PROMOTING THE WELLBEING OF CHILDREN IN CARE

MESSAGES FROM RESEARCH

Editors: Tom Rahilly and Enid Hendry

NSPCC

EVERY CHILDHOOD IS WORTH FIGHTING FOR

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The chapters of this book were written before the extent of child sexual exploitation in Rotherham was highlighted in late 2014. The findings of Professor Jay's inquiry into child sexual exploitation in Rotherham starkly demonstrate the need to improve the protection of the most vulnerable children and young people in the UK. They serve to make the messages in this book about the need to strengthen the voice of children in care, improve therapeutic support, and ensure we protect our most vulnerable children more pertinent.

Photography by Jon Challicom and Tom Hull.
The children featured are models and volunteers.

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Introduction

The decision to take a child into care is one of the hardest that can ever be made. It has far-reaching consequences for the child and their family. Ensuring that the care system provides effective help for our most vulnerable children requires all who work with children in care – including policy makers, local leaders, commissioners and practitioners – to critically examine their practice. They must think about how the needs, experiences and interests of children in care are put at the heart of what they do, and identify the improvements needed to the services and support they provide.

Over the past decades we have witnessed a range of programmes designed to improve the quality of care and prevent the abuse of looked after children. There has been much success and the evidence suggests that our care system plays a critical role in keeping children safe and helping them overcome the effects of abuse or neglect that they have suffered. However, in spite of improvements in policy and practice, major challenges remain with significant variations in practice across the UK.

This book brings together leading academics, practitioners and policy analysts to set out the implications of the latest research and examine the challenges faced by children in care. It aims to help policy makers and practitioners identify and enact cutting-edge changes for children in and on the edge of care. It bridges the gap between recent research and practice, bringing together the best available evidence to increase understanding of today's safeguarding challenges and to set out solutions for tomorrow's care system.

The chapters of this book are based on the issues and experiences that children in care tell us are central to improving the support available to them and that are critical in keeping them safe from harm. Each chapter has a different author and focuses on a distinct issue but they have much in common. The importance of strong relationships, proactive working to support children in care and the need to improve analysis and decision-making are the common themes relevant to children and young people across the UK as well as those in different care placements, whoever the provider.

The aim of this book is to bring together the latest research and provoke discussion about the steps needed to improve support for children in care to ensure they are all protected from harm.

Solutions and next steps are drawn together in a final section of this book. It presents a challenging agenda for change in the care system. Proposals include changes of attitude and mindset, the development of skills and knowledge, and changes to system design and accountability. Despite the great pressure on resources currently faced by local services, these changes are achievable and must be delivered for our children in care.

You should read this book if you are:

- a national or local policy maker with responsibility for looked after children or child protection

- a practitioner or manager with particular operational responsibilities for looked after children and/or for child protection in children's social services, health, education, CAMHS or the voluntary sector

- responsible for making decisions in relation to children at risk of abuse and neglect, which includes those working in courts, independent reviewing officers, guardians ad litem, solicitors, and those serving on children's panels.

Why re-examine the safeguarding and support of looked after children?

Since 2008 the UK's care population has risen from 82,520 to over 100,000, with the numbers of looked after children in England, Scotland, Wales and Northern Ireland having increased by 14.5, 9.1, 24.1, and 15.5 per cent respectively; rises that in part reflect an increased awareness following the death of Peter Connolly of the risks that children and young people can face. The majority of children and young people now enter care as a result of abuse and neglect. It is this harm - how it can be prevented, and how children can be helped to overcome the effects of it – that is the focus of this book.

In response to the changes in the UK's care population there has been an increased focus on how to best meet the needs of children in care. The UK government has introduced reforms to the family justice system in England; across the UK there has been significant action to increase the number of children who are adopted, and work is underway to examine changes that are needed to improve residential care and other permanence options for looked after children, such as support for children in long-term foster care.

However, care continues to be seen by some decision makers as a damaging last resort, to be used only when all else has failed. This can result in some children remaining far too long with neglectful and abusive families, while others are returned, sometimes repeatedly, to still dangerous homes where little has changed.

While there are comprehensive legal frameworks in place for looked after children, implementation remains a major issue with significant variations between local areas, and between different teams within the same authority. At its worst this exposes some children to further harm. There has yet to be comprehensive improvement and reform that ensures the care system meets the needs of all children in care. The drive to improve and reform is compromised by a continuing squeeze on local authority budgets, with a risk of thresholds for entry to care being raised still higher and pressure to use cheaper placement options mounting.

We believe it is necessary to focus attention on the protective role of care, but also on the changes needed to keep children safe *and* help them overcome the effects of harm. This book calls for a transformation of practice in the care system to address the challenges identified so that it *always* provides a safe, effective and positive choice for children at risk when needed. It sets out practical changes that will help practitioners and policy makers achieve this task.

Overview

The introduction to this book provides an insight into the views and experiences of children and young people in care. The majority of children in care say that overall, their experience is good. However, all children the NSPCC has spoken to identified areas for improvement and things that must be done differently. The case for improving the support to children in care is clear.

The changing nature of the care population, differences in the way care is provided, and new insights into the nature and sources of risks faced by young people call for a re-examination of the way in which children in care are protected and supported. These changes and insights have implications for safeguarding policy and practice that are highlighted below and addressed in detail in the chapters of this book.

Our care population is mobile and dynamic, with over 28,000 entering and leaving care in England each year. New entrants to care range in age from newborn to adolescents and they all have different

and specific sets of needs. The majority of looked after children have suffered from abuse and neglect and often have received insufficient support while on the edge of care, despite often having been known to social services and others for an extended period of time. As a consequence many have considerable emotional and mental health needs, which increase their vulnerability and need for therapeutic care. Too many children move in and out of care on a number of occasions, which impacts on any stable relationships they are able to form, placing them at significant risk.

In our first chapter, June Thoburn looks at the history of care in the UK following the Children Act 1989. Thoburn identifies two broad models of care – child welfare and child protection – and looks at the impact of these two concepts on the support that is provided for children, young people and their families. Thoburn details evidence about the positive impact that care can have on children's lives and argues that it is vital that we move away from language about 'children languishing in care'. Using the latest UK and international research she sets out seven principles for an effective care system and details the steps needed to achieve them.

Recent research has highlighted the risks faced by children and young people at different stages of the care journey, beginning with entry to care. Removing a child from their birth family will always be one of the most difficult of professional decisions. However, the overwhelming majority of children who were interviewed for a report by the Children's Rights Director (Ofsted, 2010), thought that the decision had been right for them. Negative views about care have contributed to reluctance by social workers and courts to remove children who are experiencing abuse and neglect from their birth families. As a result some children continue to be exposed for far too long to unacceptable levels of chronic neglect and to risks of abuse, often associated with parental substance misuse, mental health difficulties and domestic violence.

A number of recent research studies summarised by Davis and Ward (2011) have highlighted the importance of taking early action when children are found to be maltreated. The authors conclude: "If children cannot live with their birth parents, early separation and speedy progress towards permanence are likely to be the least damaging courses of action" (p.87). This need for more proactive, evidence-based action is repeated across the decisions that are made for children in care.

In Chapter 2 Julie Taylor and Tom Rahilly examine how decisions about whether or not a child should go into care are made. They identify inadequate support for children on the edge of care. Delays in decision-making for some children, leading to prolonged exposure to abuse or neglect followed by emergency entry to care, which creates even more difficulties for their journey through care. Looking at models of support and decision-making such as the New Orleans Intervention Model and the Family Drug and Alcohol court, the authors argue for improved multi-agency decision-making for children on the edge of care which, crucially, should be combined with evidence-based interventions for the child and their parents throughout the assessment and decision-making process.

Following entry, the way in which care is provided has changed, leading to different safeguarding challenges. Seventy-five percent of children in care are in foster care. There are fewer residential homes, which are also smaller and care mainly for adolescents, but these young people, often with the highest level of needs, are cared for by some of the least qualified and poorest paid staff. There is an increased use of private residential care, with a majority of provision now in the private sector. Despite efforts to reduce out of area placements, many children are placed in residential care often at considerable distance from their local authority, creating difficulties in supporting these young people.

The increased use of both traditional and kin foster care and the desire not to undermine these relationships raises questions about how best to monitor and support the needs of children in foster care. There is a tricky balance to be achieved between trusting and empowering those charged with the care of children, and maintaining the necessary vigilance against the few who abuse this trust.

In Chapter 3 Enid Hendry, Nina Biehal, Robert Tapsfield, Jackie Slade and David Berridge ask whether a different, more nuanced and individual approach to safeguarding is needed. They highlight what is known about abuse in foster and residential care and ask whether there has been too great a focus on safeguarding policies and procedures and not enough focus on the steps needed to build strong, supportive relationships between children and their carers, which are critical to effective safeguarding. The authors argue that it is vital that safeguarding checks are in place, but that our approach must be individual to each child, based on an understanding of their experience of care. Carers must be supported to make the decisions

that develop the lives of the children and young people in care as a central part of keeping them safe from harm.

Research shows that around 45 per cent of looked after children, rising to over 70 per cent of those in residential care, have diagnosable mental health problems. Addressing this need is critical to keeping children and young people in care safe, and ensuring that they are able to overcome the effects of abuse or neglect that they have suffered. However policy and practice far too often fail to recognise or address this and put barriers in the way of young people and their carers who try to access help. Specialist mental health services are often only available once a crisis point is reached and a placement is on the verge of being disrupted. Identifying and meeting these needs early is vital to any approach to safeguarding.

Kim Golding, in Chapter 4, sets out the clear evidence that more needs to be done to meet the mental health needs of children in care. Given the significant levels of need, Golding powerfully sets out the case for a universal specialist assessment for all looked after children, along with dedicated support for looked after children – support which is still not available in all areas. This is not a challenge that can be met by Child and Adolescent Mental Health Services alone and Golding demonstrates the importance of wider therapeutic support for children and young people, such as that provided by schools and leisure activities, along with the need for effective support for carers to help them develop stable therapeutic relationships with children in their care, which are critical to improving children's wellbeing.

There is now a better appreciation of the wide range of risks faced by young people in care. Between 1967 and 2000 there were 18 public inquiries into child abuse in children's homes across England, Scotland and Wales (Corby et al 2001). Cases of institutional abuse frequently involved multiple abusers and large numbers of child victims, both male and female. The abuse took various forms, including sexual abuse, excessive physical punishment and restraint, emotional abuse and neglect. While the majority of these public inquiries relate to residential care, a smaller number relate to abuse in fostering and adoption, such as the case of Eunice Spry (Lock and Butcher, 2007), where children were beaten with sticks and metal bars, had their skin scrubbed with sandpaper, and were forced to eat lard, bleach, their own vomit and faeces.

Following the numerous abuse scandals in care, much attention has rightly been given to preventing the abuse of looked after children

by their carers. Much has been learnt from these inquiries about the characteristics of unsafe organisations and people. As a result, a range of strategies and mechanisms have been developed to prevent institutional abuse. However, less attention has been given to the risk of peer abuse, bullying and abuse outside the home. Recent cases have highlighted how some children in care, especially those who go missing, are being groomed and targeted for sexual exploitation. Peer abuse and child sexual exploitation outside the home require different safeguarding strategies and these will vary depending on the setting and the age of the young person.

In Chapter 5, Christine Barter details what is known about peer abuse and its impact on children in care. Barter highlights that the biological children of foster carers as well as children they care for can be significantly affected by peer abuse but this an issue that remains largely unaddressed. The author calls for a much better understanding of the risks associated with peer abuse. Too often matching, placement and support decisions are taken only with reference to the individual child. Understanding the potential impact of that child on others in a placement, can help to address issues such as placement stability and breakdown, ensuring that the needs of all children are better met.

Isabelle Brodie, in Chapter 6, explores the links between care, children who go missing, and child sexual exploitation (CSE). Understanding of these interrelated issues has grown over recent years, which is reflected in specific policies throughout the UK. However, although a framework is in place to support good practice, the author argues that the systems for dealing with issues relating to care, missing children and CSE are often poorly joined up, with separate sets of guidance, separate services and specialist support leading to an overly fragmented approach to the way in which children are supported. LSCBs have a key strategic role to play in using local data to ensure coordinated and well-informed responses; young people need good sexual knowledge and awareness of risks. In order to provide this, carers and professionals need to be better trained. Brodie also calls for professional curiosity about child sexual exploitation and confidence to challenge harmful assumptions and prejudices that leave children in care unnecessarily exposed to additional risks.

Despite the significant focus on adoption, the most common outcome is for children to return home to a parent or relative. Recent research

has highlighted the need for great caution when deciding whether to return abused or neglected children home from care. It is estimated that half of children who enter care as a result of abuse or neglect suffer further harm when they return home. Action to protect them is often slow or non-existent. Around half of children who return home re-enter care, often more than once, with serious consequences for the children and significant cost to the local authority. In contrast, outcomes in terms of stability and wellbeing are better for those who remain in care than for those who go home. There is therefore strong evidence to demonstrate that care can be a positive choice for children who have suffered abuse or neglect, posing a challenge to existing policy and practice. This is not to say that children should not be reunited with their birth parents, but significant improvements are needed to ensure that children are protected from harm.

Despite the messages from research, policy and practice relating to children returning home from care have, until recently, received relatively little attention. In Chapter 7, Elaine Farmer summarises the keys messages from research, setting out the factors that are known to help ensure successful returns home from care, along with those that are known to contribute to unsuccessful reunification. At present research indicates that a local authority's approach to reunification is a bigger factor in determining whether or not a child returns home than the needs of the child. It is clear that significant improvements are needed to assessment, decision-making, monitoring and support prior to and following a child's return home, which Farmer argues will not be achieved without a significant increase in the attention paid to this area of practice.

Leaving care is often regarded as a transition to adulthood, but it is a transition that takes place too early in children and young people's lives and is fraught with complexity and risk. From the *Care Matters* white paper (Department for Education and Skills, 2007) through to the current *Care Leaver Strategy* (HM Government, 2013), attention has increasingly been paid to ideas for improving support for care leavers, with proposals for lengthening the time young people can stay with carers after their 18th birthday as well as improving support for education. Much of this is still to be achieved and even so, planning often focuses on the practical support a young person will receive, such as education, housing or financial support. Responding to the mental health challenges faced by care leavers is central to ensuring their safety and future prosperity, yet remains largely unaddressed.

In Chapter 8, Jim Wade uses the latest research to set out the mental health and wellbeing challenges experienced by young people leaving care. Transitions to adult services are fraught with difficulties and higher thresholds often mean that no support is available, leaving young people to fend for themselves during this vulnerable period of their lives. Wade argues that much greater attention needs to be paid to this transition point in order to break down the rigidity in access to adult mental health services and develop specialist-supported accommodation for those in the greatest need.

In addition to the specific challenges identified above and new insights from research there are also systemic reasons for re-examining the role of care. While there has been much important work there has, arguably, been little systematic thinking about how to ensure the wider protection and therapeutic support of looked after children. There is no national data collated and published on the abuse or neglect of children in care. There is no reliable data on incidence and no benchmarks against which to measure the effectiveness of safeguarding arrangements or how children's wellbeing is being promoted. Without this, how can those *in loco parentis* know with any confidence what is working and where change is needed? And how can they be held to account?

Thinking about the care system is too often compartmentalised and disjointed, failing to address the diversity of children and young people in care, the complex range of issues they face, or to identify how best to meet their needs. Care is generally thought of as a separate system, isolated from wider child protection and family support systems. Instead, care needs to be thought of as part of the wider system of children's services that includes entry to care, leaving care, as well as support for parents whose child is in care or returned to them from care.

In our final chapter, Harriet Ward examines what is known about decision-making for children in care and the factors that drive the choices that are made for children and their families. It is clear that resource constraints, which of course are particularly acute at the time of writing, have a significant impact on care thresholds, the availability and choice of placements, and the availability of specialist support for children and their parents. Alongside this, Ward identifies a range of other factors that also impact on the choices that are made for children in care. Reflecting the evidence set out by Thoburn in Chapter 1, Ward details how professional attitudes

and misunderstandings about the impact of care on children and young people shape the way in which care is used and the support that is provided. Coupled with practitioners' professional skills and knowledge, these views and attitudes have a fundamental impact on our care system. Ward also explores how professionals identify and analyse risk and parental capacity to change as well as their own understanding of child development. In this powerful final chapter, she argues that successful implementation of new interventions and strategies to improve our care system must be accompanied by efforts to tackle attitudes about care and professional capacity to understand and use evidence about risk, parental change and child development.

The concluding section of the book distils the cross-cutting lessons from each of the chapters that are central to thinking about ways to improve the care provided for children and young people. These cover the importance of relationships; support that is based on an individual's specific needs; a greater focus on mental health and emotional wellbeing; supporting and developing the workforce; viewing care as part of a family support and child protection system, and addressing variation. Each sits alongside the specific recommendations of each chapter, and provide important insights into about how to improve support for children in care.

Conclusions

This book aims to complement the work that is going on across the country to improve support for children and young people in care, for families whose children are on the edge of care and for those whose children have returned home. Alongside work to develop legislation, guidance and policies for children and young people in care, it is a sustained effort to examine and improve practice that will provide the future that children in care deserve.

Eileen Munro suggested that the cumulative effect of policy and guidance changes can produce obstacles to meeting the child's needs. An important debate therefore is whether we have developed an over-elaborated, bureaucratised and risk-averse care system, and whether we should be more trusting of those who wish to work with or care for children. Could less actually be more effective? Before steps are taken to reduce 'red tape' and dismantle measures designed to protect children in care it is important to understand their relative importance and effectiveness as well as any unintended negative consequences their existence may have for children. This book aims

to contribute to that debate, bringing together research evidence to help inform practice.

Most authors would argue that, while there are gaps that can be addressed, there is a clear legal framework for children in care. However, tackling new and continuing safeguarding challenges requires something different. We need to change the public and professional mindset about the role of care and develop ways of working that are based on the best available evidence. This includes more proactive approaches focused on the child's best interests to prevent the serious harm caused by delay.

Uniform or standardised approaches to safeguarding for all children will not work. Children in care are not a homogeneous group and neither are the risks they face. A more nuanced approach requires the exercise of a high degree of professional judgement and discretion, which in turn depends on the knowledge and understanding of research evidence and the abilities of skilled and well-supported professionals and carers, working as partners.

Relationships are critical to keeping children safe. These need to be warm, caring, stable and continuous. Too often these relationships are disrupted and of poor quality. The House of Commons Children, Schools and Families Committee report on children in care (2009) saw the quality of relationships as critical to improving outcomes:

> "The greatest gains in reforming the care system are to be made in identifying and removing whatever barriers are obstructing the development of good personal relationships and putting in place means of supporting such relationships when they occur" (p.27).

These challenges remain as true today. These and many more are addressed by each of our authors in turn.

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The views of looked after children and young people on the care system

The views of looked after children and young people on the care system

By Louise Bazalgette

"It's only us who've been through it who can really understand it."

Introduction

No publication on the care system would be complete without the views of those young people who have experienced it directly. Our exploration of the changes that are needed to improve the wellbeing and safeguarding of children in care therefore starts with a discussion of the strengths and weaknesses of the care system as voiced by young people in care and care leavers themselves. The insights summarised in this chapter reflect the views of children and young people from diverse backgrounds and with a range of characteristics, based on their experience of the care system in England, Scotland, Wales and Northern Ireland.

As the issues highlighted in this chapter reflect the views of children and young people themselves, this chapter is structured differently to the others in this book. Nevertheless, a set of themes emerges that is not too dissimilar: based on their experiences, children and young people stress the role of care in keeping them safe from harm; the importance of strong relationships; the need for improved support for mental health and wellbeing; the risk of going missing; the risk of abuse – including peer abuse – in care, and the challenges of leaving care or returning home. Each of these issues is explored in detail in subsequent chapters, informed by the experiences of children and young people and the latest research findings.

Research for the chapter is based on 11 'life story' interviews with children and young people, exploring their experiences of being in care in the UK, as well as focus groups with Children in Care Councils in England. It is backed up by a literature review of research into the experiences of looked after children in the UK. The

research was carried out in partnership with the NSPCC's Young Ambassadors, who helped shape the focus of the research and develop the questions used in interviews.

In total, 29 children and young people with direct experience of care participated in the research that informed this chapter (18 from England; 4 from Wales; 3 from Scotland, and 4 from Northern Ireland). Six of these young people were under 18 while 23 were recent care leavers over 18. The gender split was roughly equal, with 15 female participants and 14 male participants. Those who took part in the life story interviews had experience of a variety of placements including adoption, foster care, residential care, residential schools, psychiatric units, secure units, kinship care, and living independently in a variety of settings, including independent living units, hostels and supported lodgings.

Summary

The experiences of children and young people demonstrate significant variations in support that they received: there is no single experience of care. This variation is present wherever the child was from in the UK, and occurs within a single local authority as well as between different authorities. Some of this variation reflects the differing needs of children and young people in care – they are not a homogenous group – but all too often it reflects a lottery of support that is available to children in care.

However, even with this variation, children and young people's discussion of their experiences of care can be organised into a number of clear themes. The first section of this chapter explores young people's reflections on their experiences of care, while the second draws out their main recommendations for improvement.

Young people's reflections on their experiences of care can be grouped into five themes:

- **Positive experiences of care**
  Nearly all of the young people felt that their contact with the care system had enhanced their life chances in some way. These positive experiences included being removed from harmful situations, experiencing increased support to engage with their education and new opportunities to develop close, caring and supportive relationships.

- **Disrupted relationships**
  Unfortunately, some of the young people did not experience the consistent relationships that they would have liked while in care. Instead they discussed frequent changes in foster carers, children's homes or social workers, and the cumulative negative impact of these changes on their wellbeing.

- **Going missing from care**
  Young people highlighted the challenges of going missing from care and explained that they had run away from care for a variety of reasons. These included being reunited with a loved one, escaping a situation that felt unsafe, or wanting to have fun with friends. Some young people described tensions between their carers' concerns about their safety and their own desire for independence and excitement, which were difficult to resolve.

- **Stigma and discrimination against children in care**
  Some young people felt that poor understanding of the care system among the general public contributed to discriminatory attitudes towards looked after children. Some referred to stigmatising attitudes to children in care and others said that they preferred to keep the fact that they were in care a secret from friends.

- **Poor quality and harmful care**
  Even within safe and stable care placements, children's needs to feel safe, loved and cared for are not always met. Some of the young people we interviewed described painful experiences of emotional neglect and rejection while they were in care. At worst, some young people had experienced abuse from carers or other young people in their placement.

Suggestions for strengthening the care system can be grouped into six themes:

- **Ensuring young people's voices are heard**
  Many young people described circumstances in which they felt their social workers or carers had failed to listen to them, with consequences that were sometimes very detrimental or even put them at risk of harm. There was a strong message from the young people who took part in this research that they wanted children in care to have more control over important decisions in their lives.

- **Strengthening the social care work force and improving practice**
  One of the main areas of reform the young people identified was the need to increase opportunities for social workers to spend time with children and young people in care. They argued for a reduction in social workers' case loads, and some said that they would like social workers to have more relaxed and informal relationships with children in care.

- **Promoting the right to advocacy**
  Young people often mentioned that their views had been ignored and argued strongly that more needed to be done to ensure that every looked after child and young person was informed about advocacy and complaints services.

- **Improving emotional support**
  Many of the young people we consulted did not think that the emotional needs of young people in care were adequately supported. They argued that more emotional support should be made available, which might take a variety of forms depending on the young person's needs.

- **Supporting transitions in and out of care**
  Young people described chaotic experiences of leaving care and felt they had not been adequately supported to cope with it. In general, young people tended to view leaving care as a (perhaps unnecessarily) stressful experience. They argued that instead of imposing arbitrary cut-off points, supportive services should be available to care leavers for as long as they were needed.

- **Improving public understanding of the care system**
  Some young people felt that discriminatory attitudes towards children in care were caused by ignorance of the care system among the general public. They argued that measures should be taken to educate members of the public and politicians about care.

As these points suggest, despite their own very varied experiences the young people who were consulted to inform this chapter all believe passionately in the need to improve the UK care system. Collectively they communicate a vision that all children and young people who enter care in the UK should be offered caring and supportive relationships with adults who will listen to their needs and remain committed to them long after they have left care. Their exact words

are frequently quoted throughout this chapter to allow them to communicate their experiences and opinions to the reader directly.

Children's experiences of care

Positive experiences of being in care

Nearly all of the young people who took part in detailed 'life story' interviews felt that their contact with the care system had enhanced their life chances in some way. This is consistent with larger-scale research undertaken by the Children's Rights Director for England in 2010, which found that in all, 70 per cent thought that coming into care had been either 'definitely' or 'probably' the right thing for them. The reasons given predominantly fell into the categories of feeling well looked after, happier and more settled, or having a better life and more opportunities (Ofsted, 2010).

In the research conducted for this chapter, young people's discussion of the positive aspects of being placed in care reflected similar themes in that they focused particularly on their removal from previous harmful situations, increased support to engage with education and, most importantly, new opportunities to develop close, caring and supportive relationships.

Protection from harm and increased life chances

Some of the young people we consulted explained that entering care had enabled them to be removed from very harmful or dangerous situations:

> If I hadn't come into care I would have topped myself a long time ago.

> If I'd not come into care I would have ended up dead or in jail. I had to sign myself into hospital as my head was going… I would have killed someone.

> If I had stayed at home you can guarantee that I would have got pregnant and it would have been to him [my stepfather].

Several of the young people also said their placement in foster care or residential care had increased their ability to engage with their education:

It's good we were all together in a mostly law abiding atmosphere with structure. We were going to school so we had the means of escapism – when you are surrounded by chaos it's hard to see a way out.

I wouldn't have had the opportunities I've had if I hadn't come into care […]. Growing up as a teenager I would probably have lost interest in school. In foster care there was routine you know and I wouldn't have had that with my mother.

It still comes as a shock to me now… turning 18 and being in university. […] Even when I first got into care I didn't expect to finish my GCSEs, didn't expect to go to college.

Another young person reflected that care had given him "better opportunities" because he "felt safe". These findings concur with the views expressed by children in the Children's Rights Director's report (Ofsted, 2010).

Making Not Breaking, a report by the Care Inquiry (2013) states: "The weight of evidence, from all quarters, convinces us that the relationships with people who care for and about children are the golden thread in children's lives" (p.2). This was certainly the case for the young people we interviewed for this chapter, who told us that it was the quality of their relationships with carers, social workers and family members that had the greatest impact on their experiences while in care.

New relationships with carers and social workers

We asked the young people whether they thought the care system could provide an experience similar to family life. Their responses reflected very varied experiences of being in care. Several young people said that they *did* feel they had experienced family life in their foster care placements. Comments included:

Even if I did something wrong she would be like a proper mother and tell me off, give me chores to do, it was so close and that's what I needed… She respected my opinion as well… these people were like my family.

The family adore me and my foster mammy loves me and that…. and they do class me as a family member.

I'd say care can provide you with a family life. Well it's down to the people you are with really. We always had someone to talk to about things, I felt a part of the family.

Another young man who had experienced both foster care and residential care said that his residential care placement had felt more like a family than his previous placement in foster care:

I felt a lot more comfortable and settled, and it did feel like a family.

He explained that he had partly rejected a previous foster care placement

… because it wasn't my family… I couldn't see them as a family because they weren't my family. I think it was me who didn't want it, not them.

Two other young people also explained that their experiences of residential care were largely positive. However, they did not think this had felt like being part of a family. One young man explained:

The staff [in residential care] try their hardest but it's not like a family. The sheer fact that there are other young people there who all have their own case files… you can't know much about them unless they want you to know about them and the shift pattern of the staff, it's not very family at all. […] We came home and had our tea… you get close to a few members of staff but not the whole staff team.

Not all of the young people we spoke to had been seeking family life in their care placement. One young man said that after eight years in residential care

… the relationships I built up I'll have for life.

However, he emphasised the distinction between this experience and the relationships he had with his birth family, which he felt could not be replaced:

Although you're looked after like a family I wouldn't say it was exactly like family life. You don't go into care because you don't have a family you go into care because you've got problems with your family.

Some of the young people also explained the hugely positive impact on their life of social workers with whom they had been able to develop a close and trusting relationship:

> My old social worker was absolutely amazing, the best one I've ever had. […] She cared. She gave it 110 per cent. She genuinely cared. She'd do everything she could for you. She'd fight for what you wanted, even if it's not what social workers would want to hear.

> My 16 plus worker is like my mum. I am still in contact with her. Hugs when I've done well, lectures when I've done something wrong… […] I wish I didn't have her as a social worker, I wish she was my friend.

It is important to remember that relationships with birth family members also continued to be very important to some children, providing an important source of comfort and reassurance:

> [My dad] had been looking for me for years. He'd been in England a long time and when he came back he got in touch… and I got to see him, it was class! We are two of the same people…

> I saw my mum sometimes so it was not too bad.

However, as the discussion in the following section will demonstrate, for some children contact with family members could also give rise to feelings of confusion, conflicted loyalties or emotional distress.

Disrupted relationships

A range of research now suggests that the care system provides a safe and supportive environment for the majority of children.[1] However, as Harriet Ward observes in Chapter 9, the majority of children who enter care will already have experienced abuse or neglect. Therefore, children in care remain a vulnerable group who can be made more vulnerable if they experience poor standards of care and do not have their emotional and other developmental needs met.

Research has also shown that children who have higher levels of emotional and behavioural difficulties when they enter care are at greater risk of experiencing unstable placements, which in turn can have a negative impact on their wellbeing and mental health (Hannon et al, 2010). When children have unstable experiences of care with more placement moves, they are also more likely to experience challenges in engaging with their education (Biehal et al, 2010). Research with looked after children published by the Children's Rights Director for England in 2011 emphasised the message that

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1   See the evidence cited in Chapters 1 and 9.

"young people disliked having to put up with all of the changes in their lives, whether placement moves or changes of carers or social workers." (Ofsted, 2012, p.13). As such, the Care Inquiry's 2013 report has emphasised the importance of achieving "permanence" for children in care, which was defined as "security, stability, love and a strong sense of identity and belonging." (Care Inquiry, 2013, p.2).

Unfortunately, some young people did not experience this sense of permanence while they were in care. Instead they discussed the negative impact of changes in foster care or residential care placements, which could have a cumulative effect:

> My foster care home broke down when I was 15. […] I got moved to a temporary placement and started to lose faith in the system. I was angry and upset, you know?

> There were times when the [residential] staff come and go and that was upsetting – someone else walking out of your life – quite heartbreaking at times.

> I had about ten or eleven moves in three years.

> One thing that I've found is that when you're happy somewhere, they're quick to move you backwards and forwards. But a big experience of mine personally is that when they know you're in a bad environment and you're actually quite at risk, and there's a hell of a lot going off, they're happy for you to stay there for months.

One young person reflected that she might have had a better chance of experiencing something similar to family life if she had had a stable placement:

> I think if the child has been there from a young age it would be like a proper family life, but I was moved around a few times.

National data for looked after children in England collected in 2013 show that 11 per cent of children had three or more separate placements that year, 23 per cent had two and 66 per cent only one placement (DfE, 2013). The 2011 Children's Care Monitor found that while most of the children who participated had only experienced one change of placement, across the group children had experienced an average of five placement changes (Ofsted, 2012). These findings suggest that multiple placement moves, found to be so destabilising by some of our interviewees, are still far from an unusual occurrence.

In addition to frequent placement moves, a change of social worker can also have a destabilising impact on children's lives. A study by Harriet Ward published in 2009 found that during the four years of the study period, 17 per cent of children and young people experienced four or more changes of social worker (Ward, 2009). Comments from the young people we interviewed included:

I had six or seven social workers in three years. It was annoying as you had to make that connection with someone all over again.

Frequent changes of social workers is absolutely the worst thing about being in care.

From 12 to 16 I had seven social workers. I knew their names at the time but now I don't want to remember them.

So although the benefits of positive relationships with carers and social workers can be very significant, some young people in care are clearly missing out on feelings of closeness and belonging.

Some of the interviewees were also very sad that they had been separated from their siblings whose care plans meant they were unable to maintain regular contact:

I've got a brother who is younger. He came into care after me but then went for adoption so…. I've not had any contact for a while.

The contact with my brothers who were also in care was not good. We were all split up… I saw the two in Scotland but not the one in England.

Where children in care do have contact with their family members, this can cause tense and difficult situations that give rise to conflicting emotions. Two of the young people we interviewed described their difficult experiences with contact:

The social workers had a great idea to let [my foster carer] supervise the contact with my mother, and she was a very jealous woman and she hated it… I always felt like I was being tortured afterwards.

I had to bite the bullet and go down to that house to see my sisters and I hated it. He [my stepfather] never let me alone with them so if anything was happening they never told.

Where contact with family members is not supported, the desire to be reunited with family members can sometimes lead to children putting themselves at risk by running away from care. Being placed far away

from friends and family has been identified as a risk factor for children going missing from care (APPG, 2012).

Children who go missing from care

Police data show that approximately 10,000 children go missing from care each year (APPG, 2012) and research by the Children's Society suggests that children in care are three times more likely to go missing overnight than children who live with their birth family (Rees and Lee, 2005). In 2009–10, looked after children counselled by ChildLine were five times more likely to discuss running away than children counselled by ChildLine overall (NSPCC, 2011). Going missing was often mentioned by the children and young people we interviewed, and the issues relating to this are further discussed in Chapter 6 in this volume.

Previous research has shown that young people run away from care for a variety of reasons. A report by the Children's Rights Director explained that: "Children may run from a placement or problems they cannot cope with, or to a place where they want to be or to a person they want to be with" (Ofsted, 2012b, p.7). The young people who took part in that research gave three main reasons why children run away from care:

- to have fun, with the intention of then returning to their placement

- to be with someone (e.g. friends and family) or to stay with them

- to get away from things "you can't cope with" at your placement.

The young people in care and care leavers who took part in life story interviews for this report gave similar reasons for going missing from care. At least three had at some point run away from their care placement. One of them felt that she had had no other option than to run away and go and live with her grandmother because she and her siblings were being abused in their foster care placement. She thought this abuse was being ignored by their social worker.

Another young person ran away from his foster care placement because he was upset by the violent language his foster carer had used:

In that time I'd run away a few times, I remember running away once because the foster carer came down stairs and asked me […] "If [the other foster child] slit her wrists, would you too?" I was only like 8!! I flipped – I walked out and was gone.

A third young person described running away from his placement as an important turning point that had subsequently led to him taking better care of himself:

I ran away… broke out of the unit for a day. I didn't feel safe. I felt sick at going back but when I got there I felt safer. From that day I started to educate myself and read more books… It hit me that if I wanted to get out of the paranoia I was going to have to change my life and think differently – stop using the violence.

In some cases it was clear that young people thought it was preferable to go missing than to comply with the rules enforced by their carers:

It wasn't technically running away – I would go off on my own or go to a friend's house… Any phone calls I had I'd turn my phone off. I didn't want to have to deal with saying where I was, who I was with, what I was doing, what phone numbers I had to give out… having to give out parents' phone numbers… it was really embarrassing.

I ran away several times. It was stubbornness or unwillingness to listen to my staff members. Or I was bored! There were issues about staying out. Obviously when you're young you want to stay out with your mates and stuff… but we got stuck with "You're going to need a security check" or "we're going to need a month's notice." It's ridiculous!

One young person, aged 17 at the time of the interview, explained that he was reported missing to the police each time he was absent from his care home. He seemed to view this mainly as an inconvenience:

There's all this procedure and stuff. Sometimes I want to go out with friends and have a drink and stuff and stay out at their house but because I'm on a s31 it's against the rules so they have to report me missing to the police and that is so annoying… every time… I get a phone call at 2 in the morning: "Are you safe?"

This young man was dismissive of his carers' professional concerns about the risk of sexual exploitation, which to him was irrelevant to his life:

> They're [the care staff] not worried about me that much but they're always on about sexual exploitation… I'm like "if I was being exploited love I'd tell you!!" But you know… [laughs].

These interviews demonstrate the tension between the responsibility of carers to keep looked after children safe, and young people's desire for greater independence and (in some cases) participation in risky behaviours outside the home for escapism or excitement. While this may reflect a common dynamic between parents and teenagers, the institutional context of the care system creates an expectation that carers will behave differently from parents in private households. This research suggests that in some cases the rules that operate in foster care and children's homes create an incentive for young people to go missing rather than submit to bureaucratic procedures (eg security checks), which to their mind do not meet their needs.

In some cases, the procedures put in place to safeguard adolescents in care are not effective and at times may even be counterproductive. 'One size fits all' procedures clearly have the potential to damage relationships between young people and their carers if there is no flexibility in how they are applied. Previous research by Berridge et al (2012) explored what young people living in children's homes wanted from their relationships with care staff. These young people identified important factors as "staff sensitivity and listening skills; reliability; a sense of humour; and relationships that felt akin to family" (ibid, p.88). However, the same study found that in two of the 10 children's homes included in the study, staff were "rather detached" (p.60). This suggests that more work is needed to examine how we can support carers to develop these trusting relationships with young people, to keep them safe while recognising their individual needs.

Stigma and discrimination against children in care

In 2012, the Children's Rights Director found that while over two-thirds of children in care felt that they were not discriminated against as a result of being in care, a smaller group (17 per cent) thought they "sometimes" or "often" suffered from discrimination (Ofsted 2012a, p.55). This theme is highlighted by June Thoburn in Chapter 1, in

which she reflects on the language used to describe the care system and children and young people in care. Indeed, some of the young people interviewed for this chapter felt that poor understanding of what it means to be in care among the general public contributed to discriminatory attitudes towards looked after children:

> People think we're damaged or problem children. They think about abuse because that's the only thing that's ever in the media. And that we're not very intelligent. There's a general stigma attached to it.

> I was always looked down on coz [sic] I was in care… […] People need to take a hard long look at themselves and not judge me or anyone else who is in care.

One young person gave examples of this discrimination in action:

> I used to live next to a shop and as soon as they found out that one of the young people that was coming in was from a care home, they used to ban them from the shop because they thought they were going to steal.

This young person also said that he had once been refused a job because the prospective employer "found out I were in care. He said it to my face".

This sense of stigma attached to the care system meant that some of the young people we interviewed were reluctant to tell their friends that they were in care:

> I wanted to be judged on who I am, not on your ideas of what my past makes me.

Poor quality and harmful care

Experiences of emotional neglect and rejection by carers

Reflecting the findings of Enid Hendry and colleagues in Chapter 3, the interviews with young people found that even within safe and stable care placements, children's needs for safety, and to feel safe, loved and cared for, are not always met. Some of the young people we interviewed described painful experiences of emotional neglect and rejection while they were in care. One young woman reflected that:

Physical contact and emotional warmth was definitely lacking in my placement […] we never ever ever hugged, never ever… but obviously deep down that's what any child in care would want really, they want to feel accepted.

A young man remembered sharing his foster placement with a six-year-old who had wanted to be hugged. However, he explained that the foster carers were "really uncomfortable with that and they were always trying to stop him doing it". This situation had been made all the more upsetting by the fact that the foster carers were openly affectionate with their own grandchildren: "They seemed to like to keep their family separate from us if that makes sense".

Two other young people also described feeling that they had a separate status within the foster carers' family:

I would have liked them to involve me in their family life! I never really felt involved – both practically and emotionally.

I was the lowest of the low in the family. Obviously the little toddlers who were also in care were top of the list, then her daughters, then herself and then her ex-husband and her family and then it was me.

A young man, aged 17 at the time of the interview, described his traumatic experience of being rejected by his foster carers because they did not accept his sexuality:

I started becoming a teenager and exploring my sexuality and they were really Christian and they didn't like that and I was moved [from that placement] on the grounds that being gay was against their religion. […] What I didn't like about care was the rejection. I've never had the family thing – I've learnt now that when I went into care I locked up all my emotions.

These comments highlight the importance of finding *the right placement* for children in care. As previous studies have noted, stability is profoundly important for children in care but it is arguably even more important that a child's placement meets their emotional needs (Hannon et al, 2010). In some cases the disruption associated with a move to a more appropriate placement may be outweighed by the increased wellbeing a child experiences as a result of having a better relationship with more appropriate carers. A report by the Children's Rights Director provides evidence to this effect, showing that in 2011 more than two-thirds of the children surveyed (68 per cent) thought that their last placement move was "in their best interests"

(Ofsted 2012a, p.45). Surveys conducted in the previous three years had similar findings. A qualitative study by Young Minds also found that many of the young people they interviewed "identified previous placements as less positive [than their current placement] and stated that they did not think that their carers understood their needs" (Young Minds, 2012, p.3). As Sinclair et al have argued, placement stability should never be prioritised over children's wellbeing if their current placement is inappropriate (Sinclair et al, 2007).

Abuse by carers

Research into the prevalence of maltreatment in foster and residential care suggests that only a very small minority of children experience neglect or abuse. Recent NSPCC-funded research by the University of York did not find any recent evidence of children being abused by staff in residential care. While abuse in foster care was also uncommon, the study found a small number of confirmed instances of abuse or neglect of children in care each year. The research did find that many children are exposed to peer abuse and bullying in these settings (Biehal et al, forthcoming). This mirrors findings from an NSPCC report, which found that many looked after children counselled by ChildLine found relationships with other looked after children difficult. These relationships were sometimes characterised by bullying, intimidation and physical abuse (NSPCC, 2011).

One of the young people that we interviewed explained that she and her siblings had often been threatened with violence by their foster carer and were sometimes locked in their bedrooms. When she was physically assaulted by her foster carer's daughter, one of her carers witnessed the incident but did not intervene:

> I was 13 and the daughter was 18 – she was bigger than me and I was just shocked – the foster dad was at the doorway and he didn't say anything.

This abusive treatment culminated in her decision to run away from her placement.

A male care leaver also explained that his adoptive mother had been physically abusive towards him, therefore he had been relieved when the adoption broke down and he was able to move to a residential care placement:

> If I had stayed with my adoptive family I think I would have been low in confidence, very shy, not having many friends, a bit of a loner.

He explained that his subsequent residential placement felt safe in a way that his adoptive placement had not.

Peer violence, discussed by Christine Barter in Chapter 5, was the most frequently cited form of abuse experienced by the young people we interviewed. Five of the 11 interviewees reported experiencing or witnessing some kind of bullying or abuse by another young person. Two young people experienced peer abuse in foster care placements. For one young person this was dealt with by a fairly rapid placement move:

> I was there for 12 days and I really didn't like it. I remember the siblings used to gang up on me – I didn't like it and I asked to move.

