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Evidence scope: models of adolescent care provision

Susannah Bowyer and Julie Wilkinson

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This rapid review examines the evidence on models of adolescent care provision beyond the residential children's home model. A 2012 report by the Education Select Committee found that the child protection system does not meet the needs of older children and recommended an urgent review of the support offered to this group (House of Commons Education Committee, 2012). This view is endorsed by the Association of Directors of Children's Services (ADCS) who recognise a poor track record of intervening with adolescents, particularly when they first enter the care system in their teens (ADCS 2012).

This review provides evidence on the following questions:

- what alternatives are there to approaches currently taken in this country for adolescents in care?
- what is the evidence on outcomes in relation to these approaches?
- are there particular messages on effective work with young people who enter the care system as adolescents?
- how might promising models inform service redesign if a particular approach is not replicable in England?

An on-line search using social science databases (SocINDEX and Social Care Online) was undertaken, as well as searches of key websites such as Department for Education, Research in Practice (RiP), Thomas Coram Research Unit and others. Responses were sought from local authorities engaged in innovative practice. This is by no means a full systematic review, but a summary of evidence from a variety of sources intended as a springboard for discussion.

Summary of key messages

Whatever the service approach or socio-cultural context, positive outcomes are associated with the quality and stability of the relationships that a young person in the care system is able to maintain and/or develop with key adults and with pro-social peers. This may include birth parents; in kinship care it will focus on other family members. Social workers, residential care workers, social pedagogues, teachers, peers and mentors are all potential key figures. Building damaged young people's capacity to develop sustained relationships of trust may require formal therapeutic intervention. It will certainly require stability. It will also call for perseverance and tenacity from those engaged with young people likely to be displaying challenging behaviour and with negative attachment models from their early family life. Putting in place the structures to support and maintain such relationships should be the core focus of service development across all and any models of care provision.

- advances in child development research provide new evidence of the impact of maltreatment on every aspect of early child development which may lead in adolescence to increased risk-taking behaviour, delinquency, promiscuity, eating disorders and addictive behaviours and difficulty controlling emotions. These developmental issues need to be taken into account when formulating services for young people with a longstanding family history of maltreatment

- while different forms of service offer promising alternative approaches there is no one 'magic bullet' model of care that has been found to be more effective than those currently in use in England
- differences in culture and attitude towards both welfare services and the construct of 'family' inform the concept of care and the shape of services internationally
- where care is seen as part of a continuum of services, and not as a last resort, early support is likely to be available to children and families with the potential to avert the escalation of problems and entry to care as a result of a crisis incident
- where residential care is viewed as an important support and therapeutic service there is a high degree of professionalisation of residential care staff
- social pedagogy is widely used in some European countries, in children's homes, child care, education and other services. This takes a holistic view of the child and emphasises working closely with the child or young person, the family and the wider community
- the evaluation of the social pedagogy pilot in England did not show significant differences in outcomes between children in pilot homes and non-pilot homes. However, the results must be interpreted in the context of challenges to the implementation process and a short term evaluation study
- kinship care is an alternative form of provision and generally provides a higher degree of stability for younger children, though older children have higher levels of disruption. Many formal and informal kinship carers are grandparents dealing with children with very challenging behaviour, as well as the pressures of poverty, ill health and disability. They receive limited support to meet these challenges, particularly in informal kinship care arrangements
- a number of intensive interventions have been found to be effective for young people with challenging behaviour and/or at risk of being placed in care or custody; these include Multi-Systemic Therapy, Multidimensional Treatment Foster Care and Family Functional Therapy
- gradual tapering off of support after specific interventions are completed increases the likelihood that gains made whilst on the programme are sustained
- implementation of new models and programmes must take account of the growing body of evidence on supporting successful implementation (see for instance Wiggins et al's report for DfE 2012)
- young people leaving care are vulnerable. Provision of support and, where possible, the option to stay with their foster family are crucial in ensuring that a transition to independence is akin to that experienced by young people in the general population.

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1. Adolescence: the challenges and opportunities

> *Around the time of puberty the brain has a growth spurt in the higher regions which govern planning, impulse control, reasoning and the regulation and reaction to emotions. Prior to this growth spurt young people are more prone to engage in dangerous risk-taking behaviour and are not sufficiently able to interpret emotions, particularly if there is no secure attachment figure available to help them negotiate these tasks. This is because they rely on their more primitive limbic response and lack the more mature cortex which can override it. Capabilities in these areas may always be inhibited if young people have experienced aggressive/hostile or neglectful parenting in childhood* (Brown and Ward 2012: 47)

Key messages

- When working to achieve permanence and stability there are challenges and opportunities at every stage of children and young people's development. Working with the evidence on developmental stages in order will increase the likelihood of successful engagement and intervention
- adolescence is a period of accelerated physical, hormonal and neurological development. One aspect of this is a propensity for impulsive and risk-taking behaviours
- for adolescents who have been maltreated during childhood, risk-taking behaviour may be exacerbated by the combination of developmental factors and the likely absence of a positive adult attachment figure
- exposure to chronic stress in early life can result in impairment to the areas of the brain that are responsible for 'executive functioning'
- around 80% of neglected and abused children are thought to develop the disorganised attachment styles strongly associated with later psychopathology
- any discussion of care options should be linked into wider systems thinking about how intervention earlier in children's lives may mitigate these damaging impacts of adversity
- good chronology and case records and proactive case management are vital to a clear understanding of young people's past experience and its impact on the present.

