (34%) the separation from their birth family was compounded by further moves and separations from caregivers as children experienced living in two or more foster homes. The statistical analysis in chapter 7 showed that children who had two or more foster homes

were significantly more likely to have a poor outcome compared to those with just one or no foster placements.

The continuity of foster care is of course important, but quality of care is another vital consideration. The good news is that for over two thirds of children (69%) the adoptive parents believed that the child had experienced a supportive and nurturing relationship with the foster carer before being adopted. Twenty percent of parents however disagreed with the statement 'I was confident about the previous carers care of my child' and in response to open questions parents' concerns mainly were around a lack of stimulation or physical or emotional neglect.

12.2.2. What factors led the respondents into adoption, and what were their expectations? How well did adopters feel they were prepared for and supported around the process of becoming an adoptive parent to their child?

Chapter 9 focused on the adoptive parents, including their motivations and expectations. Almost three-quarters of adoptive parents (72%) were initially motivated to adopt at least in part because of infertility or related issues preventing them having a birth child. Thus the starting point for most adoptive parents was not primarily an altruistic motivation to help a child in care. Helping prospective adoptive parents understand what it may mean to parent a child from care is a key challenge of the contemporary adoption system in the UK (Dance, Neil and Rogers, 2017). The vast majority of adoptive parents did feel *supported* during the preparation and assessment period (60% felt very well supported, and 32% quite well supported). Somewhat fewer, but still the majority (77%), felt at least moderately well *prepared* to adopt. What adoptive parents had valued during this preparation period was sensitive, consistent and reliable support from knowledgeable practitioners. They also valued being given full information about their own child's development and history, as well as information about how children's life experiences may affect their future relationships and development. The key complaints that adoptive parents had about the preparation period related to changes in the worker, delays in the process, and a lack of complete information passed on to them about the child.

When asked to look back to the point where they were matched with their child, most adoptive parents (72%) indicated that they had not significantly changed their initial views about the type of child they wanted to parent. Some parents had changed their preferences because of greater knowledge, confidence or understanding, or because of attraction to a particular child. Other parents however had changed their preferences primarily because they felt pushed to do so in order to increase their chances of having a child placed with them. Most people who had changed their preferences felt that their adoption was going well, but 29% said they were

'really struggling' overall compared to 19% of those whose preferences had not been 'stretched'. This association between this 'stretching' of preferences and parents ratings of the adoption outcome was statistically significant.

The adoptive parents participating in the survey were all beyond that stage of getting the adoption order so could, to some extent, reflect on how the adoption had worked out (even if it was still in the early days) compared to the hopes or worries they had had before adopting. Half of parents (50%) said they experienced more rewards than expected whilst the challenges of adoption were no greater than they thought they might be. One fifth of parents (19%), felt that adoption was both more rewarding and more challenging than they imagined it might be. For just under a third of adoptive parents however (30%) adoption had been more challenging than they anticipated, and in most cases less rewarding.

A number of factors seemed to explain this balance between expectations and experiences of parents, the most obvious one being how the child was actually progressing in the adoptive family. Some parents experienced their children as having few difficulties and being very rewarding to parent. Other parents felt their children were really rewarding to parent despite or even because of the difficulties that children struggled with. Parents who reported fewer rewards often talked about very high levels of difficult behaviour of children (in some cases including violent behaviour towards adoptive family members) and/or a lack of reciprocity in relationships. But parent's reflections also revealed that the extent to which they had been helped to *expect and understand* children's problems was of crucial importance as was the support they received (or did not receive). This emphasises the necessity of looking not just at the parent and the child, but the professional systems around the family.

12.2.3. How well did adopters think their children were cared for in foster care and what role did they feel their child's previous foster carer should play in their lives after the adoption? How well did adopters feel the transition of their child to their adoptive family was managed?

The impact of the transitional period when children move from foster care to their adoptive family is underexplored in research, but is being increasingly highlighted as an area of concern in practice. Thus the questionnaire included a section exploring these transitions, and the results were presented in chapter 5. This chapter focused just on children who had a planned move from foster care to adoption; those adopted by foster carers or in early permanency placements were excluded.

We found that the large majority of children (87%) had moved to living full time with their adoptive family within just two weeks of first meeting them. Most adoptive parents (74%) felt the timing of the move was "about right", whilst others thought this handover period was either

too fast or too slow. About three quarters of adoptive parents were generally positive about the support they and their child received from the foster carer during the handover, the information they received about their child in the foster home, and they were confident about the quality of foster care. Parents were asked how easy or difficult they felt their child found it to cope with the move and about one third of parents (32%) thought their child found the move somewhat or very difficult.

Despite these generally positive overall appraisals of the handover period, the qualitative data provided by parents suggested this process of moving children from one family to another was experienced as a highly emotional and exhausting time for adoptive parents, foster carers and often children. From the analysis of adopters' comments about factors that helped and hindered the move, what stood out as helpful were welcoming and supportive foster carers and sensitive and available professionals. Some parents however felt they had not received the necessary support from professionals. Others felt foster carers had struggled emotionally with the move and had not been able to keep the child's needs in mind or be encouraging to adopters. A particular challenge appeared to be achieving a transition plan that could be flexible enough to respond to unfolding events and the particular circumstances of the family, whilst at the same time retaining a clear focus on children's needs rather than the needs of adults or "the system".

In the statistical analysis of factors affecting children's progress in the adoptive family (reported in chapter 7) the model included whether or not the parents felt the child had found the move from the foster home to adoptive home difficult. This did emerge as a significant factor in predicting children's outcomes: where parents perceived that the child found the move difficult the child's later outcomes were poorer. This suggests the importance of managing children's moves from foster care to adoption with great sensitivity; young children do naturally feel upset when separated from trusted caregivers and ensuring that children feel emotionally supported by foster carers and adopters is vital.

Once in their adoptive homes, in three quarters of cases adoptive parents had had at least some contact with foster carers. Whether or not this happened was reported by parents to be largely determined by their wishes and those of foster carers rather than the views of professionals or children's expressed wishes. As adopters and foster carers may know the child best it could be argued that this is appropriate. But in many cases adopters' comments suggested that decisions were not always child focused. For example, a foster carer might not want to keep in touch because it was too painful for them, or adoptive parents might feel threatened by the child's relationship with the foster carer. This suggests there is a role for professional guidance around foster carer contact, though involving adopters and foster carers

in planning contact is vital. Where contact with foster carers had taken place 74% of parents felt it was positive for the child, adopters citing the importance of relationships, continuity and identity for children. Some children were thought by their parents to have desperately wanted contact with foster carers, but foster carers had refused this.

12.2.4. How were the children getting on? What were their strengths and challenges? What diagnoses had children received, if any? How were they progressing in education?

These questions were at the heart of this research project, and findings were reported in chapters 4, 6, 7 and 8. The overall picture that emerges is that adoption had provided a stable loving and supportive family environment for the vast majority of children, but that many children and adopters continued to need help and support in a range of areas, particularly support for children in managing emotional and behavioural difficulties and developmental challenges and disabilities.