Some of the young people who were placed in residential care also described being exposed to taunting, aggression or peer pressure by the other young people they lived with:

> When the younger lads came in a lot of the lads would be like "come and get drunk with us or we'll batter you". I thought that was a bit out of order.

> I think there is a lot of bullying that the staff do not see. You can bully emotionally by saying something and no one sees that and you might not say so.

Another young person admitted that in the past he had caused fights with other young people in his unit:

> I've put aggression towards them and they've done that to me. […] Sometimes it's good to let that anger out but not through fighting… not bottling it up.

Previous research has found that young people in residential care are more likely to experience assault by another young person than by a member of staff (Barter, 2003), while an earlier study found that 40 per cent of children placed in residential care had been bullied by other children in their placement (Sinclair and Gibbs, 1998). This was clearly a significant concern for some of the young people we interviewed who had lived in residential care.

Building a better care system

Young people in care and care leavers also gave their views on how the care system could be improved. Their recommendations can be grouped into six themes.

Ensuring young people's voices are heard

The young people said that most basic requirement for a positive experience of being in care was to feel that they were being listened to. Unfortunately, many described circumstances in which they felt their social workers had failed to listen to them, and the consequences were sometimes very detrimental, even putting them at risk of harm:

> I would say the decisions were just made; I was never listened to or asked what I want.

> If they'd listened to me six years ago I would have been healthy years ago but they didn't listen to me, they kept sending me back to my ma and da's. […] People should listen to you, not do what they think is best for you.

> The LAC review decided I should go home. But I wasn't listened to there because I said I wasn't ready to go home.

One young woman explained that she had had to resort to becoming extremely confrontational with her social worker to ensure that her voice was heard:

> I've learnt that if you make a scene you get dealt with. But if I phone my social worker politely and say 'hi there, can you sort this out?' nothing happens. But if I phone her and say "oi you, this is what needs to happen, right now, or I'm going to come down to the office and bring hell," then I get a call back.

This was not a situation that either she or her social worker was happy with. However, she felt she had no other option than to assert herself in this way.

The Children's Rights Director for England's 2011 survey of looked after children found that 14 per cent said they were "not usually" or "never" asked their opinions on things that mattered to them (Ofsted, 2012a, p. 21). In the same survey, only 20 per cent of participants thought that their opinion always made a difference to decisions about their lives, while 5 per cent thought their opinion *never* made

a difference. The decisions that children most frequently wished they had more say about were decisions about which placement they would live in, decisions about their future and decisions about contact with their birth family.

There was a strong message from the young people who took part in this research that they wanted children in care to have more control over the decisions that affect their lives:

> I'd like to see children being more involved with decisions and having more of a say.

> Children and young people have the right to be informed and the right to be listened to. Those are two massive ones that were so woefully lacking from my carers and social workers.

> Young people should have more input into the policies that relate to them. More input into contact and the orders and stuff. When they feel ready, not when the courts says they're ready.

One young person argued passionately that it is time put children and young people in charge of driving forward reform in the care system:

> You need to treat each young people with respect. Something needs to be done by the young people. We're tired of people overseeing things and taking down notes. We want to do it. If you want us to get better at it, train us!

The young people acknowledged that Children in Care Councils could have a really important role in this process: "Now it got kick-started it's really made a difference". They argued that Children in Care Councils should be made universally available and their effectiveness improved, to help ensure children in care can make their voices heard:

> I think something like that should be running in every area so the young people can face forward to social services and deal with the issues within care.

Strengthening the social care workforce and improving practice

Many of the young people were conscious of the pressures faced by social workers and the impact of their workload on their ability to build relationships with young people. This issue is also highlighted

in Chapter 9 as a driver of decisions in social work. As a result, one of the main areas of reform identified by young people was the need to reduce social workers' caseloads in order to increase opportunities for them to spend time with children and young people in care. One young person argued:

> We need more money so we can hire more social workers and reduce case loads. I'd like to see more respect for social workers and more respect for social work as a profession, so that it's not something people feel they can just do, it's something people want to do, and it's a competitive thing because so many great people want to go and work with children in care.

Reflecting the importance of strong relationships highlighted by many contributors to this book, several young people argued that they would like social workers to have more relaxed and informal relationships with children in care. One young person went so far as to complain that her social workers had treated her "like you're a file put in the cupboard." Suggestions that were made included:

> You should spend more time with that person to make them feel comfortable so they can talk.

> You need a lot more social workers… more social events out of the office… bowling, ice skating… a big day or residential thing. You really get to know people that way. You need to get them the heck out of their offices. You're working with children you're not lawyers!! Be seen as a fun person! Not stuffy or intimidating to the young person… loosen up… more child-friendly.

These recommendations echo what children and young people told the *Munro review of child protection*: the need for social workers to spend less time on paperwork and more time building relationships with the young people they support (Munro, 2011).

Two participants in our research suggested that children and young people should have greater involvement in training student social workers, to teach them to see things from their perspective. One young person also argued that it should be easier to change your social worker if the relationship is not working, instead of the current situation where "you put it in writing and then it gets declined unless you've got a really good reason for it."

Promoting the right to advocacy

Young people frequently raised the issue of their views being ignored, and advocacy was an important theme of discussion. Many spoke about how they had resorted to a formal advocacy service at some point to make sure their voice was heard:

> Having an advocate changed things 100 per cent. […] She got involved and we made complaints about my treatment from the foster carer and social services and we got my care order discharged in favour of a residency order with my grandmother and yeah, she was great at a time when I really needed an advocate.

> I don't remember who told me about [the advocacy service] but it definitely wasn't my social worker. […] When I first found them I thought they were like gold dust. I used to walk away and laugh and think "[my advocate] will be in contact!" That really worked for a while.

However, not all of the young people were aware that advocacy was available to them. This reflects survey findings from the Children's Rights Director's report, which show that 15 per cent of children do not know how to access an advocate, and in fact 30 per cent do not actually know what an advocate is (Ofsted, 2012). One young person we interviewed commented that "not enough young people know about advocacy, probably because social services don't tell them."

The young people we spoke to argued strongly that more needed to be done to ensure that every looked after child and young person was informed about their advocacy and complaints services. Concerns were also expressed that not enough children in care are informed of their rights and entitlements generally:

> How are they going to make a good decision if they don't know the range of options and they're not kept up to date with everything that's going on around them?

One young person argued that "when social workers work with young people that come into care, they need to lay out what they're entitled to."

Improving emotional support

Studies have shown that a high proportion of children in care have emotional and behavioural difficulties that put them at risk of poor outcomes (see Chapters 4 and 7). However, while these difficulties

are well evidenced, the quality and availability of emotional and mental health support for children in care varies considerably between areas.

Many of the young people we consulted did not think that the emotional needs of young people in care are currently supported adequately within the care system. One young person commented that:

> Services tend to focus on practicalities, not emotional stuff… making sure you're ok in day-to-day life rather than the core of the issues. That's what I found myself… I've had to deal with it my own way… and I think a lot of kids find that too and because they can't deal with it, it breaks them apart and they get into drugs and stuff or they have to sort it out their own way, or else you can't keep going.

Experiences of mental health services among the young people in care and recent care leavers varied a great deal. Some had benefited from counselling but others had not been open to the idea of accessing a mental health service – "If someone tells you need therapy then it's offensive!" One young person wished that she had accessed therapeutic services when they were available, ie before she left care, saying: "now I think I need them!"

Some young people who had not wanted counselling had benefited from other types of emotional support. One young woman recalled the huge impact personal advisors had had on her life. Another young person discussed how much she valued the drop–in centre that was available to her, as she knew that she could always go there if she needed help or someone to talk to.

Some of the young people made recommendations about the types of emotional support they thought should be made available to young people in care:

> Everybody should have emotional support. Someone to talk to… not heavy like a counsellor – someone like a third party that you can bounce ideas off. Maybe like a relaxed counsellor… student support or something.

> I'd say counselling, befriending, anger management, even groups or things that are interesting for young people to go to… social outings… good holidays… […] where you can experience something.

One young person suggested that to offer most benefit to children in care, mental health services need to be flexible:

> Being flexible gives the young person more control – so many kids in care have had control taken out of their hands, so if there is an opportunity to give that control back in some way and to show this is a process that you can lead, not only is it beneficial in the type of service, it's beneficial lifetime-wise.

Further recommendations on tailoring mental health services to the needs of looked after children are explored further in Chapters 4 and 7.

Supporting transitions in and out of care

Young people described chaotic experiences of leaving care or returning home. They felt that they had not been given adequate support to cope with these experiences, a finding supported by Elaine Farmer and Jim Wade in Chapters 7 and 8, respectively. One young person explained:

> It was planned for me to be moved, all my stuff was packed but it broke down two weeks before… I was at my gran's for the weekend and then on the Monday I had a call from my social worker saying that my foster carer didn't want me back.

Another young person explained that the policy at his children's home meant that children were often "forced" to move out on their 16th birthday. He argued strongly that this caused children to experience an unnecessary sense of rejection:

> When it's your birthday and you're throwing somebody out, it's just like saying "nobody wants you, we're just throwing you out on your birthday," when that's a day when you should be celebrating everything you've achieved in that year.

Another young person found that when he returned home from care at 16, his family issues had not been resolved, and consequently the arrangement did not last long:

> I feel when I went home I wasn't ready, to be honest. I still had the problems in my home, my family home, they weren't really solved they were just left. […] The problems were still there… and it boiled over and kicked off again and then I was homeless.

In general, young people tended to view leaving care as a stressful experience:

> Even when you're 18 it [leaving care] is a stress time you know?… You are excited but somehow you're scared, too – there's fear there, too. I didn't think there was any help, really I didn't get any help.

> I left there at 19, just after my birthday. I had to go. There was a lot of pressure put on. The council thought I was too old to stay.

Young people particularly identified emotional support for care leavers as a gap in support structures:

> Emotional support in general… it's rubbish. […] Once you have left you don't get any emotional support at all. […] I think the way they see it is that "I'm a social worker, not a counsellor" so there's always that clear distinction but the way I see it, that's your job as well!

Some young people who had received support when they initially left care were now concerned about losing entitlement to this support as they got older:

> I'm worried now about turning 21… I'll finish my degree and won't even be a student then… Although they've told me they'll still be there for me… […] I still worry about the little things now and I think I always will… Things I should really know but still need to ring up for reassurance.

> At the minute I'm going through depression and half of that is because I'm going to lose my social worker… I've adapted to her and I'm not a good person when I lose people… I go down very quickly coz [sic] I'm sick of losing people in my life you know?

As a result of their experiences, young people argued strongly that there should be more support for care leavers, particularly around the emotional side of preparing for independence and coping with independent living. One male care leaver, who had already experienced support being withdrawn from him after he turned 21, argued:

> I think you should have support until you're 25… Because I went through a lot of stuff in the last couple of years – failed college and that. I could do with a bit of support now I'm going back to college. But as soon as you're 21 in [city], that's you done.

These young people were very concerned by the arbitrary cut-off points that shaped services for children in care, and the speed with which they were withdrawn once the young people reached a certain age. They argued that instead, services should be available to care leavers for as long as they were needed. These issues are discussed further in Chapter 8.

Improving public understanding of the care system

Finally, young people identified the need to address the way children in care are perceived by others. Some of the young people felt that the care system is currently not sufficiently understood by the public:

> Nobody seems to understand the care system if you haven't been in or worked with the care system. No-one outside the care system really understands how it works. Especially teachers and things. […] They make decisions based on what the media tells them, which isn't very true.

These young people's concerns about discriminatory attitudes toward children in care led them to argue for better efforts to engage the public with the care system in more positive ways: "We need to change how the public see people in care."

Some young people who were members of a Children in Care Council felt that they had witnessed positive efforts from politicians to understand children's experiences:

> I think they try to [understand it]. They do have an interest in it. You see through their actions and the way they talk to you. Especially when you go to Parliament and you go to the meetings and you see [the Minister for Children in Care] and he's really passionate about what he does and he gets really angry when you tell him stories about bad things that you've heard.

However, one care leaver argued that greater political commitment was still needed before lasting reforms could be made to improve public care:

> I want to see politicians showing more interest in the care system. The only way there's going to be an overhaul of the social work system and caseloads will be reduced is if more money is directed at it. For that to happen someone in power needs to take an interest in it… rather than only reacting to the bad things.

Conclusion

This chapter has attempted to give a voice to the real experts on the care system: looked after children and young people themselves. As the young person quoted at the beginning of the chapter told us, "it's only us who've been through it who can really understand it."

The views of these children and young people contain many rich and detailed reflections on their own experiences of care. Above all, these young people emphasise the importance of children having the opportunity to develop relationships with carers and professionals who will listen to them, love and support them. They ask for the assurance that if a child's relationship with their carers is not meeting their needs, their 'corporate' parents will listen to their concerns and, ultimately, protect them from harm. They set out the need to address variations in the support received by children and young people in care, to ensure that support is always based on need. And finally, they ask that the supportive relationships that children are given by virtue of being in care should to be allowed to continue for as long as they are needed, rather than being arbitrarily curtailed at 16, 18 or 21 at the behest of local or national policy.

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CHAPTER 1

Providing an effective out-of-home care service for vulnerable children and their families: an overview

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Providing an effective out-of-home care service for vulnerable children and their families: an overview

By June Thoburn

1.1 Introduction

This chapter provides an overview of the reasons why children and their families need high quality out-of-home care, making comparisons between services in similar developed countries. It discusses the reasons for different rates of entry to care in otherwise similar countries, including the impact of the degree of confidence in the ability of the care system to turn young people's lives around. The UK is identified as having passed through a period of doubt about the capacity of the state to be an effective 'corporate parent'. However, a brief summary of research on outcomes for children in care argues that work is still needed to move away from a largely negative view of care and to develop a more nuanced position on the strengths and weaknesses of the UK's care services.

The chapter identifies how the different needs of children and young people are met through different approaches to care. Some children need a shorter term placement as part of a coordinated family support service, or a safe, stable, skilled and caring home while longer term decisions can be made. Others need long-term substitute parenting that provides them with an alternative 'family for life', while maintaining appropriate links with members of their birth family. The chapter then identifies and briefly explores the key components of an effective 'out-of-home' care system. It calls on politicians and service providers to build on the growing knowledge base about

effective practice and be more confident about what they can, and indeed must, achieve for this most vulnerable group of children and young people.

1.2 Children in care at home and abroad

The place given to out-of-home care within family support and child protection services varies considerably between different countries. Gilbert et al (2009; 2011) identify two broad (though at times converging) approaches to recognising and assisting vulnerable children and families: a 'child and family welfare' approach and a 'child safety' approach. The first is the dominant approach in Europe, Japan, New Zealand and some provinces or states in Australia and Canada, and the second is dominant in most Australian states, Canada and the USA.

In most of Western and post-communist Europe a duty is placed on state agencies to provide a range of services to families experiencing psycho-social or relationship problems or serious environmental stresses, as a result of which children are at risk of suffering harm or "impairment to their health or development" (the language of section 17 of the England and Wales Children Act 1989). This includes families where there are concerns about abuse or neglect, but also a wide range of other stressors that may or may not be the fault of parents. In most of these countries the services to prevent and deal with the consequences of abuse and neglect are integrated within the generally available locality–based social services.

In countries adopting a broadly 'child safety' approach, specialist child protection agencies respond to notifications of maltreatment. Where reports are 'unsubstantiated', as well as in many cases where a child is assessed as being at risk of abuse or neglect, families either receive no service or are referred to third sector agencies (Gilbert et al, 2011). These differences are reflected in the legislation with respect to out-of-home care.

The first of these approaches views care as predominantly a family support service, aiming to maintain parent-child relationships by keeping children who are in care in touch with their families, even when it is not possible or desirable for them to live with them full-time (Boddy et al, 2009). In contrast, in mainly 'child safety' jurisdictions care is viewed as a (usually temporary) response to allegations of serious maltreatment. If speedy attempts to return

children home are assessed as inappropriate or unsuccessful, parental ties are usually terminated and the aim is for children to exit the care system as soon as possible through adoption or legal guardianship (Thoburn, 2010).

The England and Wales Children Act 1989; the Northern Ireland Children Order 1995; the Children Act Scotland 1995, and accompanying and subsequent guidance locate UK nations within the 'child and family welfare' paradigm, with detailed provisions about 'looked after children' incorporated in Part III (the family support sections) of the 1989 Act. The original guidance to the Act states:

> "A wide variety of services, including short-term out of home placement may need to be employed in order to sustain some families through particularly difficult periods… If out-of-home placement is necessary, the least coercive legal status consistent with meeting the child's needs (including no order at all) should be the first choice." (DH, 1989, p.8).

However, in the 20 or so years since the 1989 Act was implemented, custom and practice in many English local authorities have moved towards a 'child safety' approach. This is in part because of a wish to free up resources for early intervention, but is also underpinned by a lack of confidence among professionals in the ability of the out–of–home care services to meet children's needs (see Tunstill et al, 2010).

More recently the combination of a more 'risk-averse' climate triggered by the death of Peter Connolly (Haringey Safeguarding Children Board, 2009) and recognition of the potentially lifelong consequences of chronic neglect have moved social workers away from the 'partnership with parents' approach (a central principle of UK children legislation), towards the increasing use of more coercive administrative and legal powers, ie the formal child protection system and court adjudication. This has resulted in an increase in the numbers entering care via a court order in most, but importantly not all, English local authorities. At around the same time, the evidence from research that well–planned and stable placements in care can improve the life chances of neglected children has resulted in a reappraisal of the place of out–of–home care within child protection services. (Bullock et al, 2006; Thoburn and Courtney, 2011, and other chapters in this volume).

Despite this, the word 'care' remains frequently associated with the words 'drift' or 'languish' in both public and professional discussions

about care. A similarly negative meaning is conveyed by the often-used term 'at risk of care', implying that it is something bad to be avoided. In summary, despite the underlying premise in the legislation about the importance of a range of family support services that include care placements when appropriate, for some years the dominant message in the UK has been: 'keep them out if you can; if you can't, get them out as soon as possible,' either by returning children to their parents or placing them with adopters or family and friends carers.

Such language must be avoided. Instead, we should look at the evidence about our use of care and its impact on children and young people, establishing a more nuanced debate and conveying the message that a placement, especially if carefully planned, may be an entirely appropriate response to particular child and family circumstances.

1.2.1 Numbers and characteristics of children entering care in different countries

There is considerable variability in the use of care across apparently similar countries as well as between apparently similar authorities (Dickens et al, 2005; DfE, 2013). As shown in Table 1, in 2009-10 the highest rate of *entering* care in 'rich' countries was 34 per 10,000 children in the USA, compared to 25 in England (even after the impact of the death of Peter Connolly). However, different attitudes towards the value of longer stays in care are evident from the rates in care at a given time, which are influenced by average lengths of stay. This rate is 57 per 10,000 in the USA, 58 in England, but over 70 in Denmark, France and Germany. Wales and Scotland also have comparatively high rates in care (Thoburn, 2010).

Table 1: Numbers and rates of children in formal care and entering care in different jurisdictions (table adapted from Thoburn, 2010)*

Country/state (year of data)	0–17 in care population	Rate in care per 10,000 <18	Rate entering per anum per 10,000 <18
Australia (2009)	23,695	70	27
Denmark (2005)	12,408	102	30
France (2007)	129,880	97	N/A
Germany (2005)	112,170	76	30
Ireland (2003)	5,060	50	N/A
Italy (2007)	32,400	32	N/A
Japan (2005)	38,203	17	6
New Zealand (2005)	4,962	49	24
Norway (2009)	9,278	79	15
Spain (2004)	38,418	51	18
Sweden (2004)	12,161	63	32
UK/England (2010)	64,400	58	25
UK/N.Ireland (2005)	2,531	56	21
UK/Scotland (2009)**	8,000	76	20
UK/Wales (2010)	5,162	82	30
USA (2010)	424,000	57	34

* See detailed notes on sources and other contextual comments in Thoburn (2010).
** In Scotland the data are not entirely comparable. Differences in the legislation impact on data reporting conventions, especially for children in 'formal' and 'informal' kinship placements and living with parents under supervision requirements.

The different aims of care systems impact on the characteristics of children *entering* care (the 'flow') and those *in* care on a given date (the 'stock'): In Continental Europe the heavier emphasis on keeping families together is also reflected in the ages of children entering care. In the USA, the UK and Australia larger proportions enter care under the age of 12 months (15 per cent, 23.1 per cent and 16 per cent, respectively) than in Germany (4 per cent) and Denmark (5 per cent). In contrast, 28 per cent of care entrants in Germany and 34 per cent in Sweden are aged 16-17, compared to 20 per cent in the USA and 12.8 per cent in England.

These variations, especially between the ages of children entering care, impact on how care services are organised to achieve their aims in different countries, and should be taken into account when policy makers seek to learn from others when planning how best to meet the needs of children, young people and their families.

1.3 The purposes of out-of-home care

In a landmark study of large numbers of children entering care in England, just prior to the implementation of the England and Wales Children Act 1989, Rowe et al (1989) listed the purposes of care and the proportions of children with different care service aims. While 15 per cent of placements were for 'care and upbringing' outside the family, 85 per cent had short or intermediate term aims. These fell into the following categories: temporary care 46 per cent; emergency care 14 per cent; preparation for long-term placement 14 per cent; assessment 13 per cent; treatment 9 per cent, and 'bridge to independence' 4 per cent. In essence, the predominant aim was to provide emergency care and assessment followed by return home or a longer term 'parent supplement' service, but for a smaller number it was to provide a 'parent substitute' service.

While the proportions with these different aims will vary over time and by country (Thoburn, 2010), this categorisation (explored in more detail in the next section) provides a sound starting point for considering how the care service might meet the differing needs of children who have been or are at risk of being maltreated, and of their families and others who care for them.

1.3.1 Short and intermediate-length care for family support or assessment purposes

There are, broadly speaking, six types of short or medium term care placements (sometimes referred to as 'task-centred' or 'task-focused' placements) that can help ensure that children's long-term needs are met – by returning to their parent, maintaining meaningful relationships through longer-term 'shared care' arrangements, or by assessing their needs so that alternative long-term placements can be made (Sellick et al, 2004):

1. regular planned 'respite' or 'support' placements

2. planned and occasionally emergency placements under voluntary arrangements in response to family stress or a crisis, as part of a package of family support

3. planned or emergency admission to care to assess long-term needs

4. a planned period of therapeutic foster or group care for troubled children, with associated work with their parents or long-term carers

5. a 'bridge to independence' for teenagers with highly conflictual family relationships

6. a planned longer-term shared care arrangement as part of a family support package.

Research on series of short term placement arrangements (as provided for by Section 20 [Regulation 9] of the 1989 Children Act) – sometimes referred to as 'support' or 'respite' care – demonstrates positive outcomes for children and parents. Its use has flourished for disabled children. However, despite the positive findings of Aldgate and Bradley (1999) its use for families under stress has declined.

Evaluation of short term Section 20 accommodation after the implementation of the 1989 Act, by Packman and Hall (1998) found that it was used increasingly for children when there were concerns about abuse or neglect. There were concerns about misuse of the provision in some cases where the offer of 'voluntary care' was a precursor to an immediate application for a care order, and in other cases where children yo-yoed in and out of care. However, in the majority of cases the opportunity provided by short-term care to relieve stress and identify the longer term support and therapy needs proved beneficial to both children and their parents.

However, despite the evidence to the contrary, there has long been a view that short-term care should be avoided because, as has been argued, 'once in care it is hard to get children back home again.' Concern has also been expressed that the first entry to voluntary care could be the start of a process of children yo-yoing in and out of care. However, Dickens et al (2005) concluded from an analysis of data on all care entrants in 24 authorities that, although 15 per cent of the children who returned home re-entered care within a 12 to 18 month time frame:

"Children are not generally being looked after on a revolving door basis. […] For the majority of children, the period of being looked after is a one-off, whether the period itself is short or long."

However, a proportion of these children will not have been maltreated or experienced poor parental care and it should be noted that Farmer et al (2011) and Wade et al (2011) report less positively on outcomes of accommodation placements for abused or neglected children (see Chapter 7).

An essential first step is to reduce the number of 'predictable emergency' entries to care or accommodation. While some emergency entries into care are unavoidable, Packman and Hall (1998) point to the negative impact on children and parents of management processes that result in decisions about children recognised to be 'on the edge of care' being delayed, thereby making an unplanned entry to care inevitable. Parents and young people tell researchers that traumatic and unplanned separations set back their willingness to work positively with social workers (Fletcher, 2006; Broadhurst and Pendleton, 2007).

Specialist short–term treatment foster care, as part of longer–term planned services, can be a positive option for children past infancy and teenagers with challenging behaviour whose parents try and fail to meet their needs and resort to inappropriate and/or abusive parenting strategies (Biehal, 2009; Biehal et al, 2012). However, as yet this form of foster care is experienced by only a minority of children and these comparatively short stays are provided by an even smaller proportion of carers. In 1989 a study reported that 9 per cent of foster care placements had the aim of 'treatment' (Rowe et al, 1989) but by 2007 another study found that only 2 per cent of the placements explicitly had this aim (Sinclair et al, 2007).

In contrast, 11 per cent of the children in the study by Sinclair et al (2007), compared with 4 per cent in Rowe et al (1989), had the aim of providing a 'bridge to independence' – another short term aim which in some cases can, if arranged in timely fashion, help troubled teenagers and their birth– or adoptive parents to avoid the irretrievable breakdown of their relationship.

Finally, for some disabled children or those with significant behavioural or emotional difficulties, a longer term 'shared care' placement can be valued by parents and children. The young person can get the specialist care they need, and meaningful links with

birth parents are maintained. Some of these children will have been vulnerable to maltreatment because parents, often themselves with disabilities or mental health problems, have been unable to meet their very special needs. This sort of longer term 'shared care' or 'parent supplement' placement can also be particularly helpful to some adoptive families with very troubled children, intervening in spiralling parent–child conflict and enabling adopters to maintain the child's place as 'part of the family' and be available to them as they move into adult life.

Foster families are found to fulfil each of these roles. Leaving aside boarding schools, residential care usually plays a short-term, task-focused role for young people who (in England) will almost all be over 10 (Sinclair et al, 2007; Berridge et al, 2012). Boarding education, with support to the birth or adoptive parents or caring relatives during holidays, has an important part to play for some of the most troubled children and young people (Berridge et al, 2003). Unsurprisingly, given the greater emphasis on care as a family support measure and the larger numbers entering care as teenagers, much greater use is made of residential care in this way in European jurisdictions. In Denmark 41 per cent and in Germany 54 per cent of children in care in 2004-5 were in residential placements, compared with 9 per cent in England and 19 per cent in the USA (2010 figures).

1.3.2 Care and upbringing placements

In recent years, there has been a change in the balance of placement aims. As noted earlier, researchers in the 1980s found that 15 per cent of placements were for 'care and upbringing' (some of these with the intention to proceed quickly to adoption), and that 85 per cent had a short-term aim (Rowe et al, 1989). However, we have seen a shift towards foster family care being used more frequently alongside adoption, as a 'family for life' option, and by 2007, in a cross-sectional sample that included a higher proportion of long-stayers, Sinclair et al (2007) found that 52 per cent of placements were for 'care and upbringing', in addition to those that were for 'preparation for permanence' outside the family. Even allowing for differences in the samples, the change is quite evident. The importance of aiming to achieve long-term family membership (in their own or substitute families) for children who enter care has been further underscored

by the regulations and guidance on care planning that followed the implementation of the 2008 Children and Young Persons Act.

1.4 A brief overview of the characteristics of children associated with better or worse outcomes from care

Before considering in more detail what is known about the essential characteristics of effective placement services, it is important to summarise the evidence of outcomes for the different groups of children for whom an out-of-home care service may be appropriate.

Age is the key variable associated with more or less successful outcomes for children, in both 'task-focused' and 'care and upbringing' placements, with older age at placement associated with less successful outcomes, however measured. Linked to this, children who enter care when young and remain for longer periods are more likely to have stable placements and better outcomes than abused or neglected children who have shorter periods in care or children who enter care when older.

Unsurprisingly, children who are already displaying symptoms of serious emotional and/or behavioural disturbance at the time of placement are less likely to have good outcomes, as are children who have experienced abuse or neglect over an extended period of time and those who have 'genetic risks' because of mental health problems, learning difficulties or addictions of their parents. Evidence about age at placement as a key risk factor for placement disruption should not obscure the research finding that some young children in care are 'hard to parent' – Neil et al (2011) found that 28 per cent of those adopted before age four (the majority having been placed when under 12 months) had emotional or behavioural difficulties. It is also important to be aware that some children who are older when placed do well in substitute families or in residential care. Differences in research samples with respect to these characteristics, and the differences identified earlier between different countries (in terms of thresholds, aims and age groups of children in care) help to explain why there are differences in reported outcomes both between countries and between local authorities. For this reason it is essential to avoid reaching general conclusions about outcomes for children in care based on a particular study or particular cohort of care entrants.

It is also very important to consider what young people have to say about the strengths and weaknesses of care (as do several of the contributing authors in this book). When consulted about the 2008 Children and Young Persons Act, young people who had experience of care opposed the idea of targets for keeping numbers in care down (House of Commons Children Schools and Families Committee, 2008). They wanted better services to help more children to stay at home, but were clear that for many, entry to care was the right thing to have happened. This message is repeated by many whose views are reported by the Children's Rights Director (Timms and Thoburn, 2006; Morgan, 2007). Sadly, those consulted did not all get a good enough service, but most would agree with the conclusion of Wade et al (2011) based on a study of neglected children that "… all other things being equal, being in care is likely to enhance the wellbeing of maltreated children"(p.198).

1.5 What are the essential characteristics of an effective care service?

Building on the evidence of outcomes for children and young people in and on the edge of care, international research and child development literature, and especially those studies that report on the views of parents, children and their carers, this chapter now highlights the essential characteristics of a quality care system, which can be summarised by 'seven Ps' for positive practice (Thoburn, 2011):

- Paramountcy of the child's short- and long-term welfare

- Protection from significant harm (by parents, carers, peers, predators and also 'system abuse')

- Permanence – being part of a family into adult life and beyond

- Parenting (skilled and committed)

- Professionals who are caring, dependable, skilled and knowledgeable

- Partnership and participation – for children, parents and carers and between professionals

- Proportionate and timely decision-making processes and practice.

The following provides an overview of whether and how the principles for best practice are being achieved, or can be improved on in family support care and alternative family or group care

placements. These themes are expanded on in other chapters in this volume.

1.5.1 Paramountcy of the child's welfare

International conventions and UK legislation are clear that the child's welfare must be paramount: in whatever decisions are taken about placements, legal status or the detail of services to be offered, the child's short- and long-term wellbeing must be at the forefront. The welfare of children entering care is most likely to be promoted when service providers keep in mind the needs of different groups of children who may benefit from an out-of-home care service, and when practitioners and reviewing officers keep each individual child and family in mind when putting together and reviewing care plans.

But that does not mean that services provided to important adults (birth parents, relatives, foster carers, adopters) can be skimped on, or that they can be consulted – as required by law – and then their wishes not taken seriously.

Research has shown that services to birth parents, once their children go into care, are more often than not inadequate and/or inappropriate (Neil et al, 2010; Schofield and Ward, 2010; Farmer et al, 2011 and Wade et al, 2011). Based on their detailed findings, these studies argue that effective work with parents is critical to improving the wellbeing of children in care, particularly when considering that the most common outcome for a looked after child is to return home to a parent or relative.

1.5.2 Protection from significant harm

Protection is obviously an essential component of an effective care system. Physical or sexual abuse by carers happens far less frequently than abuse or neglect when children return to birth parents. However, psychological abuse can occur in care and often remain undetected, usually when kin or non-kin foster carers, adopters or children's home staff are unprepared for the negativity and 'testing out' behaviour that children in care can display.

Peer abuse and sexual exploitation are continuing dangers, especially for those in residential care (see Chapters 5 and 6, respectively). But the major abuse of children in care is abuse by the 'system': most obviously multiple placements; precipitate moves; being 'prepared for

independence' and moved on when what the young person and their carer want is to remain together as a family; being moved in order to cut costs when a child is well settled, and last but not least multiple changes of social worker.

The search for placement stability – bringing with it stability of relationships with peers, teachers, health professionals and social workers as well as an enhanced opportunity to develop or retain meaningful relationships with adult birth-family members and siblings who live elsewhere – has to happen alongside the search for permanent substitute family placement. The young people consulted by the Children's Rights Commissioner emphasise the importance of stable relationships (Morgan, 2007). However, along with Sinclair et al (2009), they also stress that social workers and reviewing officers must remain alert to the signs that a particular placement is not working out and that a move is necessary.

1.5.3 A sense of permanence

Research has established that it is a 'sense of permanence' that is the key to children settling in a placement. Systems have to be in place to ensure that temporary foster carers and residential workers allow themselves to grow fond of the child as part of their 'family', and this is essential for those providing 'care and upbringing' placements. Birth parents need to be confident that the child's return to their care will be supported by sensitive practice and services that meet their needs and the needs of their children.

As early as 1984, the Short Committee Report that preceded the 1989 Children Act (DHSS, 1984) regretted that adoption had come to be seen as synonymous with permanence. This was contrary to the intention of those who introduced the concept of 'permanence' into the UK from the USA (see especially Rowe and Lambert, 1978). It was also not the intention that 'permanence' should come to be seen as having relevance only for children entering care in the youngest age groups.

All children need stability; continuity with the past; to be valued as the people they are, and to know that important relationships will be nurtured and not broken off unless absolutely essential for their physical or psychological safety (Thoburn, 1994). For most, that means being confident that they are 'part of the family' they live with and, for children who need long-term care away from birth parents,

sometimes part of multiple families (Schofield, 2003). Achieving these benefits of permanence for young people who enter care when older and with complex existing relationships is challenging, but it is a challenge that has to be accepted, also for children placed in longer term group care.

The Children and Young Persons Act 2008 and the Care Planning Guidance (DfE, 2010) require that there should be an agreed permanence plan for all children who are accommodated or in care, irrespective of age and placement type. The two preferred placement options are return to parents or placement with friends and family. Beyond those, the placement must be chosen that has the best chance of meeting the needs of the particular child. The legal status, administrative provisions and professional practice to support a placement are obviously important parts of the 'permanence package' but outcome research gives the clear message that a legal order does not make up for a poor decision about with whom the child will live and have a continuing relationship. It is 'a sense of permanence' – for the carers as well as the child – that must be the essential aim.

1.5.4 Skilled and committed parenting

It is important to consider what research tells us about those who care for children in care, and how they develop the knowledge and skills to meet their basic and additional needs. Some foster carers will have a 'foster care career' that results in them having many children placed with them for anything between a few days and two to three years. This is also the case for most residential workers. They will work collaboratively with many different social workers and professionals who join them in the teams that look after the children in their care. They must also use their skills and knowledge of the children placed with them to help the birth parents or 'permanent parents' to whom the children will return or move on, as well as the children themselves.

'Care and upbringing' foster carers (the greater number of carers at any one time) may take only one child or sibling group in the course of their 'foster care career', or they may take two or three children (concurrently or sequentially) and see them through into adulthood. Though the term 'career' is inappropriate to kinship carers, they also may care for children on a short- or long-term basis. Some foster carers combine these two main roles, concurrently or sequentially, most often because a child they cared for on a short–term basis cannot

return to the birth parents and the foster carers and professionals conclude that it is in the interest of a particular child to remain with them as a part of their family until adulthood and beyond.

There is now a considerable body of research (summarised in Sinclair et al, 2004; Wilson et al, 2004 and Schofield et al, 2008) that identifies the essential characteristics of foster carers relevant also to those who care for children in residential care. Irrespective of their role, successful carers:

- enjoy spending time with children and are family-centred

- enjoy a challenge

- understand and are sensitive towards the complex needs of children in care

- accept the children placed with them for who they are, rather than wanting to turn them into a child they might have wanted to have – especially relevant to 'care and upbringing' foster carers or adopters

- are sensitive and proactive to the individual needs and temperaments of children but also to birth family issues, so that they empathise with parents, including those who have maltreated their children

- facilitate appropriate links with birth family members or previous carers – Neil (2012) refers to 'communicative openness' that is essential even when there is no face to face contact

- provide active parenting with respect to education, activities, life skills, and having fun

- want the child to achieve to the best of their ability but are able to see success in small steps forward.

Although the evidence about the impact on long-term child welfare outcomes of different preparation and parenting programmes for foster and residential carers and adopters is still not strong, the past fifteen years or so have seen a considerable increase in resources devoted to training carers who fulfil different roles. It is important that this evidence is used to support carers.

1.5.5 Professionals who are caring, dependable, knowledgeable and skilled

The three remaining 'Ps' that define an effective care service summarise what children, their parents and their carers have a right to expect from social workers and independent reviewing officers, and their managers and colleagues in other disciplines who are part of networks formed around each child and their families. Along with other studies, the research referred to in this volume enriches the quantitative data with qualitative accounts of aspects of services that children, their parents and carers find helpful. Thomas (2005) and Butler and Hickman (2011) have taken forward the messages from research for working directly with children. Sinclair, Wilson and Gibbs (2004), Schofield, Beek and Warman (2008) and Biehal et al (2010) all identify approaches to social work and interdisciplinary practice with foster carers that are most likely to enable them to meet the needs of the children in their care.

Neil et al (2010) and Schofield and Ward (2010) identify ways of working with 'parents without children', the former with respect to adoption, the latter with respect to 'part of the family' foster care. Farmer et al (2011, and Chapter 7 in this volume), Wade et al (2011) and Thoburn et al (2012) provide over-views of the evidence on practice when children return home from care. The research on continuing contact once children join new families is summarised in Neil and Howe (2005), Schofield and Stevenson (2009) and Wrobel and Neil (2009). Neil (2011) provides an account of young children's progress when placed from care with adoptive families and the ways in which they make sense of having two families. Planning, facilitating and, when necessary, supervising appropriate contact is a highly complex social work task that should not be left to unqualified workers other than in a support role.

1.5.6 Partnership-based practice – with children, parents and carers and between professionals

While it will not always be possible to engage them as partners, parents and some young people who are opposed to elements of a protection or care plan should always be given time to say what they want to say, be respectfully listened to and kept as fully informed and involved as possible in decision-making processes. At the heart of participatory practice is the capacity to empathise. More recent

terminology describes this as 'mind-mindedness': see especially Howe (2012) and Bell (2011) with respect to participatory practice with children. Consulting children about when an independent advocate is needed and then working collaboratively with child and parent advocates is an important skill for social workers and independent reviewing officers.

1.5.7 Proportionate and timely decision-making

There has been much emphasis in the child protection research and practice literature on assessment (especially the assessment of risk and protective factors) and decision-making (see other chapters in this volume, especially Chapter 9). It is important to stress that decision-making and helping are equally important components of an effective service and that, wherever possible, care plans should be arrived at jointly by parents, professionals and the young people themselves, only invoking coercive child protection procedures and the courts when this is unavoidable. Human Rights legislation requires that any court or administrative decision to intervene in family life against the wishes of parents and/or children must be 'proportionate', and UK legislation requires that parents and children be consulted and due consideration given to their wishes and opinions about the appropriate care plan (see, for example, House of Commons 1989 and 1995). For example, the courts may not make an adoption order (permanently severing a child's legal ties with the birth family) without parental consent unless there is evidence that 'the child's welfare requires [consent to be dispensed with]'. This goes along with the need for a timely and effective decision to be made so that after coming into care the child can return to a parent or relative, or be placed with a permanent alternative family, as soon as possible.

Nowhere is this tension more in evidence than with respect to infants coming into care whose parents have addiction-related problems, as evidenced by the evaluation of the Family Drug and Alcohol (FDAC) pilot project (Harwin et al, 2012). In these court hearings, the parents' right to family life and the child's right not to be separated unnecessarily from her family of origin are in tension with the child's right to have the opportunities that come from quickly joining and being brought up by committed and competent parents, if the birth parents are unable to meet his or her needs.

The dilemma around timeliness is also demonstrated with respect to older children when there is a tension between the need to avoid

unnecessary delay, but also to avoid moving the child too quickly to a placement that, in important respects, does not meet his or her needs and is therefore at greater risk of disruption. The tension between avoiding delay, yet ensuring that children's assessed needs are met is also apparent when making a decision whether to split siblings (perhaps placing the youngest child for adoption) or delay until a suitable family is found where they can grow up together.

1.6 Conclusion

These principles for effective practice are drawn from practice texts (evaluations) from different times and jurisdictions. The English Department of Health and more recently the Department for Education have a strong track record in providing robust annual statistics on placements and outcomes for children entering and leaving care and placed for adoption (DfE, 013) and in funding relevant peer-reviewed research (some of which is summarised in this volume). Statistics and research studies, as well as the voices of young people themselves, indicate that there is awareness among policy makers, service managers, social work educators and practitioners of the components of good quality services and practice. For example, placement stability is improving (DfE, 2013) and the care planning guidance and IRO handbook emphasise permanence for all care entrants, not just the youngest.

In other respects, the lessons from research are not being learned or acted on. These include the importance of devising strategies for reducing the numbers of traumatic emergency entries to care, providing a coherent and adequately-resourced service when maltreated children return to a parent, and adequately supporting formal and informal kinship carers.

As illustrated by the variability with respect to rates in care in different countries, some of which (the Nordic countries for example) are generally considered to provide a good service to vulnerable children, there is no 'correct' rate for entry to care. The appropriate rate will vary depending on the needs of the children in a particular country or local authority, the aims of the service and also its quality and appropriateness for the children in its care. It is 'easy' to make comparisons between local authorities or whole countries in quantitative ways, but setting targets – whether for rates entering care, or exiting care through adoption or speedy return

home – risks leading to perverse incentives and harmful decisions for individual children.

The challenge for policy makers, managers, practitioners and inspectors such as OFSTED is to find ways of satisfying themselves that those children who should not remain at home enter care at the right time and have their needs met, and those who don't need to be in care are helped by appropriate services to return to or move on to parents, birth relatives or adopters. A first step, which is beginning to happen, is to uncouple the 'in care' or 'LAC service' terms from their negative connotations of 'drift' and 'languish' in the minds of the public, politicians and practitioners. Thoburn and Courtney (2011) provide a more nuanced summary statement on the achievements and weaknesses of care systems in developed countries, stating:

"There is no room for complacency and every reason to seek to prevent the need for long-term care: the evidence is that the state can succeed in ensuring good parenting to children who have to spend short or long periods away from their families but also that it fails too often to do so."