Neurological development in maltreated children and young people

Like the early years, adolescence is a time of dramatic physical and hormonal change. Normal puberty and adolescence lead to physical maturation, but the brain lags behind in development, especially in the areas that allow teenagers to reason and think logically. Most teenagers act impulsively at times because their frontal lobe (the cortex), which governs planning, impulse control and reasoning, is not yet mature. Impulsive behaviour, poor decisions, and increased risk-taking are all part of the normal teenage experience. Similarly, sensation seeking and risky behaviours are associated with the teenage years, particularly amongst adolescent boys (Child Information Gateway, 2009).

Teenagers who have been abused or neglected are at greater risk of displaying impulsive, or other maladaptive behaviours. Abusive experiences cause the parts of the brain that focus on survival to become over-activated, and can "wear out" other parts of the brain, particularly those parts involved in executive functioning. There are three key dimensions to executive function: working memory, (the capacity to hold and manipulate information in the brain over short periods of time); inhibitory control, (the skill to master and filter out thoughts impulses and distractions, and think before action is taken); and cognitive or mental flexibility (the capacity to adjust to changed demands) (Child Information Gateway, 2009; Brown and Ward 2012).

If a child lives in a threatening, chaotic world, their brain may become hyper-alert for danger. This chronic stimulation of the brain's fear response means that the regions of the brain involved in this response are frequently activated, while other regions of the brain, such as those involved in complex thought and abstract cognition, are less frequently activated (Perry, 2000; Child Information Gateway, 2009; Brown and Ward, 2012)

Brain development is sequential, so early alteration of the brain's architecture can have severe consequences for future learning, behaviour and health. Stress exposure early in life can result in long-term dysfunction in the systems that mediate emotional responses, abstract thinking and social interaction. This may impair a child's ability to cope with stressful circumstances, increase risk taking behaviour, and inhibit children and young people's ability to form positive relationships. This makes the teenage years particularly risky, with increased likelihood of risk taking behaviour, delinquency, promiscuity, eating disorders and addictive behaviours and difficulty controlling emotions (Brown and Ward, 2012; Child Information Gateway, 2009).

Children who have experienced the trauma of abuse or neglect may show a range of maladaptive behaviours:

- **Hyperarousal:** When children are exposed to chronic, traumatic stress, their brains sensitize the pathways for the fear response and create memories that automatically trigger that response without conscious thought. These children have an altered baseline for arousal, and they tend to overreact to triggers that other children find non-threatening. They may be highly sensitive to non-verbal cues, such as eye contact or a touch on the arm, and may read these actions as threats. Because they feel the need to constantly monitor non-verbal cues for threats, their brains are less able to interpret and respond to verbal cues, even when they are in a non-threatening environment
- **Dissociation:** Children who are the victims of repeated abuse may respond to that abuse -and later in life to other unpleasantness -by mentally and emotionally removing themselves from the situation. This coping mechanism of dissociation allows the child to pretend that what is happening is not real
- **Disrupted Attachment Process:** Young infants depend on positive interactions with caregivers to develop appropriate emotional control and response. Ongoing abuse or neglect can result in disrupted attachment. Children who have experienced disrupted attachments may have more

> difficulties regulating their emotions and showing empathy for others. These children may also have difficulties forming attachments later in life. (Child Information Gateway, 2009)

The evidence of the damaging impact of early childhood neglect and abuse makes a compelling case for early preventive action. Children who have been abused or neglected need nurturance, stability, predictability, understanding, and support. They need frequent, repeated experiences of these kinds to begin altering their view of the world from one that is uncaring or hostile to one that is caring and supportive (Brown and Ward, 2012; Child Information Gateway, 2009).

Brown and Ward (2012: 94-96) outline potential 'pathways to permanence' in relation to a child remaining with or separating from a birth family. These timelines, which show the best and worst case scenarios related to child development timescales, illustrate how proactive and reactive case work can lead to different outcomes.