As reported in chapter 4, 44% of adoptive parents felt the adoption was going really well and 35% said they were managing challenges (35%). One in five adoptive parents were really struggling to manage parenting their adopted child, though only four adoptions in the sample had broken down. The perspective of children in these families was not gathered, but is reasonable to assume that these were not only very unhappy parents, but very unhappy children and young people.

More difficulties were reported by parents whose children were older at the time of the survey, and by those whose children were older at the time of placement. Where children did have difficulties, these could be across a wide range of areas, though problems with behaviour in the home and in other settings, and concerns about the child's emotional well-being were the most prevalent problems identified.

Parents completed standardised measures about the emotional and psychological health of their children, and these data were the focus of chapter 6. The results of these standardised measures confirmed adoptive parents' subjective ratings of their children's difficulties. A substantial minority of children (44%) had clinically significant difficulties on the Strengths and Difficulties Questionnaire (SDQ). Even higher levels of problems were revealed by the Tarren Sweeney assessment checklist, a measure designed to pick up the problems that can be experienced by children who have been in care. On this measure 55% of children scored in the clinical range. The highest levels of difficulties were reported by the parents of teenagers.

When examining the results of these standardised measures against adoptive parents' overall ratings of how the adoption was going, it was seen that the vast majority of families who were 'struggling' were parenting children with high levels of emotional/behavioural problems. These

families were in crisis and had needed/were needing urgent help. But even amongst the parents who felt they were 'managing challenges', the majority of children (61 to 65% depending on the measure) also had clinically significant difficulties, evidencing that support is needed for many families not yet at crisis point. A third of the children in the study had received a diagnosis from a clinician of an emotional or behavioural problems, mental health problem or developmental disorder, though not all of these were receiving treatment or support. The results of the standardised measures suggest that many children may have mental health difficulties that have not been clinically assessed, diagnosed or treated.

Given the high levels of mental health difficulties that children in this sample had, the fact that many parents felt that they were at least 'managing challenges' and that parenting was rewarding, may be a reflection of the majority of parents believing that they and their child had formed a positive relationship. As reported in chapter 4, 70% of children were said to have a good relationship with at least one of their adoptive parents. Comments from parents showed that where the emotional bond between parents and child had been built, parents tended to feel positive overall; many parents felt great pleasure in seeing their children make small steps forward and children were loved regardless of any difficulties.

Turning now to how children were getting on in school, most children were in mainstream state schools and most parents felt their children enjoyed going to school. But levels of school exclusion (11%), the numbers of children with education, health and care (EHC) plans (19%) were much higher than in the general population. Most children who had educational special needs or difficulties in school had problems that spanned other areas in their life for example learning disabilities or emotional and behavioural difficulties. Many parents however felt that the education system was not good at responding to the particular needs of their children, and this could related to the child's mental health, development or adoption specific needs. Problems were particularly apparent for children in secondary schools with parents of children in this age group being much more likely to feel that their child was achieving below average, not enjoying school or not getting on with their peers at school compared to parents of younger children. This may reflect differences in the profiles of older versus younger children in our sample. It may however also indicate the secondary school environment is less responsive to the complex needs that some adopted children have.

12.2.5. How did the outcomes for the children relate to factors such as child characteristics (age and gender), the child's pre and post placement experiences, adoptive family structure and birth parent characteristics?

Chapter 7 reported the results of the latent factor structural equation modelling analysis which explored the links between children's histories of maltreatment, and their outcomes at the time

of the survey. Children reported by their parents to have more adverse outcomes had generally experienced higher levels of maltreatment. Other factors significantly associated with poorer outcomes were: being distressed when moving from the foster home, having spent more than a year in care, having two or more foster homes, exposure to drugs or alcohol in utero, and having a birth parent with a learning disability.

This method of analysis was helpful in that it enabled a range of factors to be considered alongside each other – for example the child's age at placement and their age at the time of the survey. This was important as many variables were highly correlated. But the model had limitations - only a certain number of factors could be included because of sample size. Furthermore both the child's background factors and the child's current outcomes were reported by adoptive parents only and the child's current progress may have affected parents' retrospective appraisal of children's backgrounds. Nevertheless this analysis is helpful in understanding which children may need more support later on based on information known at the time of the adoption. The findings also point to the importance of reducing further adversity for children once they come into the care system by ensuring that any placement moves are minimised and that children have emotional support through the process of moving to their adoptive families.

12.2.6. What was the nature and extent of post-adoption birth family contact experienced by the adoptive families? What were the challenges and benefits associated with contact, according to the adoptive parents?

Chapter 10 explored the topic of children's contact with their birth relatives. Looking first at birth parents, face-to-face contact with birth parents was exceptional (3%), and in most cases not planned from the start of the adoption but initiated at a later stage. About two thirds of adopters had experienced some letterbox contact with birth parents, though difficulties in achieving rewarding two-way communication between adoptive families and birth families were widespread.

When looking at sibling contact, half of children with siblings outside of their adoptive family had no sibling contact at all - a quarter had letterbox contact, and a quarter had face-to-face contact. Where face-to-face sibling contact was in place, 79% of adoptive said the contact was positive for their child. When it comes to the extended birth family, levels of any type of contact were very low, three-quarters of children had no contact with extended family members.

An exploration was made of whether the child's age at placement, the agency placing the child, or the time since adoption affected which children had contact. In comparing children placed under age 2 with those age 2+; the older group had higher levels of contact with

siblings, parents and grandparents. For example 35% of children age two or older at placement had face-to-face sibling contact compared to 15% of those placed under age two. Neil's previous research however found that where children were younger (under age 2 at placement) birth family contact was often more straightforward (Neil et al, 2011).

In terms of agency factors there were some suggestions in the data that certain agencies were promoting more contact than others. For example 11 of 15 parents from Bradford had some form of two-way contact with their child's birth parents compared to 8 out of 28 in Leeds. Children who had been adopted more than five years before the survey were more likely to have two way sibling contact and birth parent contact compared to those adopted in the last five years (sibling contact: 47% vs 37%; birthparent contact: 55% vs 43%). This could indicate that in more recent years there has been less promotion of birth family contact by professionals. Other explanations are that for the more recently adopted group contact might not yet have started, and for older children contact might have been initiated at an older age. It could be helpful for the new regional agencies to explore their differences in practice between local authorities and across time in more detail.

The main benefits of contact reported by adopters were that it helped them to get more information about their child's birth family, and that it helped children to feel that their birth relatives were interested in them and cared about them. In some cases, particularly sibling contact, parents felt that contact had enabled their children to maintain and build important relationships. The main challenges of contact as seen by adopters were not receiving replies to letters, not being able to establish sibling contact where children wanted this, or replies from birth relatives that were viewed by as inappropriate or unsettling for their children. All these findings echo previous research around contact (Neil et al, 2011; Neil et al, 2015).

Adoptive parents had varying views about the value of contact for their children, with less than half (45%) feeling it was important for the child to have contact with birth relatives.

12.2.7. What types of support had the adoptive families accessed, and how helpful did they find this support? What support would they have liked to be available?