While there are still gaps, there is a sound knowledge base pointing the way towards tackling poor practice, and building on the good practice. This is evidenced by the many young adults for whom a short- or long-term placement in care provided the opportunities for a successful future.

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CHAPTER 2

Entry to care

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By Julie Taylor and Tom Rahilly

2.1 Introduction

Decisions concerning children on the edge of care are perhaps the hardest to make. Whether abuse or neglect is an issue, and the decision is about placing a child in care away from home or returning them to a potentially abusive family, getting it wrong can have possibly fatal consequences. Yet the evidence suggests that such decisions are too often ill-informed and can be delayed to the point at which the potential benefits are compromised. Children with the greatest unmet needs are likely to be those who hover on the edge of care, never achieving permanence either at home, through adoption or in care placements. Most significantly, outcomes for these children demonstrate how difficult it is for all those professionals involved to keep the welfare of the child at the centre of decision-making.

Findings from serious case reviews (SCR) and equivalent arrangements in Scotland, Wales and Northern Ireland highlight the clear importance of improving decisions about how children and young people enter care, and the support and protection they receive in care. Between April 2009 and March 2010, 21 children who were the subject of a serious case review were in the care of the local authority (Ofsted, 2010). The preceding year's analysis showed that 19 children in care were the subject of an SCR, a further two were adopted and 23 more children had been looked after when they were younger or had a sibling who had been or was looked after (Ofsted, 2009). Similar figures and patterns are shown year on year and in other analyses (Brandon et al, 2009; Morris et al, 2012).

What such figures tell us is clear: children are not always best protected by our current approach to care. This is especially true when considering that those who become the subject of a serious case

review are those most extremely harmed, who thus represent the tip of the iceberg. This chapter will explore why decisions are so difficult when children are on the edge of care, and what might be done to improve them.

2.2 Numbers of children entering care and local variation

Since 2008 the UK has seen an unprecedented rise in the numbers of children entering care. The number of looked after children in England rose from 59,400 to 68,110 in 2012-13, with over 28,000 new entrants to care – the level last seen in 1997, prior to efforts being made to reduce the numbers of children in care (see Figure 1). Similar patterns have been seen in Scotland, Wales and Northern Ireland. This recent rapid rise in the numbers of children entering care has placed significant pressure on social work teams, who often report that they are struggling to cope with the increase in demand. However, it should be noted that internationally, the UK does not have the highest rates of number of looked after children or rates of entry into care (see Chapter 1). Neither can it be assumed that higher rates mean that more, or fewer, children are safe. It might be indicative of better care decisions, but it is not a numbers game. We should be seeking to achieve the right decisions for each individual child.

Abuse and neglect have become the main reasons for children to enter care. Maltreatment accounts for around 62 per cent (42,480) of looked after children in England (DfE, 2013), and there is evidence that in fact a higher proportion of children in care have experienced such harm. Similar patterns exist across the other countries of the UK. Changes to the population of children entering care have seen a particular rise in those entering care as a result of neglect (CAFCASS, 2012), perhaps indicating a greater awareness and increased understanding of the impact of neglect on a child's wellbeing. It may also be indicative of a more risk-averse approach: a fear of 'getting it wrong' or 'playing on the safe side'.

Research indicates that the rise in entrants to care does not represent a significant change in the needs of those children entering care, or the circumstances that they face. Instead it may represent greater proactive action by local authorities, intervening to protect children and meet their needs earlier than they previously would have done.

Research that examined care applications found that the vast majority met the threshold for intervention (Masson et al 2008) and in their study *Three weeks in November… three years on…*, which analysed the rise in the number of children entering care, the Children and Family Court Advisory and Support Service (CAFCASS) in England found that "court applications to protect vulnerable children are being made in a more timely way than in 2008 and at an earlier stage of the local authority's involvement with the family" (p.i). In particular, CAFCASS reported that neglect cases were being acted upon more quickly in terms of making applications to court. Guardians interviewed for the study reported that they believed the local authority's care application was the only viable course of action in the vast majority of cases (85.4 per cent), and proceedings were not being brought prematurely or unnecessarily

Figure 1: Number of children starting and ceasing to be looked after in England

(CAFCASS, 2012).

Number starting
Number ceasing
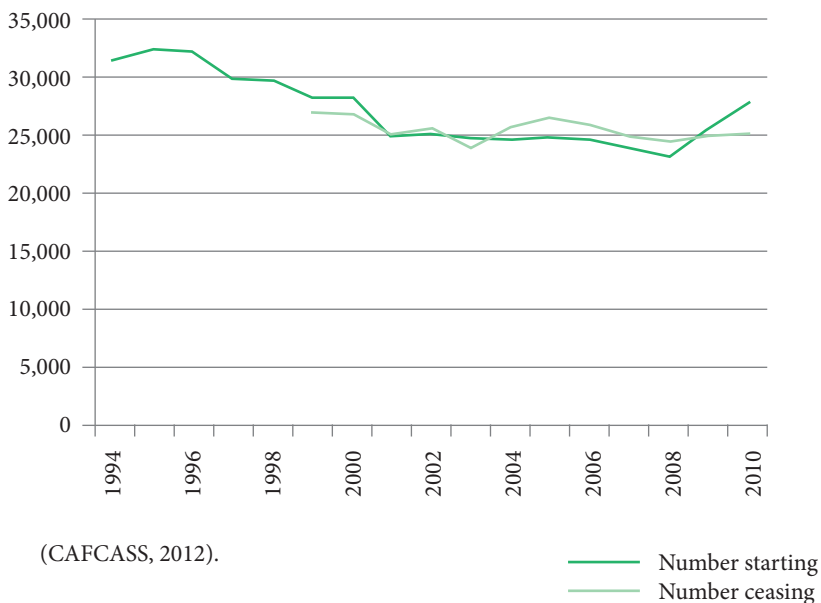
However, despite these changes, it is clear that too many children are still left in damaging situations on the edge of care, suffering from abuse and neglect with insufficient help, support and intervention. Overall trends mask significant differences between local authorities (the social care administrative function in each area) and how they

Figure 2: Rate of looked after children per 10,000 from 2006-2010, by area
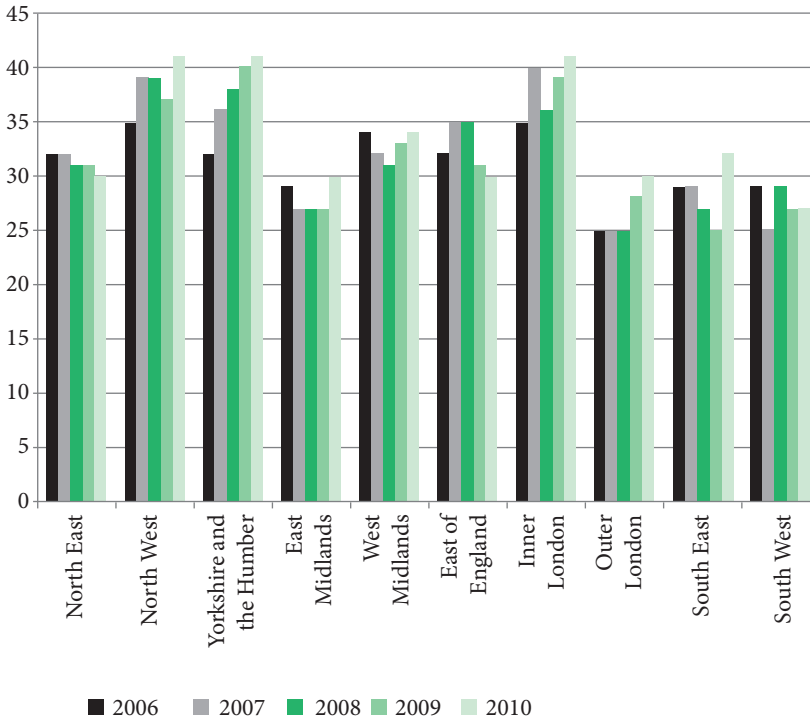
approach supporting children and young people on the edge of care. The picture of rising numbers of children entering care is accompanied by large variations in rates of children and young people being looked after across local authorities: a picture that has remained true over time, irrespective of the overall rate of entry to care (see Figure 2). For example, in 2013, 24 out of every 10,000 children in the Wokingham local authority area were being looked after, compared to a rate of 166 per 10,000 in Blackpool (DfE, 2013). There are also considerable variations in the percentage of children taken into care across local authorities[2]: In Rochdale and Walsall 77 per cent of children who became looked after during the year were classed as being 'taken into care', compared with only 31 per cent in Croydon (ibid). There is a range of reasons for this variation,

2 DfE percentages based on the number of children who became looked after during the year.

discussed below. However, such variation has led to the care system in England being described as "not one but 150[3] different [care] systems."(Narey, 2007, p.10).

Research has identified similar variations within and between local authorities in approaches to family support, thresholds for beginning care proceedings, use of family and friends care (Narey, 2007) and the use of emergency powers (Masson 2006). Variation in inter-authority practice was also identified by Macleod et al (2011), who found that just under a third of local authorities reported a change in the types of cases leading to a court application for care after the death of Peter Connolly. Neglect became the most commonly cited type of case where change had been witnessed. This reinforces the fact that a 'postcode lottery' for entry into care has existed and potentially continues to exist.

2.2.1 Causes of variation

This high level of inter-authority variation is likely to mean children who should be in care are being left at home in potentially dangerous situations for far too long. Analysis of the variation in the numbers of children entering care shows that differences in inter-authority care patterns can be explained only partially by differences in level of need, as areas with similar demographics present very different care patterns.

Factors associated with local authority care pattern variations include:

- the impact of deprivation and need in different local authorities
- historical and geographical influences
- local authority operational processes such as the availability of preventative services and decision-making procedures, resources and staffing levels
- the wider culture of the department including beliefs about care and attitudes of individual members of staff
- the number of children subject to child protection plans
- the way in which statistics are collected and recorded.

(See Bebbington and Miles, 1989; Oliver et al 2001; Dickens et al, 2007; Schofield et al, 2008;Tunstill et al, 2010).

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3   There are now 152 local authorities in England.

2.3 The need for continued support for children and families

Children who come into care are often known to social services for a number of years before action is taken to bring the child into care. Judith Masson's care profiling study (Masson et al, 2008) demonstrated that while many of the families were receiving some form of social work support, a significant number were "families [who] had been known to the Social Services Department but [where] there had been no recent social work activity leading up to the [care] application" (p.25) including families where there had been previous proceedings leading to the removal of a sibling. In nearly half of these 'inactive' cases in the study, the application for the child to be taken into care was triggered by the need for a crisis intervention. Nearly three quarters (72 per cent) of these crisis cases had been known to the local authority for over a year, and a third had been known for over five years. As Masson says:

"The families in these cases were typically those described by Olive Stevenson as 'bumping along the bottom' (Stevenson, 1996) which may make up a large proportion of the caseloads of Children's Services Departments, but only a few of which deteriorate, often suddenly, to a point where a court application becomes necessary as a matter of urgency." (Masson et al, 2008, p.26).

It is clear that these children and families are not receiving the support that they need to protect them from abuse and neglect. Practitioners commonly report that for many children, the need to enter care could have been identified effectively at a much earlier stage. For too many children, the impact of this delayed decision-making and entry to care is to prolong their experiences of abuse and neglect. On entry to care, these children experience greater degrees of difficulty and the specialist services they require are less likely to have an impact (Davies and Ward, 2012).

Furthermore, the high thresholds for care seen in some areas can be said to operate as barriers to families in accessing services, which results in greater harm to increasing numbers of children (Tunstill et al, 2010). Similarly, if local authorities are discouraged from making applications, then although pressure on the courts will be reduced, some children will wait longer for protection, potentially further increasing their level of risk (Masson, 2010).

Delayed decision–making can result in reactive, ill–conceived actions at the time of crisis. Furthermore, research shows that there is a relationship between indecision, delays in making permanence plans and instability in care. First (emergency) placements are often stop-gap solutions that lead to further moves, with evidence that the pattern of movement does not slow down significantly until the third year of a care episode. This creates instability for the child, hampering the ability of the care system to provide a therapeutic environment for children and young people that helps them to overcome the effects of abuse or neglect they have suffered.

2.4 The role of social work and professional decision-making

Decisions and support for children and families on the edge of care are influenced by a range of factors that include: understanding of the impact of care; skills and knowledge relating to the identification of risk and protective factors experienced by the child; understanding of child development, and external factors such as organisational culture, legislation and resources (see Chapter 9 for a further discussion of these issues).

There are clear, long-standing problems relating to poor outcomes for looked after children. However, there is increasing evidence of the positive difference that care can make to the lives of children and young people. A majority (89 per cent) of children and young people in care think that their care is either 'good' or 'very good' (Ofsted, 2012) and a number of studies have demonstrated the difference that care can make (see for example DfE, 2011; Schofield et al, 2012, and other chapters in this volume). Recent work on maltreated children who return home from care (see Chapter 7) indicates that, across a number of measures, outcomes for maltreated children in care are better than for those who return home (Wade et al, 2011).

Despite this evidence, practitioners across a range of health and social care disciplines continue to hold a negative view of care. Care continues to be seen as an option of absolute last resort resulting, in some cases, in efforts to keep children at home for longer than is in the best interests of the child. In addition, practitioners display a 'rule of optimism' (see for example Ward et al, 2012), overestimating the effectiveness of parents' efforts to change and underestimating

the impact that parental problems such as drug or alcohol abuse, or parental mental health difficulties, will have on the child.

Assessments of children on the edge of care are too often inadequate (see Farmer et al, 2011; Ward et al, 2012). In too many cases, how to identify risk and protective factors, understanding their impact (see Hindley et al, 2006), and the likelihood of harm to a child are not sufficiently understood (Davies and Ward, 2012). This problem can be exacerbated by insufficient understanding of child development, the impact of abuse and neglect, and the importance and effect of parent-child attachment, resulting in continued difficulties in decision-making about whether or not a child should enter care.

All efforts should be made to support children within their families. However, the welfare of the child is paramount. Effectively supporting our children and young people – and keeping them safe from harm – requires us to improve understanding of how to identify damaging situations, and our decision-making about when it is in a child's best interests to enter care, ensuring that decisions are well planned and taken in a timely fashion.

2.4.1 Role of the courts

The family courts and Children's Hearing System in Scotland have a critical role in a child's entry to care. It has been argued that the test for the removal of a child in to care has "been raised overtime by judicial interpretation." (Howe, 2009, p321) Concern has been expressed that the interpretation of the test for removal "has made it extremely difficult to obtain the interim removal of a child from their home," and a local authority "has to prove a *prima facie* case not just of significant harm but something greater and more injurious."(ibid, p323). In order to justify the immediate removal of a child, local authorities often therefore need to demonstrate that the risk of harm has become acute and imminent. However, while attitudes may be changing, it can be extremely difficult to demonstrate heightened and imminent significant harm in cases of cumulative neglect, emotional abuse and domestic violence. (Brandon et al, 2008 and 2009; Farmer et al, 2008; Ward et al, 2010).

It has been asserted in care case commentaries that there is a lack of clarity about whether threshold criteria could be satisfied on 'evidence' that raises a 'real possibility' of significant harm, but which cannot be proven to the level of 'fact' (eg Keating, 2009).

High thresholds can therefore result in children and families with substantial, chronic problems and high levels of need, such as the case of Peter Connolly, failing to receive timely help (Biehal, 2005). Furthermore, for children in care high thresholds for entry (in the UK) have resulted in a looked after population characterised by a "high concentration of disadvantage," which consequently leads to "poor outcomes overall." (Rowlands and Statham, 2009, p.86).

2.4.2 System reform

Addressing these challenges calls for a rethink about how we support children and families on the edge of care, and how we make decisions about when it is in a child's best interest to enter care. We must, of course, be ever cautious about the impact of state intervention, but we need to develop an effective continuum of support for children that includes identifying the role that care plays in our child welfare, family support and protection services. We need to improve our decision-making, using an improved understanding of the evidence of the risks and protective factors experienced by a child, and of a parent's capacity to change.

For some children care should be an earlier option, providing the necessary protection they need and the support to overcome the effects of abuse or neglect. It should be seen as a way of supporting children, with support for parents while a child is in care. This includes the use of care as respite and short- to medium-term family support. Other children should be provided with effective family support to prevent the need for entry into care. Ensuring the provision of family support in both of these ways will help to ensure better outcomes for these children and other children in the family.

Achieving this change is critical in enabling children in care to form strong relationships with their carers and the professionals who work with them to meet their needs. As Chapters 3 and 4 of this volume show, these relationships are critical to effective safeguarding and therapeutic support of children in care. As we will set out, an assessment of these relationships should be central to decision-making about a child's entry to care. Achieving change and reform for children on the edge of care is not easy, but there are lessons to be learnt from significant examples and a growing evidence base internationally. Extracting the 'active ingredients' from these illuminates how reform may be possible.

2.5 Interventions for vulnerable children and families on the edge of care

There are considerable numbers of services, models and programmes for children and families that impact undoubtedly upon outcomes for children on the edge of care. If services work intensively with families where there is parental mental ill-health, domestic abuse and/or substance misuse it is likely that in many cases families are moved away from the edge of care and satisfactory solutions are found within the family. It is also the case that families previously unknown may, as a result, come to the attention of child protection agencies.

Rigorous evaluation of these programmes is increasing and research is beginning to demonstrate which services have an evidence base (eg the Family Nurse Partnership; Triple-P) and to nuance the success criteria, setting out the families and children for whom they are effective. Useful examples can be found in a Cochrane review of short-term interventions that target maltreating birth families (Barlow et al, 2008), two narrative reviews of home-based preventative interventions for high-risk birth families (Olds et al, 2007; Tanaka et al 2010), and five randomised controlled trials of specific home-based preventative interventions (Olds et al, 1986; MacMillan 2005 et al,2005; Dawe and Harnett, 2007; Barlow et al, 2007; Lowell et al, 2011; Zimmer-Gembeck and Skinner, 2011).

While programmes that focus specifically on the entry to care are not plentiful, the ones that do exist appear to have a number of common aims and threads, including:

- Stabilising the family unit and intervening to ensure risk factors (such as substance misuse) are addressed. These interventions are often bespoke and usually intensive and multi-disciplinary.

- Comprehensive assessment of the family and child situation to inform decision-making about permanent placement – either within the family home, in care or adoption.

- Reducing the number of care placements endured by a child – and in particular the shuttlecock effect between family and repeated care episodes (often in different placements) – which we now know are so damaging to children in both the short and longer term.

- Reducing the time-lag between entry into care and permanent placement.

- Providing the courts with confidence in the decision-making processes about what is best for particular children.

- Training and support to foster carers.

2.5.1 Promising approaches to decision-making and support for children on the edge of care

Of the programmes that provide most or all of these things, the New Orleans Intervention Model NIM) and the Family Drug and Alcohol Courts (FDAC) stand out in terms of their comprehensiveness and promise in current evaluations. NIM is concerned primarily with infant mental health and the attachment relationship between the child and his or her carer, while FDAC works with families where substance misuse is the main issue of concern.

The New Orleans Intervention Model (NIM) aims to improve the quality of permanent placement decisions so that children can experience appropriate secure care as early in life as possible, leading to improvements in the child's wellbeing and mental health (Zeanah et al, 2001). The attachment relationship between children and their parents is assessed for every maltreated child under five who enters care and a tailored intervention is provided to each family, with the aim of improving the parent-child relationship. These assessments of relationship quality and the degree of change achieved by parents then inform recommendations to the court (or Children's Hearings in Scotland) about the permanent future care of the child.

Where significant change has been achieved, children are rehabilitated back with their birth family. If not, the recommendation is for adoption. An evaluation of the NIM suggests that the programme results in an increased rate of adoption, but those who are returned to birth families also experience a reduction in repeated maltreatment, as do their subsequent siblings (Zeanah et al, 2001). A recent seven year follow-up of children supported by the NIM shows that on many mental health measures, 'graduates' of NIM, whether adopted or returned to their birth family, differ only slightly from the general population (Robinson et al, 2012). This is remarkable when the high rates of mental health difficulties in populations of children in care are considered. NIM is currently being trialled in Glasgow, Scotland, as a collaboration between the NSPCC, health and social care authorities and Glasgow University.

The UK Family Drug and Alcohol Court (FDAC) works with parents with substance abuse problems where the child is on the edge of care, based on a US model that has shown considerable success (Green et al, 2007). The FDAC was set up as a collaboration between the health service (Tavistock and Portman NHS Trust) and Coram (a long-established children's charity) and originally commissioned by Camden, Islington and Westminster local authorities. It is now being set up in other places in the UK and there are around 20 FDACs running in the USA.

FDAC aims to stabilise or stop parents using drugs and/or alcohol and where possible keep families together. Where this is not possible, quicker decisions are made about alternative permanent placements. It also aims to improve the court's confidence in decision-making without the need for a wide range of external reports. Families present at court more often than they would normally and are seen by the same judge on each occurrence, allowing problems to be addressed as they arise and to regularly review intervention plans. A multi-agency team works intensively with the family to coordinate a range of services that might be of most benefit, with parent-mentors (i.e. people who have had similar life experiences to the families) central to the offer of support. Although the inclusion criteria are wide and concerned largely where drugs or alcohol have been a central concern, exclusion criteria apply where there is a history of severe physical or sexual abuse; where domestic abuse is an issue, or where parental psychosis would prevent meaningful engagement with the programme.

An external evaluation of the FDAC by Harwin et al (2011) demonstrates significant success: in the FDAC group 39 per cent of mothers were reunited with their children, compared with 21 per cent of comparison mothers in ordinary care proceedings, and the vast majority of parents were in favour of the FDAC system. Costs to local authorities were reduced as a result of shorter care proceedings, fewer out-of-home placements, and fewer contested cases. More parents controlled their substance use than those in the comparison group did.

Both the NIM and FDAC undertake constant and comprehensive assessments of the child and family situations and use these to develop bespoke interventions to support the child and family relationships with a view to returning the child home where possible and informing the courts of the best decision. NIM works also with the

foster family – in its original form in Louisiana, foster carers became the adoptive parents where children were not returned home. While this has not been possible so far in the UK trial, concurrent planning has been a focus in another Coram project.

The Coram Concurrent Planning Project has been running for more than a decade in London. It is based on the twin premises that attachment is a crucial for children and, as supported by recent evidence from neurobiological studies, that permanency is needed as quickly as possible to enable optimal development for the child. Concurrent planning was developed in the USA in the 1980s to encourage a speedier resolution of legal procedures and earlier permanency for children likely to experience drift within the care system (Katz et al, 2005). In essence, the methods used in the US model and replicated in the UK include:

- known effective interventions with parents to address their difficulties and regain care of the child

- reduced caseloads for workers

- intensive services

- written contracts with parents, acknowledging that permanence is necessary and thus adoption may be the outcome.

Coram's Concurrent Planning Project (CCPP) places children up to two years old with carers who are approved as adopters and foster carers. The primary aim is permanence and stability for the child, supporting parents to make necessary changes but where this is not achieved the child is adopted by a family with whom the child is already familiar. In the UK, children with concurrent planning arrangements take about half the time of that used for other children to achieve permanency from first entry to care (Monck et al, 2003). The benefits to the child are obvious: there is just one other family to become acquainted with apart from their own; contact visits with the birth parents take place with the foster parent, who may become their adoptive parent, and there are no feelings of clamouring for attention among other foster children (Wolfson, 2010). While there are fewer perceived benefits for parents, the 'threat' of adoption can motivate parents to change and even where reunification does not happen, these changes may be beneficial to subsequent children. Indeed, evaluation of the CCPP showed that parents usually had a positive experience as they were supported during care proceedings

and working with an organisation separate to the one responsible for taking their child(ren) away (Wolfson, 2010).

However the CCCP has some challenges as well. The parenting competence and socioeconomic advantage of concurrent carers can be demotivating to parents, sometimes leading to them 'giving up' early on in proceedings. On the other hand, concurrent carers have to juggle a role between foster carer and potential parent, often creating a difficult emotional burden. For children, two styles of parenting behaviour can be confusing and distressing, and over time contact with the birth family can become more difficult for them. It is a model with promise, but the challenges must be acknowledged.

While the evaluation is limited to 52 children, it highlights a range of issues that need to be overcome in improving support for children and families on the edge of care, including a lack of suitable carers available at short notice for children in particularly high-risk families; few minority ethnic families available as concurrent planners; the high turnover of social workers, resulting in difficulties in establishing and maintaining relationships; perceptions about cost, and a view from some members of the judiciary that this is a back door to adoption. Most worrying of all, Wolfson (2010) refers to an unexpressed but strong, albeit mistaken, underlying belief across the different agencies that come into contact with children: that they are in fact too young to remember change and different placements or moves between different sets of foster carers, residential units and the family. As a result:

"children's needs for stability, secure attachments and early permanency are not always, in reality, given priority." (Wolfson, 2010, p.49)

2.5.2 Other support

There have been two high-quality systematic reviews of interventions focusing specifically on interventions for foster carers (Everson-Hock et al, 2011; Leve et al, 2012). The results of these are not particularly encouraging. They indicate that while it is possible to implement evidence-based programmes with foster carers, the programmes covered by the evaluations are often complex and costly and have limited impact on the behavioural problems, placement stability and emotional health and wellbeing of the children (Leve et al, 2012).

The programmes that did show more effectiveness were those of longer duration and where the child was younger.

Evidence suggests that administering tools to assess the mental health and wellbeing of children at entry to care can help practitioners make decisions about relevant interventions. For example McCrystal and McAloney (2010) advocate the use of the strengths and difficulties questionnaire, following a study in Northern Ireland that compared a sample of children in care with those who were not. In Scotland, Blower et al (2004) describe a combined qualitative and quantitative assessment for mental health services for children in care. Certainly there is evidence that children in care due to maltreatment meet criteria for major psychiatric diagnosis in around 60 per cent of cases, with post-traumatic stress disorder (PTSD) the most common category (Milburn et al, 2008); this is at the heart of the NIM model described earlier. Further work is needed to evaluate the effects of such assessment tools and how the results might be interpreted by frontline social work practitioners, but what is clear is that there are not enough specialised mental health services for maltreated infants and young children – these are non-existent in many areas of the UK (See Chapter 4 where this is discussed in further detail).

Finally, some interventions have sought to improve decision-making and support for children on the edge of care by focusing specifically on the role of the court. The Cafcass PLUS model is an intervention premised on the early involvement of Family Court Advisors (FCAs) in pre-proceedings social work. Their role is to independently assess and advise on the best interest of the child and improve the quality of assessments undertaken during this time, providing a head start to those cases that proceed to court. The interim evaluation demonstrates promise (Broadhurst et al, 2012). However, some major obstacles have been challenging to the process, most noticeable in gaining parental consent (there is no legal mandate for the involvement of social workers in the pre-proceedings period). However, the early involvement of the FCA was particularly valued by children on the edge of care (Broadhurst et al, 2012).

2.6 So what does all this mean?

As is becoming clear, intensive assessment and focused interventions that aim to provide a multi–agency approach, bringing together local authority and (mental) health support, seem to offer the best chance of stability and positive outcomes for children. These approaches have been shown to stand the test of time. A literature review and audit in the United States 10 years ago usefully categorised how decisions about entry to care were made (Doran et al, 2001). The authors categorised the criteria used for placement decisions in four ways:

- formal assessment of children with level–of–care (threshold) criteria

- formal assessment of children without level–of–care criteria

- level–of–care criteria without formal assessment of children

- no level–of–care criteria and no formal assessment of children.

At that time, the majority of states were making decisions in the last category: no level–of–care criteria and no formal assessment of children. The State of Georgia, however, stood out as following best practice overall (it fell into the second category: formal assessment of children without level–of–care criteria), because it was using a state-wide effort to address placement needs through a multidimensional team approach that includes developmental, medical, educational, psychological and family assessments. Where recommendations were followed, children had a significantly greater chance of placement stability (Doran et al, 2001). The programme has been modified and developed in the intervening years, but remains at the heart of the Georgia welfare programme and is still regarded as current best practice (U.S. Department of Health and Social Services, 2012).

In the UK, Ofsted undertook an analysis of 11 local authorities in England to highlight successful intervention services as identified by Inspectors of Children's Services (Ofsted, 2011). Across these authorities, there was a demonstrable commitment to managing the risks associated with maintaining children and young people within their families and communities. A range of service interventions was noted, and while no single UK authority demonstrated all key factors, a number of these key factors emerged as the ones most likely to successfully support a child on the edge of care. The most salient factors noted in the Ofsted survey as being crucial to success were:

- The personal qualities of the professional(s) involved, especially the key professional. Disciplinary background and qualifications

were varied, but all showed tenacity in persevering with families who often did not want to engage with them. They were reliable, honest and trustworthy, and gave unambiguous messages about what might need to change. They worked intensively with families and worked from the families' starting points, responding quickly and often outside normal working hours. They achieved a balance between the central needs of the child and the needs of other family members.

• The explicit range of interventions, with clear methods and models and a range of tools that professionals could pick up and use with families. Importantly it seemed that it was the clarity of the model rather than the model itself that supported success, giving practitioners confidence in their working methods, and families clarity about direction and timescales.

In combination with these two key factors, a range of other factors were also found to be important:

• strong multi-agency working

• clear and consistent referral pathways

• a prompt, flexible and persistent approach

• a clear plan of work based on thorough assessment and mutually agreed and regularly reviewed goals

• good record-keeping to document intervention and improvement.

2.7 Conclusion and recommendations

It is clear that, with reform, we can improve our decision-making for children on the edge of care, ensuring that we better meet the needs of children, protect them from harm and support their families. Achieving this change requires:

• **Greater use of multi-agency approaches to assessment and support for children and families on the edge of care**: The Departments for Education and Health, and their counterparts in Scotland, Wales and Northern Ireland, should work with the College of Social Work, relevant Royal Colleges and other health bodies to develop and share effective practice. This should include amending the care planning guidance and its equivalents to highlight the promise of these multi-agency approaches.

- **Revised training for social workers and other practitioners so as to ensure an improved understanding of child development; the identification of risk and protective factors, and parental capacity to change**: The Department for Education, together with the College of Social Work, should work with the UK's universities to identify how the course content of social work degrees and post-qualification training can be improved in this regard.

- **Improved support for parents that continues in line with need, irrespective of the decision whether to take a child into care or not**: The Department for Education, and their equivalents, should work with local authorities to identify ways in which this support can be funded in order to save costs further down the line. This should include consideration of new funding approaches such as social impact bonds, and exploring the development of new approaches to family support.

- **Improvements in undergraduate and post-qualification training should also ensure that social workers and other professionals are able to develop a better understanding of the impact of care and effective interventions**: Practitioners should understand the growing evidence base of the impact of care and be comfortable using a range of evidence-based assessment tools and delivering a range of evidence-based interventions, with a clear framework for supporting families.

- **Greater effort to ensure stability for children and young people on the edge of care, and following their entry to care**: Approaches to family support and care planning must be based on the child's needs and support the development of strong supportive relationships, which are central to effective safeguarding. Local authorities should redesign their care planning processes from the perspective of the child, ensuring continuity of placement and workers along with improved support for foster carers to help ensure placement stability.

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CHAPTER 3

Refocusing our approach to safeguarding looked after children in placements

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By David Berridge, Nina Biehal, Enid Hendry, Jacqui Slade and Robert Tapsfield

3.1 Introduction

Over the last two decades a range of safeguarding measures have been introduced to prevent the abuse of looked after children. However, these measures can present a challenge in providing looked after children with warm, stable substitute care and close lasting relationships, while guarding against the risks of these relationships and care becoming abusive. Have we got the balance and focus right?

Numerous inquiries over the years into the abuse of looked after children have led to a comprehensive range of initiatives, legislation and guidance in different parts of the UK: some to raise care standards, management and accountability; some to enhance the child's voice and rights; and some to introduce specific safeguarding measures, such as improved vetting and independent scrutiny. A review of the *Progress on Safeguards for Children Living Away from Home* (Stuart and Baines, 2004) found legislation, policy and procedures were much improved, but effective implementation was more problematic. It also identified weaknesses in relation to some more marginalised children, including disabled children and those with emotional and behavioural problems.

More recently the policy focus has moved away from addressing loopholes and gaps in the safety net to questioning the need for and value of all of the measures. It has been argued that measures to keep looked after children safe have been too reactive and scandal-driven

(Gallagher, 2000). Work has concentrated too much on sexual abuse and preventing the employment of known offenders (Erooga, 2009) and is not designed to address peer abuse (Barter, 2003). Cumulatively these measures can create obstacles to meeting the needs of the child and may have unintended negative consequences (Munro, 2011). More needs to be done to recognise children's competency; to develop their life skills, including their ability to seek help, and to actively ensure every child has a safe, stable and nurturing relationship with their caregivers.

The Munro Review of Child Protection (Munro, 2011) concluded that the child care system had become unbalanced, with too great a focus on compliance – "doing things right" rather than doing the "right things" (p.6) – and that this had the effect of reducing professional judgement and de-skilling practitioners. Munro argued that attitudes to risk and decision-making would have to change. She criticised the standardisation of services and argued for more attention to be given to developing and supporting expertise and professional judgement, and working directly with children and families.

Revised frameworks of regulation, standards and guidance for looked after children in England reflect this intention to strip away some of this bureaucracy, to give greater autonomy and decision-making authority to foster carers, and to reduce obstacles to children in care having as normal a family life as possible. Guidance emphasises a proportionate approach to risk assessment and makes clear, for example, that CRB checks need not be made automatically for an overnight stay with friends or relatives, only when there is reason to do so, thus emphasising the place of professional judgement.

Progress has been made in the extent to which looked after children feel safe in care, but there is no room for complacency, particularly as the care population now has a greater concentration of vulnerable and multiply disadvantaged children than ever before, and this continues to make them a target for abuse. But how do we get this right? This chapter summarises what is and is not known about the extent, nature and sources of maltreatment in different care settings, and the implications for strategies to prevent abuse. We examine what is known about the effectiveness and impact of measures that are introduced to prevent abuse, including some unintended negative consequences, and argue that now is the time to fine-tune our safeguarding arrangements. We argue for a more nuanced and personalised approach to managing risks that recognises the diverse needs, capacity and strengths of individual children and young people

in different care settings. Quality of relationship must be seen as the central foundation to keeping children in care safe.

3.2 Safeguarding children in foster care

The problem of maltreatment in foster care has long been recognised. Fostered children face the same risks as those faced by all children, but their backgrounds and experiences also expose them to additional risks: their families or networks may be dangerous; they may be less able to anticipate and judge risky situations; they may be vulnerable to further abuse and exploitation; they may have poorly developed attachments, which prevent them from trusting their foster carers or seeking help or advice.

Foster carers often help children to transform their lives. However foster care itself is risky for children and also carries risks for foster carers and their families (see Chapter 5 in relation to risks to children of foster carers). The very qualities of size, privacy and normality that make fostering the 'placement of choice' for so many children are the same qualities that make for tensions and dilemmas in safeguarding them.

Safeguarding children in foster care therefore extends over two areas: firstly, social workers and foster carers acting together to protect children from the range of harms that they encounter 'in the world' – eg health and safety issues, exploitation, bullying, contact with dangerous relatives – and secondly, social workers acting to safeguard children from any harm posed to them by the foster carers or members of the fostering family.

The first documented case of abuse in foster care was that of Denis O'Neill, who died at the hands of his foster father in 1945. The more widespread problem of poor standards of foster and residential care also has a long history and was noted in the 1946 Curtis Report, which followed the inquiry into the O'Neill tragedy and provided a blueprint for the Children Act of 1948. Since the mid-1980s concern about allegations of maltreatment by foster carers has heightened awareness of this issue, even though some of these allegations may subsequently be judged to be unfounded (Bolton et al, 1981; Nixon and Verity, 1996). However, research has shown that many children do well in foster care, particularly if they are able to settle in their placements long-term, although outcomes may be poor for some children and placement instability remains a continuing problem (Beek and Schofield, 2004; Farmer and Moyers, 2008; Biehal et al,

2010; Wade et al, 2011). The majority of foster carers feel a strong sense of commitment to the children they care for and many speak of their close emotional involvement with them (Sinclair et al, 2004; Nutt, 2006; Biehal et al, 2010). There is therefore a tension between a general acknowledgement that foster care is beneficial to most children who need it, and the recognition that maltreatment or poor quality care can nevertheless occur in this setting. This can lead to strategies for managing risk that may not always be in children's best interests.

For example, children happily settled in long-term foster placements may sometimes view statutory reviews as a bureaucratic intrusion into their lives. Similarly, despite government guidance to the contrary, some local authorities continue to be reluctant to delegate decisions about children's everyday activities to foster carers, often insisting on authorisation by social workers. Subjecting low-level decisions about children's daily lives to bureaucratic scrutiny reinforces representations of these children as 'different' both to themselves and importantly, from a child's perspective, to their peers (Sinclair et al, 2005; Biehal et al, 2010).

These dilemmas highlight the ambiguous position of foster carers at the nexus of the private and the public spheres (Nutt, 2006). On the one hand they must make children feel they are part of the family and they are expected to provide them with the family–like relationships and 'normal' family life, which are the strengths of foster care (Schofield, 2003; Biehal et al, 2010; Loughton, 2010). On the other hand, fostering is a public service, albeit one that is located in the private domain of the family. Despite efforts to enhance the role of foster carers, there is a continuing tension between a desire to enhance the normality of children's lives in the private sphere of the (foster) family, and the fact that foster care is a public activity entailing the care of some of the most vulnerable members of society, with a need to ensure the child's safety, and therefore subject to regulation and scrutiny.

Without careful thought these tensions and ambiguities can result in a bureaucratic 'one size fits all' approach to the monitoring of foster placements, rather than one that is tailored to the particular circumstances of each child, which might allow a lighter touch approach in some circumstances. How do we make foster care feel as much like a supportive, family environment as possible, while maintaining an appropriate level of scrutiny? How do we avoid

undermining warm, caring relationships that are vital to children's healthy development and to safeguarding, while keeping a responsible watching eye? A first step is to understand the evidence on the extent and nature of maltreatment in foster care.

3.2.1 What is known about maltreatment in foster care?

Until recently, it has been difficult to come to clear conclusions about the frequency with which children experience maltreatment in foster care. Most previous research on the incidence of confirmed maltreatment has come from the USA. This suggests that maltreatment is substantiated for 0.27-2 per cent of fostered children per year (Biehal, 2014). Recent evidence from the UK indicates that maltreatment is experienced by just under one in a hundred children fostered children each year (Biehal et al, 2014). Other UK evidence mainly comes from broader studies of foster care and refers to maltreatment experienced by fostered children at any time rather than in a single year, so the estimates are higher.

Three English studies suggest that 3-4 per cent of children may experience maltreatment at some point during the time they are in foster care (Sinclair et al, 2005; Farmer and Moyers, 2008; Hunt et al, 2008). However, an Australian study of all children fostered in one Australian state suggested that the figure may be much higher, as 19 per cent had been maltreated by foster carers at some point in their lives (Tarren-Sweeney, 2008). Such large differences between reported rates are likely to be due in part to differences in definitions of what constitutes maltreatment.

It is also unclear whether maltreatment is more, or less, likely to occur when children are fostered by relatives. The rate of *confirmed* maltreatment was 4 per cent for both groups of carers in one English study (Farmer and Moyers, 2008), although kinship carers were more likely to be the subject of *unsubstantiated* allegations than unrelated carers, mainly by parents seeking to undermine the placement. This study also noted that very unsatisfactory placements with kin lasted significantly longer than those in unrelated care (Farmer and Moyers, 2008), suggesting that social workers may be slower to acknowledge maltreatment in placements with family and friends. Placements with relatives were more likely to be of poor quality than those with unrelated carers (Sinclair et al, 2005). While kin placements have many benefits, the application of a different, lower set of standards to their quality and safety is to be avoided.

It is important to distinguish maltreatment *in* foster care from maltreatment *by* foster carers. Again, the evidence on this issue is limited, but it suggests that in many, or most, cases the perpetrators of the maltreatment are foster carers themselves, who are reported to be responsible for 44–68 per cent of cases of maltreatment in foster care (Zuravin et al, 1993; Hobbs et al, 1999; Tittle et al, 2001). However, there is also evidence that children may be abused by other children in the placement, including other fostered children or the foster carers' own children (Spencer and Knudsen, 1992; Morris and Wheatley, 1994; Nixon and Verity, 1996; Farmer and Pollock, 1998; Hobbs et al, 1999), or by other adults, unknown to the foster carers (Morris and Wheatley, 1994; Tittle et al, 2001). Several studies have also found that fostered children may be re-abused by their parents during contact (Hobbs et al, 1999; Tittle et al, 2001; Sinclair et al, 2005; Hunt et al, 2008).

Accounts of substantiated maltreatment range from reports of poor supervision and smacking to instances of serious physical abuse and sexual intercourse (Benedict et al, 1994; Gardner, 1998; Triseliotis et al, 2000; Farmer and Moyers, 2008; Biehal et al, 2009). Several studies have outlined a range of emotional abuse in foster care, describing small numbers of foster carers as cold or insensitive and reporting incidents of fostered children being scapegoated, treated less favourably than carers' own children, experiencing a general lack of warmth and care, or being rejected (Morris and Wheatley, 1994; Gardner, 1998; Biehal et al, 2009). This emotional abuse by foster carers may have serious consequences for children. One study, for example, found that children who had previously experienced emotional abuse by foster carers were 4.5 times more likely to suffer from food maintenance syndrome (hyperphagia). Those experiencing emotional abuse in their current placement were 17.4 times more likely to have this condition (Tarren-Sweeney, 2006).[4]

Further work is needed to define what counts as maltreatment and what behaviours should more properly be regarded as evidence of poor standards of care. There is certainly clear evidence that fostered children may experience serious neglect and physical, sexual or emotional abuse, but studies generally report these examples of serious maltreatment alongside examples of less serious behaviours by carers. One English study concluded that the 'majority' of incidents

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4   This study had collected data on the children's mental health before the abuse came to light.

of maltreatment reported concerned poor standards of care by foster carers rather than abuse as such, noting particular problems of excessive discipline or rejection (Sinclair et al, 2005). Another study of 270 fostered children similarly found that poor standards of care were more common than clear maltreatment. It assessed 10 per cent of family and friends placements and 6 per cent of unrelated foster placements as being of a very poor standard. Evidence from case files revealed that the children concerned had been bullied, beaten, neglected or singled out for rejection (Farmer and Moyers, 2008). Action must be taken to address both, but in developing effective responses we must also identify the distinction between direct abuse of individuals and poor standards of care. This is vital in order to plan appropriate remedial action both at a service level and at an individual case level as the causes of maltreatment may be very different to those of poor quality care.