Age of child	Key points in a child's developmental timeframe	Proactive case work and timely decision making: positive outcomes	Reactive case work and delayed decision making: cumulative jeopardy

Pathway to permanence: remaining with birth parents

Adolescence	Around the time of puberty the brain has a growth spurt in the higher regions which govern, planning, impulse control, reasoning and the regulation and reaction to emotions. Prior to this growth spurt young people are more prone to engage in dangerous risk taking behaviour and are not sufficiently able to interpret emotions, particularly if there is no secure attachment figure available to them to help them negotiate these tasks. This is because they rely on their more primitive limbic response and lack the more mature cortex which can override the limbic response. Young people may never develop these capabilities if development in other areas of the brain is not sufficient.	• Young person has remained with birth parents and has close bond with extended family. • Young person's brain is continuing to develop healthily and young person has started to be able to plan, control impulses, reason and regulate and react to emotions. • Young person continues to have secure attachment figures who help to negotiate their developmental tasks of adolescence. • Young person engages well with school and plans to continue in higher education.	• Young person has frequently moved between parents and relatives as situation at home has been unstable. • Parents have often made slight improvements and have abstained from drug use over short periods but this has not been maintained in the long term. • Domestic violence has continued throughout. • Young person engages in risk taking behaviour and finds it difficult to form positive peer relationships. • Young person also has difficulties in being able to empathise, to reason and to regulate and interpret emotions. Development in young person's higher regions of the brain has been limited. • Young person involved with youth offending team and does not engage with school. • Young person has begun to use alcohol.

Pathway to permanence: separation

Adolescence	Around the time of puberty the brain has a growth spurt in the higher regions which govern, planning, impulse control, reasoning and the regulation and reaction to emotions. Prior to this growth spurt young people are more prone to engage in dangerous risk taking behaviour and are not sufficiently able to interpret emotions, particularly if there is no secure attachment figure available to them to help them negotiate these tasks. This is because they rely on their more primitive limbic response and lack the more mature cortex which can override the limbic response. Capabilities in these areas may always be impaired if the young person has experienced a childhood of aggressive, hostile or neglectful parenting.	• Young person has remained with adoptive family. • Young person's brain is continuing to develop healthily and child has started to be able to plan, control impulses, reason and regulate and react to emotions. • Young person continues to have secure attachment figures who help to negotiate their developmental tasks of adolescence. • Young person is making good progress in school.	• Young person has remained in foster care and has experienced several placements • Young person engages in risk taking behaviour and finds it difficult to form positive peer relationships. • Young person also has difficulties in being able to empathise, to reason and to regulate and interpret emotions. • Development in child's higher regions of the brain has been limited. • Young person excluded from mainstream school due to aggressive behaviour.

Support for adolescents in the UK

Hicks and Stein (2010) suggest a number of ways that services for adolescents can be improved. Although the focus of their work is adolescent neglect, the findings are relevant to other areas where teenagers are at risk of harm or display particularly challenging behaviour. They argue that because teenage neglect is multi-faceted in its origins and consequences, it needs a multi-agency response, with professionals from CAMHS, CAFCASS, children's social care, Educational psychology, GPs, LSCBs, teachers, and youth and youth offending services. Enablers of inter-agency collaboration include:

- understanding and respecting the roles and responsibilities of other services
- good communication, including information sharing, regular contact and meetings
- joint training
- knowing what services are available and who to contact
- clear guidelines and procedures for working together
- shared concern and responsibility.

Interventions for adolescents at risk of entering the child protection system and their families need to be holistic and offer support in a range of areas including:

- basic resources such as housing
- links to networks to reduce social isolation and increase parenting abilities
- involvement of mentors and peer groups
- cognitive-behavioural approaches
- individual interventions e.g. alcohol counselling, stress management
- family system interventions e.g. family therapy
- many of these are incorporated in programs such as Multi-Systemic Therapy (MST) and Multidimensional Treatment Foster Care(MTFC), which have been introduced in recent years in England (Hicks and Stein, 2010). These models are discussed more fully in chapter six.

Resilience

Resilience refers to the qualities that cushion a vulnerable child from the worst effects of adversity (SCIE: 2004). Various studies have explored how to build resilience in looked after young people in foster or residential care. For example, Schofield et al (2012) found that the care system is effective in providing good care where it promotes security and pro-social values. It is particularly effective when secure attachments and stability are available and engagement with the community is promoted.

Late entry to care in adolescence is a crucial period that has a number of risk factors associated with it. However, there are windows of opportunity for building resilience and to encourage positive change. The chances of success are greatest if care capitalises on the protective strengths of relationships and involvement in constructive activities (Schofield et al, 2012).

Attributes of young people associated with strong levels of resilience include:

- higher intelligence
- being more flexible
- having a positive self-concept
- learning, problem solving and self-regulation skills
- positive views of the self and one's capabilities
- opportunities to develop skills and talents
- having strong connections with one or more effective parent/carer
- positive bonds with other pro-social adults and peers
- connections with positive organisations (e.g. clubs or faith groups)

(Schofield et al, 2012; Hicks and Stein, 2010)

Reviews of research on promoting resilience for children and young people in care (Bowyer, 2011; SCIE 2004) underline the importance of authoritative parenting and supportive friendship groups. A sense of direction is important, as is self-esteem, which flows from positive attachment experiences, but can be enhanced by participation in valued activities. Self-esteem is closely linked with developing a sense of self-efficacy, which includes qualities of optimism, persistence and believing that one's own efforts can make a difference.