The findings about families' experiences of support were predominately discussed in chapter 11. A service use inventory was used to gather information from adopters about services they had accessed to meet their children's needs and over three quarters of parents (77%) reported that their child had received some help or input from the services detailed in this inventory. The most frequently used services were lower tier services such as social events for adoptive families, support groups for adopters, and online support services. Parents were asked about services they had wanted but never received and the 10 most frequently mentioned services were reported. Six of these were various forms of therapeutic intervention such as therapeutic

parenting training, counselling, or family therapy. The other four services mentioned were life story work, help with birth family contact, therapeutic camps or respite, and clubs/activities for disabled children.

Adopters said that most services had been funded by the local authority. However parents had funded some services themselves, and examples were available across all types of service areas the most common being holiday clubs and activities, support groups for adopters, and adoption classes or training. One quarter of parents had applied to the adoption support fund, though not all successfully, and this funding was mainly used to pay for therapy and theraplay courses.

Parents' experiences of trying to obtain and using support services were highly varied. Some adopters found adoption social workers to be responsive, knowledgeable, understanding and committed. But others had experienced great challenges in accessing support from these teams and they talked about delays, a lack of resources for support, or being blamed for the problems – a small number of adopters were referred down a child protection route by the local authority. Delays in accessing therapy or emotional support were often mentioned. In contrast peer support services were much more accessible and frequently spoken about positively by adopters. Across all types of provisions adopters valued being able to build a trusting relationship with a supportive professional who was competent in understanding and meeting the needs of adopted children.

12.3. Key messages for policy, practice and for adopters.

Some key messages for child welfare policy and practice that can be drawn from this research will be briefly summarised below.

12.3.1. Reducing risks before adoption: supporting birth families

This study shows the impact that children's adverse early life experiences can have on their subsequent development. The birth parents of the children had similarly been affected by multiple adversities, a pattern highlighted in a recent study of mothers in recurrent care proceedings (Broadhurst et al, 2017). The multiple psychosocial problems experienced by the birth parents of children adopted from care need addressing. Adoption policy cannot be looked at in isolation from broader welfare policies (Featherstone, Gupta & Mills, 2018). Adoption services need to be the absolute end point after all efforts have been made to support children to remain with their families, including the funding of services which can help parents break cycles of repeat removals of their children.

Supporting birth parents through and after the adoption process is also a vital component of an ethical adoption system (Neil, 2017). Birth parents and other relatives are entitled to support

services under the Adoption and Children Act 2002 and should be encouraged and supported to access independent support services from the point adoption is identified as the plan for the child. Parents using such services may benefit in terms of their own mental health and coping with adoption, and this may enhance the quality of any contact that takes place with the child (Neil et al, 2010).

12.3.2. Reducing risks in the care system:

Where a child's entry into care is unavoidable, the quality, continuity and duration of time children spend in the foster care system are important considerations. Government policies have focused particularly on reducing delay and minimising moves for children in care. Fostering to adopt is one such initiative. Whilst most adopters in this survey felt their child had good quality foster care and a supportive relationship with their carer, this was not true for all. Children who subsequently go on to be adopted (and of course those who return home, go to kinship carers or remain in long-term foster care) will benefit from sensitive and involved foster care where they can begin their developmental recovery. Some children may be challenging to care for because of their experiences of separation and maltreatment, and foster carers need effective support and supervision to ensure that foster care is a reparative experience for children. Foster carers may needs breaks between placements and help with managing their grief when placements end, and training on 'safe care' should avoid conveying the impression that children should not be cuddled (Meakings et al, 2016).

12.3.3. Good quality information at the matching stage

There are risks for both children and adopters when children are placed with parents who lack understanding of their child's likely future needs. Whilst it is not always possible to fully anticipate how children will grow and develop, there were clear indications from this study that more can be done to ensure that adoptive parents are fully informed as far as is possible about a child's future needs. This includes prospective adoptive parents being made aware of the detail of the child's behaviour and relationships in the birth and foster family, the background details of the birth family, and good developmental assessment of the child prior to adoption. Whilst prospective adopters need information about the potential risks of factors such as the impact of maltreatment, heritable conditions, and substance misuse in pregnancy, deterministic views of inevitable difficulties should be avoided (Woolgar, 2015). Providing good information to adopters is important for a number of reasons: to help prospective adopters make informed decisions about a match, to reduce the chance of a failed match or early disruption if and when this information emerges later on, to help inform the adoption support plan, and to ensure that good information is available for children if and when they want to know more about their background. Children's social workers need to ensure that good

records are kept of the child's history, particularly experiences that may impact on the child in the future. Adoption family finders have a key role to play in co-ordinating this process of helping adopters make informed decisions at the matching stage, facilitating the involvement of others such as child care workers, medical specialists, foster carers and birth family members. Child appreciation days should be considered as these can have an important role in helping adoptive parents learn about children (Sayers & Roach, 2011). Child Permanence Reports and other documents need to be sufficiently detailed to enable adopters to make informed decision regarding matching. Involving experienced adoptive parents and in peer support and adopter preparation could be a useful resource in preparing prospective adopters.

12.3.4. Planning the move to adoption at the child's pace

Moving in with an adoptive family involves further loss and separation for children, and where children are not helped to cope with this it can affect their relationships and progress. Planning for children's moves to adoption needs careful consideration and sensitivity to the particular circumstances of each child, and to the needs of their foster and adoptive families. There was little diversity in how transitions were handled in this study, with the vast majority of transitions being short and seemingly quite intense and often stressful. The 'Moving to adoption' practice development project at UEA (Neil, Beek and Schofield) has developed five key practice principles in planning moves to adoption, these being: a positive relationship between the foster carers and the adopters is helpful to the child; the timescale for the move should meet the needs of the child; there needs to be overlap between the child's current and new relationships, to enable trust to build gradually; the child's feelings should be held in mind and responded to sensitively; some continuity of environment and relationships will support the child building trust. Two agencies are piloting the 'Moving to adoption' practice programme and are testing out more gradual introductions for children to their new families, so that both children and adopters feel more familiar with each other by the time the handover begins. A recent article by Lewis (2018) also makes practice suggestions including encouraging meetings between foster carers and adopters, planning longer introductions, early foster carer contact after the move and recognising the emotional impact of the move on adopters and foster carers.

12.3.5. Early assessment of adopted children's needs and offering support at an early stage and throughout the adoption.

Many adopted children in this study needed more than ordinary good parenting to recover and thrive after experiencing early harm. Children and their families need access to specialist support services that are adoption sensitive (Thomas, 2013). Some children may need more ongoing support than others. Factors such as exposure to drugs or alcohol before birth, higher

levels of maltreatment, older age at entry to care, and/experiencing poor quality or disrupted foster care may provide indications of who may be at risk, although children vary in their sensitivity to risk (Woolgar, 2015) . All adopted children should have an adoption support plan to address the child's future needs. Especially where children have a number of risk factors and/or where they are already showing signs of developmental problems, a thorough assessment of their developmental needs should be carried out to inform this plan, and the results of this discussed with prospective adopters. It seems both ethical and likely to be cost-effective to offer support when children are young and before problems have escalated and become entrenched, as opposed to just providing crisis services later down the line. Children who have been exposed to drugs or alcohol in the womb were at particularly high risk of poorer outcomes. Where there is a history of mothers using drugs or alcohol during pregnancy, this information needs to be available to prospective adoptive parents. Children may need specialist assessments so that the impact of alcohol on their development is better understood, particularly as only a few children affected by in utero exposure may have facial features of FAS that make diagnosis obvious.