This issue is complicated by broader questions about what society defines as maltreatment, which varies historically and across different jurisdictions (Fallon et al, 2010). The threshold at which poor parenting practices become defined as abusive is likely to be lower for foster carers than for parents, as they are quite rightly held to higher standards of behaviour. However, some younger children (under 11) may remain for prolonged periods with foster carers with whom they are unhappy because they are too young to 'break' the placements themselves (Sinclair et al, 2007). There is also evidence that a rule of optimism may sometimes apply, due to professional reluctance to acknowledge that maltreatment has occurred, or concern that another suitable placement may not be available due to a shortage of foster placements (Rosenthal et al, 1991; Marshall et al, 1999; DePanfilis and Girvin, 2005; Parrott et al, 2007).

3.2.2 Managing risk in foster care

As we have seen, some foster carers are responsible for serious abuse or neglect. Although the current research evidence suggests that this occurs only in a minority of cases, no child should experience this harm. It is likely that the majority of cases involve poor standards of care, or poor quality care verging on maltreatment, such as a lack of warmth and care. This is a serious issue, as poor care may compound children's already extensive difficulties and, in any case, all looked after children should receive high quality care. Local authorities may themselves contribute to the problem of poor quality care. Fostering

is a demanding task and foster carers are increasingly required to care for extremely challenging children. In the context of a national shortage of foster carers, some local authorities may overburden carers by asking them to exceed their terms of approval with respect to the age or number of children they take, or to accept children with needs they are ill-equipped to deal with, and the authority may provide inadequate support to carers even in these stressful circumstances (Pearlman, 2010). They may therefore increase the risk of poor quality care by pushing foster carers beyond their capacity to care safely, instead of supporting them to do so, although there is currently no research evidence available to indicate whether this is, or is not, the case.

Conversely, local authority responses to reports of maltreatment in foster care may also compound the problem, as the way in which the risk of maltreatment is managed may in itself be harmful to children. Defensive, risk-averse practice may lead to disproportionate responses to allegations about poor standards of care, including sudden decisions to remove children from placements without warning and a lack of preparation or consultation with the children concerned. The Independent Review Mechanism, which provides among other things an independent review of a foster carer's suitability to foster, found in their investigations of allegations of maltreatment that some children are precipitately removed from their foster placements when allegations are made, without a balanced assessment of the potential harm to the child of either keeping them in, or removing them from, the placement (Pearlman, 2012).

Decisions are sometimes taken to remove children from long-term placements without a full assessment to balance the level of risk to children within the placement against the adverse consequences of disrupting it (Pearlman, 2010). Other children living in the placement may also be removed at a moment's notice. All allegations of abuse need to be taken seriously and investigated carefully and with an open mind. Prompt removal of children may be right and necessary in cases where there is reason to believe a child is being abused, but precipitate responses to allegations about behaviour that does not pose an immediate risk to children may themselves be harmful to their emotional wellbeing. It is difficult but important to get the balance right. What is important is getting the right decision in each case, which requires skilled decision-making and the exercise of professional judgement.

Even unfounded allegations can have serious consequences for children and foster carers. The situation is further complicated by the fact that investigations into allegations are often inconclusive, although Utting (1997) noted that inquiries into maltreatment in foster care sometimes uncover a history of allegations that have not been taken seriously (Rosenthal et al, 1991; Nixon and Verity, 1996). Where allegations are unfounded, or investigations inconclusive, children may be unnecessarily moved from placements or, alternatively, left in unsatisfactory placements and demoralised foster carers may give up fostering.

3.2.3 Safeguarding children in foster care

There is therefore a dilemma in balancing a desire to make foster care approximate as closely as possible to 'normal' family life, while ensuring that fostered children are adequately safeguarded. This seems particularly important for children in long-term foster placements, although it is important to note that these too may experience maltreatment (Utting,1997; Biehal et al, 2009). Statutory reviews for children in long-term placements may need to be more comprehensive at some points in children's lives but could possibly be lighter touch at others. Similarly, support to children and foster carers in these placements may need to be either more or less intensive at different stages in children's lives, or in response to particular events. However, fostered children should always have positive, ongoing relationships with social workers and see them alone on a regular basis so that if any concerns arise, including concerns about the placement, there is a trusted professional independent of the placement they feel they can talk to.

The management of uncertainty and risk can lead to bureaucratic responses and defensive practice that is not in children's best interests (Barlow and Scott; 2010, Munro, 2011). Too light a touch may expose children to poor quality care or maltreatment. However, a low tolerance of risks of harm may lead to overly bureaucratic monitoring of all foster placements and the precipitate removal of children when allegations are made. A disproportionate use of safeguarding measures may result in the disruption of relationships and multiple placement moves which are themselves harmful to children. Getting the balance right is difficult. Getting it wrong may have serious consequences for both children and foster carers. In the

next section we consider how policy and practice have developed in response to these issues and what further changes are needed.

3.2.4 'Safer caring' and the development of the risk-averse culture

'Safer caring' is the umbrella term used in fostering services to encompass the foster carers' and the service's roles in safeguarding and good practice to avoid unfounded allegations and complaints from fostered children or members of their family. This work originally served the purpose of informing newly approved foster carers about the reality of sexual abuse, drawing attention to the risk of allegations against members of the fostering family. Later work paid greater attention to the safeguarding challenges faced by foster carers and placed a greater emphasis on positive care rather than 'just' risk avoidance. The focus also shifted to include the risks faced by sons and daughters in addition to those faced by the foster carers themselves.

As an increasing proportion of looked after children were placed in foster care, local authorities and fostering services became more aware of the risks as well as the benefits of public care within a private family context and policies and procedures designed to avoid risky situations proliferated. Regulations set out safeguarding duties regarding the assessment of foster carers, visiting children in foster care, unannounced visits and independent visitors. Difficulties arose, however, in respect of services' own policies and procedures. As they attempted to cover every eventuality they became increasingly prescriptive about what fostered children could and could not do. Social workers' managers tended to interpret guidance more rigidly.

Despite the government's efforts to encourage local authorities to give greater freedoms and flexibilities to foster carers, in too many cases lip service continues to be paid to foster carers' professionalism and ability (with training) to carry out risk assessments. They are sometimes not authorised to make decisions about the most basic of day-to-day issues such as overnight stays, school trips or whether children can discard their dressing gowns in centrally heated houses. In addition to this, the basis of some of the 'safer caring' guidance about what should or should not happen in the foster home has not always been clear. Is it truly about helping children to be and to *feel* safe, or is it more about defensive practice and organisational back-covering?

3.2.5 The perspectives of young people and foster carers

Children say that being in foster care makes them *feel* different and nearly a quarter of the foster children in a survey by the office of the Children's Rights Director for England said that they had been bullied just because they lived in foster care (Morgan, 2005). Some children value the relationship with their social worker, but often there is also ambivalence when the social worker leaves (ibid). However, all too often children in foster care do not have a relationship with their social worker that they value, and there can be problems when social workers are needed to make decisions. Children still speak of missing trips and holidays because it took too long to get signatures and feeling 'different' in school because they have additional hurdles in getting permissions for photos or after-school activities.

Surveys of foster carers and consultation groups run by the Fostering Network (Slade and Priestman, 2011) confirm that foster carers believe they are often caught between their fostered children's needs and social workers who are unavailable or do not know who can make certain decisions. They describe confusion, delay and frustration and confirm that delays in decision-making cause many problems. 'Blanket' policies or guidance (or their interpretation by social workers and their managers) can inhibit normal life in the foster home to the extent that children can miss out on ordinary physical affection and the reassurance of touch that is so important for healthy development. 'Feeling different' may not just be about having to wait until a form is signed. It can mean living for extended periods deprived of the feelings of closeness that other young people take for granted.

These problems create doubts in young people's minds about their care. 'Does foster care feel comfortable for me? Can it meet my needs?' These doubts point to a more pressing question for children's services to answer: why would *anyone* want to remain in foster care if they feel singled out; if their opportunities to do normal things and receive normal treatment are curtailed, and if the decisions about what they are allowed to do take an age to come through and rest in the hands of people they do not know well? And what can it feel like to know that the people entrusted with your care are not trusted to exercise the most basic of judgments and decisions on your behalf?

3.2.6 The challenge – and a way forward

In practice, some foster carers and social workers have been finding ways round the rules and regulations in their efforts to offer the children in their care a full experience of family life as well as improve safeguarding practice. Many have also welcomed the moves to delegate authority to foster carers. The *Care Planning, Placement and Case Review (England) Regulations* and Statutory Guidance 2010 (Children's Act 1989[4]) makes it clear that foster carers should be authorised to take more day-to-day decisions for the children in their care. However, despite the changes in guidance and ministerial exhortations, the evidence (Slade and Priestman 2011) is that change is still needed in the authority delegated to foster carers. A lack of change continues to impact on carers' ability to provide the children they foster with a 'normal' experience of family life. The challenge that remains is to build on the policy intention and shift the culture and practice to ensure an appropriate balance between measures intended to safeguard and enabling children in care to have a positive experience of family life.

The Munro Review (Munro, 2011) describes the importance of working from sound principles rather than attempting to cover every angle in guidance. It is the *quality* of the decision-making rather than the outcome that should be judged when things go wrong. Childcare social workers require a good knowledge of foster care and the perspective of foster carers in order to safeguard children and become more inclusive and collaborative in their practice. Foster carers need to understand safer caring principles and then receive the tools, training and support to collaborate fully in care planning and decision-making. Joint training must feature in all local authorities' strategies for change.

To support these changes, the Fostering Network has produced a third edition of *Safer Caring – a new approach* (Slade, 2012). Written for foster carers but relevant to all parts of the corporate parent, it describes how foster carers, local authorities and fostering services might think and behave differently. It promotes three significant themes or threads that overlap and complement each other:

1. **Improving the role and status of foster carers.**
   Power imbalances between foster carers and social workers make for risky safeguarding practice. Ensuring children are safely cared for in foster care requires everyone in the team around the child, including foster carers, to work together, each respecting and

valuing the contribution of the others. Information relevant to children's safety and welfare has to be shared with foster carers if they are to do their job.

2. **A 'risk–sensible, not risk–averse' approach.**
   Historically we have assumed that policies and procedures make children safe. Social workers need to examine realistic and proportionate approaches to risk and offer foster carers ways of thinking and talking about these issues. (See *Safer caring: a new approach (Slade, 2012)* for specifics).

3. **Individualising decision-making through greater delegated authority.**
   When foster carers are not allowed to make day-to-day decisions about a child it makes it much more difficult for them to provide the child with the security and care they need. Decisions are less likely to be based on detailed knowledge of the individual child. When a foster carer can respond to a need promptly, even if it is to say 'no', the child can relax and the carer is more likely to feel more confident in their ability to meet the child's needs. Increased delegation will only work if local authorities, fostering services and foster carers work together to accept individualised arrangements that safeguard children while allowing foster carers more day-to-day discretion.

The fact that children can be maltreated in foster care and that foster carers can experience allegations must be treated with utmost seriousness, but we need to take a broader approach to safeguarding that also addresses the poor standards of care experienced by a wider group of children. In some cases the protective strategies that we have in place can be damaging in their own right. Foster carers have to be given responsibilities and allowed to make *more*, although not *all* decisions. They must be seen as trusted carers, but children's safety in their care cannot be taken for granted. The balance between safeguarding and achieving a normality in which children can trust foster care to work for them should be openly discussed at every service level, in every placement.

The expectation that foster carers demonstrate higher standards of parenting than parents is a reasonable one. However alongside this it is important to recognise the level of a child's emotional and behavioural problems that we expect foster carers to cope with, while balancing their needs with the needs of other children and of their family. This is a task made more difficult by the varying levels

of support available, which should be taken into account when local authorities consider whether to remove a child from their foster carers. They must be satisfied that the threshold for the sudden removal of a child from an adult to whom they are attached has been reached.

We also have to strive for a learning culture. Foster carers can experience social workers closing ranks and becoming punitive when they make mistakes (Slade and Priestman, 2011). This is not in the interests of children. Improving foster carers' status and social work practice when things go wrong or when allegations occur is not just about respecting the sensitivities of individuals. It is *a critical* safeguarding priority.

3.3 Safeguarding young people who live in residential children's homes

The residential care of children and young people has long been a controversial field. The widespread scandals of physical and sexual institutional abuse are still a recent memory. Recent UK research suggests that there may have been changes in the extent and nature of abuse experienced in residential placements (Biehal et al, 2014). Predatory adults (usually men) may now be more likely to seek access to vulnerable children in ways other than employment in residential children's homes. Indeed, in recent times there have been major concerns about men in certain localities, including Rotherham, Rochdale, Derby and Oxford, 'grooming' residents for sexual exploitation outside the home. It is clear that safeguarding responsibilities apply to activities outside the home as much as within a residence itself.

We obviously need to remain vigilant and the strongest safeguard against maltreatment of residents is probably to raise overall professional standards and awareness, as the phrase 'Quality Protects' reinforces (Stein, 2009). This brings us to the factors in residential care that lead to the provision of a caring, stable environment that supports young people, strengthens their confidence and responsibilities, and helps to construct boundaries that contain and hopefully prevent anti–social or risky behaviour.

3.3.1 The evolving nature of residential care

Two recent studies of children's residential homes in England undertaken by Berridge, Biehal (contributing authors to this volume) and others (Berridge et al, 2011; Berridge et al, 2012) offer insights into how modern residential care has evolved. Most homes nowadays are small (average number of places is six in the studies) and residents are usually older teenagers – on average 15½ years. Older residents tend to be more independent in their actions including outside interests and friendships, so it can be problematic for staff to be aware of the wider social activities in which residents are involved. In open community settings, preventing or discouraging contacts with undesirable or anti-social peers is a particular challenge. As there is now much less residential care, this can be exacerbated as individual homes often serve a variety of purposes, catering for both short- and long-stay residents, as well as a range of needs, which presents difficulties. This can lead to conflict between residents, some of whom may not be ideally placed due to a lack of alternatives. Consequently, residents can face very significant problems, including violence and exploitation from partners or older men (Wood et al, 2011).

Efforts to ensure that homes are effective in safeguarding and promoting the welfare of young people can be complicated by the fact that a stay in a residential home is often brief, making it difficult to have a noticeable impact. With this in mind, the research referred to above came up with mixed results for residents' outcomes. In a short follow-up there was little difference in the number with behavioural problems, going missing or misusing drugs or alcohol. On the other hand, half of those with prior criminal records did not reoffend and there was some improvement in the pattern of school attendance. A quarter reduced their level of risky behaviour, although some others started to take risks. There was much variation across homes and it is clear that we must learn from the good practice.

3.3.2 Successful intervention

So what is associated with successful interventions and how can residential homes safeguard young people more effectively? Unsurprisingly, there is no single 'magic bullet' and the dynamics are complex – encompassing young people's backgrounds, characteristics, and motivation; structural features of homes, and staffing variables.

A previous major study of children's homes (Sinclair and Gibbs,1998) concluded that homes are more effective if they are kept *small*: managing the group is more straightforward, delinquent sub-cultures are more easily fragmented, and peer conflict and intimidation can be addressed (see Chapter 5). *Leadership* is also key, helping to set an overall ethos as well as defining the problems and means by which they are to be tackled. Another important element is *staff consensus* (which can stem from good leadership): agreement about the task, getting on with one another and working to some form of theory or shared philosophy (see also Berridge and Brodie, 1998). Staffing ratios and the level of staff qualifications *per se* do not seem to be the major variables associated with improved outcomes. That is not to say that they are unimportant but, in isolation, they are not necessarily the most important factors, and management efforts should not focus on these exclusively rather than the other issues.

Though the relationship is not straightforward and depends on the resident group and other extraneous factors, we would generally expect homes offering a higher *quality of care* to achieve improved outcomes for young people. It has long been accepted that forging close, trusting relationships is at the heart of effective residential care. This practice is consistent with the government's social work reforms after the *Munro Review* (Munro, 2011). Young people have not always had reliable, committed adults in their lives in the past and sharing problems can open up greater control over life and help to introduce controls. Indeed, a systematic review of challenging behaviour in residential care concluded that, although further research is needed, there was no evidence that any single model of intervention was more likely to be more effective than others (Berridge and Lucas, 2008). Instead: "… it is likely to be the way in which such models are implemented, to whom, by whom and in what context rather than their intrinsic merit."(ibid, p.27).

3.3.3 Defining high-quality care

It is complex to define what exactly is meant by 'high-quality care', let alone qualities such as 'warm and caring' and 'accepting' (ibid). Few would wish to deny their importance, yet recognising their presence, let alone ensuring how they can be guaranteed, is difficult. A recent publication developed a detailed *Quality of Care Index* for residential and foster care based on existing research (Stein, 2009; Berridge et al, 2008). The eight key dimensions in this were: care

and control; safety; inter-professional working; family links; close relationship with at least one adult; ethnicity and culture; friendships, and planning and aftercare. This tool, being used for the first time, did not predict young people's outcomes as strongly as may have been wished – life is not that straightforward and there are many extraneous factors. However, there was some evidence that young people's general happiness and their satisfaction with schooling were linked to the measures of the quality of care they received.

When interviewed about the quality of their care for recent research (Berridge et al, 2012), young people were mainly complimentary about the residential experience and felt that they were treated fairly. But they were often wary of their co-residents (see Chapter 5). Qualities they valued in staff especially were listening skills and sensitivity, reliability and a sense of humour and we should further encourage these skills. It is disappointing that the research concluded that only about half of the 10 homes visited provided what was judged to be a consistently warm and caring environment, over time and across the staff group. The report summarised what this should comprise:

"Everyday examples would include staff acknowledging young people, being respectful, making eye contact, smiling, talking and spending time in their presence. This may appear obvious but not all children have experienced it. These everyday examples, which many of us take for granted, can be highly therapeutic for deprived children." (Berridge et al, 2012, p.44)

Encouragingly, most staff were approachable to young people and spent the bulk of their time interacting with them – including helping with homework, collecting from school rather than relying on taxis and chatting with residents while preparing meals. However, in two of the 10 homes studied, staff seemed unapproachable to residents, spending more time in an office or engaged in practical tasks and thereby avoiding young people's company, appearing to be insensitive and unprofessional.

3.3.4 Safeguarding residents

As has been highlighted by recent high profile cases of the sexual exploitation of young people in residential care, the main safeguarding issue to arise from studies concerns young people *outside* the home. The studies by Berridge et al (2011; 2012) found that although

there could sometimes be friction or conflict within the residential home, this was usually not the main problem. However, drug misuse with friends or contacts outside the home was often a concern. In response, staff gave strong messages about the health and interpersonal risks of misusing cannabis and other drugs.

The other main concern was the behaviour of vulnerable young people in the community, especially girls falling prey to sexual exploitation. Nearly all homes were taking active strategies to manage these risks but it felt precarious. Young people joined residential homes with troubled pasts including physical or sexual abuse and harmful peer networks. Homes were not secure units but open environments and there were strong safeguards against the deprivation of liberty (Levy and Kahan, 1991).

Physical intervention (including restraint) is allowed only in exceptional circumstances to prevent direct physical injury to self or others, or serious damage to property. In any case, we should not further oppress victims by restricting their liberty. The main focus should be on preventing men from sexually exploiting teenagers in the first place, and in strictly punishing those who do.

In an open unit, the staff goal is ultimately to establish a parenting role: discussing problems, achieving positive self-regard and exerting pro-social influence. Young people also need to perceive that what is on offer in the residential home is more beneficial or attractive than external relationships or delinquent excitement. Given what may have preceded entry to care and the residential home, this can be a tall order and not all parents achieve it with their own adolescents in more straightforward circumstances. However, it is negligent for homes not to be fully focused on young people, meeting their needs and managing their problems.

The Berridge et al (2011; 2012) studies found that when young people were going out to meet friends, the strategies staff employed included: asking who the friends were, what they were doing and what time they would be returning; discouraging undesirable contacts; giving residents lifts and collecting them later; inviting friends to the home; in some circumstances seeking to curb mobile phone use, and accompanying young people to local shops. The researchers encountered one situation in which two workers were taking a young woman away for a weekend to a holiday centre in an endeavour to break the pattern of her relationships.

Any lack of engagement with young people was not primarily due to homes being unduly 'risk-averse', preventing close (including physical) contact, although it occupied much attention behind the scenes. 'Risk aversion', although necessary to some degree, need not get in the way of personalised care. The homes that were studied had often developed guidelines for offering physical reassurance, particularly relating to what was allowed when contact was initiated by young people, eg a kiss on the cheek. These guidelines included reference to its public nature, brief duration, strategies for 'side-hugs' and playfully ruffling boys' hair etc. Men are inevitably more cautious. In addition, the researchers did not sense that homes were unduly restricting activities due to an over-cautious approach (or 'health and safety'). The best example was probably a home offering short breaks for disabled children and their families, where a group of young boys with autistic spectrum disorders undertook some boisterous and challenging activities on a day out, demonstrating that risk-taking is possible.

3.4 Three further safeguarding issues in residential care

It is important to finally cover three issues currently relevant to children's residential services. The first concerns the approach to residential care in England compared with other European countries (though there are similarities, there are differences between England, Scotland, Wales and Northern Ireland and it is best not to generalise). The second is the changed nature of modern provision; the third the issue of safeguarding adolescents.

3.4.1 Approach to residential care in England

Children's residential care in England has often been criticised in the past and unfavourably compared with, for example, Scandinavian countries that use a social pedagogy approach, where 'outcomes' have been perceived to be superior. The evaluation of a pilot initiative (Berridge et al, 2011) showed that this is more complex than it may initially appear. Homes employing social pedagogues did not necessarily achieve better results than comparison homes that had adopted a more traditional approach, nor were social pedagogues always observed to practice differently to their English counterparts. Social pedagogy has its appeal in terms of coherence, breadth,

emphasis on reflection and workers' use of self. However, the main contrast with English residential care is that if offers essentially a small, residual, short-term, transitory and stigmatised service. Social pedagogues across Europe tend to have a higher status with greater autonomy, and the profession requires a substantial period of study. In England, in contrast, the residential sector is under-professionalised with low levels of professional social work qualifications, (although as noted above, improved qualifications per se do not lead directly to improved outcomes for children).

3.4.2 The changed nature of modern provision

Most residents (60 per cent) are now accommodated in private or voluntary sector facilities rather than local authority homes (DfE, 2013). Nearly half of all residents are placed outside their local authority boundaries and a third live more than 20 miles from their local communities. Consequently, on average 45 per cent of local residents are the responsibility of another council. Indeed, different councils make very different use of residential care. There are important safeguarding implications of so many children living a long distance away, including the communities in which residential homes operate, and some children require specialist national resources. There are concerns that current patterns may have arisen as much by default as design, and measures have recently been taken by the Department of Education in England to address some of these concern. However, careful scrutiny of their implementation and effect is needed.

3.4.3 Safeguarding adolescents

We are only able to address this issue briefly here. Teenagers can be subject to serious abuse and neglect (Rees et al, 2010), both in similar ways to younger children as well as in other specific forms such as partner violence and exploitation (Barter et al, 2009). Many enter care late, after a lifetime of damaging experiences and poor, inconsistent parenting, which makes them difficult to care for. Despite legal protection, it is also known that there is less public and professional sympathy towards adolescents, and fewer available services. The cases in Rochdale revealed reluctance on the part of the police and children's services to listen to teenage girls and respond to what they said about sexual abuse. Partner agencies can be less forthcoming with multi-professional protection plans for adolescents than for young children. As the group of children living in residential

care is now mainly an adolescent population, no doubt problems in the residential sector are also part of this wider problem. It is hoped that current reforms of social work and safeguarding services will offer better protection and more rewarding experiences to the residents of children's homes, who are among the most disadvantaged and troubled children nationally.

There have been watershed moments in children's residential care in the past, and it feels like another has arrived. In response to the revelations in Rochdale and Derby, government has initiated a programme of work to improve the quality and safety of residential care. There clearly are issues concerning commissioning and the private sector, with so many homes concentrated in the north-west and many children travelling long distances. It is not clear whether the child care 'market' has created the pattern of services that best meets residents' needs. Furthermore, it seems that the legal requirement (Children and Young Persons Act 2008) for councils to be more self-sufficient in local placements is not working and should be revisited.

Finally, as this book is based on the best up-to-date evidence, we should also point out that there is virtually no large-scale, detailed research in the UK on private provision of children's residential care, even though it provides the majority of placements. There is no firm basis of knowledge about, for example: who lives and works in private homes; why are young people referred; how are they run and to what effect; what are the consequences of distance in terms of contact with family, follow-up from local professionals and access to local services. Hopefully the current disquiet about the residential sector will allow these and other issues to be addressed.

3.5 Conclusions and overall recommendations for safeguarding policy and practice in foster- and residential care

Foster close, trusting relationships

Vigilance by all those in contact with children in care and effective safeguarding measures remain vital to prevent abuse, especially in light of the increased vulnerability of the care population. This chapter has highlighted how close, trusting relationships are critical to keeping children safe and that regulations and procedures on their own are

insufficient. Every child in care must have at least one meaningful relationship and someone independent who they can ask for help in times of need.

Balance policies, guidance and practice

Safeguarding policies, guidance and practice should be balanced and not overly restrictive, reactive or defensive. A better balance is called for in foster care: between too much and too little trust and empowerment of carers; too much and too little scrutiny; over- and under-reaction in response to allegations, and being risk-sensible rather than risk-averse. Effective, balanced assessments of the potential harm to children from poor quality foster care should be made before precipitate action to remove a child is taken, which in itself can be harmful. Such balance requires well-trained, skilled professionals who are enabled and supported through effective supervision to make good professional judgements. Balanced practice is likely to thrive in organisations that are not defensively preoccupied with the avoidance of risk, but promote a learning culture. This in turn requires confident political and operational leadership resolutely focused on achieving the very best outcomes for each child in care.

Ensure quality of care

Poor standards of care, verging at times on maltreatment, are a major concern and are responsible for harming more children in care than physical and sexual abuse. The quality of care remains far too variable, with too many children in both residential and foster care not living in warm, caring environments, where carers are approachable, involved and interested. Emotional abuse and neglect by carers should be treated as seriously as any other form of maltreatment. Local authorities should ensure that they have effective mechanisms in place to identify poor standards of care and maltreatment, and take action to raise standards and ensure all looked after children enjoy supportive and caring relationships, for example, through inspection, supervision, carer selection and development. The government should commission further work to better understand and define the nature and character of poor standards of care, abuse and neglect in the care system, and help local authorities to improve the consistency of practice.

Broaden the focus of safeguarding strategies

The safeguarding strategies of local authorities, providers and other partners must be broadly focused and should not merely be aimed at

preventing maltreatment by carers to the exclusion or oversight of other sources of harm. The evidence shows that there are multiple sources of risk of harm, which change with the age of the young person. Local authorities should review their existing safeguarding policies and established practices to ensure a proportionate, 'risk-sensible' approach that encompasses the whole range and sources of those risks.

Personalise and tailor the approach to monitoring, review and risk management

The care population is diverse. Overly standardised or one-size-fits-all approaches to monitoring, review and risk management should be replaced with more personalised and tailored approaches. For some children this may mean a lighter touch at different stages of their care career; for others (especially those without a voice because of age, language or disability) additional measures may be needed. Local authorities should ensure that carers are treated as partners in developing and implementing individualised safeguarding plans for children in placement as they have unique insights into what is most likely to work for a particular child in their care.

Adolescents are the majority of those cared for in residential settings and there are particular challenges in safeguarding them effectively, with due regard to their maturity, rights, previous experiences, behaviour and vulnerability. Care, control, boundaries and the exercise of a parenting role have to be skilfully negotiated. Providers need to ensure that staff receive training and support to help manage challenging behaviour and keep young people safe from risks of sexual exploitation, peer abuse, and substance misuse. Local authority commissioners should incentivise this practice and governments should ensure that good practice in reducing risky behaviour in adolescents is shared between homes.

Qualifications, valuable as they are, are not *per se* the critical determinant of improved outcomes for children in residential care. Consistently warm and caring environments matter, where staff are committed, interested, good-humoured, engaged, and actively interact with young people rather than spending their time in the back office.

Ensure adequacy of local supply

Placement choice and the adequacy of local supply are critically important, as recognised in legislation and guidance. However,

continuing shortfalls lead to inappropriate placements, multiple moves, carers being pushed beyond what they can safely manage, placements out of county and at a distance. Barriers to improving placement choice require investigation and action by the national and local governments. There is a need for the national government to lead the development of strategies to ensure the adequacy of specialist provision.

Carry out better research into maltreatment

Better information and research about the nature and extent of maltreatment in different care settings is needed in order to fine-tune our preventive strategies and to tackle the significant variations or inequalities between local areas. Local authorities and LSCBs should actively review the effectiveness of their own safeguarding arrangements for looked after children compared with similar local authorities. At present there is a lack of transparency, which hinders open scrutiny and limits learning about how best to ensure all looked after children stay safe and well.

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CHAPTER 4

Meeting the therapeutic and support needs of children in care who have experienced early abuse and neglect

CHAPTER 4

Meeting the therapeutic and support needs of children in care who have experienced early abuse and neglect

By Kim S. Golding

4.1 Introduction

> Paul and Alison spent their early years with their mother and
> violent, unpredictable step-father. Their mother was physically
> abused as a child. Little is known about their fathers. Despite
> support the children's mother could not protect or meet the
> emotional needs of Paul and Alison, so they were removed on a
> care order when they were 3½ and 18 months old, respectively,
> and moved to foster care while decisions were made about
> their future.
>
> [composite case study]

Studies over the last two decades have highlighted the prevalence
of mental health problems among looked after children in the UK[5]
and in other parts of the Western World;[6] a substantially higher rate
than children living in private families in both deprived and non–
deprived circumstances (Ford et al, 2007). A recent review of these
studies revealed that more than half of children living in care have
clinically significant mental health problems and a further quarter

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5   For example see McCann et al, 1996; Dimigen et al, 1999; Meltzer et al, 2003;
    Skuse andWard, 2003; Blower et al, 2004; Sempik et al, 2008; Ward et al, 2008.
6   See Milburn et al, 2008; Egelund and Lausten, 2009; Pecora et al, 2009.

have difficulties that approach clinical significance (Tarren–Sweeney, 2010b). An earlier study also found that two-thirds of children living in residential care in England had a diagnosable mental disorder (Meltzer et al, 2003).

Research suggests that these problems with mental health and emotional wellbeing are an outcome of children's pre-care experience as well as the secondary impact of living in the care system (Vostanis, 2010). Important contributory factors to the development of difficulties include abuse and neglect; exposure to detrimental environments pre- and postnatally; the experience of removal from and loss of family (Chambers et al, 2010) and genetics (Minnis et al, 2007). If the trajectory of looked after children's lives is to be improved then the availability of appropriate therapeutic support has to be an important part of mental health provision.

However, the mental health needs of looked after children are all too often unmet due to difficulties in accessing mental health services. A 2008 review of the Child and Adolescent Mental Health Service (CAMHS) identified a particular shortage of therapeutic services for children in care (DH, 2008). The review also identified barriers to looked after children accessing support from CAMHS, including carers' lack of awareness of their mental health needs, overburdened services, long waiting lists and inflexible rules that can mean children without a stable placement are ineligible for support (ibid).

Responding to these challenges, this chapter draws on clinical experience alongside theory, research, and the views of service users to explore the therapeutic and support needs of children living in care within the United Kingdom. It also follows Paul and Alison's story, based upon a composite of the experiences of real children at various stages of their journey through care, and uses this story to illustrate the discussion throughout.

The chapter concludes by setting out how the mental health needs of looked after children could be met more effectively and making recommendations for strengthening policy frameworks and services. In summary these are that:

- Key aims of care planning should include early intervention to ensure that children do not remain in damaging family environments; to secure stable placements that meet children's emotional needs, and to facilitate, where necessary, access for

children and their carers to services that support good mental health and emotional wellbeing.

- Local authority looked after children teams should ensure that children and young people receive a specialist assessment of their emotional and mental health needs on entry to care. If emotional or mental health needs are identified, social services should work in partnership with carers, health services and schools to ensure the child or young person has access to appropriate support services. This support should be provided early on in their care journey to prevent the onset, or worsening, of mental health problems.

- Health and wellbeing boards should ensure that looked after children in their local authority area have access to dedicated mental health services with specially trained staff. These services should form part of a multi-agency approach whereby mental health professionals work closely with carers, social workers and schools to combine mental health support with good care planning and classroom support.

- Dedicated mental health services for looked after children should have a broad focus on building resilience rather than a narrow focus on symptom reduction. Direct therapy with the child is only one of a range of possible interventions to support the needs of the child, family, carers, school and professional network. Appropriate forms of support might include parenting and emotional support for carers as well as building children's resilience and social and emotional competence through arts and leisure activities and specialist therapies.

- Commissioners and service providers should ensure that eligibility for mental health support is not restricted to children in stable placements. Mental health professionals can contribute to placement stability by inputting to care planning processes, parenting support and school support.

- Commissioners and service providers should ensure that looked after children, their carers and relevant partners from health and social care are involved in the process of designing and developing mental health services that are accessible and meet looked after children's needs.

4.2 Understanding the therapeutic and support needs of children living in care

4.2.1 The mental health needs of looked after children in the UK

A substantial proportion of children who grow up in care following early experience of abuse and neglect have extensive and complex mental health needs. Common problems experienced by looked after children include attachment and relationship difficulties; anxiety associated with trauma; attention and conduct problems including oppositional defiance, and difficulties with sexual behaviour (eg Milburn et al, 2008; Tarren-Sweeney, 2008).

Such mental health needs can cause difficulties with emotional, cognitive, social, behavioural and relationship functioning (see Arcelus et al, 1999; Milburn et al, 2008; Vostanis, 2010, Tarren-Sweeney, 2010b). Therefore, they will often go hand in hand with a range of developmental and educational needs, including learning and language difficulties (Chambers et al, 2010), as well as poor physical health. Unsurprisingly, educational outcomes for looked after children are generally poor compared to the general population (Meltzer et al, 2003; Tarren-Sweeney, 2010b).

Paul and Alison are typical of this profile. Initially Paul was very aggressive within his placement. He was a loud, hyperactive child who had to be closely supervised. He wanted to climb everything, and would quickly run off if taken outside. On the other hand he was also a tactile child who enjoyed being cuddled and comforted. He liked to sit on the carers' laps and found it difficult if they were giving his sister attention. He would often cry and it was difficult to soothe and settle him. Once he started school the teachers found him to be a bright, articulate child who could be very engaged when focused on a task. Much of the time, however, it was difficult to focus his attention, as when he was with his carers he was loud and boisterous. When uncertain he clung to his teacher, often wanting to sit on her lap. In the playground he needed to be closely supervised, as his level of risk-taking was high.

Alison was a very quiet, almost frozen child with quite severe developmental delay. For the first few months Alison watched rather than entered family life. Her large brown eyes noticed everything going on but she rarely engaged in play. Her brother could be quite violent towards her but she just appeared to accept this, barely making a fuss. The foster carers experienced superficiality in the emotional connection that Alison had with them. At the local nursery she was initially quiet and withdrawn but over time she became more settled and active. Staff had few concerns about her at the nursery. Alison demonstrated more abilities with her carers than in the nursery. Thus her speech appeared markedly better developed when she was with her foster carers than in nursery.

4.2.2 Barriers to looked after children accessing specialist mental health services

As the examples of Paul and Alison illustrate, looked after children often have needs that could potentially be helped by mental health services. However, it can be difficult to access appropriate services for them. Studies in the UK have identified a variety of barriers to accessing mental health services for children, including long waiting lists; stigma; lack of awareness and support from carers; lack of placement stability; poor information; lack of home visiting; off-putting venues, and inconvenient appointment times (Street and Davies, 2002; Blower et al, 2004; Beck, 2006; DH, 2008; Golding, 2010). A particularly problem is the fact that children's difficulties often go undetected if professionals or carers lack the skills to recognise mental health difficulties or are reluctant to pathologise children's behaviour (Callaghan, 2004; Milburn et al, 2008). There is also evidence that children and young people with a diagnosable mental health disorder tend to be prioritised by services; consequently children with less overt problems often do not meet the threshold for support (Minnis and Del Priore, 2001).

Dedicated mental health services for looked after children are not universal (Vostanis, 2010) and in the absence of such services it is likely that Paul and Alison's carers would struggle to access support. Paul's behaviour may attract attention, but his lack of a permanent stable home would reduce opportunities to access services, many of

which make stability a precondition of treatment (DH, 2008). In spite of her foster carers' concerns about the way she relates to them, Alison's day-to-day functioning may look adequate in a superficial assessment and therefore in the absence of diagnosable mental health difficulties or overtly challenging behaviour, Alison is unlikely to meet the threshold for a CAMHS service.

4.2.3 What do children and carers want from services?

Research by Young Minds with looked after children demonstrated that strong relationships are at the heart of what children want from care (Young Minds, 2012). Children want others, including teachers and carers, to understand their difficulties and emotional and mental health needs. They want people to build relationships with them and to have continuity in these relationships, including when they leave care (see also Chapter 8).

The Young Minds study found that reliable and trusting relationships with non-judgemental adults are critical to looked after children's ability to access mental health services. It is also important to children and young people that services focus on good mental health rather than on mental illness, provide accessible, non-clinical, environments, and timely support unhindered by waiting lists. Children want imaginative and creative services that provide help through art, play, drama and music (Young Minds, 2012). These insights should be used to improve therapeutic support for children in care.

The study by Young Minds also highlights the importance of consulting looked after children and young people and their carers about the design and delivery of the mental health services they use (Young Minds, 2012). However, this process of reconciling the differing wishes of children, carers, and professionals clearly has its challenges. For example, professionals and carers can be more focused on behavioural difficulties while the children view difficulties as emotional or as the fault of other people (Beck, 2006). Quite understandably, looked after children sometimes underrepresent the level of difficulty they are experiencing, preferring to be regarded as similar to their peers (Richards et al, 2006). However, when asked, these children will report high levels of loneliness, isolation and lack of support (Shaw, 1998).

Asking the right questions, listening and finding ways to take into account children's and carer's views in service development can be

challenging. However, actively listening and acting upon multiple viewpoints is an essential part of service planning, leading to services that children and their carers can comfortably engage in (Golding et al, 2006).

4.3 How can services best meet the therapeutic and support needs of looked after children?

Vulnerable children like Paul and Alison need a different approach to care planning and structuring services that gives greater priority to meeting their emotional needs. Prevention, early intervention and stable and supportive placements are important prerequisites to positive emotional wellbeing for children in care and the successful provision of mental health support.

4.3.1 Prevention and early intervention

Children who remain in damaging family environments for unnecessarily long periods of time due to indecision or delay experience increased risk of developing mental health problems that threaten their future emotional wellbeing (Hannon et al, 2010). The design of an effective care system therefore requires early intervention to ensure that children are not exposed to harm. Additionally, once children enter care, mental health support needs to be targeted early on in their care journey.

This preventative approach requires a thorough and holistic assessment by trained professionals early on in the child's care journey to identify potential sources of risk and resilience, so that support can be planned that builds on resilience factors while at the same time reducing risk.

All too often referral to mental health services and/or the provision of specialist parenting support does not happen until problems have emerged that are overwhelmingly challenging for parents and for social care professionals. The provision of specialist advice for the carers at an earlier stage might help to increase security for a child at risk of developing attachment insecurities due to previous experience of neglectful or abusive parenting. Rather than wait for this insecurity to reveal itself through challenging behaviours and crisis within the foster family, parenting support can be provided to help the child

connect with and experience a foster carer as sensitive and nurturing. Specialist parenting support can ensure that looked after children experience warm, nurturing care even when this is challenged by their behaviour or difficulties with relationships. The value of this kind of support is set out in the first quality standard identified by the National Institute for Health and Care Excellence (NICE, 2013).

4.3.2 The importance of stability

There is increasing evidence that connects looked after children's emotional wellbeing at entry to care to their subsequent experiences of placement stability (Hannon et al, 2010). Other studies have provided evidence indicating that placement instability in care can independently cause or exacerbate mental health problems among looked after children, contributing to a downward spiral of instability and poor emotional wellbeing (Rubin et al, 2007; Ward et al, 2008). Therefore improving placement stability and children's emotional health are equally important goals.

How to improve children's emotional health needs careful thought. For example, a lack of placement stability can reduce the effectiveness of some CAMHS services, such as individual therapies; if children do not feel safe they are less open to engaging in therapeutic relationships with CAMHS professionals. However, while increasing provision of individual therapy may not be the answer for all children experiencing placement instability this does not mean that CAMHS professionals have to wait for social care professionals to provide increased stability. They can play an important role in supporting interventions that can both increase stability and lead to improved mental health: contributing to multi-agency working though advice, consultation, parenting support and training can lead to a situation where placements are more stable; children are emotionally healthier, and individual therapies are effective.

Instead of waiting for placement stability, we need to design a system that identifies and addresses children's emotional needs at the earliest opportunity. This includes:

- Multi-agency working that provides a range of support and therapeutic interventions rather than a narrow focus on CAMHS professionals providing individual therapy.

- Achieving permanence via adoption, kinship care, stable long-term foster care, residential care (or in some cases returning

children to their birth family), as essential to ensuring that children's early experiences of trauma are not exacerbated by experiences of instability and a lack of opportunity for secure attachment following the child's entry to care.

- Parenting support interventions to help carers get the parenting right once children are in care.

CAMHS professionals, alongside social care and education professionals, are an important part of the multi-agency networks that can achieve these goals. Multi-agency working that offers a range of interventions avoids the 'chicken and egg' situation of no service without stability, but stability being unachievable without the support of services.