Linked to this is developing a sense of identity associated with:

- the quality of care and attachments
- young people's knowledge and understanding of their background and personal history
- their experience of how other people perceive and respond to them
- how they see themselves and the opportunities they have to influence and shape their own biography (Stein, 2005).

Mentoring to support resilience

Young people who lack a strong family and social network often need supportive relationships and strategies to navigate their way through life. Vulnerable young people who do manage to overcome adversities generally share one important factor: the presence of a consistent person to provide continued support. This does not need to be the most important person in the young person's life; it could be a personal advisor, a lead professional or a mentor (Philip and Spratt, 2007).

Clayden and Stein (2005) summarise the evidence on mentoring and conclude that there is a lack of robust evidence on the effectiveness of mentoring programmes. The evidence is strongest in relation to improvements in problem behaviour and education and employment, but less certain in terms of social, emotional and psychological adjustment. The authors argue that mentoring needs to be part of a range of support available for vulnerable young people.

Participants valued the relationship, in particular the advice and help with practical matters such as accommodation, education employment and training and finding work. They also valued the help in dealing with relationship problems, building confidence and improving emotional well-being. Mentoring offered a different type of relationship to that of professional help and troubled

family relationships. However, the researchers also found that half of the young people and mentors reported negative outcomes. These included lack of engagement, missed appointments and unplanned ending of the relationship (Clayden and Stein, 2005).

A more recent pilot and evaluation of a mentoring programme for looked after children also suggested some positive outcomes for some young people (Renshaw, 2008). The programme was aimed at looked after children aged between 10 and 15 years to help with schoolwork, improve school attendance, improve social and life skills and help the young people to participate in social networks and group activities. Most of the children who participated in the programme were in foster care (76%). Children with complex problems (e.g. mental health problems, suffering from trauma, experience of frequent placement moves) were not accepted on the programme as it was believed that it would be too difficult for volunteer mentors to deal with.

Most of the young people reported that all areas of their schooling had improved as a result of the mentoring relationship, especially their homework and their behaviour. Most rated their views of how they felt about themselves and their future as improved, and that their relationships with others had also improved. Several young people specifically mentioned that it was the mentor who had made the difference for them and also indicated that the voluntary nature of the relationship was particularly important. These views were borne out by stakeholders, who noted that positive gains had been made in self-confidence, schoolwork and relationships with others. SDQ scores indicated that, on average, young people's level of difficulties fell in comparison with the scores at the start, and the average score for positive social behaviour rose (Renshaw, 2008).

Young people's views

Involvement with children's social care

Professionals may believe disclosure of maltreatment is easier for young people than for children, because young people generally have more ability to seek help on their own behalf. However, interviews with young people with experience of children's social care involvement suggest that their heightened awareness of the potential impacts of disclosure on themselves and their family creates a different set of barriers (Rees *et al* 2010).

In fact, adolescents are much less likely to ask for help than younger children, with boys almost seven times less likely to talk to others about their problems and disabled children much less likely to disclose abuse than non-disabled peers (C4EO 2010: 4). The most important elements young people identified for disclosure of abuse were confidence in themselves, feeling safe to speak out and trust in others.

> *... the only reason why I didn't speak out for nine months was because of low self-esteem and I was terrified. [kids] have to have the confidence and they have to have a big safety net around them cos if kids don't feel safe they don't do anything. Emma, age 14* (Rees et al 2010:44)

Some young people discussed colluding with parents to cover up maltreatment. These comments highlight the importance of ensuring that young people see a professional alone on a regular basis - a one-off occasion is unlikely to elicit an accurate picture of what's happening. Managing confidentiality between young people and parents is a particular issue, and communication between professionals about families and an accurate history of contact and incidents within families must be maintained (Rees et al 2010: 41).

For many of the young people interviewed, a consistent, long-term relationship with a professional throughout the referral and safeguarding process was the most important factor in disclosure and protection. (Rees et al 2010: 55). Conversely, the lack of consistency of social work contact and the large caseloads held by individual social workers present barriers to young people disclosing abuse and neglect during the referral process.

If young people do approach a professional for help this is likely to be someone they know and trust. Children and young people were aware of a number of sources of help (e.g. Independent Reviewing Officers, Cafcass, children's care councils, advocates and guardians); however, they were most likely to see their social worker, their foster carer or a teacher as the person most likely to be able to help them to solve a problem (Minnis et al, 2012). Children and young people viewed social workers as very important in their lives; where their social worker supported them, they felt well looked after. In particular they wanted reassurance from their social worker at times of stress, practical support and continuity. They also wanted to be able to contact social workers when they needed to and for social workers to be more proactive in contacting them. Flexibility was key in meeting the individual needs of children and young people (Minnis et al, 2012).