Many parents in this study experienced significant barriers in accessing therapeutic support, particularly via CAMHS. A culture change is needed such that access to therapeutic services is seen as the norm rather than the exception, and children can receive the help they need quickly without parents having to go to enormous lengths to access services.

There is wide variation in terms of the type and intensity of support that families will require, but certain areas emerge as key. These include:

- **Supportive interventions in the early days** of placements to help children and parents build their new relationship (e.g. Theraplay, Safebase, parenting interventions based on promoting parental sensitivity e.g. VIPP Juffer et al, 2008, the ABC intervention developed by Mary Dozier -http://www.infantcaregiverproject.com/). These interventions could be provided by appropriately trained adoption workers and offered to all new adoptive parents.
- **Support where children have emotional, behavioural or mental health problems** (available for families who are managing as well as those in crisis). Services will be needed from a range of providers. Those working in children's social care need an understanding of the range of difficulties that can affect adopted children, and the risk factors associated with these, in order to understand when to refer children on for further assessment. Some children will have needs that require specialist assessment and treatment from health care professioanls (e.g. children with autism, suspected FASD, ADHD.) Children need access to specialists in treating problems such as

conduct disorders, attention problems, attachment difficulties, emotional dysregulation and trauma symptoms, and violent behaviours towards parents or siblings. Services should match children's assessed needs rather than be based on one particular model of understanding problems (Woolgar & Baldock, 2015). Because of the complex and often overlapping difficulties that adopted children can show, specialist assessment may be needed to determine priorities for intervention (Selwyn, 2017). New regional 'Centres for excellence' have a role in providing such specialist assessment. Service brokers and providers need to be 'adoption aware' and a collaborative approach is needed where professionals listen to parents and children and work together to agree solutions (Livingstone-Smith, 2014). Where children have significant difficulties, the impact on adoptive parents and other children in the adoptive family needs to be recognised; services should be targeted at the whole family rather than focused narrowly on 'fixing' the child. Some families may need respite in the form of supportive breaks for children or parents.

- **Supporting adoptees with identity issues.** Making sense of and integrating life history into a sense of self is a lifelong task for adoptees (Grotevant & Von Korff, 2011). Services need to be available to assist children, young people and adopted adults with this, and the primary role of adoptive parents in helping children make sense of their identity should be recognised (Von Korff & Grotevant, 2011). Adopted children need information about their background and a lifestory book made for them when they are very young is a starting point for building a lifestory narrative. In line with statutory guidance (DfE 2014b) social workers (where possible in collaboration with foster carers and birth family members) need to ensure all adopted children have a life story book when they are first placed for adoption.

At the stage of preparing adopters, adoption agencies need to set the tone in terms of understanding the future identity needs of the child by emphasizing the importance for all adopted children of adoption communication openness (Brodzinsky, 2005; Neil, 2007). It may be helpful during preparation (and later) to enable prospective adoptive parents to learn from the experiences of adopted young people and adults about the future identity needs of adoptees. As children age, they will need more detailed information about their life history and adopters may need support in using and updating lifestory books (Watson et al, 2015) and discussing difficult topics with their child (Neil, 2012). Workshops on this topic could be offered by adoption agencies, and parents of older children who are beginning to ask questions may especially benefit. Some children may need support with lifestory work some time after adoption, particularly in adolescence. Selwyn (2017, p.21) argues that 'Life story work can be

considered as a form of therapy and is about assimilating past events and the effect of significant people on a child's life.' Whilst identity issues may come to the fore for some young people in adolescence, others may wish to focus on other issues such as education, careers or relationships whilst putting adoption issues to one side, returning to adoption issues at a later stage (Neil et al, 2015). Services around identity and life history therefore may be needed beyond childhood and adolescence and into adulthood.

- **Support for birth family contact** - effective support for contact needs to address the needs of all parties: children, adoptive parents and birth relatives (Neil et al, 2011; Neil et al, 2015). The provision of independent support to birth parents should include services to help birth parents take part constrictively in contact with their child after adoption (Neil et al, 2010). More help to set up and maintain sibling contact was particularly wanted by many families.

  The practice resources developed by the first author, in collaboration with practitioners and Research in Practice, could be of use. http://contact.rip.org.uk/. Drawing on a longitudinal study of contact after adoption, Neil et al (2015) have set out a model for planning and supporting contact (Neil et al, 2015; https://www.uea.ac.uk/contact-after-adoption/resources) and this has been developed further by Baynes (2015). This model argues that contact plans need to consider the child's long term needs in relation to attachment, loss and identity and initial contact plans should be clear about the intended goals of any contact arrangements. For example, one arrangement might be intended to enable information sharing between adopters and birth relatives whilst another plan may hope to enable children to maintain and/or build important relationships for example with siblings. Contact plans should be based on an assessment of the particular needs of a child and also the strengths (and difficulties) of children, birth relatives and adopters rather than following 'standard plans'.

  Where birth relatives and adoptive parents can work together in a way where each supports the child's membership of both families, then face-to-face contact can be a positive option and may avoid some of the complications of letterbox contact (Neil et al, 2015). Greater consideration could be given the involvement of extended family members in contact, especially siblings and grandparents as previous research has suggested such contact can be particularly positive (Neil et al, 2011; Neil et al, 2015; Boyle, 2017). Birth relatives, prospective adopters and (where old enough) children need to be involved in the contact planning process as it is important to establish a sense of shared goals and collaboration between the birth and adoptive family (Neil et al, 2015). Adoptive parents should be offered the chance to review contact

arrangements to ensure they are working for all and to take account of changes for the child, adopters or birth family. At the most basic level this could take the form of the adoption agency contacting families every one or two years to ask how contact is going and if any needs have changed. Some older children may need help thinking about their future contact needs as their feelings about their birth families change in adolescence. For example young people may want to open up more contact or reduce contact when they reach the age of 18, or even at younger ages (Neil et al, 2015).

- **Support for families in relation to education**. Parents need support in understanding how to get additional help for their children in school. PAC-UK and Adoption UK, in collaboration with DfE, have recently launched free online guides for adoptive parents and for schools http://www.pac-uk.org/schoolsguides/. Schools must understand the needs of children which stem from being adopted, and/or having experienced early harm and the PAC-UK website also gives access to guides for teachers and schools for example. 'Welcoming an adopted child to your primary school'. Adoption agencies should introduce guides such as these to prospective adopters and those who have already adopted and should work with colleagues in education to make professionals aware of the resources. Virtual school heads need to monitor how pupil premiums are being used to ensure these funds specifically benefit the adopted children for whom they are awarded.