4.4 Designing effective mental health provision

A variety of UK, American and Australian studies have identified the following key characteristics of effective mental health services for looked after children:

- carer support as well as therapeutic interventions for the children (Milburn et al, 2008)

- multi-agency working with accessible and child-friendly health services (Golding, 2010)

- multi-disciplinary assessments to ensure children's mental health needs are identified early on (Tarren-Sweeney, 2010b);

- dedicated mental health services for looked after children, which ensure that assessment and intervention are provided when needed, irrespective of placement stability (Minnis and Del Priore, 2001; Vostanis, 2010)

- indirect work such as parenting support provided alongside more direct interventions (Anderson et al, 2004).

Each of these points is explored in more detail below.

4.4.1 Supporting carers and professionals to provide a therapeutic environment

As discussed above, indirect interventions involving children's carers can contribute to achieving placement stability by facilitating the provision of supportive, therapeutic environments for looked after children. Such interventions are therefore an important part of meeting the second quality standard for children to live in stable placements (NICE, 2013).

All services for looked after children need to be informed by a comprehensive understanding of these children's pre-care and in-care experiences and take into account the impact of abuse, neglect, loss and instability on children's health and wellbeing. Social workers require specialist knowledge of these issues, which can in turn inform the training, advice and consultation they provide to carers and their wider professional networks. It is important that this training and support has a broad focus on children's wellbeing rather than a narrow medical model: this takes into account environmental and developmental contexts as well as mental health (Tarren-Sweeney, 2010b).

Clinical practitioners, such as psychiatrists, clinical psychologists, mental health nurses and other mental health practitioners, also need to be informed about social care practice to facilitate stronger multi-agency working with a shared knowledge base for all involved. This can inform how all can help support the child, including support for the carer. There are several bodies of theoretical work that should inform service development for children growing up in care. The influence of attachment theory on professional practice has grown in recent years, as witnessed by the many attachment-informed services[7] and interventions[8] developed for looked after children. There is a growing body of research demonstrating the impact of early attachment experience upon children's brain development. Research by Allan Schore (2001), Dan Siegel (2007), Peter Fonagy et al (2002) and others has demonstrated how vulnerable infants' and children's brain development is to their early parenting experience, and the subsequent impact of this experience on their later development and growth.

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7   See Street and Davies, 2002; Vostanis, 2010; Golding, 2010
8   See Dozier, 2003; Schofield and Beek, 2006; Golding, 2008; Hughes, 2011

Understanding the link between children's attachment experiences and trauma provides a rich vein of theory that can inform service development and delivery. When abuse and neglect within the family are experienced early in life, this has a traumatising effect on the child's development (van der Kolk, 2005). The pervasive influence of such trauma on a child's development has been well documented (see Perry, 2002and 2006; Gerhardt, 2004; Cook et al, 2005).

4.4.2 The importance of multi-agency working

Recent public health guidance (SCIE/NICE, 2010) and the subsequent NICE *quality standards* (NICE, 2013) highlight the importance of partnership working, beginning at a strategic and commissioning level and underpinned by a robust audit and inspection framework. The guidance and quality standards promote multi–agency working as a way of ensuring professional collaboration and the appropriate sharing of information. They suggest that dedicated services and practitioners for children in care are central to promoting their mental health and emotional wellbeing, with a focus on good health assessment and capacity to meet the children's needs through early intervention, flexible and accessible services and tailored interventions. Both documents also highlight the need to be sensitive to the cultural, religious and diversity needs of the children, recognising the range of backgrounds the children stem from and the disproportionate levels of physical and learning disabilities that may exist within this population. Particular attention is paid to the wishes, views and knowledge of children and young people, modelling the importance of such engagement to inform service development.

Practitioners have been influential in the development of innovative services for children in care that are in line with the public health guidance cited above (eg Street and Davies, 2002; Anderson et al, 2004; Callaghan et al, 2004; Richards et al, 2006; Golding, 2010; Tarren-Sweeney, 2010b) and research has shown that when services are developed within a multi-agency context, mental health provision becomes part of a much more comprehensive, joined-up service that attends to mental health as part of the holistic needs of the children, including general health, education and socialisation. Richards et al (2006) demonstrates that such multi–agency working creates a climate within which creative solutions can be found to the complex needs being presented. In addition, joint commissioning and closer working together between agencies facilitates shared understanding between

practitioners; appropriate referrals, and closer working within and between agencies (Golding, 2010).

Despite this evidence many mental health services continue to provide therapeutic support to looked after children as part of the general child and adolescent mental health provision, rather than providing specialist services with the resources to support this level of multi-agency practice. In fact, with tight budgets and cost savings having to be made, some dedicated multi-agency services for looked after children are ending and mental health provision is being returned to the general mental health services: a move away from what the evidence suggests is most helpful for looked after children.

4.4.3 Multi-disciplinary mental health assessments at entry to care

An effective response to the mental health and emotional needs of looked after children relies on good quality assessment on entry to care. However, there is little evidence of a systematic approach to detailed mental health assessment and effective identification of support needs in the current care system (Chambers et al 2010).

Timely assessment that joins up health and care planning can contribute to improved care planning and ensures appropriate referral when necessary (Anderson et al, 2004; Blower et al, 2004). However, supporting mental health requires systematic assessment by appropriately trained practitioners, which then informs intervention plans (eg Tarren-Sweeney, 2010b). In addition to improved care planning, effective assessment can help children get access to services in a timely manner, and give carers and parents a better understanding of the child and their relationship (Milburn et al, 2008). However, studies have also identified that recommendations following health assessment have a low implementation rate (eg Minnis et al, 2006; Wood, 2008). Monitoring and review is therefore also a critical part of the assessment process.

The *Healthy Care* Programme developed by the National Children's Bureau provides a good example of an intervention that seeks to promote timely universal and comprehensive health assessment, including physical health, developmental progress and mental health (Chambers and Miller, 2006). Such a programme requires standardised measures and specialised screening tools suitable for this population of children, and takes into account relationships and

an understanding of wider family, school and community systems. (Chambers et al, 2010).

> Professionals involved with Paul requested a diagnosis of ADHD. More comprehensive assessment revealed that many of his behaviours were emotionally driven, settling when stress reduced. However Paul also demonstrated a neuro-developmental fragility, probably a combination of early experience and genetics. Paul's emotional regulation was immature, with impulsivity and difficulties in delaying gratification. Intervention will need to take into account attachment and neuro-developmental difficulties, with fluctuations in functioning dependent on context and level of stress.

4.4.4 Importance of dedicated mental health services for looked after children

The importance of dedicated mental health services has been highlighted in public health guidance and quality standards (NICE/SCIE, 2010; NICE, 2013), reflecting an acknowledgement that generic Child and Adolescent Mental Health Services (CAMHS) can quickly get overwhelmed by demand, complexity and the long-term nature of the difficulties that looked after children can present.

Looked after children frequently face multiple barriers to accessing CAMHS services, including unstable placements, long waiting lists and eligibility thresholds that often require a diagnosable mental health disorder (Minnis and Del Priore, 2001; DH, 2008). Designated services for looked after children can overcome these challenges, by providing specialist support that is targeted at the unique needs of this population but is still embedded within core and universal services (Vostanis, 2007; Golding, 2010).

The CAMHS tiered approach to multi-disciplinary provision provides a useful model for the commissioning and development of specialist services that provide dedicated support and interventions for children in care. A number of authors have considered ways in which this model of service provision can be developed further for looked after children. For example, if psychiatric, psychological, social and child care perspectives are combined within multi-agency teams, this allows for a range of consultative, advisory and therapeutic

interventions focused on the child, their carers and the broader care system within which they are living (Street and Davies, 2002; Tarren-Sweeney, 2010b).

Tarren-Sweeney (2010b) argues that an effective model of service delivery for looked after children would require a specialised and highly trained workforce that can bring an increased level of expertise to the assessment and formulation of attachment and trauma-related difficulties. Good care planning needs to ensure that appropriate services are in place to meet the needs of child and foster family, while practitioners must remain mindful of the pre- and post-care family experience of the children (ibid).

If such a dedicated mental health service were to be made available universally, clinicians would be able to play an advocacy role to ensure that looked after children's needs were adequately met. It would also allow for more comprehensive assessment, preventative and long-term engagement with children and carers, and good partnership working between agencies. As has been argued earlier in this chapter, it is essential that specialist services for looked after children consult with children and carers to ensure they are acceptable to service users. They also need to work closely with carers to support them in their role of providing looked after children with a normalised and supportive upbringing.

4.5 The use of indirect interventions to meet the therapeutic and support needs of children in care

Mental health services for looked after children are often associated with the provision of therapy. While some children living in care will benefit from therapy, this is not always where services are at their most effective. As highlighted above, engagement with therapy is most easily achieved when children have some sense of safety in the world and trust in adults (Golding et al, 2006). However, mental health services can also provide support and advice indirectly through carers and other professionals involved with the child; these interventions are not dependent on the child being ready to engage with services.

Research has identified children's challenging behaviour and foster carers' lack of confidence in managing this behaviour as the two most common causes of placements being disrupted (Sinclair et al, 2005).

It is therefore vital that we improve the support, advice and training provided to carers and other professionals to ensure that they can support the children in their care and reduce unnecessary placement breakdown. Consultation with carers, advice, training and support interventions all contribute to providing therapeutic environments for children at home and school. Such an approach can change the focus from a narrow emphasis on mental illness and symptom reduction to one that helps children to build resilience and experience positive emotional wellbeing (eg Street and Davies, 2002; Fisher et al, 2006).

Alongside the practical support and mentoring that social care teams provide to carers there are three areas of support that would benefit from the contributions of appropriately trained mental health practitioners:

1) parenting advice and support for carers

2) support for the emotional health of carers

3) increased understanding of children's emotional needs in school.

4.5.1 Parenting advice and support for carers

Successful parenting rests on the capacity of parents or carers to be attuned and responsive to their children. However this task is more demanding for carers of children who have been exposed to abuse or neglect, because of the developmental and behavioural impact of these experiences and the resulting separation and loss that the children bring with them into placement (Golding, 2007). To address this, foster carers, adopters and residential workers need a good theoretical understanding of attachment development and of the impact of trauma, separation and loss. They also need to understand how to translate this theory into practice so that they can meet the diverse needs of the children (see, for example, Schofield and Beek, 2006; Golding, 2008). Achieving this will help them understand the challenges that the children present and increase the therapeutic quality of the parenting that they provide.

Macdonald et al (2012) refer to the case of Northern Ireland, where residential social workers were trained in models that increase their understanding of the impact of trauma and attachment experience, thereby helping them to provide a more therapeutic approach to child care. This moved them away from an approach of containing behaviour to one aimed at improving self-regulation, sense of identity, self-esteem and competence in the young people. Staff

reported that the enhanced understanding, 'depersonalisation' of challenging behaviours and more consistent and appropriate responses lead to reduced conflict and confrontation. The young people reported improved and more relaxed atmospheres and less emphasis on punishments.

In England a randomised controlled trial of the *Fostering Changes* training programme for foster carers (developed by experts at the Maudsley Hospital and King's College London) found that the behaviour of children whose carers had received the training experienced statistically significant improvements. Foster families that received the intervention also experienced a significant reduction in the severity of carer-defined problems and improvements in attachment between the foster carer and the child (Briskman et al, 2012). The *Nurturing Attachments* programme, developed by the author of this chapter, has also produced some encouraging outcomes, including statistically significant changes in comparison to a waiting list group. Carers report increased understanding, competence and confidence in their parenting abilities as well as changes in children's behaviours after receiving the intervention (Golding, 2013).

A study by Dozier (2003) highlighted the need of carers to be available and responsive – imperative for all parents – but also to be gently challenging in helping the child revise beliefs and assumptions developed as a legacy of their early experience. For example 'parents can't keep me safe', 'I am bad and will not be loved' or 'parents always leave you'. This requires carers to understand the way children can miscue them, expressing and hiding their needs based on their expectations of the carers (ibid). Carers will need advice and support to help them develop enhanced parenting skills if they are to meet the behavioural, developmental and therapeutic needs of the children (see Figure 1).

Adoptive parents and carers with residence and special guardianship orders also need a high level of parenting advice and support in order to reduce the rate of family breakdown, particularly during adolescence. The *Draft Children and Families Bill* (DfE, 2013) recognises the importance of support in the proposal to require local authorities to give adoptive parents access to personal budgets so that they can purchase specialist parenting support. Whether this is the best way to ensure these families have the type and amount of the support they need remains open for discussion. The parents of children who return home from care also need access to similar types of support.

Figure 1 Parenting needs of children who have experienced early abuse and neglect.

Recovery from
Trauma and Loss

Therapeutic Parenting
(Relationship-focused)

Behavioural

Authoritative Parenting
(Autonomy/Boundaries)

Developmental
Special Needs Parenting
(Meet developmental needs
matched to level of maturity)
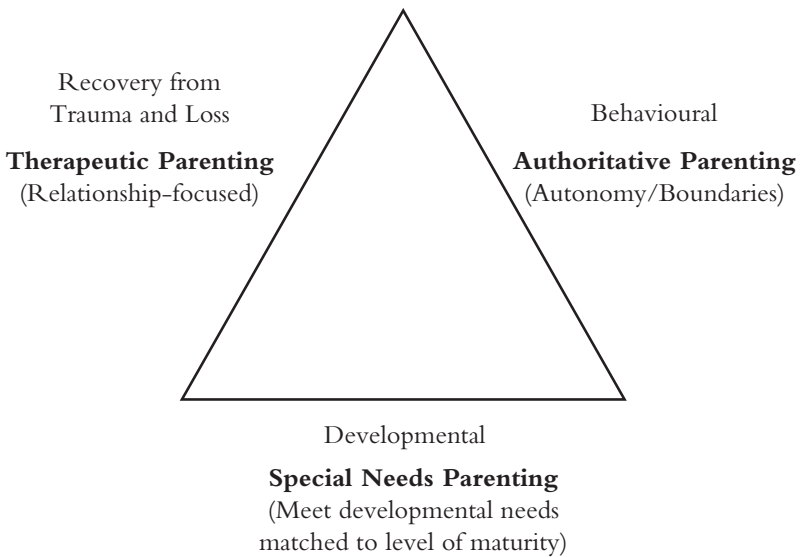
As his anxiety increased Paul became more hyperactive, risk-taking, chatty, loud and attention-seeking in order to ensure that adults were available to him. Paul struggled to reflect on experience. To some extent he used his loud, boisterous behaviour and his hyperactivity in order not to think.

Alison's early traumatic experience has left her with quite complex emotional needs. When levels of stress increased she regressed developmentally and became more emotionally withdrawn, to the point of appearing 'shut down' on occasions. At times of less stress Alison did build some trust in adults. However, these developing attachments remained insecure, and Alison retained self-reliant strategies to increase feelings of safety. For example she would approach strangers with coy, endearing behaviours rather than seek reassurance from her familiar carers.

In response, Paul and Alison's foster carers were helped to understand how both children experienced difficulties in attachment. They were helped to notice how the children lacked a foundation of trust in the foster carers and therefore adapted their behaviour to achieve some feelings of safety.

4.5.2 Supporting the emotional health of carers and fostering families

An effective care system must also respond to the problem that parenting children in care is highly stressful. Chambers et al (2010) note the high levels of stress carers report during interviews, although this can be under-reported in questionnaire completion. It is therefore important that foster carers receive support to manage their own stress and reactions to the children in their care. Residential carers may have some respite at the end of the shift, but on the other hand they are also caring for some of the most emotionally needy children in the care system. This can be expressed through highly challenging and sometimes risky behaviour. The emotional support needs of residential carers are therefore likely to be as high.

Equally, it is important to consider the needs of all family members within foster families. Bringing a child with complex needs into a family can impact on existing family dynamics, leading to additional stress for all family members. The foster parents' biological children can be especially vulnerable emotionally as they can witness a range of behaviours often directed at their own parents. They may also be chosen as the focus for some uncomfortable disclosures or behaviours from the foster child. While the biological children may demonstrate care and sensitivity towards the foster child, they can also struggle to share their home and their parents with the other children (Watson and Jones, 2002) (see also Chapter 5 in this volume by Christine Barter on peer violence). Carers' children can be very positive about fostering, reporting companionship and developing maturity as positive outcomes for themselves. However, the impact of the foster child's behaviour; loss of privacy, and loss of relationship when children move on can make fostering a stressful experience for some foster carers' children (Part, 1993; Pugh, 1996; Spears and Cross, 2003).

Support for the emotional needs of carers and their families can be achieved in a range of ways:

1) Provide consultation, advice and training

Carers need access to consultation, advice and training to increase understanding of the experience of the child in care (Golding, 2003 and 2004; Chambers et al, 2010; Vostanis, 2010). Research that explored a consultation model for carers concluded that as their understanding of the level of difficulty presented by the child

increased, they experienced reduced feelings of failure or pessimism. Increased confidence and reduced stress emerges when difficulties are better understood in relation to the child's previous experience (Golding, 2004).

2) Provide parenting support interventions

These can have a dual role, providing parenting ideas while also helping the carers reflect on the impact the child is having upon them. Increasing capacity for reflection allows the carers to remain regulated and to better manage the challenges that the child presents.

It is helpful when some support is separate from the monitoring role of fostering social workers and residential managers. Providing emotional support relies on trust and an open and honest relationship and it can be more difficult for carers to share the impact the child is having upon them when they know that the person they are disclosing to will also be monitoring their competence. A mental health practitioner brings both expertise and independence.

Parent training and support interventions need to be central to services for children in care. Behaviour management is an important part of this support. For example, behaviour management is central to Treatment Foster Care (MTFCE national implementation team, 2010), an approach widely rolled out within the UK. There is an argument, however, that parenting advice and support needs a broader focus, with attachment relationships of central importance (Schofield and Beek, 2006; Golding, 2007; Golding, 2008).

3) Provide trauma-informed emotional support

Trauma can impact at a neurobiological level, leading to changes in the chemistry of the brain – reduction in oxytocin and dopamine levels for example – which directly impact on the capacity to care. This can lead to a state of blocked care within which capacity for parenting is reduced (Hughes and Baylin, 2012). It is therefore important that carers are provided with help to understand the impact of secondary trauma (Cairns, 2002) and supportive relationships to 'unblock' the capacity to care (Hughes and Baylin, 2012).

4) Provide group support for the birth children within fostering families

As described above, foster carers' children are an important part of fostering families. The experience of fostering can provide significant benefits for these children but this experience can also be highly

stressful as the children are exposed to challenging behaviour; disclosures by the foster child and witnessing the impact of the foster child(ren) on their parents. The value of group support for foster carers' children has been recognised, in that it provides the children with opportunities to meet other children with similar experiences and to receive support for the emotional impact of fostering (eg Pugh, 1996; Spears and Cross, 2003). However, this remains an under-researched aspect of foster care and actual provision of this support is often lacking.

4.5.3 Increased understanding of children's emotional needs in school

It is clear that the influence of early trauma extends beyond the home into school. It impacts on children's feelings of safety, which affects their ability to learn, develop healthy autonomy and engage in successful relationships with adults and peers. School offers children the opportunity for healthy relationships and emotional support, which promotes good mental health.

The emotional needs of the children within schools should therefore be as much part of the focus of educators as their learning needs. Addressing the two goes hand in hand: when emotional needs are supported the child's learning needs are more easily met (see Geddes, 2006; Bombèr, 2007 and 2011; Golding et al, 2012). Perry (2006) highlights the importance of children attending a school environment that supports therapeutic interventions. This needs to provide appropriate regulatory support, positive interactions and repeated and frequent restorative relationships and experiences.

Education support combined with health and social care practices can provide a powerful trio of support to help children recover from poor early experience and to benefit from their care experience. Education professionals are an important part of multi-agency support for the children and need time and a forum where they can reflect with health and social care professionals, ensuring that shared understanding and ways of supporting the children are in place (see eg Golding, 2004).

Paul and Alison received indirect support when they were referred to the local specialist service for looked after children because of concerns raised by the foster carers. A clinical psychologist, therapeutic social worker and specialist teacher provided consultation to the foster carers and network. This included staff from Paul's school and Alison's nursery, the children's social worker and the fostering social worker.

This consultation provided advice reflecting the complex attachment and neurodevelopmental difficulties that Paul was displaying. Foster carers were advised to provide Paul with a highly structured and predictable environment, offering opportunities for relationship development and developing his capacity for emotional regulation through careful co-regulation of his escalating arousal. School staff were encouraged to offer similar structure and predictability with opportunities to develop a close one-to-one relationship with a key person who could draw on a range of calming strategies when needed.

Foster carers were encouraged to continue helping Alison to connect with them emotionally, offering nurture even when she was signalling a need to be self-reliant. When Alison sought comfort from strangers she needed to be gently redirected back to the foster carers. The nursery staff became more aware of Alison's emotional needs, recognising her increased need for support even though she appeared to be coping. They were reassured that as Alison became more secure her ability to learn and develop cognitively would increase.

It was agreed that the children were likely to find the transition to adoption a difficult one. They were both likely to regress and become more challenging during this time. They would need a prolonged period of stability and responsive care in order to feel safe with their adopting parents.

Following the consultation the team continued to offer parenting and education support to the foster carers and school/nursery staff. The foster carers were supported in their preparation of the children for adoption, and the adopting family were offered some transitional support.

4.6 Providing direct therapeutic and resilience-building interventions for children and young people

As discussed earlier in this chapter, children exposed to abuse, neglect, family violence and/or loss of caregiver typically meet the diagnostic criteria for a range of difficulties (Cook et al, 2005). We need to think further about how best to meet the needs of these children.

Traditional cognitive and behavioural interventions tailored to respond to these diagnosable difficulties can be ineffective for traumatised children as they do not take into account the different physiology of the traumatised brain (Howe, 2005). Children under stress experience an increase in emotional arousal; they become emotionally overwhelmed and their thought processes are less effective. When children are less stressed they are calmer and therefore more open to talking and thinking. Perry (2006) therefore places importance on 'bottom-up' therapeutic interventions that take into account where the child is on the arousal continuum, providing regulatory support to meet high arousal and more reflective support once emotional regulation is improved.

While children may need mental health support in order to recover from trauma and loss, the focus of this support needs to be imaginative and not focused too narrowly on symptom reduction, but also on skill and resilience development. A focus on leisure, sports and the arts can be as important as any specific therapy provision (Perry, 2009).

Based on this, there are specific models that have been developed to help children who are developmentally traumatised. These include:

- **The ARC model**
  The Attachment, self-Regulation and Competency model focuses on relationships to build resilience by supporting the child to build skills, reduce distress and improve capacity for regulation (Blaustein and Kinniburgh, 2007).

- **The ITCT-A model**
  The Integrative Treatment of Complex Trauma for Adolescents is based on the self-trauma model. This is a multi-modal, comprehensive intervention model that takes into account a range of psychological, social, and cultural issues. A range of interventions are selected based on individual assessment of current

problems and functioning. In this way treatment is linked to ongoing assessment (Briere, 2002; Briere and Lanktree, 2013).

- **The neurosequential model**
  This model focuses on the importance of understanding the child's history and current functioning, so that specific therapeutic techniques are matched to the developmental stage of the child and the impact of brain functioning on the problems being displayed (Perry, 2006).

  Children need help to benefit from safe and healthy parenting relationships, and direct work with children should be complemented by parent-and-child and family work. This has been the focus of two models that aim to help children feel safe with and build trust in current parents while helping them recover from earlier trauma:

- **Attachment and Bio-behavioural Catch-up programme**
  This well-researched programme has been designed with the needs of looked after infants and toddlers in mind. It targets three issues demonstrated by research to be critical in the development of young children in foster care. These are helping the foster carers to re-interpret behavioural signals that appear to push them away when the children are experiencing a need for comfort; providing nurture at times when this does not come naturally, and providing an environment within which the children develop capacity for regulation (Dozier, 2003).

- **DDP**
  For older children DDP (Dyadic Developmental Practice) is an increasingly recognised, although still under-researched, therapeutic approach tailored for looked after and adopted children. This model helps family members to develop healthy patterns of relating and communicating which help them all feel safe and connected. This is achieved by helping parents with day-to-day parenting based on principles of PACE (playfulness, acceptance, curiosity and empathy), as well as through therapeutic sessions. (Hughes, 2011). A programme of research into the effectiveness of DDP is underway to ensure a robust evidence base is provided alongside the already robust theoretical basis for this approach.

The care system should aim to provide looked after children and their carers with a range of interventions from health, education,

social care, and community services. It is clear that one size does not fit all and we urgently need research on the efficacy of attachment- and trauma-informed interventions in meeting the specific needs of looked after children and their families.

4.7 Policy and practice recommendations for meeting the therapeutic and support needs of children living in care in the United Kingdom

We have seen that children in care in the UK frequently display complex mental health needs that compromise their emotional wellbeing. A combination of pre- and post-care experiences leaves these young people vulnerable to a range of trauma, attachment, education and developmental difficulties. Their needs are not easily met by traditional mental health services that have a focus on throughput, short-term interventions, and treating diagnosable illnesses.

The policy landscape relating to looked after children's mental health has developed only recently, with a range of policies and guidance informing the care of looked after children. Two of these are particularly important in setting out how services should support their mental health and emotional wellbeing: *Statutory guidance on promoting the health and wellbeing of looked after children* (DCSF and DH, 2009) and *Recommendations on looked after children: promoting the quality of life* […] (SCIE/NICE, 2010). These have informed new quality standards for the social care of looked after children and young people in England (NICE, 2013).

However, further improvement is needed. The following recommendations reflect progress to date but draw on the evidence presented in this chapter to set out how we might address continuing weaknesses and gaps in services to meet the therapeutic and support needs of children in care.

Care planning informed by considerations of early intervention, stability and emotional wellbeing

The quality of care planning is a critical factor in enabling children in care to access and benefit from mental health services. Delay in a child's entry to care can increase the child's exposure to a damaging

family environment, while frequent placement moves reduce access to services (Beck, 2006; Vostanis, 2007). This is in contrast to stable placements, which are associated with children receiving continuity of support, increased resilience and improved health and wellbeing (Bellamy et al, 2010; Simmonds, 2010). As observed above, placement breakdown alone can account for deteriorations in children's mental health (Tarren-Sweeney, 2010b). Good quality care planning therefore needs to be informed by multi-agency decisions, led by a social worker, with a focus on the quality of relationship between the child and carer as well as on the stability of education (Minnis et al, 2010; SCIE/NICE, 2010).

> For Paul and Alison, decisions were made after a year in foster care, when the children were freed for adoption. They remained in the same foster placement while a family were identified and the foster carers were fully involved in helping the children make the move to their adoptive home.

Timely assessment

Local authority looked after children teams should ensure that children and young people's emotional and mental health needs are assessed by a trained professional at entry to care. This assessment should inform care planning. If emotional or mental health needs are identified, social services should work in partnership with carers, health services and schools to ensure the child or young person has access to appropriate support services. This support should be provided early on in their care journey to prevent the onset or worsening of mental health problems.

Dedicated mental health services for looked after children

As observed earlier, looked after children frequently experience multiple barriers to accessing mental health support. Health and Wellbeing Boards should ensure that looked after children in their local authority area have access to dedicated mental health services with specially trained staff. These services should form part of a multi-agency approach that involves mental health professionals working closely with carers, social workers and schools to combine mental health support with good care planning and classroom support. Support should be provided early to prevent problems developing.

A broad focus on building resilience

Dedicated services for looked after children should have a broad focus on building resilience rather than a narrow focus on symptom reduction. Such a resilience-building model focuses on the environment around the child, strengthening parenting and school support as well as identifying the child's strengths and competencies that can be built upon.

Interventions should take a holistic approach so that therapeutic work with the child is only part of a wide range of work tailored to the needs of the child, family, school and professional network (see Figure 2). Parenting support for carers and competence-building through arts, leisure and support may be as important as the provision of specialised therapies, depending on the needs of the child.

Figure 2. Meeting therapeutic needs within therapeutic and support services for children living in care

Systemic service working
with child, family, school
and community

Parenting support
interventions at group and
individual level

Dyadic work with
carers and children

Direct work with
children, supported
by carers
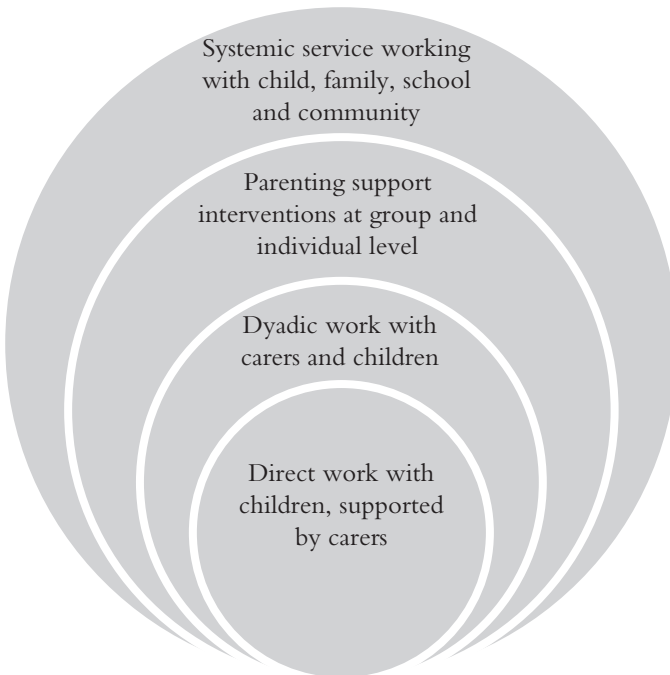
Access to mental health support regardless of placement stability

Local commissioners and service providers should ensure that eligibility for mental health support is not restricted to looked after children who are in stable placements. Instability can make it hard for children to benefit from direct therapeutic work because of a lack of safety or trust in relationships with adults, but this does not preclude other support interventions. Mental health professionals can very usefully input into care planning, parenting and school support and multi-agency discussions about the child, thus contributing to securing placement stability.

Involve children and carers in service development

Commissioners and service providers should ensure that the relevant mental health services are informed by the multiple and culturally diverse viewpoints of looked after children and carers alongside those of practitioners, bringing their different perspectives and combined wisdom to service design. Children in Care Councils and carer support groups provide opportunities to ensure the involvement of children and carers. Multi-agency planning and service development must find a balance in meeting different needs, allowing all voices to be heard.

We end as we began this chapter, thinking about Paul and Alison. They made a successful transition to adoption. Their adoptive parents continued to need ongoing support to maintain their understanding of these complex children and their parenting needs as they progressed developmentally. They also needed support to manage the impact on themselves of caring for two developmentally traumatised children. The children's special needs were recognised in school and additional support was provided for them as needed. While their teenage years were particularly challenging, the children's security with their adoptive parents was sufficient for the parents to hang on through this 'roller-coaster' time. The resilience that the children developed through experience of a high-quality and well-supported foster placement is likely to have contributed to this success.

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CHAPTER 5

Peer Violence in Foster and Residential Care

Contents

CHAPTER 5

Peer Violence in Foster and Residential Care

By Christine Barter

5.1 Introduction

Children in care have consistently raised the issue of peer violence and bullying as a significant problem affecting their lives (Paterson et al, 2003, Morgan 2008, Kendrick 2011). Research findings testify to the detrimental impact that peer violence can have on the wellbeing of looked after children as well as the biological children of foster carers. It is related to poor outcomes, especially disrupted placements, leading to instability and discontinuity of care. Consequently, as this chapter will show, negative peer interactions, particularly those involving high-level conflict and violence, need to be viewed as a central consideration in policy and practice developments for looked after children. Residential and family placements have a range of organisational, structural and relationship dynamics, which need separate consideration. Nevertheless, what is clear is that across all settings, peer violence is associated with negative welfare repercussions for looked after children.

Despite this, peer violence, including physical, sexual, emotional and indirect (such as damaging personal property) forms of violence (Barter et al, 2004), remains an unaddressed issue. This chapter outlines what is known about the scale and nature of peer violence in residential and fostering placements and its underlying causes. It sets out how it must be addressed through improvements to support for children and young people, foster carers and residential staff, and by ensuring that the potential for peer violence is recognised as a central issue in care planning and placement decisions.

5.2 The scale and nature of peer violence

What do we know about the scale and nature of peer violence in residential and foster care placements? Looking initially at residential care, a range of studies have shown that peer violence, which includes bullying and emotional abuse as well as physical violence, constitutes a significant issue for children's welfare in residential settings: one early study on residential care found that one in six children had been bullied or ill-treated by other children (Triseliotis et al, 1995). Farmer and Pollock (1998) established that bullying was a serious problem in children's homes, often occurring undetected over a prolonged period of time. Similarly, difficulties in relationships with peers emerged as a common problem in secure units (O'Neill 2008).

Perhaps the most influential work in this area has been undertaken by Sinclair and Gibbs (1998) and Barter et al (2004). Sinclair and Gibbs (1998) reported that just under half of young people in 48 children's homes reported someone had 'attempted to bully' them during their residential placement. Younger children, especially those under 12 years old, were particularly vulnerable to peer violence. Moreover, nearly a third of girls – though only a minority of boys – said that since being in residential care another young person had tried to take advantage of them sexually. Other studies report similar findings, showing that sexual violence, especially sexual violence towards girls, is of serious concern (Farmer and Pollock, 1998; Green and Masson, 2002; Barter et al, 2004; Green, 2005; O'Neill, 2008). Previous victimisation is associated with increased levels of violence while in care: Gibbs and Sinclair (2000) found that residents who experienced bullying before entering care were also more likely to be bullied while in placement.

Barter et al (2004) have, to date, undertaken the only UK study to focus exclusively on peer violence within residential children's homes. This qualitative study provides worrying findings. Three-quarters of children had experienced physical violence from another peer in at least one of their residential placements. In many of these incidents other residents were involved either as active participants or as passive supports. Half of the young people suffered non-contact forms of violence, such as property damage, invasion of privacy, threats of physical injury and coercive control mechanisms. Girls perceived property damage and invasion of privacy to be more upsetting than boys did. Nearly all reported verbal abuse, and half stated that it was severe. Boys were slightly more likely to suffer physical forms

of abuse; girls non–contact forms of violence. A significant number of victims also used violence against others. International research by Silverstein et al (2004) and Freundlich et al (2007) on residential provision endorses these findings, uncovering a high frequency of peer-on-peer physical violence, threats and intimidation.

The available research on foster care indicates that peer violence also constitutes a worrying problem for both foster children and carers' own biological children. Early research showed that a significant minority of children in fostering households reported violence or abuse from another child (Fletcher, 1993; Hobbs et al, 1999; Farmer et al, 2004). One study, for example, found that a fifth of referrals due to abuse in foster care involved another child as the instigator (Hobbs et al, 1999). Half of these referrals alleged that the instigators were other foster children; a third were siblings, and the remainder the biological children of the foster family or other unrelated children. Farmer et al (2004) found that a quarter of fostered adolescents had been physically aggressive to other children or adults during the placement, and a minority had put other children at risk due to their sexual behaviour. Others have highlighted that sexual violence from fostered children is a particular concern (Elgar and Head, 1997; Farmer and Pollock, 1998) and the issue of peer sexual violence in foster care has been identified as a major problem for children's welfare in international research (Rosenthal et al, 1991; Benedict et al, 1996).

The impact of peer violence in care is not restricted to looked after children. Research highlights incidences of peer violence against carers' own biological children (Part, 1993; Quinton et al, 1998; Watson and Jones, 2002). A study of 116 biological children of foster carers identified difficulties, including having property stolen or damaged, bullying and physical assaults by foster children (Watson and Jones, 2002). This resonates with Karim's (2003) survey of 102 Scottish children of foster carers:

> "… 38 per cent answered that 'aggression' had become part of their lives… Many have had to deal with children coming from violent homes. Others have suffered directly in the form of bullying from those children staying with them."

> (ibid, p.45)

International research also provides evidence on the potential impact of peer violence for biological children of foster carers

(Linares, 2006). A large-scale multi-method Swedish study of adolescents whose parents fostered identified a range of issues, with 'peer conflicts' causing major difficulties (Höjer, 2007). Examples of 'conflicts' included physical and verbal aggression, although no detailed definitions were provided. Almost a quarter of children in the sample stated that they often found themselves in conflict with foster children. These conflicts were described as 'abnormal' by two-fifths of children, but most excused the behaviour of the foster children on the grounds of their previous difficult experiences.

The research evidence provides some rather disconcerting insights into the extent of peer violence in fostering placements. However, the absence of research in this area explicitly focused on the UK means that the precise extent and nature of peer violence in fostering households remains elusive. More research on peer violence in residential care has been undertaken but, given the variation in the nature of provision, we cannot simply transfer learning from one setting to another.

Although no research has been undertaken to systematically document the incidence and dynamics of peer violence in foster care, the above evidence does nevertheless show that it is a major area of safeguarding concern. Studies have also considered the incidence of peer violence for looked after children outside their placement. Findings show that children in foster and residential care are more likely to experience peer violence and bullying at school or college compared to children in the general population (Morgan, 2008). One exploratory UK study has indicated that looked after young people, especially girls, were more likely to experience physical, sexual and emotional forms of violence in their intimate relationships, and that their experiences of intimate violence were more frequent and severe compared to those who are not looked after (Wood et al, 2011). Consequently, when addressing peer violence we need to recognise that violence outside placement also requires attention. Overall, the evidence suggests that peer violence constitutes a substantial problem for children in residential and foster care, with a significant impact on their wellbeing and care experiences.

5.3 The impact of peer violence

5.3.1 Children's wellbeing

Research has consistently shown that experiences of peer violence are associated with physical, sexual and psychological harm for children both in the general population (Radford et al, 2011) and for those in care (see Barter and Berridge, 2011). Indeed, for children who have been placed in foster and residential care because of previous experiences of violence and abuse, this re-victimisation by their peers often has a profound negative psychological impact (Sinclair and Gibbs, 1998). A number of studies on residential and foster care provide evidence on the negative impact of peer violence for children's wellbeing (Sinclair and Gibbs, 1998; Silverstein et al, 2004; Barter et al, 2004). Sinclair and Gibbs (1998) looked at children's evaluations of happiness, and concluded that although attempts at bullying and sexual harassment *before* placement were significantly associated with unhappiness, attempts *in* placement were *more* strongly linked to children's unhappiness. Barter et al (2004) similarly found that peer violence impacted negatively on children's placement experiences and self-esteem. Non-physical forms of violence were viewed by young people as being as damaging as physical forms.

It is worth noting that a residential context may provide greater scope for peer violence to occur throughout all areas of young people's lives – invasion of personal space; young people's previous experiences of violence and abuse; detachment from external support networks (especially if placed out of area); cultures of non-disclosure ('grassing'), and attacks at night: all may increase the impact of violence (Barter et al 2004).

5.3.2 Disrupted placements

One area where the impact of peer violence has been clearly articulated is its relationship to placement breakdown. Quinton et al (1998) looked at disrupted placements and found that peer conflict, including aggression between the incoming child and the established siblings was associated with increased risk of placement breakdown. More recent UK studies demonstrate that the problem has not diminished. Research on the placements of adolescents with behavioural or emotional difficulties (Lipscombe et al, 2004) showed that violent and aggressive behaviour that had a negative physical

or emotional impact on other children in the foster home was significantly correlated to increased placement disruptions.

Karim (2003) found that fighting with foster siblings was one of the main reasons for an unplanned placement change in a Scottish study. A study on multiple placements in foster care (Ingley and Earley, 2008) identified that peer conflict was responsible for half of unplanned placement moves. Again, conflict between a new foster child and an existing child was shown to be particularly problematic. Case file analysis revealed that conflicts often concerned aggressive behaviour, bullying, physical violence, anger and aggressive jealously. In the vast majority of cases the *established* foster child's placement broke down. This was despite the fact that prior to the new child's arrival the placement had been rated by carers as successful. The authors conclude that introducing a new child into an established placement without appropriate support can jeopardise the tentative, fragile bonds developing between the foster carers and an established child. Ultimately, the cycle is repeated when the 'established' child is moved to another placement where other foster children are present.

5.3.3 Biological children of foster carers

One of the distinguishing aspects of foster care, compared to residential settings, is the presence of carers' own biological children. Although research on the impact of fostering on this group remains relatively scarce, several findings show that foster children's behavioural problems, including violence, can present a substantial risk to the wellbeing of carers' own biological children (Part, 1993; Quinton et al, 1998; Watson and Jones, 2002; Karim, 2003). For example, Part (1993) and Quinton et al (1998) found that carers' birth children could be adversely affected by the placed child's misbehaviour, with bullying or fighting being reported by many in the sample. Despite these difficulties, most stated they enjoyed fostering, a finding that is echoed by Sinclair et al (2005).

Conversely, carers' biological children can also pose a threat to fostered children's happiness. Morris and Wheatley (1994) found that foster carers' own children were the most common perpetrators of sexual abuse in foster care (11 out of 24 cases). They continued:

"A significant factor seemed to be the age-difference between the predominantly male abusers and the foster child; the abusers were commonly two or three years older."

(ibid, p.38)

It is clear that peer violence can have a significant impact on the immediate and longer-term wellbeing of children in residential care and those in foster placements. This impact can also extend to the sons and daughters (and grandchildren) of foster carers. In addition, the accumulative research clearly shows that peer violence is strongly associated with placement disruptions, which in turn are widely recognised as constituting a threat to children's short- and long-term welfare and ability to thrive.

5.4 Causes of peer violence

The causes of peer violence in residential and fostering placements can be viewed in relation to two associated factors: children's previous negative experiences prior to entry into care and the failure of the care system to adequately respond to a child's behaviour.

5.4.1 Children's previous experiences

The vast majority of children enter care because of previous experiences of violence, abuse and neglect. Often these children display behavioural problems, including violence, as well as attachment difficulties associated with their previous negative life experiences (Baker et al 2008). Consequently, some children in care will struggle to develop positive and supportive peer relationships (Price and Brew 1999; Barter and Berridge 2011).

These experiences have an impact on children's behaviour in care. Higher levels of problematic sexualised behaviour are known to be related to greater numbers of previous traumatic events such as knowing someone who has died, being in a serious accident or witnessing domestic violence (Baker et al 2008). Research that focused on the sexual abuse of children (Benedict et al, 1996; Farmer and Pollock, 1998) revealed that the majority of children who had abused others before and/or during a placement had been sexually abused themselves. Farmer and Pollock (1998) found that of 22 children who had sexually abused children before entering care, three-quarters went on to sexually abuse another child while in

placement. Peer violence has also been found to be more frequent during the fostering of adolescents with behaviour and/or emotional difficulties (Lipscombe et al, 2004).