A systematic review of the literature on children and young people's views of the processes associated with being placed in care found that, overall, they wanted more involvement in decisions made about them (Minnis et al, 2012). The majority reported that the decisions to take them into care were the right ones; however, there was often little choice about where they would live. They felt that their views are not listened to and that they cannot influence important decisions about their lives. Children and young people stressed the "importance of taking into account individual needs and choices". They felt that adults responsible for their care determine 'what is best', regardless of whether they themselves viewed it as the best option for their situation.

From a young person's perspective, social care is not about the child protection plan or the case conference, but is all about their relationships with social workers. Children and young people experience the child protection system as 'unfamiliar and mysterious. They had no idea what was likely to happen and why, and there appeared to be little effort to inform or reassure them' (C4EO 2010: 4). They do not understand the differences between professionals' roles (duty team or long-term social workers, for instance) or the safeguarding process overall. Many were confused about what had happened to them and why, and did not feel that their views had been listened to.

In all areas of human services, building relationships of trust is at the core of successful intervention. This is perhaps even more pertinent for adolescents for whom volatile developmental changes are coupled with their movement out of the sphere of family influence and into wider social networks.

2. Looked after children and young people in England

Key Messages:

- the number of looked after children in England has been rising steadily in recent years
- children who enter care for the first time at age 11 or older have often been known to social services for some years
- the costs associated with placing a child in care and maintaining the placement vary widely in relation to the needs of the child and to the services they receive
- stability is key: research suggests that a child experiencing multiple placements over a 4.5 year period can cost a local authority twice as much per year while in care than a child in a stable placement
- there is evidence that outcomes for maltreated children, particularly those who have been neglected or emotionally abused, are better for those who remain looked after than for those who return home, even when reunification remains stable
- neglected adolescents are often subject to 'service neglect' and professionals' lack of engagement in response to challenging behaviour
- for a range of reasons, young people are often reluctant to seek help
- there is a predominance of crisis admissions into care for adolescents, often following a breakdown in family relationships. As a consequence, there is little time for professionals to consult the young person and their family and consider what options are available and in the best interest of the young person

At 31 March 2012 there were 67,050 looked after children (LAC) in England, an increase of 13 per cent compared to the same period in 2008 (Department for Education, 2012a). Of those who started to be looked after in 2011-12, the largest proportion (30%) was aged between 10 and 15 years, followed by infants under one (21%). The majority (75%) of LAC are in foster placements (11% with a relative or friend and 54% with an unrelated foster carer).

There are two patterns of entry into the care system for adolescents: 'adolescent graduates' who enter care under the age of 11 and remain in care through adolescence, and 'adolescent entrants' who enter at the age of 11 or over, though not necessarily for the first time (Biehal, 2009). Research by Sinclair et al (2007) found that adolescent graduates account for over a quarter of LAC. This group tends to enter the system as younger children, generally due to abuse or neglect. They may be settled in long-term foster placements or have experienced an unsettled care history. Of those who entered care at the age of 11 or over, half were re-admissions. It was common for this group to have experienced multiple episodes of care, with repeated attempts at reunification with family.

Those who first enter care at the age of 11 and over have often been known to social services for a number of years (Farmer et al, 2004, Biehal, 2005). They

have often been staying with relatives or friends immediately prior to placement, becoming looked after when these informal arrangements break down. A small number re-enter care due to adoption disruption (Biehal, 2009).

Analysis of SSDA903 data has shown that there are a number of differences between those who enter care for the first time between 10-15 years of age compared to those who re-enter the system at this age (Boddy et al, 2009). Compared to those re-entering care, new entrants:

- generally spend less time in care
- are more likely to go to a children's home (although foster care is the most common option)
- are more likely to be accommodated voluntarily
- are more likely to be placed because of family problems or the young person's behaviour (rather than needing protection from abuse and neglect).

Expenditure on looked after children

In the financial year 2009/2010 the total gross spend on looked after children living in England was approximately £3 billion (House of Commons, 2012). Ninety-two per cent of this was spent on foster care (around £1.25 billion) and residential care (around £.97 billion). Other looked after children services accounted for £1.7 billion (Asmussen et al 2012).

Ward and Holmes (2008) calculated the average yearly costs of various processes associated with looked after children. In 2005-06 the average costs to social services of case management processes for a looked after child in foster care with no additional support needs were broken down as follows:

Deciding child needs to be looked after and finding a first placement	£615
Care planning	£115
Maintaining the placement per month	£1,625
Exit from care/accommodation	£253
Finding a subsequent placement	£197
Review	£392
Legal processes	£2660
Transition to leaving care services	£1119

(Ward and Holmes, 2008)

Within each process there was a wide range of costs, according to children's needs, service responses and differences in local practices. For example, the

cost of Process Five (finding a subsequent placement) ranged from £77 for a child with no additional support needs placed in a local authority foster home to more than £1000 for a child with complex needs placed with agency carers.