12.3.6. Implications for adoptive parents and prospective adopters.

Linking to the suggestions above, the study also has important messages for adopters (including prospective adopters). The main implications are:

- Understanding that adopting a child from care is likely to be rewarding but that experiencing often quite significant challenges is the norm, not the exception.
- To be open to learning as much as possible about the likely future needs of children adopted from care in general, and individual children proposed for a match. At the matching stage ask for specialist advice and assessment where children have particular risk factors. Advice may be needed from professionals but the child's foster carers and experienced adopters are also 'experts' in what it is like to parent a child with special needs (the joys and the challenges) and can be important sources of information and support. 'Stretching' preferences after finding out more about a child can be positive, but agreeing to a match out of a feeling of desperation or pressure from the agency should be resisted.

- It is important to be open to using support services (and the support of peers) from an early stage, even when problems may not be apparent. A proactive approach to using and seeking help may be better than 'waiting to see' if early problems will get better particularly where significant risk factors in the child's history are present. Social difficulties in early childhood may be an early sign that a child could benefit from help as may high levels of distress on moving from the foster home. Be prepared to act as an advocate for your child with a range of service providers (education, health and social care) to push for your child needs to be met.

- Be prepared that moving a child from trusted foster carers can be a mixed experience for all involved, and children loving and missing foster carers they have come to trust is not a negative sign. Children may be naturally distressed and will need support with feelings of loss; some ongoing contact with foster carers may be important in helping children settle.

- Recognise that the teenage years can be particularly difficult for adopted children and that it is OK to ask for help even if you haven't been in touch with services for many years.

- Think long term about children's' needs in relation to loss and identity – addressing these issues is important for all adopted children regardless of what contact (if any) a child is having. Even though contact with birth family members may seem to have little purpose when children are young, getting contact going at an early stage may be easier in the long run that trying to re-establish links when children are older. When discussing contact plans try to establish a shared sense of purpose and boundaries with others involved (birth families members and/or adopters or carers of siblings), ideally through discussion with the other parties rather than just through the agency as a third party. Ask the agency supporting the contact what plans they have to *support* birth parents or relatives to maintain contact. Create an open and evolving dialogue with children about their wishes and feelings about their birth family, including any thoughts they may have about contacting or being contacted by birth relatives via social media. Try to use contact events (such as writing to receiving letters or meeting with birth family members) as an opportunity to open up adoption related conversations with your child and help them make sense of their feelings and life story.

12.4 Conclusion

This research has provided a picture of contemporary adoption in England based on the views of parents who adopted a child from care. Family life for most was both very rewarding and also challenging, with many adopted children having serious difficulties affecting them in their

everyday lives. Adoptive parents who were best able to support children manage these were those who had been helped to develop realistic expectations from the start, built on good information about their child. They received sensitive, timely and competent responses when they needed help, and were recognised as central to the solution rather than part of the problem. They could access support (from both peers and professionals) who understood the particular feelings and problems their child might have both as an adopted child and a child who had experienced adversity. Where these factors were not in place, and children had high levels of problems, the strain on the whole adoptive family could be immense. The key implication for policy and practice for any state considering the adoption of children from care is that provision of support services for adopted families must be an essential component of this policy. There are important messages from this research for prospective adoptive parents and those already parenting, social workers and other professionals in health and education.

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Appendix 1 – Children in care and adopted from care in the 15 Yorkshire and Humber local authorities over the past five years.

Table A1: Further details on numbers of looked after and adopted children in the local authorities in the Yorkshire and Humber adoption consortium (derived from Department for Education (2017a) data.)

	All children looked after year ending 31 March 2017	Rates looked after per 10,000 under age 18	% leaving care to adoption 2016-17 and variation over last 5 years	Numbers adopted from care
Sheffield	585	50	19 (15-28)	50
Rotherham	485	86	15 (15-28)	30
Doncaster	510	78	19 (13-23)	35
Barnsley	290	58	30 (18-30)	35
Leeds	1255	76	19 (19-27)	80
Bradford	925	86	15 (15-25)	40
Kirklees	700	70	16 (14-21)	45
Calderdale	315	69	19 (19-31)	20
Wakefield	520	74	17 (17-27)	25
North Yorkshire	425	36	19 (16-29)	30
York	205	56	13 (13-19)	10
East Riding	285	46	8 (8-28)	10
Hull	695	124	13 (9-30)	35
North Lincolnshire	225	64	13 (13-32)	20
North East Lincolnshire	295	87	14 (14-28)	10
Totals for Y&H region	7720	67	17 (17-23)	480
Totals for England	72670	62	14 (14-17)	4,350

Appendix 2: Definitions of abuse and neglect included in the survey.

Medical neglect	Where carers minimize or deny a child's illness or health needs and/or they fail to seek appropriate medical attention or administer medication and treatment
Nutritional neglect	Where a child does not receive adequate calories or nutritional intake for normal growth. At its most extreme, nutritional neglect can take the form of malnutrition
Emotional neglect	Where a carer is unresponsive to a child's basic emotional needs e.g. failing to interact or provide affection. It is distinguished from emotional abuse by the intention behind the action: emotional abuse is inflicted and emotional neglect is an omission of care
Physical neglect	Where a carer does not provide appropriate clothing, food, cleanliness and safe living conditions
Lack of supervision and guidance	Where a carer fails to provide an adequate level of guidance and supervision to ensure a child's safety and protection from harm. A child may be left alone, abandoned, left with inappropriate carers or not provided with appropriate boundaries about behaviours
Educational neglect	Where a carer fails to provide a stimulating environment or show an interest in the child's education at school. They may fail to respond to any special needs or their child may not attend school regularly
Emotional/psychological abuse	Where a parent/carer deliberately tries to scare or humiliate a child or isolates or ignores them
Physical abuse	Where a carer deliberately hurts a child which may cause injuries such as bruises, broken bones, burns or cuts. Or a carer may make up or cause the symptoms of illness in their child, giving them medicine they don't need and making the child unwell
Sexual abuse involving contact	This involves forcing or enticing a child or young person to take part in sexual activities; it may not include violence and the child may not be aware of what is happening
Sexual abuse not involving contact	This includes children looking at, or being involved in the production of sexual images, watching sexual activities, being encouraged to behave in sexually inappropriate ways, or being groomed in preparation for abuse including via the Internet
Witness to domestic abuse	Domestic abuse is any type of controlling, bullying, threatening or violent behaviour between people in a relationship. It includes emotional, physical, sexual, financial or psychological abuse as well as physical violence
Singled out for rejection	Living in a household with other children but being the only one to receive harmful or neglectful treatment - or receiving it to a more severe extent to that received by the other children
Exposed to excessive or dangerous drugs before birth	Taking drugs in pregnancy causing potential harm to the unborn child
Exposed to alcohol before birth	The taking of excessive alcohol in pregnancy causing potential harm to the unborn child

Appendix 3: (Statistical appendix - Chapter 7)

Detailed description of the four components estimated simultaneously in the two-latent factors structural equation model (graphically presented in figure 7.1, chapter 7)