Having recognised that many children who enter care are likely to have varying degrees of behavioural and emotional difficulties, including peer violence, it is imperative that the care system provides effective management and interventions to ensure these problems are addressed. However, research shows that frequently this does not occur. Not only do system deficiencies fail to address the problem, in some instances they actually exacerbate it.

5.4.2 System failures

System failures occur at three stages: pre-placement, during placement, and in relation to the provision of external appropriate therapeutic or behavioural interventions. Foster carers consistently state that prior to agreeing a placement they require accurate information on the child's needs, especially in relation to behavioural difficulties (Farmer et al, 2004; Sinclair et al, 2004; Biehal, 2005). Carers uniformly highlight the importance of ensuring that they are provided with enough information and support to evaluate their ability to meet the child's needs and to prepare the fostering household for any potential difficulties (Triseliotis et al 2000; Farmer et al, 2004; Kirton et al, 2004; Sinclair et al, 2004; Biehal, 2005). However, research indicates that unfortunately, referral information on peer violence is often missing or inadequate, with some carers only becoming aware of a child's history of violence once a placement has started (Farmer and Pollock, 1998; Triseliotis et al, 2000; Sinclair et al, 2004; Rodger et al, 2006). International research has also raised similar concerns about social work practice (CYFS, 2007; Murray et al, 2012). Similarly, residential placements often fail to adequately assess how a child will 'fit' into the current resident group and how their needs will be met within the setting (Barter et al, 2004). However, in practice many residential settings have little control over which children are referred due to an ever increasing pressure on placements, which has been exacerbated by a diminishing residential sector having to cope with the ever increasingly complex and challenging needs of young people (Berridge and Brodie, 1998).

During placement, carers have highlighted a number of related concerns that impact negatively on their ability to care for children with behavioural problems. Most often these are associated with

a perceived lack of emotional support for foster carers from social workers and an absence of professional recognition. A number of national and international studies provide some clarity about the factors that contribute to this negative perception. These include:

- foster carers feeling they are not being treated as a professional member of the team (Triseliotis et al, 2000 Farmer et al, 2004; Kirton et al, 2004; Sinclair et al, 2004; Rodger et al, 2006)

- a lack of shared planning (Farmer et al, 2004; Kirton et al, 2004; Sinclair et al, 2004; Rodger et al, 2006; Murray et al, 2012)

- foster carers not having their views valued or taken seriously (Triseliotis et al, 2000; Farmer et al, 2004)

- social workers being unresponsive and unsupportive to carers' requests for assistance (Triseliotis et al, 2000; Sinclair et al, 2005) – in one study, foster carers stated feeling left on their own to try to deal with children's behaviour and their needs (Sinclair et al, 2004)

- administrative inefficiency (Sinclair et al, 2004; Murray et al 2012).

Interviews with foster carers have also highlighted the challenges they face in caring for children who sexually abuse (Farmer and Pollock, 1998). Carers report being under considerable stress, fearful of allegations against them, and are often given incomplete information about the children's sexual behaviour. Another study of adolescents found that dealing with sexualised behaviour was a particularly difficult area for foster carers, and only half had received specific training (Lipscombe et al, 2004).

A related system failure concerns the lack of support and recognition for carers' own biological children. Lipscombe et al (2004) discovered that foster children who had a negative impact on other children in the placement, and especially carers' biological children, were likely to experience a decrease in carers' warmth and commitment, accompanied by an increase in carers' use of negative sanctions and aggression. Consequently, it may be that a carers' response actually exacerbates the problem and contributes to the placement being seen as untenable. Lipscombe et al (2004) also found that social workers often seemed either unaware or reluctant to recognise the full impact of peer violence on foster carers' biological children, and were therefore unable or unwilling to provide the appropriate advice or support.

Many foster children state they greatly appreciate having a 'normal' everyday life no different from their peers (Andersson, 1999; Sinclair et al, 2001). However, as Höjer (2007) argues, in order to achieve this ordinary life the biological children of foster cares can be exposed to changes that make their lives less "ordinary" (ibid, p.81). Foster carers' biological children are expected to be sympathetic and not retaliate when they are victimised by a foster sibling; in essence they are sometimes expected to place someone else's needs before their own welfare (Martin, 1993). In addition, the biological children of carers often have to negotiate this complex process in the absence of dedicated training or professional support (Watson and Jones, 2002): only a fifth of carers' biological children said that a social worker or placement worker had asked how they felt or had taken their views into account. In comparison, participants who attended a support group for the biological children of foster carers felt that their views were taken seriously in the fostering process (ibid).

Martin (1993) emphasised that the whole family fosters, and professionals must take into account the demands that caring has on the children of foster carers. However, they found little evidence of systematic planning for the involvement of the whole family in preparation for fostering and a lack of ongoing consultation and support for all family members. Walsh and Campbell (2010), in their recent review indicate little has changed: while they identified some evidence of good practice, overall the needs and experiences of the biological children of foster carers remained largely unrecognised.

Some of the above system failures also apply to the residential context, especially lack of professional recognition, missing information and lack of placement planning. Residential childcare has, over the last three decades, largely become perceived as a 'last resort', predominantly for 'difficult' adolescents (see Chapter 3). This makes it difficult to ensure that children 'fit' together and that contrasting needs can be met, as the availability of residential placements has also diminished. Although the number of senior residential staff with professional qualifications has increased and residential staff are now more experienced, a lack of confidence, leadership and negative stereotypes, alongside an absence of therapeutic and theoretical approaches, still persists (Berridge and Brodie, 1998). Inevitably, these institutional and cultural factors all impact on the incidence and management of peer violence within residential settings.

A number of specific residential risk factors have also been identified. Peer group hierarchies represent a central mechanism in which violence can be experienced in residential homes. Parkin and Green (1997) and Barter et al (2004) found the widespread existence of 'top dog' networks in which a minority of children exercised considerable power and influence over others by actual or perceived physical strength and manipulation. These hierarchies enabled young people to bolster their reputations, enhance or diminish those of others, and have influence with the staff. Young people's hierarchies were often viewed by staff as a normal and accepted aspect of peer relationships and consequently they remained unchallenged (Brannan et al, 1993; Barter et al, 2004). This may be especially true for young males whose use of physical violence is often viewed as a natural if unwelcome developmental stage (Dishon et al, 1999; Barter et al, 2004). It is clear that in children's homes where derogatory and offensive language (especially misogynist language) is viewed as routine by staff and young people, levels of violence will often be higher (Barter et al, 2004).

One qualitative study explored the experiences of US and Canadian gay and lesbian adolescents in care (Mallon, 1998) and found that peer violence was an ever-present reality. Almost all of the young people reported verbal harassment from peers; half of them reported physical peer violence. Many reported that when they told someone about the violence they themselves were blamed. Some young people hid their sexual orientation in placement for fear of violence. This is evidently an area requiring further attention.

A range of organisational features associated with peer violence have been documented, including: a physical structure and size of homes that makes supervision of peer interactions difficult; lack of clear placement aims and objectives; 'inappropriate' referrals leading to a 'difficult' mix of young people; emergency referrals that can disrupt established placements, and lack of external professional assistance (Farmer and Pollock, 1998; Gibbs and Sinclair, 2000; Barter et al, 2004). Addressing these issues requires clear leadership and an organisational culture in residential care, embodied by all staff, that promotes a violence-intolerant environment.

5.4.3 Interventions

The last form of system failure relates to the lack of appropriate and effective external interventions. External interventions are often

difficult to access, and provide too little help too late (Kirton et al, 2004). However, even if external services are available, carers are not always positive of the support and assistance they receive with respect to children's behavioural difficulties (Farmer et al, 2004; Sinclair et al, 2004). For example, compared to children with a mental health disorder, mental health service assessments for children who display behavioural or attachment difficulties often receive a more arbitrary and less informed response (Rao et al, 2010; Tarren-Sweeney, 2010). Positive behavioural change is often minimal due to a lack of professional understanding in these areas (ibid). The provision of specialist therapeutic support that addresses wider behavioural difficulties, not mental health disorders alone, is central to tackling the problem of peer violence for some children, and improvements in the accessibility of support are needed.

Only a small number of dedicated interventions for peer violence in care have been developed. Most are based in residential settings (see The Centre for Residential Child Care, 2000; Littlechild and Sender, 2010; Stevens, 2010; Carter, 2011), although some address foster care (Silver et al, undated). Although some evaluations were being undertaken at the time of writing, robust outcome data was as yet unavailable and therefore it is not possible to ascertain their effectiveness. However, they do provide useful signposts for future directions, focused on two main interrelated areas: first, the provision of a residential therapeutic intervention and second, the implementation of a dedicated, regular, forum for children, young people, residential staff, therapists and foster carers to talk openly about issues of peer violence and its impact.

A central component of many interventions is the recognition that a child has a range of needs – social, educational and emotional – all of which must be addressed to reduce negative peer interactions. Although therapeutic interventions are embedded in slightly different theoretical and developmental frameworks, they share a number of features, including: addressing past experiences of abuse and neglect; building trusting and consistent relationships; enhancing self–esteem; providing the child with positive coping strategies, and building resilience.

5.5 Recommendations

The evidence presented in this paper highlights the clear impact of peer violence in residential children's homes and foster care on the

welfare of looked after children and the biological children of carers. Although there is a need for further research, important messages can be extrapolated from the existing studies. Chapter 3 explored the safeguarding approach needed to prevent abuse by adults, which will not be revisited here. Based on the research summarised in this chapter, the recommendations below seek to provide an overview of what is needed to safeguard children from peer violence. If followed, these recommendations will help to improve the wellbeing of children in care and those living with them.

1. Placement planning, assessments and decision-making

a) Local authorities should ensure that a systematic evaluation of a child's peer relationships, including reports from external agencies and previous placements, forms part of all placement planning. This should include the impact of the new child entering a placement on the existing children (both looked after children and biological children) as well as the peer relationships of the existing children in the placement and their potential impact on the new child entering the placement.

b) This information should be shared with foster carers or residential care staff prior to placement. Where peer violence is identified as a risk, enhanced safeguards should be put in place such as increased supervision and greater monitoring of peer interactions. This should be undertaken by the carers with support from their social worker and the child's.

c) Unplanned moves should be accompanied by a report of the previous foster carers or residential staff outlining any peer relationship difficulties and risks to the child or other children.

d) Children with emotional and behavioural problems and children displaying problematic sexualised behaviour need particularly careful placement planning and additional support.

2. Improving the involvement of looked after children

a) It is critical that children are able to express their views on how their wellbeing will be affected by their peer relationships. Children should be consulted by their social worker on how they feel a new child may impact on peer relationships in the household, any concerns this may raise and how these may be overcome. The 'fostering household' should be involved in placement decisions and the subsequent fostering process, with

all children included in the decision-making process where appropriate.

b) Children should be involved in developing a planned introduction for the new child into the family, for example they can be given special responsibilities relating to how the child is welcomed into the home.

c) The increased proportion of looked after children entering care with histories of abuse, neglect and trauma means that the provision of external specialist interventions is crucial: unless the deep-rooted problems of children who have experienced abuse and neglect are addressed, other initiatives will at best contain rather than treat the problem. Local authorities and CAMHS services must ensure that looked after children have access to specialist counselling and psychotherapeutic interventions, which should have a good understanding of the 'care context' and the drivers and impact of peer violence (Tarren-Sweeney, 2010).

3. Support for foster carers

a) Local authorities must view foster carers as equal members of the team around the child. Their experiences and expertise should be formally recognised, with assessments of children's needs and welfare being central to informing fostering decisions, monitoring and reviews. Improvements in social workers and foster carers working together should include:

- improving social workers' understanding of and respect for the foster carer role

- ongoing information sharing and improved communication

- foster carers' opinions being actively sought and valued, with carers being actively involved in decision-making (Beek and Schofield, 2004; Farmer et al, 2004; Kirton et al, 2004).

b) The provision of enhanced social work support through regular and reliable meetings with foster families, where their views are taken seriously, can lessen the strain of negative peer behaviour (Lipscombe et al, 2004). Foster carers should be provided with support that is tailored to the family's individual situation and life events (Triseliotis et al, 2000; Sinclair et al, 2004; Everson-Hock et al, 2011).

c) Support should include training that provides an understanding of the effects of past trauma and attachment issues on children's

development and behaviour, accompanied by practical, day-to-day, tailored behavioural management advice and strategies (Hudson and Lavasseur, 2002; MacGregor et al, 2006; Pasztor et al, 2006; Brown, 2007).

4. Understanding the needs of the biological children of foster carers

a) The welfare and needs of foster carers' biological children must be recognised by social workers as an integral part of the fostering agenda. Placement decisions, visits and reviews should therefore assess the needs of all the children in the household.

b) The biological children of foster carers may require support in their own right. This could include the provision of a forum where their experiences and views are listened to and taken seriously.

5. Residential care

Research demonstrates that many of the above recommendations apply equally to residential settings, in particular the need to ensure that a child's needs are met by a placement, the provision of external support and evaluations of the impact of a new child on the residential peer dynamics.

However, studies show that children's homes with very similar resident group characteristics experience very different levels of peer violence, indicating that organisational and cultural changes can profoundly influence peer interaction (Sinclair and Gibbs, 1998; Barter et al, 2004). Unfortunately, research indicates that good practice is not common enough.

a) Children's' homes need to create a violence-intolerant residential environment where negative peer hierarchies, acceptance of violence and derogative language are routinely challenged (Kendrick and Mair, 2002; Barter et al, 2004). Children's homes should actively encourage positive peer group dynamics as this can act as a powerful safeguarding mechanism.

b) It is critical that carers and other professionals build positive relationships with young people that emphasise constructive behaviour through reward and recognition, hold high expectations of acceptable behaviour and undertake close, supportive supervision of young people. The government should provide support to tackle the variation in practice in residential care.

6. The need for further research

Finally, there is a pressing need to more fully investigate the incidence, impact and associated factors of all forms of peer violence – including abuse via new technologies – for *all* children in care, and especially for children in foster care. Research is needed to understand the extent to which safeguards are now in place, their effectiveness and how risk factors are being reduced. Long-term evaluations of interventions are a priority. Research indicates that some children, such as those identifying as gay or lesbian, may be particular vulnerable. However, there is no research on other groups such as minority ethnic children, disabled children, children with religious beliefs and unaccompanied minors. There is a pressing need for practitioners and managers to understand the incidence, impact and dynamics of peer violence in their foster care and residential provisions, including an evaluation of professional responses and interventions in this safeguarding area. Central to this must be the exploration of all children's and young people's experiences, views and evaluations, including those of the biological children of foster carers.

Peer violence can be fluid – the lines between perpetrators and victims of peer violence can sometimes be blurred depending on the context, and they may change over time. What is clear is that all children need to be safeguarded. To achieve this, attention needs to be paid to understanding and improving peer relationships. If the complex needs of 'challenging' children are not met within a placement, whether foster or residential, the occurrence of challenging behaviour, including peer violence, will increase. Although the roots of problematic behaviour may stem from previous experiences of violence and abuse, the inability of the current system to respond to it, and the way it can exacerbate it in some cases, requires urgent redress. Ultimately, children need to be centrally involved and consulted in the development of appropriate policy and practice developments in this important, but under-recognised, area of child welfare.

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CHAPTER 6

Running away, going missing and sexual exploitation

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By Isabelle Brodie

6.1 Introduction

Any child or young person can be vulnerable to running away or going missing and to sexual exploitation (DfE, 2012a), but there is strong evidence that children and young people in care are at particular risk. Research shows that significant numbers of children in care go missing and are sexually exploited (Beckett, 2011; Jago et al, 2011; CEOP, 2013). This overlap is recognised in national policy, where it has been described as a 'scandal' and an issue that has not been sufficiently prioritised by government or local authorities (The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers, 2012). A recent inquiry by the Office of the Children's Commissioner (OCC) into sexual exploitation via gangs and groups has also identified those missing from home and care as representing a 'particular concern' (OCC, 2012). Given that much better information now exists about the nature of these links, it is essential that such knowledge is used to help develop better practice (Jago et al, 2011).

This chapter explores the relationship between children in care, children who go missing and child sexual exploitation (CSE). The information presented is applicable throughout the UK, though there are some differences in the development of legislation and policy in the four nations (see, for example, Beckett, 2011 regarding Northern Ireland; Barnardo's, 2011a, and Brodie and Pearce, 2012 regarding Scotland). The discussion is mainly concerned with young people over the age of 10, reflecting the findings of research on young people in care who go missing and are at risk of sexual exploitation. For reasons of space, the chapter does not examine the linked and

very important issue of young people who are trafficked, placed in care and also experience CSE. In terms of language, it is important to note the distinction between 'going missing', which is an episode of running away that is officially recorded as such, and 'running away', which applies to a larger group that is less easily counted.

It is clear that while each of the issues of living in care, going missing, and sexual exploitation are complicated in their own right, the interrelationship between these needs to be better understood if young people are to be better protected. The lives of young people prior to entering care are also important. The 'risks' that make young people vulnerable to entering care – disrupted family relationships, abuse, poverty and difficulties at school – are also those that tend to be present in the lives of young people who go missing and those who experience child sexual exploitation.

However, these experiences are not inevitable, and as this chapter sets out, the care system can provide better protection from these experiences (Dillane et al, 2005; Scott and Skidmore, 2006; Beckett, 2011; Brodie et al, 2011; Jago et al, 2011). This requires a young person-centred approach that recognises the wider context of young people's lives and does not focus solely on the fact they are 'in care'. Listening to and taking seriously the individual stories that young people have to tell is essential to understanding what will be helpful in terms of effective practice. At present, too many young people who go missing and are being exploited do not feel that their voices are being heard. The nature of the care system is perhaps less important in changing practice than ensuring that carers and others are better equipped to respond to the complex issues in the life of each child. In turn, this response needs to be embedded in strong working relationships between professionals from the statutory and voluntary sectors, who are able to use good local information to develop expertise in responding to these very complex issues.

The relationships between the care system and CSE are, therefore, both direct and indirect, and the discussion will consider the different ways in which care may heighten or introduce new risks of exploitation to young people. Crucially, however, it also aims to examine how carers, working with other professionals, can intervene effectively to support and protect young people.

6.1.1 Background

Although there is currently considerable interest in the links between going missing and child sexual exploitation, especially for young people who are looked after, this has not always been the case.

Throughout the UK, policy guidance on going missing and on child sexual exploitation recognises that young people who are looked after are at particular risk. Research shows that these links are not new: studies regarding children in residential and foster care during the 1990s highlighted the fact that young people who lived in residential homes went missing frequently and that some residential units were being targeted by older men (Berridge and Brodie, 1998; Biehal and Wade, 2000). Research into foster care also identified concerns about the extent to which foster carers were monitoring the whereabouts of adolescents in their care (Farmer and Pollock, 2003). In both foster- and residential settings, research previously found that staff often avoided talking about issues of sex and gender, which, when asked, they explained in terms of lack of confidence or training (Barter et al, 2004).

Such lack of confidence may seem surprising, but it is important to remember that a focus on the issue of child sexual exploitation is relatively new. Research in the late 1990s drew attention to the experiences of children who were working as 'prostitutes' and who were criminalised by existing legislation (Melrose et al, 1999). Department of Health guidance (DH, 2000) set out a 'paradigm shift' (Melrose, 2003) from a punishment to a welfare model, reflected in the language of 'child sexual exploitation' rather than 'prostitution'. For the first time children and young people were recognised in government guidance as a distinct group vulnerable to sexual exploitation, requiring protection rather than criminalisation. The guidance emphasised the need for a 'dual approach' of protecting young people and proactively investigating the actions of their abusers.

Further guidance, this time referring to the safeguarding of 'sexually exploited' children and young people, was issued in 2009, which emphasised the role of Local Safeguarding Children's Boards (LSCBs) in developing local protocols that would be instrumental in mapping local geographies of child sexual exploitation, developing processes for recording data, and supporting the development of effective partnership working in response to the issue. Similar guidance was issued in Wales (WAG, 2009). In Scotland, the question of revising

earlier guidance is being explored by the Scottish Parliament. In Northern Ireland, research has drawn attention to the extent of CSE among children who are in contact with social services, including those in care, and work is currently underway to develop policy in this area.

Guidance in England and Wales also identifies groups at particular risk of CSE referring to young people in care, especially residential care, and children and young people who go missing. In 2009 the Department for Children, Schools and Families (DCSF) issued a national indicator requiring local authorities to report on their service provision for children at risk of running away, as well as those who have run away and gone missing. The associated guidance on missing children is subject was updated and published in January 2014 (DfE, 2014). As with sexual exploitation, the guidance requires local protocols to be developed by Local Safeguarding Children's Boards in England and Wales, which include arrangements for recording and reporting missing incidents and the processes for different services, including the police, to work together in partnership. This also recognises the importance of return interviews for children missing from care, offering the opportunity to discuss the young person's reasons for running away, which should inform care planning.

In addition to guidance for local authorities and other partners, in 2013 the Association of Chief Police Officers and the College of Policing published new guidance on the Management, Recording and Investigation of Missing Persons (ACPO, 2013). This guidance introduced a new category of 'absent' (in addition to missing) in an attempt to help ensure the best use of police resources when responding to instances of missing persons. Such cases will not receive the same initial response, but a review time and date will be set to assess whether further action is needed and they should be re-classified as missing. Given instances of CSE can take place within a short period of time, it is important that the impact of the introduction of this 'absent' category is carefully monitored.

This work appears to offer an important framework for the development of good practice to safeguard young people whose experience cross-cuts different systems – being in care, missing, and CSE. However, as new research and information has emerged regarding child sexual exploitation, it has become clear that these systems are not working effectively to safeguard vulnerable children and young people. It may be that the issuing of different sets of

guidance contributes towards a sense of the issues as fragmented, rather than recognising their complex array of interconnections. It is essential that this is addressed at a national and local level. This can happen both formally, for example through a joint missing/CSE sub-group on a Local Safeguarding Children's Board, and informally, by offering more opportunities for joint work and training. Better scoping of the issue of CSE in local areas will also help generate better information about the nature of the links in different communities.

6.2 Looked after children, missing children and sexual exploitation

One way of looking at the connections is to examine what we know about the overlaps between the different groups of children, ie those in care, those known to have gone missing and those who are sexually exploited. As knowledge has evolved about why young people go missing and become sexually exploited, more information has also been gathered about how many young people are involved. The following section presents information from some key studies which have tried to find out how many young people are in touch with services because they have been sexually exploited, and how this relates to other issues such as going missing.

The Centre for Exploitation and Online Protection (CEOP) undertook an assessment of the prevalence and nature of CSE across the UK. Data was obtained on 2,083 victims. Of the 1,014 cases where information on missing episodes was recorded, 842 children were known to have been reported missing on at least one occasion, though it was not clear whether this was before or after the reported exploitation. Of the 896 children for whom data was available, approximately one-third (311) were already in care at the time of exploitation and a further 43 children were moved into care following intervention (CEOP, 2011).

Jago et al (2011) found that over half of all young people using CSE services on one day in 2011 were known to have gone missing. A quarter of these had gone missing over 10 times, and 22 per cent were in care. In Northern Ireland, Beckett (2011) examined a sample of 1,102 cases, all known to social services. Of these, almost one in five was assessed to be at risk of sexual exploitation. In line with other research on CSE (see, for example, Chase and Statham, 2005), more females than males were assessed to be at significant risk and the risk increased with age. However, higher levels of risk were found among

looked after young people, with just over 20 per cent assessed to be at significant risk of sexual exploitation, compared with 10 per cent of their non–looked after peers. Strikingly, this risk increased further for young persons placed in residential care, with over 50 per cent of this group considered to be at significant risk. The association with going missing is also strong – three in five of the residential group had been missing overnight or longer within the last year, compared to one in five of the overall sample.

What, then, should we take from this evidence? First, there is good evidence that young people in care are more likely to have experienced child sexual exploitation and to have run away. There are considerable numbers involved – and it is generally agreed that current information is often patchy and underestimates the scale of the problem. Second, it is important, therefore, that all professionals working with young people in the care system understand and are able to identify the signs that a young person in care may be running away and/or being sexually exploited. Finally, this evidence does not mean, however, that young people in care will *necessarily* either run away or be sexually exploited. Beckett (2011) points out that concerns about CSE are as likely to precede entry to care as to emerge after entry to care. Smeaton (2013) makes the similar point with respect to young runaways – most do *not* experience sexual exploitation. Awareness of these risks as possibilities, and recognition of the signs that these things are happening, is critical to children who are at risk of CSE but it should not translate into an assumption that these things are inevitable.

If it is not inevitable, why does it happen? Different explanations have been put forward – and it is likely that each provides a part of the answer. One explanation could be that young people in care present a more concentrated set of difficulties and are therefore at greater risk. Certainly, Beckett's (2011) study found that the looked after group scored higher on all vulnerabilities, including the breakdown of family relationships, a family history of domestic and substance misuse, different forms of abuse, disengagement from education and social isolation. Alternatively, it could be argued that other problems associated with the nature of care itself – for example, the absence of a consistent carer as a result of frequent placement change, or living in a residential placement some distance from home – could place young people at greater risk. This is true in some cases, but does not take into account evidence of young people who emphasise that care placements have provided them with greater security and stability. In

order to explore this further, it is important to take account of what we know about routes into child sexual exploitation, which highlight the relationships between the individual, their wider environment and the care placement.

6.2.1 Routes into child sexual exploitation

"Thousands of things have happened to get me here."

(Young person, quoted in Montgomery-Devlin, 2008, p.381)

The information presented so far highlights some of the problems in understanding the relationship between going missing and sexual exploitation. To explore this further, it is important to consider the evidence regarding the different routes through which young people may become sexually exploited.

Any child or young person can be exploited regardless of their gender, ethnicity or culture, or their social class or family context. Recent work has, for example, found that young people with learning disabilities and young people from Traveller communities are among those who are not always recognised as being at risk of sexual exploitation (see, for example, Smeaton, 2013). While the majority of young people who reach services are female, boys and young men are also sexually exploited.

The routes through which young people become sexually exploited are varied. Much attention has been given to the process of 'street' or 'localised' grooming and especially the 'boyfriend' model where a young person is groomed by an individual (CEOP, 2011; House of Commons Home Affairs Committee, 2013). Recent cases of CSE, for example in Oxford, Rochdale and Derby, that have reached court have highlighted that grooming may also take place via organised groups of abusers.

Other important routes include partying, where young people may be offered cigarettes, drugs and alcohol in return for sex. While there may be an age difference, attention has increasingly been drawn to the role of peers in sexual exploitation. This may involve individual young people (possibly being exploited themselves) recruiting young people for their abusers. Alternatively, it may involve more organised forms of exploitation via gangs and groups (OCC, 2012).

There is also a growing body of evidence attesting to the role of the internet and other forms of social media in relation to CSE,

in that they provide a platform through which abusers can easily communicate with each other as well as with young people (Chase and Statham, 2005; Scott and Skidmore 2006; CEOP, 2011). Young people report that social networking sites are a means by which introductions are made and new relationships quickly formed. Sexting – or the exchange of sexual images of young people – is reported as commonplace, and can be used to shame or blackmail individuals. This takes place beyond the supervision of parents and carers, many of whom report a lack of knowledge about new technologies and how they are being used (OCC, 2012).

Pearce (2003) identified three categories of girls and young women who were sexually exploited: those at risk through the types of lifestyles and relationships they were involved in; those who swapped sex for favours such as shelter, food and other things they wanted or needed – which could include drugs and alcohol but also clothes and other consumer goods – and those who self-defined themselves as choosing to sell sex, but did not recognise this as abuse. Melrose (2009) emphasises the complexity of young people's relationship with drug taking, arguing that there is a danger that policy and practice strategies too often conflate problems and fail to take adequate account of the reasons why young people may feel that the pressures associated with family and relationship problems and poverty mean that any choice is highly constrained.

What is clear is that young people who become sexually exploited have experienced multiple difficulties in their lives. Similarly, young people in care will already have experienced many difficulties. Coupled with this, young people may not be equipped with the knowledge of sex and relationships, or have information about exploitation and the ways in which this can take place. Such information could make them more alert to what is happening – and perhaps more willing to talk to someone about it.

These problems make individuals or groups more vulnerable to abusers, whether they are in care or not. CEOP (2013) identifies a specific pattern of group offending where adults target adolescents on account of their vulnerability, rather than as a result of a specific sexual interest in children. Smeaton (2013) describes the relationship between running away and going missing in terms of 'push' and 'pull' factors. Young people are running away from something, or many things – which may include sexual abuse – but they are also running *to* something, which may be food and shelter but may also be the

abuser. This model may be helpful in disentangling the significance of care in the relationship between being looked after, going missing and sexual exploitation, and especially in explaining why young people continue with these exploitative relationships.

It is therefore important that those working with young people can spend sufficient time to be able to tease out the different issues that a young person is dealing with, and also their understanding of the issues. In relation to young people going missing, return interviews – conversations with young people on their return home after going missing – have been found to be especially useful in identifying those at risk of further harm, including sexual exploitation. This is an area where there is scope for further progress, as return interviews are not routinely undertaken with all children and young people who go missing (The Children's Society, 2013). Similarly, strategy meetings for young people identified at risk of or experiencing CSE have been found to be useful, and are valued by young people in ensuring they are included and informed.

6.2.2 What difference does care make?

At this point it is necessary to return to the fact that, notwithstanding the risks encountered by many young people in respect to going missing and child sexual exploitation, those who are looked after are disproportionately represented. The different causal connections that exist between going missing and CSE should not disguise the fact that care is potentially a crucial turning point – for good or ill – in young people's experiences.

Coy (2008) interviewed 14 young women aged 14-33 who had spent various periods of time in care, ranging from 18 months to 16 years. All of this group were, at the time of interview, selling sex on the streets. All had experienced 'most or all' of the following: sexual and/or physical abuse; family breakdown; domestic violence; homelessness; exclusion from school, and episodes of running away that had led to rough sleeping.

"When asked to present a life-story narrative, the women spoke of being in care as the primary focus that shaped their lives and – crucially – linked events and emotions of their care experiences in a way that suggests that being in care itself plays a role in the path to selling sex."

(Coy, 2008, p.1409)

The extent to which young people's difficulties are *felt* by the individual to have been addressed while in care, or the extent to which care is felt to have resulted in or exacerbated a young person's running away or sexual exploitation is also significant.

Episodes of going missing may well form one element in an overall pattern of troubling behaviour, which may precipitate the entry of an adolescent into the care system. However, some young people may go missing for the first time while in a care placement. Morgan (2006) found that unhappiness; not being able to participate; bullying; abuse; not feeling listened to, or running back to family or friends were all cited as reasons for going missing by children and young people in care. Biehal and Wade (2000) distinguished between an older group of young people, predominantly living in foster placements, who were more likely to go missing to stay with family or friends, and a younger group, more often but not exclusively living in residential accommodation, for whom running away was more frequently associated with problems in placement. Frequent episodes of going missing were linked to a series of difficulties, including being out of school and offending. For those who are sexually exploited, returning to abusive networks of adults or peers may also be a factor.

Considerable concern has been expressed about the type of placement, and whether this can exacerbate risk. Specifically, serious cases of child sexual exploitation have drawn attention to residential placements, especially where young people are placed some distance from home (APPG, 2012; OCC, 2012). There are clearly specific challenges associated with working with young people placed far from home, and this is a much more common experience than in the past. Ownership of children's homes is often cited as a concern. Of the 1,810 children's homes registered with Ofsted at 30 September 2011, 76 per cent were in the private and voluntary sector. However, research indicates that there is "no simple relationship" (Berridge et al, 2012, p.63) between the type of provider and quality of care. The question is less whether homes in the private and voluntary sector can provide a safe environment for vulnerable young people, than how far standards of care are consistent across all homes. Equally, while foster care can provide a supportive environment, this is dependent on consistency of support and the development of a positive relationship with the young person.

It is important that discussion of placement type is not restricted to residential care. Research into child sexual exploitation indicates

that those who are being sexually exploited and are also looked after live in a range of placements, including foster care, supported living arrangements and bed and breakfast. Professionals working with children in all settings need to have appropriate training and access to information and support from police and other specialist services in respect to young people who go missing and who are at risk of CSE.

Discussion of these issues should be considered in the context of identifying appropriate placements for vulnerable adolescents. Smeaton (2013) emphasises the need for thorough assessment at entry to care, including patterns of running away and going missing, and evidence of sexual exploitation. This can then enable appropriate measures to be put in place where such histories exist, or preventative work to take place where potential risks are identified. This information needs to be clearly communicated to all those working with the young person. Previous research into foster care has highlighted that the absence of accurate information regarding past abuse is a major barrier to effective practice and can contribute to placement breakdown (see, for example, Farmer and Pollock, 2003).

6.3 What can be done?

6.3.1 Awareness and attention

"The most important things are that when you've got a worker that they understand, they don't judge you, they support you, they believe you."
(Young person, quoted in Jago et al, 2011, p.64)

"It's hard to explain unless it's happened to you."
(Young person, ibid, p.71)

"It's hard to be really honest with project workers and others because they would think you were 'stupid' for putting up with them."
(Young person, ibid, p.72)

The research and other information we have makes clear the dangers that may be encountered by children and young people while missing from care, including sexual exploitation. A pattern of missing episodes must be taken seriously and carers should be clear about the procedures they should follow when this is happening. They should also be alert to other signs that a young person is being exploited – for example, a young person having money or gifts that are unaccounted for or physical and sexual health problems.

However, evidence also indicates that young people frequently encounter an ambivalent response from carers and others who are working with them. Often, it seems, they are viewed as troublesome and problematic rather than as victims (Pearce, 2009). In Smeaton's (2013) research, young people who were looked after said that feeling isolated and uncared for in a care placement was a significant factor both in their running away and sexual exploitation. This perception may also result in children being criminalised: in a submission to the House of Commons, the Howard League for Penal Reform noted that victims of CSE were more likely than average to have a criminal record, and questioned why victims were being punished rather than helped (Howard League, 2012).

Carers and professionals from all agencies need to develop a 'professional curiosity' (House of Commons, 2013) regarding CSE and to have sufficient understanding of the issue to challenge assumptions about why a young person may have gone missing. This is not easy, as young people may not view relationships as exploitative and may be unwilling to talk about what is happening. Additionally, colleagues in other agencies may not attach the same significance to a young person's running away and may dismiss a professional's concerns. Research indicates that when a young person goes missing from care, it is not always taken seriously by the police, and the issue of sexual exploitation may not be considered (Smeaton, 2013).

"I've got a young person who's just had his 22nd missing episode this year who is looked after and I think there is an element of 'oh no, not again'. If the name appears regularly there's just an attitude that 'oh well, they are a regular absconder.'"

(Professional, quoted in Smeaton, 2013, p.77)

However, other evidence from research into residential care highlights that staff can be proactive and try hard to be informed about young people's friendships and social lives (Berridge et al, 2012). Young people have highlighted practical ways in which care staff can change practice to help reduce or manage the risks associated with sexual exploitation. These include practical information about how to stay safe when out with friends, and ensuring that staff deliberately make themselves available at times when young people are returning home (Dillane et al, 2005). Attention to other aspects of a young person's welfare, including education, emotional difficulties, mental and physical health problems, can also be positive in helping to keep a young person safe.

6.3.2 Provision of appropriate services

Young people who go missing from care placements and are at risk of or identified as being sexually exploited need a supportive response from practitioners in the first instance. If carers have appropriate information and training then they may well be the best person to provide support. Jago et al (2011) concluded that in the context of service cuts, including high profile examples of 'excellent' specialist CSE services, the 'overwhelming' message is that is does not matter who delivers direct work with young people so long as they are properly trained and skilled, have time and space to deliver the work and have the support of the Local Safeguarding Children's Boards and local authorities. It is therefore important that those responsible for looked after children at a strategic level ensure that carers have access to training on children going missing and CSE, and are aware of services that are able to provide relevant information. This should include services that can support different groups of young people, including lesbian and gay young people and those from different cultural backgrounds.

That said, research into children going missing and CSE services indicates that specialist knowledge is important, both in providing training and support to other professionals and in undertaking direct work with young people. It has been suggested that co-located teams focusing on CSE are particularly helpful (Jago et al, 2011). These teams are multi-disciplinary and combine statutory and voluntary services, and though their precise make-up will depend on the nature of local expertise, police involvement is crucial. These teams can act as central referral points for all cases where CSE is a concern, as well as providing a response from expert staff. Unfortunately though, services are not always able or willing to provide help for young people who fall into both the missing and CSE categories – one evaluation of a refuge for missing young people noted that those who were known to be sexually exploited represented the group professionals felt least able to help (Malloch, 2010).

There is a serious shortage of services for young people who go missing as well as for those who are sexually exploited. This reflects a wider lack of services for adolescents who have experienced abuse (Allnock et al, 2009; Stein, 2009). An added complication for looked after young people is that placement change may mean moving away from a service. It is clear that ensuring continuity of support regarding CSE and going missing should be an important element in care planning.

6.3.3 Local, integrated information

Young people who go missing, those in care and those who are sexually exploited are frequently described as 'invisible' or 'hidden'. This may be due to the low status of young people who are frequently viewed as problematic. However, young people themselves suggest that these issues are not hidden, but that "you just aren't looking" (Pearce, 2009). This can be true in terms of the knowledge and awareness of individual carers, but also at the level of local authority data and management systems.

While it is generally agreed that the quality of data concerning looked after children and young people has improved considerably over recent decades, there is rather less confidence in the data on children going missing from care (APPG, 2012). Annual data from the Department for Education (2011) regarding missing incidents of at least 24 hours shows 930 children went missing during that year. Police data, in contrast, suggests a figure of 17,000 reported incidents and 5,000 children going missing from care. This difference has led to the Department for Education piloting new ways of collecting data on missing children. The current gap in information is of concern in terms of understanding the extent of the problem and developing effective responses and it will be important to assess the impact of these pilots. In addition it is vital that we evaluate the introduction of 'absent' and 'missing' categories by ACPO and understand any difference that this makes to the support received by children in care.

Equally, systems for monitoring and recording missing episodes and sexual exploitation are poorly recorded at local level. Jago et al (2011) surveyed 100 Local Safeguarding Children's Boards and interviewed 89 key personnel. Fifty-nine per cent of LSCBs surveyed reported that they were not recording data on child sexual exploitation. Only one of the areas covered reported that data was collected at both agency and LSCB level, and that there was a shared database.

It is also important to map local 'hotspots' to identify where abusers may be approaching and grooming young people, for example local businesses like takeaways and taxi firms, or places where young people meet such as local parks. This is an area where work is developing through use of tools such as the University of Bedfordshire's Data Monitoring Tool (DfE, 2011; 2012a).

This is a strategic responsibility, but one that is crucial to supporting carers and other professionals working with looked after children. Good information enables professionals to be alert to potentially

dangerous people and places. In turn, awareness of this can enable carers to provide information to the police, which can help them find young people more quickly. This requires LSCBs to work in partnership with carers from all sectors, recognising their expertise in relation to the young people they work with.

6.4 Conclusion

There is a growing awareness of the complex relationships that exist between the experience of being looked after, going missing and child sexual exploitation. The knowledge base has grown considerably in recent years, enabling a better understanding of the nature and extent of the issues, and the most effective ways in which intervention can take place. However, there is scope for much more to be done, and progress is slow. There is evidence that carers can work effectively to support young people who are looked after and (at risk of) going missing or being sexually exploited. However, this requires coordination at a strategic level to ensure that information is shared and services are working in partnership. This is primarily a responsibility of the Local Safeguarding Children's Board, but there are concerns about the adequate resourcing of this work. Carers also need access to relevant training and support. Working with looked after young people who go missing and experience sexual exploitation is challenging at many levels. It also requires time to build up trusting relationships with young people.

6.5 Summary of recommendations

Policy responses to missing children, child sexual exploitation (CSE) and safeguarding children in care need to be better joined up. LSCBs need to recognise the links between children in care, children going missing and child sexual exploitation. These relationships need to be explored within their local areas and information gathered to inform policy and ensure the coordination of services. The exact nature of these relationships will vary according to existing local structures, but it is important that there is a recognition of the links between missing children and CSE and that this is embedded at a strategic level, and in the policies being developed by individual agencies.

Training for practitioners should recognise the complex interaction between children going missing and being sexually exploited. It should enable practitioners to spot the signs that a child is at risk

of CSE and address underlying attitudes and preconceptions about young people who are sexually exploited.

Training should reinforce the significance of the role of carers in building relationships with young people that can help keep them safe. There are benefits to this training being multi-disciplinary to ensure that practitioners have an understanding of their respective roles and the different services and expertise available.

Foster carers and residential workers should have access to training, expertise, support and resources to help them support children who are at risk of going missing or CSE. As an initial step, this will involve local authorities talking to carers about their training needs in relation to these issues. Carers should be represented in local partnerships where their expertise and intelligence about sexual exploitation in a locality can be valuable.

Young people in public care need a good sexual knowledge and awareness of risks. There should be clarity about who is responsible for providing this information (for example, foster carers, social workers or others) and they should have the necessary skills and confidence to handle this. Alongside improved sex- and relationship education, information should be provided in the context of trust-based relationships, where young people are able to ask questions and talk to workers about strategies they might use to help keep them safe.

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CHAPTER 7

Achieving permanence for children returned to their parents

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By Elaine Farmer

7.1 Introduction

A sense of belonging – of being cared for and cared about –
is fundamental to children's healthy emotional and physical
development. So, permanence planning has the aim of ensuring
that children have a secure, stable and loving family to support
them through childhood and beyond. The Children Act 2004 re-
emphasises that the first permanence option for children in care is
return to a parent. In line with this, reunification is the most common
outcome for looked after children, with 10,080 (or 35 per cent) of
children in England in 2013 returned to parents or relatives (DfE,
2013a). It is therefore odd that, until recently, reunified children
were so rarely considered in practice, policy or research. In contrast,
the small number of adopted children (3,990 in England in 2013) are
given a great deal of attention, including recent government adoption
action plans (DfE, 2012 and 2013b), which are intended to increase
the number and speed with which children are adopted from care.
This blind spot about reunified children is of significant concern,
since their lives – unlike most children in permanent placements
away from their families – are often characterised by abuse, neglect
and instability. Moreover, the way in which reunification is managed
has a profound impact on how soon and how successfully children
are placed in long-term foster, kinship or adoptive placements
(Thomas, 2013).