The average weekly costs of maintaining a placement according to the type of placement were as follows:

Foster care	£905
Kinship care	£132
Residential care	£2,571

(Ward and Holmes, 2008)

The costs of care reflect a complex relationship between the needs of children and the services they receive. The average social care costs incurred by children who showed no evidence of additional support needs were £33,634 per year, while those for children and young people with complex emotional or behavioural needs, including offending behaviour, were £109,178, over three times as high (Ward and Holmes, 2008). The Cost Calculator for Children's Services and the methodology developed by the costs and outcomes team at the Centre for Child and Family Research at Loughborough University can be accessed here http://www.ccfcs.org.uk/about-2/ .

The more time a child spends in care, the more expensive it is for the local authority. Placement stability is crucial, as multiple placements are costly for local authorities and detrimental to children's emotional and educational development (Ward and Holmes, 2008). Findings from a recent study by DEMOS suggest that a child experiencing multiple placements over a 4.5 year period can cost a local authority more than twice as much per year than a child in a stable placement for twelve years (Hannon, et al. 2010). This is illustrated below:

Child A (female)
One period in care and two stable placements

- enters care aged 3
- care proceedings to obtain a care order
- short-term foster care placement for 1 year
- long-term foster care placement for 14 years
- leaves care aged 18 with good mental health and with good qualifications

Total cost while in care: £352,053 for 14 years (£23,470 per year)

Total cost until the age of 30: £40,480.10 (includes costs of university)

Child B (female)
Three periods in care and ten placements

- enters care aged 11 (voluntarily accommodated)
- emergency foster care placement (1 week)
- short-term foster care placement (12 months)
- reunified with family (6 months)
- emergency foster care placement (1 week)· short-term foster care placement (6 months)
- reunified with family (6 months)
- re-enters care and legal processes are undertaken to obtain care order
- three foster care placements over 12 months
- placement with agency foster carer (12 months)
- short-term residential placement (1 month)
- residential placement (11 months)
- exits care at 16 and a half and lives in independent accommodation until 18
- has poor mental health and no qualifications

Total cost while in care: £393,579 for 4.5 years (£56,226 per year)

Total cost to the age of 30: £111,923.99 (includes health care and unemployment benefits)

(Hannon et al, 2010)

This analysis highlights the importance of placement stability in terms of cost effectiveness. The evidence that 'advanced' foster care (i.e. improved support to foster parents) significantly increases the likelihood of placement stability in comparison to traditional foster care (MacMillan et al. 2009) is discussed in chapter 6. The evidence relating placement stability to improved outcomes is also compelling.

Outcomes: reunification or separation

There is growing evidence that outcomes for maltreated children who remain looked after are better than for children who return home with respect to stability and well-being. Wade *et al's* (2010) research comprised a census study of 3,872 children who were looked after by seven local authorities as well as a survey of 149 of these children and interviews with birth parents and children. Outcomes were assessed around four years after the initial decision on whether the child should return home (home group) or remain looked after (care group) and comparisons were made between these two groups. Only one third of the home group remained continuously at home; almost 60 per cent had returned to the care system at least once and one in five experienced more than one attempt at reunification. Children in the care group were more settled, with 65

per cent remaining in the same placement for two or more years compared to 41 per cent of those who returned home.

Similar findings are reported by Farmer and Lutman (2010). In this five-year follow-up study of 138 children who had been neglected and subsequently returned to their parents, 65% of the returns home had ended. At the two year follow-up, 59% of the children had been abused or neglected after reunification. Researcher ratings of the children's well-being at the five-year follow-up point showed that 29% had good well-being, for a third it was satisfactory, whilst 38% had poor well-being. Children living stably away from home were more likely to have good overall well-being (58%), whilst for those with unstable outcomes it was most often poor (70%). Children who were stably at home had a fairly equal spread of good, satisfactory and poor well-being, with a third having poor well-being.

Factors impacting on stability:

Age: younger age at return is an important factor in relation to the children achieving better outcomes. Children in Farmer and Lutman's stable away from home group tended to be the youngest (mean 5.7 years), followed by children stably at home (mean 7.2 years) with the unstable group the oldest (mean 11.5 years).
Proactive case management: was generally a feature of the stable away from home and the stable at home groups and occurred less frequently in the unstable group, which was characterised by passive case management
Changes at home: if the child was returned to a changed household (changes in the parent's partner or a reunification with the other parent), then the odds of being in a stable placement increased by a factor of nearly 3.5
Local authority performance: In addition, if a child was not looked after in the poorest performing authority in the study they were 10 times more likely to be in stable placement (Farmer and Lutman, 2010).