Component 1: The measurement of maltreatment

It was assumed that a set of observed self-reported indicators of maltreatment relate to a latent maltreatment concept via ordered probit functions that involve measurement errors. The latent variable is like a "true" maltreatment score that is not directly observed. The reported indicators are the measurement that is directly observed (reported in the survey), and some degree of random measurement error that may exist such that the observed score does not perfectly match the true scores. This might arise because of the respondents' different ability to retrieve the relevant information and put them into an ordered scale. In other words, it is assumed that the true maltreatment score causes a portion of the observed score, typically with some unaccounted variance remaining. This causal hypothesis suggests a regression or path model that is graphically depicted (in Chapter 7) in the left side of Figure 7.1: the oval labelled 'maltreatment' stands for the latent maltreatment variable whereas the square boxes indicates the observed (manifested) indicators of maltreatment. Four different indicators of maltreatment were used in deriving the latent maltreatment index (physical abuse, emotional abuse, neglect, and sexual abuse). The descriptive statistics relating to these indicators are given below in tables A3.1 a-d). The ordered probit function was used to accommodate the fact that the potential values of the indicators have a natural ordering (as in none, mild, likely, moderate, and severe levels). Those indicators were also highly correlated (see table A3.4 below) so that we were able to extract the latent maltreatment concept.

Component 2: Factors influencing maltreatment

A regression model was specified of the relationship between the underlying maltreatment index and a set of covariates assumed to influence the (conditional means of the) maltreatment index. In other words included in the model were a range of factors that may influence the likelihood of a child experiencing maltreatment, these factors being the child being exposed to drugs or alcohol in the womb, parental learning difficulty, parental mental illness, and the length of time the child was potentially exposed to maltreatment-indicated by the child's age at final removal into care. All these covariates were assumed to influence the value of the latent maltreatment index at different level of significance and magnitude.

Component 3: The measurement of outcomes

It was assumed that a latent outcome index could be extracted from a set of error-prone observed self-reported outcome indicators using a procedure similar the one used in (1). In other words, adoptive parent's ratings of how well they perceived their child to be functioning in a range of areas were used, plus the parent's ratings of how well the adoption was faring overall. Note again that these indicators were highly correlated (see table A3.5) and it was therefore assumed that an underlying "true" outcome index causes the adoptive parents' response to the outcome questions. The (observed correlation) among parents' reported data from the 9 indicators (shown in chapter 7 at the right of Figure 7.1) were then used in deriving the outcome index. Descriptive statistics relating to the indicators of outcomes are given in tables A3.2 a-i below).

Component 4: Factors influencing outcomes

A regression model of the relationship between the underlying outcomes and a set of regressors was specified. The set of regressors also included the maltreatment index. In other words the extent to which the maltreatment index predicted the outcome index was explored while simultaneously taking into account a range of other factors that may also affect outcomes (these including factors to do with the child's time in care, their current age, and adoptive family variables)[12]. Descriptive statistics relating to co-variates are given in Tables A3.3a-n below.

[12] It is perhaps worth noticing that if the observed indicators of maltreatment are measured with error (when encoding the information, in the comprehension of the survey question and in the judgement and reporting of the appropriate answer into an ordered scale), their correlations with other variables (e.g. outcome indicators) are attenuated (tend to be close to zero) and then not statistically significant. Instead, the latent concept of maltreatment we developed is not directly observable and does not have measurement error associated with it. This is important because we can estimate the relations among latent variables without random measurement error. Further adding the regressors, we are also able to estimate the overall effect of maltreatment on children's outcomes by accounting for their systematic (non-random) variance associated with the regressors.

Tables

Tables A3.1a-d: Descriptive statistics on parent-reported indicators of maltreatment

a) Emotional abuse*	**n**	**%**	**Cum %**
Not experienced	122	42.1	42.1
mild	6	2.1	44.1
likely	23	7.9	52.1
moderate	61	21	73.1
significant	67	23.1	96.2
very significant	11	3.8	100
Total	290	100	

**Scores recoded so (.) = missing data or don't know and 0 = not experienced*

b) Physical abuse*	**n**	**%**	**Cum %**
Not experienced	166	65.4	65.4
mild	24	9.4	74.8
likely	16	6.3	81.1
moderate	18	7.1	88.2
significant	30	11.8	100
Total	254	100	

**Scores recoded so (.) = missing data or don't know and 0 = not experienced*

c) Neglect *	**n**	**%**	**Cum %**
Not experienced	90	29.8	29.8
mild	17	5.6	35.4
likely	16	5.3	40.7
moderate	58	19.2	59.9
significant	121	40.1	100
Total	302	100	

**Scores recoded so (.) = missing data or don't know and 0 = not experienced*

d) Sexual abuse*	**n**	**%**	**Cum %**
Not experienced	202	84.2	84.2
mild	6	2.5	86.7
likely	21	8.8	95.4
moderate	1	0.4	95.8
significant	10	4.2	100
Total	240	100	

**Scores recoded so (.) = missing data or don't know and 0 = not experienced*

Tables A3.2a-i: Descriptive statistics on parent-reported indicators of outcomes

a) Recoded 'how is the adoption faring?'	n	%	Cum %
Going really well	141	44.2	44.2
Managing challenges	112	35.1	79.3
Struggling	66	20.7	100
Total	319	100	

b) Recoded general behaviour in the home	n	%	Cum %
A particular strength	30	10.3	10.3
No challenges	76	26	36.3
Moderate challenges	141	48.3	84.6
Serious challenges	45	15.4	100
Total	292	100	

c) Recoded general behaviour outside the home	n	%	Cum %
A particular strength	41	14.1	14.1
No challenges	105	36.1	50.2
Moderate challenges	119	40.9	91.1
Serious challenges	26	8.9	100
Total	291	100	

d) Recoded physical health	n	%	Cum %
A particular strength	82	28	28
No challenges	155	52.9	80.9
Moderate challenges	51	17.4	98.3
Serious challenges	5	1.7	100
Total	293	100	

e) Recoded emotional wellbeing	n	%	Cum %
A particular strength	31	10.7	10.7
No challenges	90	30.9	41.6
Moderate challenges	117	40.2	81.8
Serious challenges	53	18.2	100
Total	291	100	

f) Recoded Self-esteem	n	%	Cum %
A particular strength	28	9.6	9.6
No challenges	101	34.5	44
Moderate challenges	108	36.9	80.9
Serious challenges	56	19.1	100
Total	293	100	

g) Recoded relationship with you	n	%	Cum %

A particular strength	106	36.3	36.3
No challenges	90	30.8	67.1
Moderate challenges	75	25.7	92.8
Serious challenges	21	7.2	100
Total	292	100	

h) Recoded social interaction with adults outside the family	**n**	**%**	**Cum %**
A particular strength	79	27.1	27.1
No challenges	128	43.8	70.9
Moderate challenges	70	24	94.9
Serious challenges	15	5.1	100
Total	292	100	

i) Recoded making and maintaining friendships	**n**	**%**	**Cum %**
A particular strength	47	16.1	16.1
No challenges	101	34.6	50.7
Moderate challenges	94	32.2	82.9
Serious challenges	50	17.1	100
Total	292	100	