This chapter starts by considering the outcomes and re-abuse rates
of children who return to their parent/s and then examines what

leads to reunification and the assessment, preparation and support that underpin it. The factors related to returns lasting are explored as are the adverse effects of leaving children too long with maltreating parents. Finally the chapter highlights some of the changes that are needed if practice is to improve.

The brief details of the main studies that are considered are as follows: Wade et al (2011) tracked a large sample of looked after children and then used a sub-sample of 149 maltreated children to compare those who returned home with those who remained looked after; Ward et al (2012) recruited a sample of 57 high risk babies aged under one, 43 of whom were followed up for three years; Farmer et al (2011) followed up 180 reunified children for two years, and Farmer and Lutman (2012) then followed up the 138 neglected children from this study over a period of five years from the original return.

7.2 Outcomes for children who return home

There is now a weight of evidence about outcomes for children who return home from care from research funded by the Department for Education (Davies and Ward, 2012). Studies by Wade et al (2011), Ward et al (2012) and by this author (Farmer et al, 2011; Farmer and Lutman, 2012), all point in the same direction: outcomes for many reunified children are very poor. However, research also suggests many ways in which practice can be improved (see also Biehal, 2006; Thoburn et al, 2012).

7.2.1 Re-abuse and neglect

Research shows that almost half of the children (46 per cent) who return home are re-abused or neglected (Farmer et al, 2011). This study shows that poor parenting is the greatest predictor of child maltreatment after return, followed by drugs and then alcohol misuse. For example, 78 per cent of substance (ie alcohol or drugs) misusing parents abused or neglected their children following return, compared with only 29 per cent of parents without these problems. Other predictors of re-abuse or neglect include domestic violence and maternal mental health problems.

Children are often returned to parents dealing with a range of difficulties. Three-quarters (77 per cent) of the children in this study were returned to parents who had previously abused or neglected them. Four-fifths (82 per cent) went to parents with a

history of domestic violence, alcohol or drugs misuse or exposure to inappropriate sexual activity[9]; three-fifths (60 per cent) went to a parent with mental health problems. Ten per cent of the mothers and 5 per cent of the fathers had learning difficulties.

7.2.2 What happened after children were abused or neglected?

It is clear from recent studies that when planning is poor and case management is passive children are left too long with abusing and neglectful parents. Too little action, or no action at all, may be taken when children are referred to children's services, sometimes repeatedly, because of abuse or neglect. For example, in our study (Farmer et al, 2011), after referrals were received about child abuse or neglect, most of the children concerned (62 per cent) still remained at home with the suspected abuser. While much of the time the decision for the child to remain at home was appropriate, 41 per cent of these children appeared to have been left at home for too long, or without sufficient help or investigation of the abuse or neglect. A few children (16 per cent) remained at home despite experiencing continuing abuse or neglect (ibid).

In such situations, children are exposed for long periods to damaging experiences, including parental substance misuse, domestic violence, mental illness and severe neglect, and as a result their chances of achieving stability or permanence away from their parents recedes. Permanence plans for these children are often seriously delayed or started and then abandoned (Davies and Ward, 2012).

When babies or young children *under* six were at risk or had been physically abused, swift action was generally taken to remove the children if risks recurred. However, practice was significantly less consistent as children became just a little older, indicating serious gaps in practice for older children returning home from care (Farmer and Lutman, 2012; Lutman and Farmer, 2012; see also Wade et al, 2011).

7.2.3 Return breakdown and repeated returns

A considerable number of reunified children subsequently return to care. Research has shown that over a third (35 per cent) of returns

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9   This included prostitution, open use of pornography or many changes of sexual partners.

broke down within six months (Wade et al, 2011), while almost half (47 per cent) broke down within two years (Farmer et al, 2011). Studies with longer follow-up periods show that breakdown rates continue to rise: to 59 per cent at the four-year follow-up stage (Wade et al, 2011) and 65 per cent in our five-year follow-up of neglected children who returned home (Farmer and Lutman, 2012). By this five-year follow-up point, not only had two-thirds of the children's original returns broken down but also, when at home, rates of repeat abuse and neglect remained high.

But that is not the end of the story. After their returns broke down, many children (62 per cent) were then returned home again, once or more. A third of the children in this study experienced two or more failed returns and this is strongly related to poor outcomes (Farmer et al 2011; see also Wade et al 2011). One such child had experienced 13 return breakdowns by the age of 16. Children tell us that repeated returns are a very negative experience. As one child said:

"I felt very disturbed… I just didn't cope any more… It was just very confusing for me… Coming home again was very, very difficult… I just felt really depressed."

(Farmer et al, 2011, p.190)

This highlights the need for proactive intervention to tackle children's and parents' difficulties and to ensure evidence of change *before* any renewed attempt at return.

7.2.4 Factors related to return breakdown and return stability

What do we know about why returns do or do not work out? Return breakdown has been found to be related to parents having continuing difficulties with alcohol and/or drugs misuse (Wade et al, 2011; see also Farmer and Lutman, 2012). We also know that return breakdowns are more likely when children have already had previous failed returns and when they have absconded from home, have severe difficulties in relating to others (Farmer and Wijedasa, 2012) or their parents show little motivation for the child to return (Bullock et al, 1998; Cleaver, 2000; Harwin et al, 2001; Sinclair et al, 2005). In addition, there are more return breakdowns when there has been no change in the membership of the family to which children return (Harwin et al, 2001; Farmer et al, 2011; Wade et al, 2011).

On the other hand, the likelihood of return stability is significantly higher when children return to the other parent (who generally has fewer problems than the parent from whom the child entered care) or when there has been a change in family composition. This could mean that a new, more positive partner (usually male) has joined the family or a former negative partner has left (Farmer et al, 2011). It is therefore critical to assess whether specific changes within the family to which children will go (such as the arrival of a new male partner) are likely to be better or worse for the returning child. We found that children have clear views on this, which need to be heard. The general message though is that changes in family membership are often positive.

In addition, when caregivers develop an exceptionally supportive relationship with the parents, there are significantly fewer return breakdowns (Farmer et al, 2011). Such exceptional support is particularly evident in foster placements (especially those for mothers and babies) and occasionally after in-patient psychiatric treatment. In such placements, foster carers (or staff) work closely with the parents and/or children to bring about change; they concern themselves with how parents and children will manage after they leave; remain available and at times involved after discharge, and sometimes provide after-care services to assist the parents or children. A few foster carers also provide respite care after children go home and this is highly valued by the children and their parents (Aldgate and Bradley, 1999). Purposeful social work, as shown for example by adequate preparation and providing appropriate services, also relates to return stability, as we will see.

7.2.5 Continuing poor quality returns

Worryingly, the study by Farmer et al (2011) showed that as many as a third of the returns that did not break down were nonetheless of poor quality for the children. For example, Tracey was aged seven when she returned to her mother, who misused alcohol and had mental health problems. She missed her foster carers but did not confide in her social worker. Her mother did not tell the social worker how difficult she found Tracey's behaviour but in an interview with researchers she said "It's been hell". Tracey was physically abused by her mother and injured in a violent argument between her mother and stepfather. The return was continuing at the

time of the researchers' follow-up, despite it appearing detrimental for Tracey, who made her unhappiness clear in interview.

Indeed, it has now been shown that children's outcomes are considerably better when they remain in care after maltreatment than if they return home – in relation to both their stability and wellbeing (Wade et al, 2011). Children who experience one or more return breakdowns have the worst outcomes, but even those children whose reunifications endure have lower levels of wellbeing than those who have not gone home. This is especially true for neglected and emotionally abused children, and requires us to examine decisions about returning these children and how we support them.

Children say that they find things difficult at home and feel sad, confused or angry, yet in the study by Farmer et al (2011) a third of the children had confided in no one. It is critical that there is clarity about when to end poor quality returns, and children's views must be listened to. There is a need to ensure that children do have a confidante – professional or otherwise – who they can talk to about difficulties at home, and some children will also need direct services such as respite care or contact with a mentor.

7.3 What do we know about the circumstances of children who return home?

7.3.1 Which maltreated children go home?

The study by Wade et al (2011) showed that maltreated children are less likely to return home when they have become looked after as a result of neglect; if they have a learning disability; if there is evidence on file that they do not want to return; if their contact with birth parents is infrequent, and where the parental problems that led to the admission of these children are still the subject of 'serious' social work concern at the time of the decision on whether to return them. On the other hand, maltreated children are more likely to return home when the risks to their safety are assessed as being at an acceptable level and the problems that led to the child entering care are considered to have improved during their care placement.

The study by Farmer et al (2011) found that improvements (however slight) in the parents' situation, (often that an abusing parent or violent partner had left the family) or, more rarely, the child's

behaviour, were the main reason for only half of the returns. In the other cases, abrupt and unplanned returns often occurred because of placement breakdown; lack of suitable alternatives in care; parental worries about children being bullied or abused in care, or children absconding home from their placements. In fact, pressures from the parents, child, placements or courts affected three-quarters of all the children's returns.

The reality is therefore that much reunification work requires planning under pressure. Nonetheless, it is easier for children's services to stay in control of children returning on court orders (who take on average a year to get home), than is the case with accommodated young people who go home faster (on average within six months), but with much less supervision of their movements.

7.3.2 Legal status

In the study by Farmer et al (2011), almost 60 per cent of the children had been voluntarily accommodated, while 40 per cent returned home on interim, care or supervision orders. The latter group were significantly younger and the imposition of a court order brought with it more assessment activity, greater service provision, the involvement of other agencies and closer monitoring. Overall, the cases of the children on orders were much better managed than those of accommodated young people (see also Wade et al, 2011), where quite often few or no services were provided for parents or young people with serious and enduring problems while they were looked after or following a return home.

The requirement in the Care Planning Regulations (DfE, 2010) – that children's services hold a review before voluntarily accommodated children return to their parents, and that a 'child in need' plan is drawn up identifying the supports and services that will be provided (Regulation 39) – should, in theory, mean that more consideration will now be given to supporting the returns of accommodated children. However it does not appear that such support is currently being provided.

7.3.3 Assessment, preparation and support

Almost half of the children (44 per cent) in the study by Farmer et al (2011) returned without any in-depth assessment (excluding initial assessments), potentially leaving them exposed to continuing

parental difficulties. This was especially the case with accommodated children who, without assessments, also more rarely received services. Multi–agency assessments and interventions were linked to court orders and to the resolution of the problems that had led children to enter care, highlighting the need for a multi–disciplinary approach to address complex family problems (The Who Cares? Trust, 2006; Stein, 2009).

Research shows that when adequate preparation for return is made, reunifications are significantly less likely to break down. However, in our study, specific preparations for the children's return were made in only a third of cases, and only a third of the children (aged over 4) were recorded as having been consulted about the timing and manner of the return. Some children said that they had gone home too quickly, without sufficient preparation. However, Wade et al (2011) found social work planning that was 'broadly inclusive' of birth parents and children in rather more cases (73 per cent).

Farmer et al (2011) found that specialist professionals saw a third of the children and half of the parents before the children returned home, but in other cases (20 per cent of parents and 9 per cent of children) referrals to mental health or other professionals did not eventuate, because the service was unavailable or appointments missed. There were many other gaps in the services provided. One important gap is shown by the finding that while almost half (46 per cent) of the mothers and a fifth (17 per cent) of the fathers to whom the children returned were known to have drug or alcohol problems, only 5 per cent were provided with treatment to help them address these difficulties. There is also insufficient help for parents in managing their children' behaviour (especially in dealing with behaviourally challenging adolescents), and a need for more help from CAMHS, which sometimes provided no services because they said the child was 'not settled'. (For more on this, see Chapter 4 in this volume, by Kim Golding).

Those who receive specialist help have better outcomes (Farmer and Wijedasa, 2012). However, once home, almost a fifth of the parents (17 per cent) and two–fifths of the children (40 per cent) were found to receive no support at all – either from children's services or a specialist agency – and as a result, some parents were caring for very disruptive and emotionally troubled children without any intervention or assistance (Farmer et al, 2011).

7.3.4 Had the situation at home changed before children returned?

The study also found that in only a quarter (26 per cent) of the cases had all the problems for the children and their parents been addressed prior to reunification. Often, issues that had the potential to ambush the success of the returns remained either unresolved or hidden from professionals, especially alcohol or drug problems, or continuing relationships with violent partners (Farmer et al, 2011).

So it is not surprising that professionals expressed concerns about more than a third of the returns (including social work reservations in over a quarter of cases). What was more surprising was that in interviews with researchers, parents often said that they too had harboured doubts about the wisdom of return at that time and about their ability to cope; while children had been worried about rejection, abuse and exposure to their parents' problems when they returned.

7.3.5 Differences in local authority practice

It has been found that the strongest predictor for whether a maltreated child returns home or not is which local authority the child lives in, rather than the needs of the child or the circumstances they face (Wade et al, 2011). For example, some authorities return children more often; in others, children more often remain looked after or are more frequently adopted. There are also differences between teams in the use of these pathways, and in how stable children's placements are at home or in care – probably because of differences in the direct work provided to support parents or carers.

There is other evidence, too, about variations in practice and in the priority and resources given to reunification in different authorities. In the study by Farmer et al (2011), return breakdown rates in the local authorities varied widely[10] from 75 per cent of returns to 32 per cent; similarly, the levels of good quality returns varied across authorities from 64 per cent to 10 per cent. These local authority variations in outcomes were particularly apparent for the *older* children, with some authorities taking insufficient action to address the parents' difficulties, protect teenagers at risk, or provide services for challenging adolescents, who as a result sometimes returned repeatedly to abusing or neglectful parents unable to cope with them.

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10 See also Dickens et al, 2007; Schofield et al, 2007; Sinclair et al, 2007.

There is a clear need for local authorities to review their policy and practice on reunification for children of *all* ages and to consider how far practice takes account of the findings of these recent studies. The contribution of purposeful social work to return stability (as evidenced by appropriate preparation, services and monitoring of children's progress) suggests that we need service arrangements that encourage the development of reunification practice skills that can be widely shared, sustained by specialist workers or specialist teams.

7.4 Which babies at risk stay at home and which go into care?

We have seen so far that there are considerable differences in reunification practice, some of which depend on the child's age and that generally, children's services intervene more quickly to protect younger than older children. The study by Ward et al (2012) gives an insight into how very young children at high risk at home are dealt with from the outset: their study highlights that delay and uncertainty about making key decisions also exists for this young age group. They found that parents were given repeated chances to prove they could look after their young child at home but in doing so, children's needs were often overlooked, especially neglected children. Written agreements with parents were often broken with no action being taken.

By the age of three, a third (35 per cent) of the babies in their study had been permanently separated from their parents. Of the children who remained at home, over half of the parents had made sufficient changes to provide adequate care and all but one of these parents had made such changes *before* their baby was six months old. This suggests that pregnancy may be experienced as a 'wake-up call' that precipitates change. However, a considerable number (43 per cent) of the three-year-olds who had remained at home continued to be at risk of significant harm from parents whose situation had remained unchanged – or had worsened – and more than half of these children had developed speech difficulties or serious behavioural problems, including aggression. It was clear that earlier, more decisive action had been needed.

7.5 How can practice improve?

The re-abuse and breakdown levels of the returns show that reunification is a challenging and high-risk area of practice. There is a need for more research on the key ingredients of good reunification practice, and the kinds of interventions and services that are useful in different circumstances. In addition, the most promising tools for analysing risk, reviewed by Barlow et al (2012), need to be piloted and developed for use in the UK (see also Reed-Ashcraft et al, 2001 and Fernandez, 2012). The NSPCC is currently undertaking work in this area. However, the research already suggests a number of ways in which practice can improve.

7.5.1 The need for early intervention

Studies underline the importance of the current emphasis on intervening early in children's lives (Munro, 2011). For example, three-quarters of the children in Farmer and Lutman's study (2012) had been known to children's services *before* they started school, yet many went on to have poor outcomes five to ten years later. Similarly, Wade et al (2011) found that problems evident in the early stages of return predicted poor wellbeing four years later. Such difficulties included behaviour problems at the six-month follow-up, serious social work concerns about the child's safety, or where the return had broken down or looked likely to do so at this early stage. These findings highlight the crucial importance of taking the opportunity to intervene decisively early on.

7.5.2 Good assessments

Good analytic assessments clarifying the key parental difficulties that need to improve before children can be returned are required (see eg Turney et al, 2011). These should include the child's full history, information on help provided in the past – what worked and did not, and why – and information on any failed returns. Assessments need to examine parents' capacity to change (Barlow et al, 2012; Davies and Ward, 2012; Ward et al, 2014), be realistic and take into account research findings on factors related to return success and failure as well as on working with alcohol and drug addiction. Assessments also need to be clearly linked to intensive services that address the parental difficulties they have identified.

7.5.3 Using written agreements, providing intensive services and making timely decisions

Intensive services need to be provided in order to address parental difficulties (and children's as well, when needed). A body of research demonstrates that services should be accompanied by written contracts agreed with parents, setting out concrete goals for the changes they need to make before return is possible. They should also include clear timescales for change, which are appropriate to children's developmental needs and should spell out the consequences if changes are not made – including that the child will not be returned and plans for permanence away from the family will be made (see also Biehal, 2006, Farmer, 2009). This approach to return is in line with findings from two studies of specialist reunification projects in the US, which concluded that purposeful case planning for children's futures, working jointly with parents from the time of entry to care, combined with written contracts agreeing clear goals with parents, were vital ingredients of the projects (Stein and Gambrill, 1977 and 1979; Walton et al, 1993).

In addition all referrals about the child and incidents of maltreatment as well as progress, or lack of progress, in improving parenting standards needs to be reported at every child's review, so that it is clear to workers, parents, review chairs or Independent Reviewing Officers whether or not the parents are making sufficient change for a child to remain safely at home or to return there (Farmer and Lutman, 2012). In doing so, it is important to bear in mind the findings of Ward et al (2012) that if children's services are involved during pregnancy and parents have not made substantial changes within six months of a baby's birth, real change is very unlikely to occur.

This more authoritative approach to reunification is essential so that plans for long-term permanence outside the family can be made when necessary. At the moment, delay in taking the decision that a child cannot live safely with their parents and in planning for permanence means that children have often been exposed for so long to parental problems (such as substance misuse, neglect and abuse) that their development is compromised by the time they come into care. This delay can seriously jeopardise their chances of settling in a care or permanent placement and also their future life chances.

Moreover, this approach is what parents themselves want. When asked what help they had needed, parents prioritised treatment for

substance misuse, combined with clarity about the consequences of taking no action with regard to their addiction and earlier recognition of their difficulties with their children. They also wanted monitoring of their progress to be combined with emotional warmth (Farmer et al, 2011). Ward et al (2012) similarly found that parents appreciated a 'straight-talking' social worker who was open that their children would be removed if their situation did not improve.

7.6 Planning and preparation for the transition home

As we have seen, there were fewer return breakdowns when there was adequate preparation of children and parents beforehand (see also Trent, 1989; Farmer and Parker, 1991). Similarly, in research by Wade et al (2012) the continuing reunions at six months had more often endured when planning for reunion had been purposeful and inclusive of children and birth families, and when children had gone home slowly, over a longer period of time. There is therefore a need for careful preparation and planning for return, as there would be for any other major transition for children (see eg Fahlberg, 2004).

7.6.1 Caregiver involvement

More involvement by foster carers and residential workers in preparing children and in providing follow-up support after reunification could prove very helpful (The Who Cares? Trust, 2006). In the US some agencies have initiated programmes with the explicit intention of developing the role of foster carers as role models and support figures for parents, and it has been shown that foster carers can play a positive role as parent counsellors, parent aides and parent educators (Davies and Bland, 1981; Simmons et al, 1981; Child Information Gateway 2006 and 2011). This is an area of practice that might usefully be further developed in the UK (see eg Greenfields and Statham, 2004; Cosis Brown et al, 2005; Thoburn, 2009).

7.6.2 Good formal and informal support

It is clear that targeted, intensive and often specialist services are needed if returns are to last. For example, returns are significantly more stable when children receive specialist help and when the

support provided overall is adequate. Returns are also more stable when practical help for the family is provided by another agency (Farmer et al, 2011). Wade et al (2011) also found that returns were more likely to be continuing at six months if family-focused social work interventions had been provided, parents had accessed more services and family problems had reduced.

For young people aged 11 or over at return, good *informal* support is also significantly related to return stability (Farmer and Wijedasa, 2012). This is often from a mentor, relative or a positive relationship with a girl-/boyfriend. When parents or young people lack adequate support from their social networks, more professional help may be needed in compensation (Farmer et al, 2004; Quinton, 2004), or more proactive attempts to initiate a network of informal support.

The social work task in arranging reunification is often huge and depends on team manager support, particularly when cases require intensive services that need to be organised and coordinated. However, in practice reunification is sometimes viewed as an area where resource savings can be made, with some cases quickly closed. This approach is counter-productive, as the returns in cases that are closed despite ongoing concerns (47 per cent) more often break down (Farmer et al, 2011).

7.6.3 Working with neglected children

Farmer and Lutman's study (2012) shows the persistence of parental neglect over many years; the difficulties that social workers can have in determining when to intervene to remove reunified neglected children, and the challenges involved if social work decisions are not endorsed by the courts. It would be beneficial if practice could be reshaped to ensure that practitioners keep detailed records of children's developmental progress and maltreatment (or other adversities) in a form that can be used later in care proceedings if the case goes to court. Social workers also need the support of a second practitioner who will visit the family with them at regular intervals to provide a second pair of eyes, review thresholds for taking more action and discuss case management with them (see also Laming, 2009).

7.6.4 Parental alcohol and drugs misuse

There is an urgent need to review reunification practice in cases where parents misuse alcohol or drugs (Maluccio and Ainsworth, 2003), to introduce clear expectations that parents will be required to undergo treatment (see Gossop et al, 2001) before children are returned to them, and that their substance misuse is closely monitored and reviewed before and during return. This is especially crucial in view of the strong link between substance misuse and a range of parenting problems, including higher levels of abuse and neglect (see eg Kelleher et al, 1994; Chaffin et al, 1996; Velleman and Orford, 1999; Tunnard, 2002a and b; ACMD, 2003; Kroll and Taylor, 2003; Cleaver et al, 2011; Farmer et al, 2011).

Greater access to treatment for parental alcohol and drugs problems is therefore required as well as more training for practitioners in how to work with parents with these difficulties and how to avoid "misplaced optimism" (Forrester and Harwin, 2004, p.129). Drug and alcohol workers who help parents with addictions need to keep the child's best interests central (Velleman, 2002; Kroll and Taylor, 2003). The evaluation of the pilot of the Family Drug and Alcohol Court (Harwin et al, 2011, 2013 and 2014) may provide important pointers for practice.

7.7 Implications for policy and practice

The evidence from these studies does show that there is a high risk of return breakdown and repeat abuse or neglect when children are reunified. Reunification practice therefore needs to be more rigorous in terms of assessment, decision-making, monitoring and review. Assessments need to be linked to written agreements containing timescales and clear consequences. Parental capacity to change can then be judged in the light of the actual progress parents do or do not make. Written agreements should specify the intensive services that will be provided to address the difficulties identified, and need to ensure that alcohol and drugs misuse services are involved when needed. Working with substance misusing parents without involving such services is unlikely to bring about change (Farmer, 2012).

Practitioners need good supervision to enable them to work purposefully with parents. They also need clarity from team managers and children's services departments, that if parents do not abide by the conditions set out in written agreements the local authority will

take action to protect children and plan for permanence away from their parents.

However, this is not the only challenge. A third (36 per cent) of the returns that survive have been found to be of poor quality, where children are living with parents with serious mental health problems or substance misuse difficulties (sometimes combined with domestic violence) who are often also physically or emotionally abusing or neglecting them (Farmer et al, 2011; see also Wade et al, 2011). This suggests that the quality of ongoing returns needs to be regularly reviewed so that decisions about such children's futures can be made more speedily than at present, in order to minimise the harm done by living with maltreating parents. It will also ensure that permanent placements away from their parents can be made without undue delay where necessary (see Farmer et al, 2010; Selwyn et al, 2010; Thomas, 2013).

In addition, there is a need to prevent children being repeatedly returned home, for example through ensuring that reviews pick up patterns of oscillation between home and care, so that more decisive intervention can be considered and permanence plans implemented. Government statistics also need to show clearly how many children's returns break down and how many times.

It is clear that leaving children too long in maltreating homes or repeatedly returning them there has serious consequences for children's long-term wellbeing. Yet the studies show that many of them are known to children's services from early on in their lives. There is no doubt that long-term work with maltreating families is often very difficult indeed. But it is also clear that earlier, more decisive intervention is needed, as well as purposeful reunification practice and robust planning for children's futures when parents cannot provide a satisfactory home for them.

Things are unlikely to change unless the government gives much greater priority to reunification, as it has begun to do with its 'Improving Permanence for Looked After Children' work programme. Government guidance and inspections should always include reunification when considering looked after children and permanence. Statistics need to be kept on the duration of returns, return breakdowns (and reasons for these) and number of breakdowns for each child (for the returns of *both* accommodated children and those on court orders) and such statistics need to published by local authority so that comparisons can be made.

Above all, there needs to be much greater recognition of the important part reunification plays in looked after children's lives, its interplay with other permanence options and the potential for good practice to improve children's outcomes. Our blindness to this area of practice is having a detrimental impact on children's lives and future prospects.

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CHAPTER 8

The mental health and wellbeing of young people leaving care

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The mental health and wellbeing of young people leaving care

By Jim Wade

Good mental health is closely associated with positive progress in other life domains after leaving care. However, a large minority of care leavers continue to struggle with mental health or emotional and behavioural problems that adversely affect their ability to cope. Only in recent years, prompted by developments in research, policy and practice, has the health of care leavers attained a higher profile. Service developments are therefore taking place from a relatively low base in comparison to other aspects of leaving-care services such as housing, finance, education and employment.

This chapter reviews international evidence on the mental health and wellbeing of young people leaving care and on factors associated with positive mental wellbeing. It summarises what is known about the support and services that are effective in meeting the mental health needs of care leavers and identifies gaps in service provision. Given the scale of mental health difficulties highlighted in this chapter it is clear that more needs to be done to meet the needs of young people leaving care.

8.1 Youth transitions and leaving care

In recent decades a restructuring of youth transitions has taken place that has created an extended period of personal and economic dependency for young people into their twenties. Changes brought about by the extension of education, the loss of labour market opportunities and changes to the welfare system have impacted on the ability of young people to make the transition to adult

independence (Bynner et al, 2002; Furlong et al, 2003). The practical and psychosocial stages of transition have become stretched and the key stages of transition – settling into employment, finding a home, choosing a partner and starting a family – take place over longer periods of time. Young people are therefore increasingly expected to rely on the resources of their family for longer, often using it as a continuing resource and returning to stay there when necessary (Jones, 2002).

However, not all young people have these resources available to them. Some may not be able to remain within the family or may be forced to leave, while others, mainly from working class communities, continue to follow more accelerated pathways to adulthood by leaving home or school at an early age or by becoming teenage parents. Central among the groups that make an early transition to adulthood are young people leaving care. Not only have they been expected to leave care at an early age, but the various stages of transition tend to overlap and be condensed into a short period immediate after departure (Biehal et al, 1995; Dixon and Stein, 2005; Dixon et al, 2006).

While some young people therefore go on to do well after they leave care, many others struggle. They face additional difficulties in comparison to their peers. They are quite likely to lack consistent support from their families. Most children and adolescents entering care will have experienced abuse or neglect alongside a range of other childhood adversities, which are known to have considerable effects on psychosocial development, cause the onset of emotional and behavioural problems and, in turn, affect educational performance (Rutter, 2000; Davies and Ward, 2011; Rees et al, 2011). While many young people find sanctuary in the care system and relief from the problems that beset their families, others experience further disruptions and discontinuities (Sinclair et al, 2007; Wade et al, 2011). This chapter addresses the consequences of these experiences at the point of leaving care and in the period after leaving.

8.2 The mental health of looked after children

At first entry to the care system, many children already show signs of mental health problems linked to genetic, pre-natal and post-natal family life experiences (Sempik et al, 2008). The high level of mental health problems among looked after children has been well documented in the UK and international literature (Meltzer et al,

2003; Ford et al, 2007; Golding, 2010; Tarren-Sweeney, 2010). Tarren-Sweeney's (2010) review of this literature highlights that regardless of location, around half of children in care have clinically significant mental health problems, and up to a further quarter have difficulties that approach clinical significance. The range of difficulties that characterise this group of children is also complex, including attachment- and relationship difficulties, trauma-related anxieties, inappropriate sexual or other behaviours, inattention, hyperactivity, conduct problems and defiant behaviour. While these difficulties may be rooted in their experience of family life they can also, for some children, be compounded by unstable and negative experiences of public care (Sinclair et al, 2005; Golding, 2010).

The scale and consistency of these findings has led to a developing consensus about the importance of early health screening, including screening for mental health and related emotional problems, as well as the integration of mental health specialists to work alongside and support social workers and primary caregivers in promoting the health, mental wellbeing and resilience of looked after children (Meltzer et al, 2003; Ford et al, 2007; McCauley and Davis, 2009; Golding, 2010). The ways in which therapeutic forms of care might help achieve this have been considered in detail by Kim Golding in Chapter 4 of this volume. These themes have also been highlighted in official guidance to local authorities, which includes the requirement for every looked after child to have regular health screening, a health plan that is regularly reviewed and an expectation that Child and Adolescent Mental Health Services (CAMHS) will provide dedicated and targeted services to looked after children (DCSF, 2009).

Young people's mental health on leaving care is intrinsically linked to their experiences in care. Early intervention is essential, not only to help children have more fulfilling and happier childhoods, but also to lessen the likelihood of poor outcomes when they leave care. Some groups may be more vulnerable than others. Children who enter care in adolescence for abuse, neglect or family breakdown often have an established level of emotional and behavioural problems that make it less likely they will settle and do well in care (Sinclair et al, 2007; Ward et al, 2008). In this group are those who continue to experience placement instability, whose care careers are more likely to be marked by offending, substance misuse, running away, truancy and school exclusion. These young people leave care for independent living at a very early age, often as a result of the behaviour

management problems they create for their caregivers, even though they are among the least well-prepared to do so (Dixon et al, 2006).

As a result, the purpose behind recent legislative initiatives in leaving care has been, as far as possible, to delay young people's transitions until they are ready to leave care (at age 18 or older) and to put a number of checks and balances in place to prevent them feeling pressured to leave. However, while recent evaluations of government initiatives in this area demonstrate that a cultural shift is taking place in professional attitudes towards young people remaining in care for longer (initiatives such as the *Right2BCared4*, *Staying Put* pilots, and the government's recent legislation to extend the right to foster care to 21), it still seems that those who stay with foster carers beyond 18 tend to have well-established familial relationships, and that young people with more complex needs still tend to be among those who move on early (Munro et al, 2011 and 2012). It remains the case that those who are least able and prepared to leave care successfully tend to be the ones to do so first. As we shall see later in this chapter, this raises important questions about the development of alternative supported accommodation options of high intensity for young people who are unable to 'stay put' but are otherwise at risk of poor outcomes.

8.3 The mental health and wellbeing of young people leaving care

Leaving care is an extended process rather than a single event. It is also a time of reflection for young people; one in which they often need to make sense of their past life experiences so that they may psychologically move forward towards a successful early adulthood. It is also a time when young people test out the reliability of the support that might be available from family members, concerned adults and friends to help them on their journey (Wade, 2008). Given the importance of these psychosocial dimensions of transition, it is surprising that the mental health and wellbeing of young people leaving care has been the focus of so little research and policy development.

One early English study of care leavers found evidence of a range of physical and mental health problems (Saunders and Broad, 1997; Broad, 1999). While almost half of the young people (48 per cent) reported at least one long-term physical health condition, 17 per cent

had long-term mental health problems including eating disorders, depression or phobias. In addition, over a quarter reported heavy drinking and two-thirds used drugs regularly.

Young people in the study took a broad view of the factors from the past and the present that negatively affected their health. These included poor housing, lack of intimate trusting relationships, the experience of unemployment, legacies from their family and care experiences, problematic access to health services and lack of preparation and support for leaving care. The importance of this holistic framework for how we must think about mental and physical health is echoed in later studies, reports and guidance, as is the need to improve the scope and consistency of health assessments and the services that flow from them (see, for example, Armstrong et al, 2000; Dixon, 2008; DCSF, 2009; Stein, 2012).

A study by Dixon et al (2006) followed care leavers from seven English local authorities over the first 12 to 15 months of their transition from care to independent living. Information relating to progress in key life areas (housing, education and employment, life and social skills, health and social networks) was collected from young people and leaving-care workers to form a baseline within three months of leaving care. The General Health Questionnaire (GHQ-12) was then used to measure changes in mental wellbeing over the follow-up period (Goldberg et al, 1997).

According to this measure, 10 per cent of young people reported poor mental health at baseline. This included depression, eating disorders, self-harming, anxiety attacks and psychotic episodes. Almost half (42 per cent) were also rated by their support workers as having emotional and behavioural problems. Among those with difficulties of this kind at the leaving care stage, more than 60 per cent were described as having moderate (41 per cent) to severe difficulties (11 per cent). Overall, taking account of those with multiple problems, 44 per cent of the sample had some form of mental health, emotional or behavioural problem at the point of leaving care (Dixon et al, 2006).

Between baseline and follow-up, some 12 to 15 months after leaving care, there was evidence of these problems having increased (see also Dixon and Stein, 2005, for similar findings in Scotland). Reports of mental health problems had doubled to 24 per cent. There was also increased reporting of 'other health problems' (28 to 44 per cent), including reports of asthma, weight loss, allergies, flu and illnesses

related to drug or alcohol misuse. Further analysis of the GHQ change scores showed an increase in symptoms for 41 per cent of young people, indicating some deterioration in young people's mental wellbeing over the follow-up period. Almost one-third (30 per cent) remained constant, while 29 per cent showed fewer symptoms: their mental wellbeing had improved.

The reasons underlying a tendency towards deteriorating mental health are complex. Some young people, as we have seen, will have a predisposition for mental health, emotional or behavioural problems arising from their genetic inheritance and/or early experiences of family life. For some, this may be compounded by negative experiences while being looked after. Evidence shows that psychological and social changes during adolescence may lead to an onset of new mental health difficulties such as psychosis or eating disorders, or make existing difficulties worse (Brodie et al, 2011). We also know that many looked after young people, especially those with already complex needs, experience great difficulty in holding together the different strands of transition simultaneously – including home, work, finance, social relationships and sometimes parenthood – and all the more so when support from social workers or other significant adults is lacking.

The study by Dixon et al (2006) found that young people with mental health difficulties tended to be struggling some 12 to 15 months after leaving care. As would be expected, young people having these difficulties at baseline predicted poorer mental wellbeing at follow-up. However, positive mental wellbeing was also closely interconnected with progress in other life domains. Scores for mental wellbeing were higher for young people who had successfully made a home for themselves; had established a positive foothold in education or employment; had good life and social skills, and were not greatly troubled by problems linked to substance misuse or offending. In contrast, young people with mental health, emotional or behavioural problems tended to have poor overall outcomes in these regards, and a lower rating for mental wellbeing and overall quality of life. These problems may not be very easy to change and may, in some instances at least, require long-term intervention and support from a range of services. However, the evidence shows that doing nothing exposes these young people to the risk of particularly poor outcomes on leaving care and reinforces the need for health screening and appropriate interventions to be provided from the point young people first enter the care system.

Experience of care may also have consequences for mental health and emotional wellbeing in later adulthood. Several UK and international studies of adults who experienced care in their childhoods (not necessarily care leavers as such) demonstrate connections between mental health and other outcomes in early to middle adulthood. Cheung and Buchanan (1997) used secondary analysis of the National Child Development Study to identify higher risks for depression among care-experienced adults at age 33, compared to the general population. Viner and Taylor (2005) used the 1970 British Cohort Study to show that care-experienced adults aged 30, when adjusted for socioeconomic disadvantage, were more likely than others to have psychological morbidity; poor general health; to have been homeless, or to have a conviction. A large-scale Swedish study of 718 young people who had been in care in their teens showed that where emotional and behavioural problems had been a reason for entry to care, psychosocial outcomes at age 25 tended to be poor, including high rates of premature death; hospitalisation for mental health problems; teenage parenthood, and low education attainment. Those who entered care for other reasons did significantly better, though still worse than their non-care peers. Finally, notwithstanding the rather more optimistic findings of a French study (Stein and Dumaret, 2011) on the health and integration of people who had been in care in middle and late adulthood, subjective reports on their health in late adulthood were nevertheless negatively correlated to persistent emotional and behavioural problems during placement and on leaving care.

Given this prognosis, it is important to consider the ways in which young people can be helped at the point of leaving care, should their difficulties not have been adequately addressed at an earlier stage. The remaining sections of this chapter will explore how young people's experiences of transition may be improved to reduce the potential for negative outcomes, and explore strategies for integrating mental health services into pathway planning and aftercare services in ways that are more imaginative, flexible and responsive to young people's mental health needs.

8.4 Moving forward: promoting the mental health and wellbeing of care leavers

The intention behind developments in legislation and guidance in the leaving-care field has been an attempt to make young people's

transitions from care more gradual and to improve the preparation, planning and support for these young people into early adulthood (DH, 2001; The Scottish Executive, 2004). Although variations in services between local authorities continue to persist, evidence suggests that these initiatives have prompted an expansion of leaving-care provision and led to some improvements in the planning, consistency and equity of these services (see Dixon and Stein, 2005; Dixon et al, 2006). A particular focus has been to delay young people' transitions from care to make the process more graduated and to provide greater continuity in young people's important links and relationships with caregivers, social workers and family members to support them through transition.

8.4.1 Delaying transitions – offering continuity

International evidence shows that that where young people are able to stay with foster carers beyond the age of 18, they fare better with respect to participation in education, training and employment up to age 24 than do those who leave early (Courtney et al, 2005; Wade and Dixon, 2006; Hook and Courtney, 2011). The additional support cushions young people, who are perhaps already well-motivated, against the effects of sudden or multiple transitions. As the findings from the evaluation of the *Staying Put* pilot suggest, the opportunity to stay on will be more likely if the relationship between the young person and foster carer is familial, the young person wants to stay, and emotional or behavioural problems are minimal (Munro et al, 2012). Since young people with more complex needs are less likely to stay on and do well educationally, they are consequently less likely to experience these benefits.

However, while this option may not suit (or be available to) all, it is clear that a range of well-supported alternative accommodation options are needed for young people with more complex mental, emotional, behavioural and health needs who leave care early. This may include supported lodgings, training flats, supported hostels (with support pitched at varying intensities) or accommodation with floating support provided by leaving-care services. Making a success of living (semi-)independently is among the most important elements of transition for young people. It is the rock upon which other successes can be built and resilience can be strengthened. The particular vulnerabilities of these young people are widely recognised by social workers, who do provide them with more intensive support.

They take up a disproportionate amount of social work time at the leaving-care stage, but practitioners also recognise the limitations of existing provision in offering support at a sufficient level of intensity to really make a difference and provide these young people with genuine turning points to help them steer their lives in a different direction (Dixon et al, 2006). Expanding the range of supported accommodation would give these young people more time and more support to prepare for later independence and reduce the risk of them becoming homeless.

Staying on may also help to cement relationships and provide continuing links for young people through transition. Over the years, the leaving-care literature has highlighted a tendency for support from foster carers and residential workers to fade away relatively soon after young people leave care (Fry, 1992; Biehal et al, 1995). Less than half of care leavers appear to retain direct contact with their carers 12 to 15 months after leaving care (Wade, 2008) and there appears to be a tendency for young people's social networks to contract, leaving them short of trusted adults to whom they can turn for advice and support (Munro et al, 2012). Young people with mental health difficulties are more likely to be among those who have experienced persistent maltreatment and/or rejection by family members. For them, the risks of social isolation on leaving care are high. It is therefore important that pathway planning takes account of all the potential sources of support that might be available to young people, including that provided by carers, extended family members and other trusted adults, and that these key people are drawn into the pathway planning process in ways that are acceptable to the young person. The fear of social isolation is a central worry for young people leaving care, especially for those who realise they will find life difficult.

Young people who leave the family home may return to stay for periods of time before they finally leave. However, the potential for young people who were in care to return to the shelter of their placements when it becomes too difficult for them to manage on their own has been insufficiently exploited (Jackson and Thomas, 2001; Wade, 2008). This is likely to be particularly important for young people with complex needs, including disabled young people taking a pathway to independence, who are quite likely to experience difficulties managing their lives (Priestley et al, 2003). Normalising the experience of transition should involve keeping the door ajar, as is the case for most young people leaving their birth families (Stein and Morris, 2010). Making transitions more gradual and more finely

calibrated and allowing for movement back and forth along the continuum towards independence may help to prevent young people falling over the edge into homelessness.

8.4.2 Pathway planning

Regulations and guidance on leaving care have tightened the rules on pathway planning. These arrangements for needs assessments and pathway plans have been broadly welcomed by local authorities. They are leading to more transparent and equitable procedures, the encouragement of forward planning including health planning and multi-agency working (Broad, 2003; Dixon et al, 2006; Cameron et al, 2007; DfE, 2010). How planning is conducted is of critical importance. There is criticism that some young people find the process bureaucratic rather than engaging, that the quality of record keeping is variable and that health records, in particular, are quite poor (Munro et al, 2011). It is suggested that pathway planning works well when it takes place gradually over time on a cooperative basis between worker and young person: a 'doing with' rather than a 'doing to' or 'doing for' basis (Ofsted, 2009). Improvements are therefore needed to ensure that pathway plans are the product of an interactive, young person-centred process that takes place over time.

Given the interconnectedness between mental health and other life domains, the role of personal advisers (or leaving-care workers) in providing 'whole person' support is vital. As we have seen, working across life domains in a holistic way can help to prevent difficulties in one life area affecting others and can therefore be protective of mental health and wellbeing. Personal advisors are responsible for staying in touch with young people (up to age 25 if continuing or resuming education); coordinating and reviewing the services required to meet the plan; helping young people establish and keep a foothold on the housing and careers ladder, and helping them hold together and reinforce the threads of their support networks.