Similarly, outcomes (stability and well-being) for Wade's 'care group' were better than for those who went home:

- most had settled well, had good relationships, were doing quite well at school and not getting into great difficulty
- many felt safer, were relieved to be away from dangerous homes and well cared for (though others were more ambivalent)
- well-being levels were higher than for those who had remained continuously at home
- problems early in reunion predicted poor well-being at follow-up
- those who had experienced one or more breakdowns at home fared worst of all

- where there is strong evidence of serious emotional abuse or past neglect, these children did best if they remained in care (Wade *at al*: 2010)

Children in the care group also fared better on a global outcome measure (measuring risky behaviour, emotional and behavioural development, school adjustment) than children who returned home, even where the reunification remained stable. The children who had unstable returns home had the worst overall outcomes. There were often early signs that a reunification would fail; over one third of the children re-entered the care system within six months of returning home. Reunifications should, therefore, be based on careful assessment and evidence of sustained change in parenting capacity.

Factors associated with enduring reunifications:

- children/young people went home slowly
- planning for reunion was purposeful and inclusive of children/young people and birth families
- the problems that had led to the child's admission to care had reduced
- more family-focused social work interventions had been provided
- parents had accessed more services

(Wade et al, 2010).

Davies and Ward's (2012) review of safeguarding children across services recommends that high intensity services are required to support enduring reunifications. Nevertheless, those services that help reunifications to endure do little to improve children's overall well-being at home.

> *Repeated attempts at reunification with birth parents should be avoided. These are damaging to children's well-being and jeopardize their chances of achieving permanence through alternative routes* (Davies and Ward, 2012: 92)

Neglected adolescents

In terms of adolescent neglect, the work of Stein and colleagues provides valuable working definitions and analysis (Hicks and Stein, 2010) which are well summarised in the training resources on neglect developed for the Department for Education.

A range of negative outcomes are associated with, while not necessarily being proven as directly caused by, adolescent neglect. These include negative health and mental health outcomes, educational disengagement, the risk of running away, bullying, and an association between neglect and anti-social behaviour.

The increased independence of teenagers makes defining neglect harder to pin down than it is for highly dependent infants. Acute neglect may become evident at a point of crisis in a young person's life, but is often characterised by a cumulative pattern of harm over time. If neglect is chronic, an adolescent may underestimate the harm they experience, having been used to an absence of care throughout their lives.

'Service neglect' on the part of agencies and professionals is a concern when adolescents become disengaged and ignored by professionals defeated by their challenging behaviour (Rees et al, 2011; Davies and Ward, 2012). In their biennial analysis, Brandon *et al* (2008) identified that a quarter of cases related to young people aged over 11. Most of these cases involved 'hard to help' young people who had a history of involvement with social care and other specialist agencies, including periods of being looked after. However, by the time of the serious incident 'little or no help was being offered because agencies appeared to have run out of helping strategies'.

Crisis driven decision making

Families of adolescent entrants frequently report long histories of difficulty and repeated requests for help. Young people themselves often find it difficult to seek help. They are concerned that they will not be believed, do not know who to tell and fear that they will be placed in care (Rees et al, 2011). Typically, family relationships reach crisis point and a parent demands accommodation for the child. Crisis admissions with limited time for professionals to consider a choice of placement or to consult with the young person and their family reduce the chances of achieving a stable placement (Farmer et al, 2004).

Adolescent entrants rarely stay long in placement. Research by Biehal (2005) found that nearly half of those entering care aged 10-15 years stayed for less than eight weeks and two thirds left within six months. They were often placed in short-term foster care to defuse a crisis and prevent long-term breakdown in family relationships. In the best case scenario short-term placement provides breathing space and an opportunity to provide family support services, but in some cases there is a serious breakdown in family relationships leading to a longer period of care. Biehal's study found that social workers 'were reluctant to use short-term accommodation in this way and tried to avoid admission at all costs'. This reluctance is often derived from pessimism about the impact of placement and concern that it might result in psychological harm to the young person. At times decisions about placement were resource driven rather than needs led. Social workers' reluctance to accommodate young people even in extreme circumstances meant that admissions that did occur tended to be emergency admissions made in a crisis (Biehal, 2009).

Admission into care as a result of a crisis are likely to reinforce a maltreated child or adolescent's experience of the world as uncontrollable and frightening (Child Welfare Information Gateway, 2009), but it is on this basis that services have developed in this country as well as in the USA, Canada and Australia. The next chapter considers other international models of child placement and support.