Tables A3.3a-o: Descriptive statistics on covariates

a) Prenatal toxic exposure to drugs, alcohol in utero	**n**	**%**	**Cum %**
Not exposed or not known to have been exposed	145	45.5	45.5
Known to have been exposed	174	54.5	100
Total	319	100	

b) Birth parents with Learning Disabilities	**n**	**%**	**Cum %**
No parent known to have a learning disability	220	69	69
One parent known to have a learning disability	65	20.4	89.3
Two parents known to have a learning disability	34	10.7	100
Total	319	100	

c) Birth parents with Bipolar disorder/Schizophrenia	**n**	**%**	**Cum %**
No parent known to have BPD/Schizophrenia	301	94.4	94.4
One parent known to have a BPD/Schizophrenia	16	5	99.4
Two parents known to have BPD/Schizophrenia	2	0.6	100
Total	319	100	

d) Age at removal from birth family before 3 mths old?	**n**	**%**	**Cum %**
No	166	52.5	52.5
Yes	150	47.5	100

Total	316	100	

e) Age at removal from birth family at 3-5 mths old?	**n**	**%**	**Cum %**
No	299	94.6	94.6
Yes	17	5.4	100
Total	316	100	

f) Age at removal from birth family at 6-11 mths old?	**n**	**%**	**Cum %**
No	285	90.2	90.2
Yes	31	9.8	100
Total	316	100	

h) Age at removal from birth family at 12-17 mths old?	**n**	**%**	**Cum %**
No	293	92.7	92.7
Yes	23	7.3	100
Total	316	100	

i) Age at removal from birth family at 18-23 mths old?	**n**	**%**	**Cum %**
No	292	92.4	92.4
Yes	24	7.6	100
Total	316	100	

j) Age at removal from birth family at or before 24 mths?	**n**	**%**	**Cum %**
No	245	77.5	77.5
Yes	71	22.5	100
Total	316	100	

k) Time spent in foster care less than 12 months?	**n**	**%**	**Cum %**
No	172	53.9	53.9
Yes	147	46.1	100
Total	319	100	

l) Time spent in foster care 12-24 months?	**n**	**%**	**Cum %**
No	206	64.6	64.6
Yes	113	35.4	100
Total	319	100	

m) Time spent in foster care less than 24 months?	**n**	**%**	**Cum %**
No	280	87.8	87.8
Yes	39	12.2	100
Total	319	100	

n) How old is your child in full years?	**n**	**%**	**Cum %**
under 1 year old	4	1.3	1.3
1 year old	10	3.1	4.4

2 years old	35	11	15.4
3 years old	26	8.2	23.5
4 years old	23	7.2	30.7
5 years old	24	7.5	38.2
6 years old	28	8.8	47
7 years old	31	9.7	56.7
8 years old	21	6.6	63.3
9 years old	24	7.5	70.8
10 years old	16	5	75.9
11 years old	11	3.4	79.3
12 years old	15	4.7	84
13 years old	13	4.1	88.1
14 years old	6	1.9	90
15 years old	8	2.5	92.5
16 years old	16	5	97.5
17 years old	8	2.5	100
Total	319	100	

o) Gender	**n**	**%**	**Cum %**
Male	168	52.7	52.7
Female	151	47.3	100
Total	319	100	

Table A3.4: Pairwise correlation coefficients between maltreatment indicators

	Emotional abuse	Physical abuse	Neglect	Sexual abuse
Emotional abuse	1			
Physical abuse	0.5518*	1		
Neglect	0.7548*	0.4995*	1	
Sexual abuse	0.3717*	0.4223*	0.3698*	1

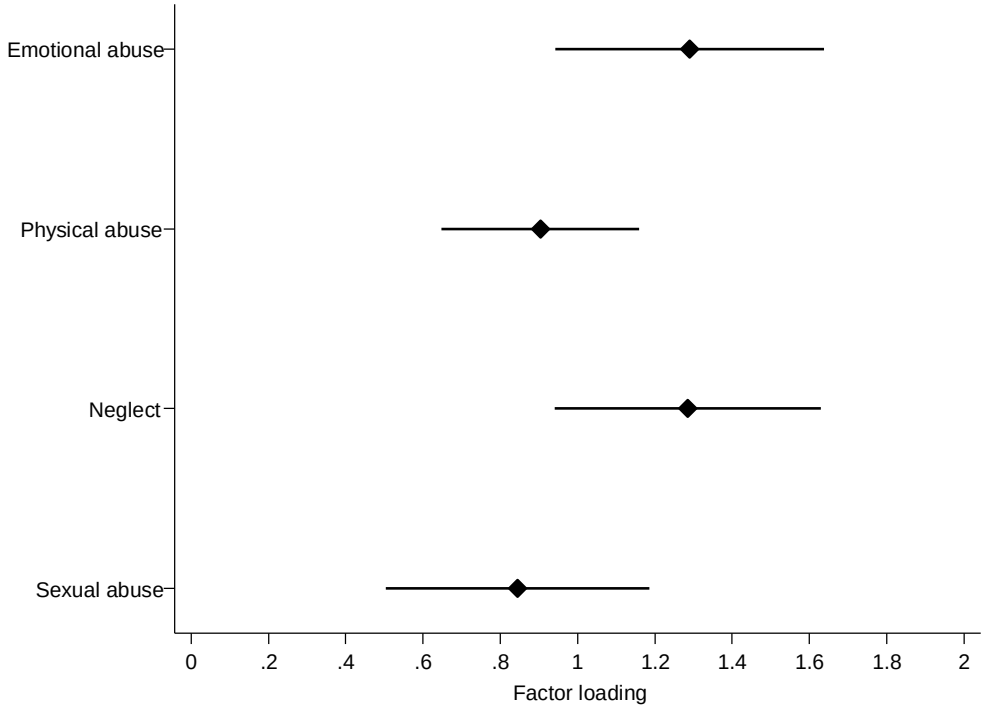
** Correlation coefficients significant at the 5% level or better.*

Table A3.5: Pairwise correlation coefficients between outcome indicators

	Adoption faring	General behaviour at home	General behaviour outside the home	Physical health	Emotional well-being	Self-esteem	Relation with the adoptive mother	Social interaction with adults outside the family	Making and maintaining friendships
Adoption faring	1								
General behaviour at home	0.6824*	1							
General behaviour outside the home	0.5669*	0.7342*	1						
Physical health	0.2561*	0.2972*	0.3116*	1					
Emotional well-being	0.6456*	0.6335*	0.5776*	0.2865*	1				
Self-esteem	0.6239*	0.5554*	0.4772*	0.2323*	0.8480*	1			
Relation with the adoptive mother	0.6492*	0.6010*	0.4589*	0.2993*	0.6029*	0.5738*	1		
Social interaction with adults outside the family	0.4628*	0.4313*	0.4820*	0.2962*	0.4642*	0.3914*	0.5528*	1	
Making and maintaining friendships	0.5861*	0.5739*	0.5637*	0.2465*	0.6332*	0.6114*	0.5456*	0.5288*	1