Young people generally welcome this support, even though services continue to be highly variable (Morgan and Lindsay, 2006). They especially appreciate having a strong relationship with their personal adviser. They want someone they can trust; who will listen to them and treat them with respect; who will demonstrate that they care by being available, responsive and by advocating for them when necessary (ibid; Ofsted, 2009). Young people also like the informality of specialist leaving-care services where these are available, including

the opportunities they provide for social activities, group work and peer mentoring that can reduce social isolation, help young people to develop networks of support and strengthen their interpersonal skills (Dixon et al, 2006). Beyond these generic services, however, some young people and those working with them will also need access to specialist therapeutic services.

8.4.3 Access to mental health services

The profile being given to health monitoring and planning for looked after children and care leavers has increased in recent years (Ofsted, 2008; 2009). However, continuing problems exist in young people's access to mental health services, especially for older young people approaching the age of leaving care and for those with a lower level of mental health need. Long waiting lists; thresholds and conditions for accessing CAMHS services (including a need for children to be settled in placement); placement out of area; regional variations in CAMHS, and the inflexibility of services (venues, appointment times and so on) can all act against young people receiving the services they need (Beck, 2006; Mooney et al, 2009). Some young people, perhaps especially those from minority ethnic communities including young asylum-seekers, face additional barriers arising from language difficulties, experiences of racism, and cultural misunderstandings that stigmatise mental health problems, leading to negative attitudes towards formal mental health services (Wade et al, 2005; Brodie et al, 2011).

Surveys of looked after young people, including young care leavers, have elicited their views on the kinds of mental health services they would like to see (Young Minds, 2006 and 2012). The services they wish for:

- are personalised and tailored to their particular needs
- help others in their lives to reach a good understanding of their difficulties
- place the development of good quality trusting relationships and positive mental health (rather than ill-health) at the centre
- are easily accessed, flexible, seek out the views of young people and maintain respect for them

- are imaginative, conducted in community-based rather than formal therapeutic settings and consult young people about the evolution of these services.

There is also evidence in research and official guidance that the engagement of looked after young people and care leavers with mental health services is improved where these are integrated into the work being done by children's social care (DCSF, 2009; Tarren-Sweeney, 2010). A review of CAMHS (2008) and work undertaken by Mooney et al (2009) to inform official guidance on health have recommended that:

- A child or young person should never be refused a service on the grounds of their placement being short-term or unplanned (an important proviso where young people are experiencing placement- or post-care instability).

- There are referral pathways that are understood and used by all agencies that come into contact with the child or young person.

- CAMHS services provide targeted and dedicated services to looked after children (and younger care leavers) where there is an identified local need (see DCSF, 2009, p.28).

Some leaving-care services have been seeking imaginative solutions in recent years. These developments have seen the emergence of what has been described as a 'corporate parenting case model' (see Stein, 2012). In this model, case responsibility rests with the young person's personal adviser as coordinator of services that wrap around the young person, and the corporate responsibility of local authorities is reflected in formal service-level agreements with other agencies. In this way, leaving-care services may integrate professionals from different disciplines (housing, education, health) through secondment or co-location to provide integrated services for young people in one place. Mental health professionals may provide indirect services by offering training and support to social workers and carers who work with young people as well as direct services to young people through group work or individual therapies. These developments, though small in scale, represent a hopeful way of integrating mental health support into the everyday lives of young people in ways that chime with what they say they want from these services.

8.4.4 Transition to adult services

Some care leavers will need continuing access to mental health services during adulthood. However, the transition from CAMHS to adult mental health services (AMHS), generally at 18 years of age, often fails to take place smoothly. Poor service transitions make it more likely that young people will disengage from mental health services even though they have a continuing need for them. Evidence from a review of research conducted between 2000 and 2011 identified some of the common difficulties experienced by young people, including care leavers (Brodie et al, 2011). Most young people, families and carers report finding the transition to AMHS confusing and difficult to negotiate. Differences in referral thresholds between CAMHS and AMHS, such as willingness to work on emotional and behavioural problems, may result in some young people not being referred or being ineligible for services. Once accepted for a service, young people's experiences of AMHS have often been poor (see also Lamont et al, 2009) and local variations in the level and types of adult services that are available have been too inconsistent. These have led some commentators to suggest the need for specialised mental health services for young people aged 16–24 to overcome these difficulties (ibid).

Research has provided a consistent range of messages in support of the positive transition practice that is well-matched to the views of young people outlined above (Brodie et al, 2011). These messages highlight the importance of:

1) situating the transition to AMHS and young people's mental health needs in the context of their broader transition to adulthood, and as part of a broader package of support

2) listening to and taking account of young people's views and involving them (wherever possible) in service developments

3) providing young people with the continuing support of a trusted professional

4) providing a flexible range of non-stigmatising services

5) improving preparation and planning for transition so that young people and their carers are well-informed and properly signposted to the services that will be available

6) developing collaborative flexible working arrangements between agencies, clear protocols, joint commissioning arrangements and transparent planning

7) making provision (incorporating the role of voluntary agencies) for the continuing support of young people with mental health needs that do not reach the threshold for AMHS.

These findings are also consistent with the conclusions drawn by the review of CAMHS (2008). In relation to young people approaching 18 years of age who are being supported by CAMHS, the review recommended that young people, their parents and carers should:

- know well in advance, following a planning meeting at least six months before their 18th birthday, what the arrangements will be for transfer to adult services

- have a lead person who makes sure that the transition between services takes place smoothly

- be able to access services that are based on best evidence of what works for young adults, which have been informed by their views

- know what to do if things are not going to plan

- have confidence that these services will be flexible and that they will focus on need, rather than age (CAMHS, 2008, p.12).

Taken together, these messages drawn from research, consultations and service reviews provide a framework in which the experience of transition to adult services for young people, carers and families could be significantly improved. For young people leaving care, continuing access to a range of flexible and responsive mental health services is critical.

8.5 Conclusion

By the time many children enter the care system they already display a range of complex mental health needs that are related to their early life experiences. These adverse experiences leave children vulnerable to developmental delay and emotional and behavioural difficulties that affect their educational progress. While many children settle and do relatively well once looked after, others do not, perhaps especially those who enter in later childhood and for whom patterns of instability and disaffection have become established.

Although young people with more complex needs may be among the least prepared to leave care, they swell the ranks of those who leave care the earliest and for whom initial outcomes are generally poor. Efforts that are being made to delay young people's transitions from

care rarely affect them and, without the intensive support provided by leaving-care services, they are at high risk of homelessness and destitution. These young people are less likely to benefit from *Staying Put* arrangements, and attention should therefore be given to developing a range of medium- to high-intensity supported accommodation options that can better cater to their needs.

Improving our support for care leavers needs to start much earlier in their journey through care. There is a clear need for improved health screening to identify these problems in children at entry to care, and for an appropriate range of therapeutic services to support and supplement the care provided by carers and social workers. Where these interventions are not provided the prognosis on leaving care is not great.

Mental health services need to be tailored to the needs and circumstances of this group of young people and be provided as part of a holistic package of transitional support. Young people experience life in an inter-connected way – what happens in one area of life affects progress in others. Making a success of home-building and being economically active has positive effects on care leavers' mental wellbeing and overall quality of life. The converse, however, is also true. Equally, the pressures of accelerated transition may also lead to some deterioration in young people's mental wellbeing in the period after leaving care. Practitioners therefore need to be alert to signs of deterioration in young people's mental wellbeing, ready to adjust pathway plans and support arrangements accordingly.

Young people want services that are personalised, responsive to their needs and delivered in a flexible way. They want some say in how these services are developed. The rigidities in accessing CAMHS and AMHS are not helpful and cause some young people to disengage from services when their need for them is great. Leaving-care services have been successful in delivering transitional support in these ways and young people generally value the consistent support provided by personal advisers.

Progress that is being made towards the integration of services and the co-location of different professionals working together does offer promise for the development of an adaptive and imaginative mental health service for care leavers that would encourage their engagement and help to improve their chances of making a successful transition to adulthood. However, so far these developments are small in scale and need to be adopted much more widely so that young people can access the kinds of therapeutic services they want and need.

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CHAPTER 9

Making wise decisions about care

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By Harriet Ward

9.1 Introduction: the needs of looked after children

On 31 March 2013, 179,090 children in England were supported by local authority children's services for reasons of abuse and neglect (DfE, 2013b). However, the vast majority received family support services, provided voluntarily within the family home: only 52,700 were the subject of child protection plans, and even fewer, 42,480, were placed away from home for this reason (DfE, 2013a; 2013b). Although only a minority of abused and neglected children enter care, high threshold criteria ensure that these are likely to be the most vulnerable of this already vulnerable population. There is also evidence that, although abuse or neglect is the primary reason for placement for only about 60 per cent of looked after children, a much higher percentage of this population has been through these damaging experiences.

Although the number of children entering care has increased since the national outcry following the death of Peter Connolly in 2007, there are still about 30 per cent fewer children placed away from home than before the Children Act 1989 was implemented. The threshold for entry has been raised over the last twenty years in response to the family-centred principles reflected in the legislation (discussed below). As a consequence, within the population who *are* looked after there is a higher concentration of children with emotional and behavioural difficulties and/or physical and cognitive disabilities; many of these often complex needs are the result of previous experiences of abuse and neglect.

Findings from the looked after children cohort of 478 children who all entered care within the same twelve months and remained for at least a year showed that at entry, 51 per cent of these long-stay children, including nearly one in five of the 0-4 year olds, were displaying emotional and/or behavioural problems of sufficient severity to be a matter of concern to their current carers. Seventeen per cent of those aged ten or over had already been convicted of an offence or given a caution or final warning. Transience had also been a common experience for children in this cohort: for instance, 12 per cent of the babies in this sample who entered care before their first birthday had already had four or more primary carers while living with their birth families. Interviews also indicated that a substantial proportion of older children had experienced frequent changes of school and lengthy gaps in their education before entry to care (Skuse and Ward, 2003; Ward et al, 2006; Darker et al, 2008; Sempik et al, 2008).

Other studies show that children who have experienced abuse and neglect may frequently go missing from home (and subsequently missing from care) and be vulnerable to sexual exploitation (see Chapter 6). Although not inevitable, children who have been sexually abused may well become abusers themselves. Peer violence can become an intrinsic part of a culture, particularly among children and young people whose life experience has been marred by abusive or neglectful parenting. Gay and lesbian children may be particularly vulnerable to victimisation (see Chapter 5).

Our care system needs to be – and should be seen to be – part of an effective child protection system. For this to be achieved, it has to be able to demonstrate that it can keep children safe from further harm and that it can offer them high-quality care and specialist support that will help them overcome the consequences of previous adversity. This means enabling children to come to terms with previous experiences of abuse and neglect and/or other traumatic life events, and overcome the negative impact these may have had on their physical, social, emotional, behavioural or cognitive development. The preceding chapters in this book have explored a range of areas, such as permanency planning; the provision of adequate mental health services; protection from sexual exploitation; support for children and young people returning home or making the transition to independence, and have identified how these all need to be improved before this can happen.

This chapter draws on the evidence from these earlier chapters as well as on additional research to explore the wide range of factors that influence the decisions made before, during and after the care episode that can enhance or diminish the effectiveness of placing children away from home. These factors fall into four broad themes:

- The underlying issues reflecting the principles behind policy and legislation and the culture of the workforce, including perceptions of the purpose and value of care.

- The assessment of the needs of looked after children and their carers.

- The extent to which practitioners have the requisite knowledge and skills to identify how these needs might most appropriately be met.

- The availability of resources (including appropriate placements).

Although all four themes will influence decisions made by professionals, different constellations of factors within these themes will hold greater or lesser sway throughout a child's journey through care, from entry through placement to reunification, permanent placement away from home, or transition to independence. It should also be noted that although professionals hold the balance of power when such decisions are made, carers, birth parents and the children themselves are also active agents in this process, both through their formal, but often inadequately supported, participation and also through the impact of their own direct and indirect actions. For instance, a number of placements in accommodation made under the Children Act 1989 (s.20) end either because children and young people vote with their feet and refuse to remain in substitute care, or because parents remove them against the wishes and/or advice of the local authority (Wade et al, 2011).

9.2 Underlying issues: principles, values and culture

Although there has been subsequent, secondary legislation in this area, the Children Act 1989 and its equivalent in the different jurisdictions of the UK still provides the legal context in which the state can legitimately intervene in the private lives of families and, where necessary, place children away from home. The Act takes up and strengthens a principle that began to emerge after the abolition

of the Poor Law, and lays down that in making decisions concerning such interventions: "the child's welfare shall be the court's paramount consideration" (Children Act 1989, s.1.1). However, maintaining a primary focus on the welfare of the child in the face of numerous other considerations continues to be exceptionally difficult to achieve, as several of the previous chapters have demonstrated (see also Ward et al, 2012).

9.2.1 Legislation and principles

Practitioners from a wide range of disciplines find it particularly difficult to maintain a focus on the welfare of the child when this appears to be in conflict with the welfare of the birth family as a whole, an issue that frequently arises when there is a question of placement away from home. The Children Act 1989 is based on a principle, also embodied in the UN Convention on the Rights of the Child, that children are generally best looked after within the family. This is reflected in the duties laid on local authorities to provide services for children in need and as far as possible to "promote their upbringing by their families" (The Children Act 1989, s.17.1); to enable looked after children to live with persons connected to them (ibid, s.23.6), and to allow reasonable contact between looked after children and their parents (ibid, s.34.1). These principles are obviously in the best interests of the vast majority of children. However, although the legislation makes it clear that this is not the intention, it has sometimes been interpreted as implying that it is in the best interests of *all* children to be brought up within their birth families, making it harder to make appropriate decisions concerning the small number for whom this is not the case (Ward et al, 2012).

In disputed cases, parents can argue that decisions to place children away from them contravene the Human Rights Act 1998, which specifies a right to respect for private and family life (Article 8). The expectation that all children are best looked after by their birth families may be reinforced by arguments based on such concepts of parental rights, which shape decisions made by the courts. The counter-argument that abused and neglected children also have a right to family life, if necessary outside their birth family, and that they also have a right not to be subject to inhuman and degrading treatment (ibid, Article 3) is less frequently heard (Munro and Ward, 2008; Masson et al, 2008). As a consequence children often remain in, or return to, abusive families, or decisions to remove them are

inappropriately delayed, to the detriment of their long-term life chances (Brown and Ward, 2012). Decisions that fail to take account of children's rights as well as those of their parents undermine principles that require the voice of the child to be heard.

9.2.2 Professional values, culture and empowerment

It is therefore particularly difficult to keep the welfare of the child at the centre of decision-making when this conflicts with parents' wishes and needs. This is an issue for all professionals involved, including judges and magistrates, but is a particular problem for social workers because their training and culture emphasises the importance of working in partnership with parents, of empowering those whose voices are rarely heard, and of valuing diversity. Moreover, many parents are very young and vulnerable themselves, and it is not always easy to relate to them as the adults in the situation. Practitioners from a wide range of disciplines are also more likely to form relationships with the parents than with the children in a family, with whom they may have fewer opportunities to communicate directly. Deciding that parents do not have sufficient capacity to overcome adverse behaviour patterns and provide a nurturing home within a child's timeframe is an exceptionally difficult decision, made harder because it goes against the grain of these expectations and working practices: it is difficult to think of an action that is more disempowering than the removal of a child[11].

9.2.3 Perceptions of the purpose and value of care

The Children Act 1989 was intended to reconfigure the relationship between child welfare professionals and parents, offering better incentives for both to work in partnership in the interests of children and reducing the adversarial nature of many of the interactions that preceded it. As highlighted, the emphasis was on constructing a child welfare model, whereby the state would safeguard and promote the welfare of children in need – including those in need of protection – by providing a range of family support services, rather than a residual, child safety model in which the state only intervened to rescue children from maltreatment (see Chapter 1). Care, in the form of accommodation under the Children Act 1989 (s.20) was envisaged as one of these supportive services (Aldgate and Statham, 2001).

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11 For a fuller discussion of these issues see Ward et al (2012); Chapter 7.

However, the strong emphasis on family preservation has made it harder to achieve this objective. If, as many practitioners argue, their primary role is to keep families together (Davies and Ward, 2012), then care and accommodation are seen as measures to be avoided wherever possible, rather than as a means of safeguarding children from harm and perhaps of supporting overburdened families by providing some form of respite. Such considerations are given additional force by the argument that care is inherently damaging for children, a view that has been much publicised despite the evidence of the positive difference that care can make (see Chapter 1). If care is likely to be a negative experience that will increase the likelihood that children's development will be compromised, then it might be less damaging to leave them exposed to an abusive family situation.

There are long-standing and well-documented problems in the English care system. These include: evidence of abusive and, more commonly, insensitive carers; the lack of appropriate specialist support for children and young people who have experienced maltreatment and/or trauma prior to entry; instability of placements; low aspirations, poor outcomes and insufficient support for young people making the transition to independence. Many of these issues have been raised in previous chapters, which highlight ways in which they might be addressed. These problems are not specific to the British care systems, but are also commonly found in other countries.

Nevertheless, the most recent research evidence from France (Dumaret and Coppel-Batsch, 1998), Australia (Barber and Delfrabbo, 2004), Norway (Slinning, 2004) and some, though not all, studies from the USA (Horwitz et al, 2001; Taussig et al, 2001) indicate that care can, and frequently does, have a positive impact on children's welfare. The same is true of British research, which also shows a broadly positive picture of care (see Forrester et al, 2009). Self-report surveys and interviews with children and young people who have been looked after tend to corroborate these findings in that they show that the majority regard themselves as having benefitted from care (Ward et al, 2005). A recent major English study of the outcomes of care found that where there is evidence of past abuse, and particularly neglect, maltreated children who remain in care find greater stability and achieve better wellbeing on a wide range of indicators than those who return home (Wade et al, 2011)[12].

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12 For a fuller discussion see Ward et al (2012), pp.23-26.

However, while the care system appears to provide a better quality of care – and better outcomes in terms of both stability and wellbeing – than reunification with birth parents who have not yet addressed the reasons why separation was thought to be necessary in the first place, what it does not yet do adequately is to help children and young people overcome these complex emotional, behavioural, social and cognitive needs that are the consequences of their earlier experiences (see Chapter 4 for further explanation). As a result, many children and young people leave care with poor social skills, challenging behaviour patterns and educational achievements that lag behind those of their peers. There is also evidence that teenage care leavers are still often expected to cope with a premature transition to independence for which they are ill-prepared (Stein and Munro, 2008). Several chapters in this book suggest how improvements might be made in these areas (see Chapter 8 in particular).

9.2.4 Impact on decisions about entry and reunification

The principle that children will generally be best looked after within their birth families; the focus on safeguarding the family rather than the individual children within it; the emphasis on the rights of parents and the need to empower and work in partnership with those who are vulnerable; the widespread misperception that care is a negative and damaging experience for children: these are all factors that intertwine and impact on decisions about care. Their impact is seen most clearly in decisions made about whether or not children should enter (or re-enter) care, and in decisions about returning home.

Because care continues to be seen as such a damaging experience, both for the child and for the family, it tends to be used as a last resort and the decision to place a child is postponed for as long as possible in the hope that it may never be necessary. The result, however, as has been pointed out in Chapter 1, is that many decisions to place away from home are then made precipitately, in response to a specific crisis and without adequate preparation or thought. There is then little opportunity to wait for a placement that is suited to a child's needs, let alone to arrange introductory visits between children and potential carers. Instead, the child is likely to be found in emergency, temporary accommodation, which is often unsuited to their needs – for instance to be with siblings or with carers from the same race and culture, or to be with carers who are skilled in understanding exceptional needs and addressing challenging behaviour patterns.

The misperception that care is a damaging experience also leads to the expectation that if it does become unavoidable, the care episode will be brief and swiftly followed by reunification. Although 34 per cent of children do return home very shortly (within six months), 66 per cent do not. There is an intricate relationship between delayed decisions concerning placement away from home, false expectations that the care episode will be temporary, and instability within the care system (Ward et al, 2006). The child's first (emergency) placement is often a stopgap solution, necessitating a further move. The false expectation that reunification will nevertheless be swift can, for some children, then lead to a series of supposedly temporary placements, which exacerbate feelings of insecurity and mistrust and can lead to a pattern of disruptions in the future.

The view that care is inherently damaging also leads to untimely reunification (see Chapter 7). There is ample evidence, for instance, that parents' mental health problems, substance misuse and domestic violence are all factors that increase the likelihood that children will suffer significant harm, particularly when they occur in combination (see for instance Hindley et al, 2006; Cleaver et al, 2011). Ensuring that parents' needs and problems have been adequately addressed should be a prerequisite to successful reunification. Yet this does not always happen, either because services are ineffective or unavailable (there is a particular dearth of services to address alcohol abuse), or because parents are resistant or lack the capacity to change. As Elaine Farmer argues in Chapter 7, insufficient policy development in this area has led to a situation where decisions concerning reunification are not always made in the best interests of the children concerned.

9.3 Assessing the needs of looked after children and their carers

Given that a number of children will not be adequately safeguarded unless they are placed away from home, and that swift reunification will not be appropriate for a proportion of this population, the first step in developing a service that is more responsive to their needs is to ensure that thorough assessments are undertaken before a placement is made. The very complex needs of these children underline the importance of interdisciplinary working, both in making assessments and providing services. For instance, in Chapter 4 it is argued that mental health assessments should be undertaken for all children at entry to care, a point that is supported by the national guidance,

which states that mental health *should* be a core element of statutory health assessments for all looked after children aged five and over (DH, 2009, p.68).

9.3.1 Assessments and decisions about placements

Thorough assessments and appropriate placement plans should not only take account of a child's previous experience of abuse and neglect, but also the impact this has had in the past on, for instance, their relationship with peers, which may be characterised by violence or victimisation. Decisions about introducing a new child or young person with high support needs into a foster family should take account of the needs of other children in the household. The untimely introduction of a newcomer may jeopardise the tentative bonds being formed between an established foster child and his or her carers. There will also be an impact on foster carers' own children, who will not only have to compete harder for their parents' attention, but who may also find themselves witnessing conflicts between the foster child and their parents, and/or become the depositories of disclosures. Again, as demonstrated in Chapter 5 these issues are frequently ignored in decisions about placements.

Assessments of children's needs should not only inform decisions about the type of placement required, but also the additional support needed for children, parents and carers. It is likely that the package of expert support required will not only include services for the looked after child, but also for residential staff, foster carers and other children in the placement. If care is regarded as an integral part of an effective child protection system, it follows that intensive psychotherapeutic and educational catch-up services should be accessible wherever the child is residing and should, ideally, follow the child from home through care to reunification. There is evidence, however, that expert support is often unsuited to a child's needs and interrupted when children move from one placement to another or between home and care (Ward et al, 2002).

Comprehensive assessments and robust care planning should ensure that looked after children are placed appropriately and receive the expert support they need to help them overcome the consequences of abuse and neglect. However, at present there is too little evidence that decisions about care, specifically about placements and their likely duration, are adequately informed by clear assessments of the complex needs of both children and birth parents at the time of

separation. Tools to facilitate such assessments have been available for several years, but they are often ignored (Brophy et al, 2012); moreover, social work assessments often fail to take account of the potential impact of abuse and neglect on children's subsequent development, or of evidence (or absence thereof) of parents' capacity to change (Ward et al, 2012). Analysis of the information collected can also be poor, so that plans sometimes bear little relationship to the evidence concerning the needs of the child and their family (Cleaver et al, 2008).

Several of the chapters in this volume indicate that the assessment and planning process and decisions about placements often fail to take adequate account of the views of children and carers. As pointed out in Chapter 3, understanding children's views in situations where they are abruptly moved following unsubstantiated allegations about carers; understanding carers' views about delegated responsibilities, or the impact of children with specific needs on the wider family dynamics should play a key role in decision-making. Failure to listen sufficiently to children and carers, or to include them adequately in the decision-making process has a severely detrimental impact on outcomes.

To some extent, insufficient attention to the views of carers and children and absent or inadequate assessments are an inevitable consequence of the precipitate nature of many admissions to care. However, gaps in social work knowledge and understanding, with time and money in short supply, also play a part, as discussed below.

9.3.2 Planning for stability

While some children and young people require intensive packages of support to meet their needs, all need consistency and stability. In recent years targets have been set and actions taken to increase the stability of care placements, with some degree of success – the proportion of children in England who experience three or more placements in a year reduced from 13 per cent in 2007 to 11 per cent in 2009-2010 in England, although the 2013 figure is still 11 per cent (DfE, 2010; 2013b). However, the frequency with which children continue to change placements still leads to a false perception that movement is unavoidable – something that should be vigorously challenged. Intensive packages of support may serve to strengthen fragile placements and prevent breakdown, but disruptions only account for less than a third of placement moves. A recent analysis of movement within the care system found that the majority of

placement changes (54 per cent) are initiated by agencies for reasons related to delayed and precipitate entry or overoptimistic expectations of a swift reunification as discussed above, rather than as a result of a breakdown in relationships between children and carers. It also found that the pattern of movement does not slow down significantly until the third year of a care episode (Ward, 2009).

The failure to provide large numbers of children with a stable and secure home base for much of their childhood is one of the greatest weaknesses of the British care system (although the problem also arises in many Western societies, see Stein and Munro, 2008). Instability in care often compounds children's experiences of transience within their birth families and is severely detrimental to their ability to form attachments, their sense of identity, and their overall long-term wellbeing (Ward, 2011). Unnecessary movement may be regarded as a form of emotional abuse (Glaser and Prior, 1997) and every effort should be made to eradicate it. Placement decisions should be informed by an understanding of the importance of providing children with a sense of stability and security.

There is an increasing amount of information concerning the needs of looked after children and their families; understanding about which interventions might be most effective in meeting their needs is also improving. It is clear that this knowledge *should* inform decision-making about placements. However, it is evident from many of the previous chapters in this volume that this does not always happen. This chapter concludes by exploring two factors that can act as barriers to making decisions about placements that are most likely to meet the child's needs: deficiencies in practitioners' skills and knowledge, and issues related to resources.

9.4 Practitioners' skills and knowledge

The *Munro review* recommended that initiatives should be introduced to move child protection work away from a compliance culture, dependent on rules and regulations, towards one that relies more on professional judgement (Munro, 2011). While there is little doubt that social workers' judgement has been undervalued in the past, sound professional judgement:

 "… requires social workers to be in possession of the right knowledge and be capable of clear reasoning. Children need and deserve a high level of expertise from their social workers who make such crucial

decisions about what is in their best interests. This expertise should include being skilled in relationships where care and control often need to be combined, able to make critical use of best evidence from research to inform the complex judgements and decisions needed and to help children and families to solve problems and to change." (Ibid, p.84, para 6.1).

A number of studies have found, however, that at present, decisions made not only by social workers but also by a wide range of professionals with safeguarding responsibilities are made from an inadequate knowledge base. For instance, recent research on safeguarding children has found that evidence concerning risk and protective factors in families where there is a likelihood of significant harm, and in particular what is known about parental capacity to change and the likely timeframes, is not widely disseminated or understood (Davies and Ward, 2012).

Similarly, recent research in a wide range of disciplines, from the neurosciences to developmental psychology, identifies the fundamental role played by the primary carer in all areas of infant development and demonstrates the long-term adverse consequences of abuse and neglect in the early years, including when it occurs *in utero* (see Brown and Ward, 2012 for a summary). Yet interviews with social workers reveal that child development has often been only a small part of pre-qualifying training, and one that is quickly forgotten. Theories of attachment are also sometimes misunderstood – for instance secure attachment to a birth parent or temporary carer is sometimes used as an argument *in favour* of separation on the grounds that it can be easily transferred (Ward et al, 2012).

Insufficient knowledge means that decisions frequently take too little account of the complex needs of children who have experienced abuse and neglect before entering care, and so insufficient attention is given to ensuring that placement changes are kept to a minimum and carers and other children in the placement receive adequate support from a multi-disciplinary team. Poor understanding also results in a mismatch between timescales for early childhood development and service responses. As a result, crucial decisions concerning entry to care can be delayed until children have been left so long in damaging situations that the consequences of abuse and neglect are difficult to overcome, even with intensive support from specialist services. Consequently, the chances of achieving stable placements in foster care or with adoptive families are increasingly diminished.

There is some evidence that the courts' unwillingness to rely on the judgement of social workers leads to unnecessary delays in decisions about care, as expert witnesses are called to make assessments that sometimes duplicate the work of the local authority (Masson et al, 2008). However, social work judgements will not be consistently reliable until practitioners have better access, through pre- and post-qualifying training, to up to date knowledge about child development; the impact of abuse and neglect; factors related to significant harm and its recurrence, and parents' capacity to change. This requires sustained investment in their continuing professional development.

9.5 Resources

Finally, any discussion about factors that influence decisions about care is incomplete without considering the impact of limited, and often inadequate, resources. Even before the current economic situation, resources, in terms of professional time as well as funding for placements and specialist services, were often considered insufficient to meet the needs of the care population: cuts to local authority budgets and increased demands have exacerbated this situation.

Care is an expensive service, and many authorities operate extensive gatekeeping processes to keep the numbers of children admitted to a minimum, and thus keep the budget under control (Ward et al, 2008). Limited resources are therefore another reason for delaying the decision to place and may contribute to the high number of precipitate entries. There is some evidence, however, that such reasoning is based on a fallacy. Delaying the decision to place children may mean that they are subject to lengthy experiences of abuse and neglect, and as a result will require more specialist, and therefore more expensive, placements when they finally do enter care. A study by Ward et al (2008) of the costs and outcomes of care found that children with complex needs (emotional and behavioural difficulties plus offending behaviour) were on average two years older when they entered care than other children who required less specialist support. Although their care episodes were shorter because of their age, they cost more than those of other looked after children because they moved so frequently from one carer to another, with each change requiring a more expensive placement. Their welfare outcomes were also less satisfactory.

Although better understanding of the costs of delayed entry to care might improve decision-making in this area, limited resources will continue to have an impact. There is probably a shortfall of about 8,750 foster carers across the UK (The Fostering Network, 2011), with the result that choice is often non-existent so that frequently, placement decisions cannot be driven by children's needs, but only by what is available. Nevertheless, better use might be made of those resources that *are* available: for instance, foster carers might be used more imaginatively to provide support for both parents and children following reunification, thus perhaps making it less likely that children will need to return to care. Better training of foster carers and greater understanding of the complexities of their task might also mean that more carers are skilled at responding to those children who have exceptional needs (see Chapters 4, 5 and 6).

Well-disseminated evidence on what services are effective might also improve decision-making and ensure that limited resources are used efficiently. A number of intensive evidence-based programmes have been developed to address the specific needs of children, parents and families where abuse and neglect are likely to occur or recur and are now being piloted and implemented in some English local authorities (see Chapter 3 and also Davies and Ward, 2012). These programmes have been subject to rigorous evaluation – a practice that could improve how resources are used and affect decisions about which interventions to utilise if they could be used more widely.

9.6 Conclusion

Decisions about care are influenced by a complex web of interlocking factors. Wise decisions that focus on the best interests of the child should be based on an understanding of parents' problems and the likelihood of their ability to overcome them within a child's timeframe. This must be informed by a thorough assessment of children's needs; the impact of abuse and neglect on their developmental trajectories; accurate information about the strengths and weaknesses of care, and the views of children and carers. Alongside this, practitioners have to grapple with the resources available to them and consider how they can best be used in a timely fashion.

In too many cases these decisions are marred by misunderstandings about the principles and values of the Children Act 1989 and misperceptions of the outcomes of care. Practitioners have insufficient

knowledge of childhood development; remain overoptimistic about parents' capacity to change; carry out inadequate or incomplete assessments, and are influenced by both perceived and genuine shortages of resources. It is vital that these issues are addressed as a prerequisite to safeguarding and promoting the wellbeing of our most vulnerable children and improving the outcomes of care.

9.7 Recommendations

1) Practitioners need to be aware of the difficulties they and others will encounter in keeping the welfare of the child at the heart of decision-making. In particular, they should be encouraged to reflect on the challenge of making difficult decisions that sometimes require them to accept the limitations of principles of family preservation and empowering vulnerable parents, when these aims appear to be in conflict with the need to safeguard and promote the long-term wellbeing of an individual child.

2) The evidence that the care system provides abused and neglected children with better opportunities for stability and for achieving long-term wellbeing than does return to birth families who have not overcome their difficulties should be widely disseminated.

3) Continuing efforts should be made to improve the extent to which the care system can help abused and neglected children to overcome the complex emotional, behavioural and social needs that are the consequence of their earlier experience.

4) Care should be developed as an integral part of an effective child protection system that offers children and young people continuing, intensive psychotherapeutic and educational catch-up services to meet their needs wherever they reside, from birth home through care to reunification or independence.

5) Changes of placement are not inevitable. Unnecessary movement of children between placements should be regarded as a form of emotional abuse and every effort should be taken to eradicate it.

6) Sustained investment is required in the continued professional development of practitioners to ensure they have sufficient access to new and emerging evidence concerning child development and the impact of neglect and abuse; factors related to significant harm and its recurrence, and parents' capacity to overcome such factors

within an appropriate timeframe. Unless social work decisions are informed by such knowledge they will not be consistently reliable.

7) Efforts should be made to improve understanding of the costs of services and their relative effectiveness, including the costs of delayed admission to care, in order to ensure that the best use is made of scarce resources.

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Putting research into practice: conclusions

Care transforms the lives of some of the UK's most vulnerable children, protecting them from harm and providing the love and nurture they need to thrive. The chapters in this book have highlighted the range of ways in which care can positively help children and young people, by providing nurturing relationships, through specialist provision, and by supporting their development.

However, the chapters also powerfully demonstrate that there is a long way to go to ensure that we provide the most effective support for each and every child and young person in care. Too many children and families are still failed by the care system. More needs to be done to ensure that care provides a therapeutic environment for all, helping children to overcome the effects of abuse or neglect that they have suffered.

Taking a child into care will always be one of the hardest decisions that we have to take. It is therefore incumbent upon all of us to make sure that our decision-making, practice, and the services we provide to children, young people and their families is of the highest quality possible. Tackling this challenge requires us to bridge the gap between research and practice and learn from what works. The chapters in this book have brought together in one place messages from the latest research about children in care and set out a range of practical ways to improve the effectiveness of our care system.

Each chapter contains specific recommendations, detailing how we can improve safeguarding in fostering and residential care, tackle abuse (including abuse by peers), improve the mental health of children in care, and address the challenges of transitions in and out of care – from entry into care, returning home, and transitions to adulthood. The recommendations of these chapters call on all of us – practitioners, local authorities, health services, and national governments – to rethink our approach and reassess how we can better look after children in our care.

Collectively, they also call on us to transform the way in which we think about care. Chapters 1 and 9, in particular, demonstrate how the way in which we think about and understand the impact of our care system influences our use of care and its effectiveness. We each

need to critically examine our mind-set and recognise the possible impact of negative views and prejudices about care. Achieving significant change requires us to re-examine the role that care plays in both our family support and child protection systems.

A number of cross-cutting themes appear time and again throughout the specific areas of investigation covered by each chapter. These themes are central to thinking about how we ensure we deliver positive change. They cover: the importance of relationships; providing services and support based on an individual's specific needs; a greater focus on mental health and emotional wellbeing; developing the workforce; viewing care as part of an integrated family support and child protection system; and addressing variation between, and within, authorities. Each of these themes sits alongside the specific recommendations of each chapter. They should all shape the way in which the recommendations are implemented and our thinking about how we improve the lives of children in care.

Strong, caring, and trusted relationships at the heart of an effective care system

All chapters in this book stress the central importance of the relationships in effective support for children in care, in particular those formed with their carers and social worker.

Children's relationships with their parents, siblings and other family members are integral to their wellbeing. Sadly, for children in care these relationships have become fractured and their parental relationships have not provided the nurture that they need. Relationships between children in care and their carer and social worker can help children to deal with separation and loss and make sense of these relationships, understanding their future and managing contact to ensure that it provides the best possible outcomes for the child.

Chapters 3, 5 and 6 demonstrate how these relationships are also central to effective safeguarding, protecting children from harm. Strong relationships with carers and social workers provide children and young people with a trusted source of support, someone they can turn to and talk to in confidence about their experiences in care, their wishes and needs. Such relationships are critical to keeping children in care safe from further harm.

Chapters 4 and 8 demonstrate the importance of relationships to the development, mental health and emotional wellbeing of children in care. Many children in care have had the key relationship with their parents disrupted by abuse, violence or neglect. This increases their vulnerability and impacts on their ability to form healthy relationships. In order to thrive they need relationships in care that are safe and trusting and that can stand up to and survive testing behaviour. These relationships are the basis of security and attachment and are critical to providing children with the love, stability and therapeutic environment they need.

There are two key aspects to relationships – their quality and their continuity. Despite the importance of stable and secure relationships highlighted by the research summarised in this book, children in care too often face instability and unnecessarily disrupted relationships. Too many children experience changes in their placement or social worker that are not in the best interests of the child. Others are in placements that provide poor quality relationships. Achieving a focus on relationships requires an improved recognition of their central importance, and a cultural shift in the way in which policy and practice development for children in care takes place. This may at times be more difficult to measure, but it is critical that it is at the heart of future reform.

Support based on individual needs

The stories and experiences told through these chapters starkly demonstrate that each child's journey through care is unique. However, too often children in care are talked about as if they are a homogenous group, and policy reform can treat them as such. The chapters highlight that we still have a way to go in terms of assessing and understanding each individual child's specific needs and circumstances, on which decisions about placements and specific services are made.

This understanding of need is critical to supporting each child's development and is also central to keeping them safe. Chapter 5 on peer abuse and Chapter 6 on missing from care and sexual exploitation demonstrate that a failure to understand children's individual needs can prevent us from protecting them from harm. Children who have been missing from care often report that they do not feel that their carers or social workers took the time to understand what their needs were. Peer abuse can arise as a result of placement

decisions that do not take account of individual children's needs, including the needs of birth children in a family.

An accurate understanding of the child's family circumstances, the needs of their parents, and the reasons for the child's entry into care is vital in identifying the best route to permanence for the child. As Chapter 7 demonstrates, for example, this understanding underpins accurate appraisal of the likelihood of the necessary and sustainable change in parental behaviour required for a safe and stable return home when there has been familial abuse.

It is critical that we view the experience of care through the eyes of children and young people in care, and understand the nature of an effective care system from their perspective. Support must be based on individual needs, not the legal status of the child. Central to this is ensuring that children and young people are given a strong voice, and that their views are acted upon. This must take place collectively, for example through strong Children in Care Councils, but also for each individual child, ensuring that their views are sought and that they are involved in making decisions that affect them.

A greater focus on improving the mental health and wellbeing of children in care

Chapters 4 and 8 highlight the challenges faced by children in care relating to their mental health and wellbeing. An estimated 45 per cent of children in care experience mental health difficulties, rising to over 70 per cent for children in residential care. These challenges underpin many other difficulties experienced by children in care.

Despite the central importance of mental health and emotional wellbeing, the chapters in this book demonstrated that too often children and young people in care fail to receive adequate support to meet these needs. Too often carers are not provided with the information, training or specialist help to meet the needs of children and young people as effectively as they could, leaving many children in care unable to access specialist provision.

Significant improvement is needed in the ways in which the mental health needs of children in care are understood and addressed. However, to date, improving wellbeing has not been an explicit focus of many of the reforms to care in the UK. As demonstrated earlier in this book, achieving this requires that all aspects of the care

system – not just dedicated CAMHS – focus on their contribution to supporting the positive mental health of children in care.

Developing the workforce

Chapters in this book have demonstrated that children in care are supported by a wide range of people. Alongside carers and social care staff, children and young people are helped by health staff, teachers, police, youth workers, mentors, advocates and a wide range of other professionals. All have important roles to play, so we need a wider conception of the children-in-care workforce that includes all of these professionals and understands the role that they play.

Working with children in care and vulnerable parents is difficult. National and local leadership are needed to ensure that staff are supported to reflect on their practice and how they can improve their role in meeting the needs of children in care. They should also be provided with ongoing training to learn from the best evidence-based practice and decision-making.

Importantly, as many chapters in this book demonstrate, this must include an improvement in meeting the needs of foster carers and residential care staff. They play a critical role in supporting children in care but too often there are still examples where they are not considered part of the 'professional team' and they are not provided with the essential information and support they need to best meet the needs of children in their care. This must change.

Care as part of a wider system of child protection and family support

The authors in this book have demonstrated how outcomes for children in care are determined by the care and pre-care experiences, along with the services and interventions provided to address their parents' needs. However, too often care is viewed in isolation from other support that is available to children and their families.

Chapter 2 showed the impact of compartmentalised thinking for families whose children are on the edge of care. Chapter 7 showed how the parents of children who return home from care are too often not provided with the support that they need while their child is in care, to address the difficulties they face, eg drug or alcohol misuse. Chapter 8 demonstrated the lack of joined-up thinking for care

leavers, who frequently have to navigate multiple, non-integrated systems at one of the most challenging periods of their lives.

These challenges exist throughout children's journeys into, through and out of care. It is critical that alongside identifying specific interventions for children in care, we understand the role played by other services and the help we must provide to parents to ensure the best outcomes for children in care.

Significant variation in the support available to children in care

All chapters in this book have demonstrated that there is significant variation in the support provided to children and young people in care. This variation exists within local authority areas as well as between them. Much of this variation is not based on need, but on the available provision in an area and individual decision-making.

Too often carers and children themselves have to fight for additional help or access to specific services. Effective provision for children in care requires us to address these variations in practice and ensure that all children and young people in care are entitled to the help necessary to meet their needs.

These challenges must, in the current climate, be addressed with diminishing resources. However, learning from research and using the best available evidence to address this variation can help to ensure that the resources spent on children in care and their families are spent more effectively.

The NSPCC is working in partnership with local authorities, health services and others to develop new ways to improve practice for children in care. Our work brings together leading academics and practitioners to develop new models of practice, based on the best available evidence to tackle problems in child protection and improve the effectiveness of our care system. Each project is evaluated and the findings are shared to help promote the improvement of support for children, young people and parents. Further detail can be found on www.nspcc.org.uk.

www.nspcc.org.uk