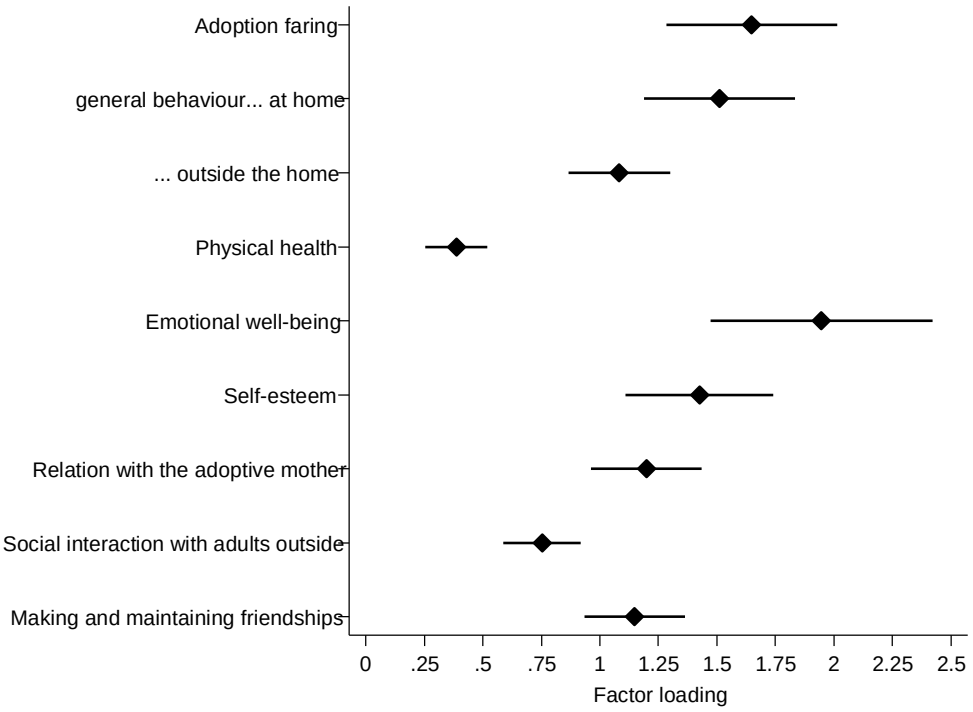
** Correlation coefficients significant at the 5% level or better.*

Figure A3.1: Plotting factor loadings from the neglect and abuse factors equations*



*****_This shows the extent to which the different types of maltreatment influenced the latent maltreatment index. As expected, all factor loadings associated with the maltreatment index are all positive and significant, meaning that the maltreatment index is higher for those children that have experienced severe levels of maltreatment. Our latent index is more sensitive to indicators of emotional abuse and neglect and slightly less sensitive to physical and sexual abuse._

Figure A3.2. Plotting factor loadings for the latent outcome index*



**The factor loadings are all positive meaning that the underlying outcome index is an increasing function of challenges (lower values suggest better outcomes for the child, and higher values worse outcomes). As expected, all factor loadings are also highly significant and they show that there are some indicators that are more relevant than others in determining the latent outcome index. The highest correlation with the outcome index was found for emotional wellbeing, self-esteem and general behaviour at home. The overall indicator "adoption faring" was significantly well correlated with the latent measure derived.*

Appendix 4: Frequency of access to support services (Chapter 11)

Table A4.1 Post adoption service according to length of times families – length of time

	1 month or less	2 to 6 months	7 to 12 months	More than a year	One off	Total	Missing/not used
Services	**Number and percentage**						
Social events for adopted young people/ families	0 (0.0)	4 (10.5)	13 (34.2)	9 (23.7)	12 (31.6)	38 (100.0)	292
Support groups for adopters	1 (5.0)	4 (20.0)	10 (50.0)	3 (15.0)	2 (10.0)	20 (100.0)	310
Special needs support/ SENCO	2 (10.0)	0 (0.0)	11 (55.0)	5 (25.0)	2 (10.0)	20 (100.0)	310
General adoptive parenting advice and support	1 (5.3)	4 (21.1)	7 (36.8)	3 (15.8)	4 (21.1)	19 (100.0)	311
Peer/social and emotional group support in a school setting	0 (0.0)	10 (58.8)	4 (23.5)	3 (17.6)	0 (0.0)	17 (100.0)	313
Adoption parenting classes/ training	3 (12.0)	4 (16.0)	6 (24.0)	3 (12.0)	9 (36.0)	25 (100.0)	305
Online chat groups or forums of adopters	0 (0.0)	2 (11.8)	11 (64.7)	4 (23.5)	0 (0.0)	17 (100.0)	313
Support from a mentor or pastoral worker	0 (0.0)	4 (26.7)	8 (53.3)	3 (20.0)	0 (0.0)	15 (100.0)	315
Play therapies	2 (8.0)	9 (36.0)	10 (40.0)	4 (16.0)	0 (0.0)	25 (100.0)	305
Online chat groups/ forums for parents of children with disabilities	0 (0.0)	3 (37.5)	3 (37.5)	2 (25.0)	0 (0.0)	8 (100.0)	322

Table A4.2 Post adoption service according to length of times families – how often

	One off session	Daily	Weekly	Fortnightly	Monthly	A few times a year	Total	Missing/not used
Services	**Number and percentage**							
Social events for adopted young people/ families	11 (35.5)	0 (0.0)	0 (0.0)	3 (9.7)	6 (19.4)	11 (35.5)	31 (100.0)	299
Support groups for adopters	1 (5.0)	0 (0.0)	3 (15.0)	0 (0.0)	8 (40.0)	8 (40.0)	20 (100.0)	310
Special needs support/ SENCO	4 (22.2)	8 (44.4)	6 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	18 (100.0)	312
General adoptive parenting advice and support	3 (25.0)	0 (0.0)	1 (8.3)	2 (16.7)	4 (33.3)	2 (16.7)	12 (100.0)	318
Peer/social and emotional group support in a school setting	0 (0.0)	3 (13.0)	20 (87.0)	0 (0.0)	0 (0.0)	0 (0.0)	23 (100.0)	307
Adoption parenting classes/ training	9 (56.3)	0 (0.0)	3 (18.8)	1 (6.3)	2 (12.5)	1 (6.3)	16 (100.0)	314
Online chat groups or forums of adopters	0 (0.0)	11 (68.8)	5 (31.3)	0 (0.0)	0 (0.0)	0 (0.0)	16 (100.0)	314
Support from a mentor or pastoral worker	0 (0.0)	3 (20.0)	10 (66.7)	1 (6.7)	1 (6.7)	0 (0.0)	15 (100.0)	315
Play therapies	0 (0.0)	0 (0.0)	14 (82.4)	0 (0.0)	1 (5.9)	2 (11.8)	17 (100.0)	313
Online chat groups/ forums for parents of children with disabilities	1 (12.5)	3 (37.5)	4 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	8 (100.0)	322