3. International Comparison of Child Placement and Support

While a review of the alternatives to adoption has not indicated any model which can be shown to be clearly superior to that currently pursued by Britain, it does suggest the value of seeking a wide range of measures to provide permanence and of the danger of neglecting the equal importance of improving support for families and preventing children coming into care (Warman & Roberts 2001). In many other countries more resources are devoted to long-term fostering and it is important that adoption does not deflect attention from the current crisis in foster care in the UK. There is growing evidence that adoption by foster parents is more successful than adoption by new parents so that any decision to move a child from a long-term foster home simply to ensure an adoptive placement must be questioned. Likewise the role of kinship care seems to be neglected. What is clearly needed is a wider range of options than adoption and traditional long-term fostering which ends at 18. [Examples such as]… enduring guardianship in New Zealand; permanency orders in Australia; special guardianship in England - show that alternative legal routes to permanence are possible, although few of these have been systematically evaluated in comparison with adoption. What is less clear is how we ensure that such options are fully resourced and that research is undertaken which will show which options work best for which children. (Selman and Mason 2005, accessed 29th November 2012)

Key messages

- social and cultural factors lead to distinct differences in placement patterns between countries
- anglophone countries tend to view child protection as distinct from a wider continuum of services and tend to delay intervention, whereas Nordic and some other European countries view care as a positive aspect of a continuum of services for children and families
- compared to England, residential care is used more extensively as a first choice for children with complex needs in France, Germany and Denmark. This care generally involves social pedagogy and other therapeutic approaches
- short-term or part-time care is also more widely available in these countries, often following a child or young person's self-referral
- placement of children in care should be seen as part of a continuum of services rather than as a last resort and as an opportunity for therapeutic intervention
- preventative and early intervention services for adolescents need to deliver co-ordinated multi-agency responses across mental health, children's social care, schools, GPs, youth services and others
- resilience can be enhanced through promoting positive parenting and young people's bonds with pro-social adults and peers, including mentoring, as well as through encouraging participation in social and cultural activities
- young people want to be involved in decisions being made about them
- the fact that other countries do not see adoption as a preferred solution and the reluctance of most countries to remove children against parental

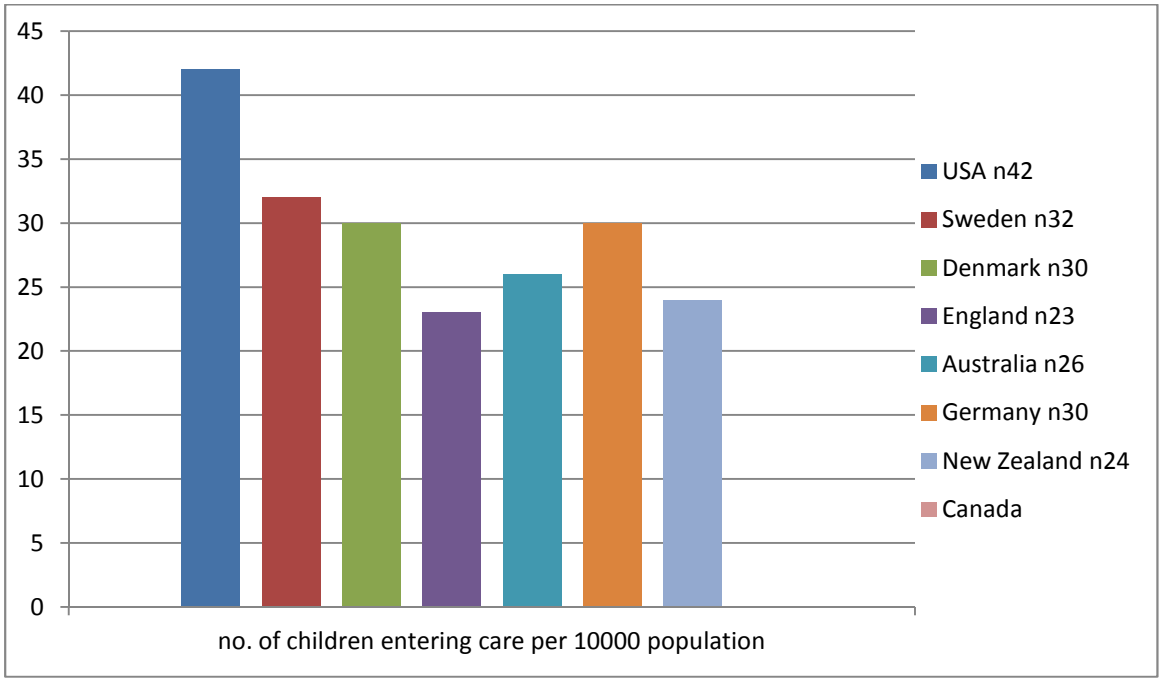
wishes 'should act as a reminder of the importance of having a wide range of options in offering permanence for looked after children' (http://www.scotland.gov.uk/Publications/2005/06/27140607/07142 accessed 29th November 2012)

- once it has been established that a young person can no longer live with their birth parents, placements should be made as soon as possible

This chapter provides a discussion of international evidence on child placement, focusing on countries with similar resources available and relatively well-developed child welfare services. Care should be taken when interpreting the findings as definitions and data differ from one country to another. In addition, the material does not focus specifically on adolescents. Nevertheless the material provides some interesting comparisons, in relation to rates of children placed in care, the types of care provided and the contextual factors surrounding these.

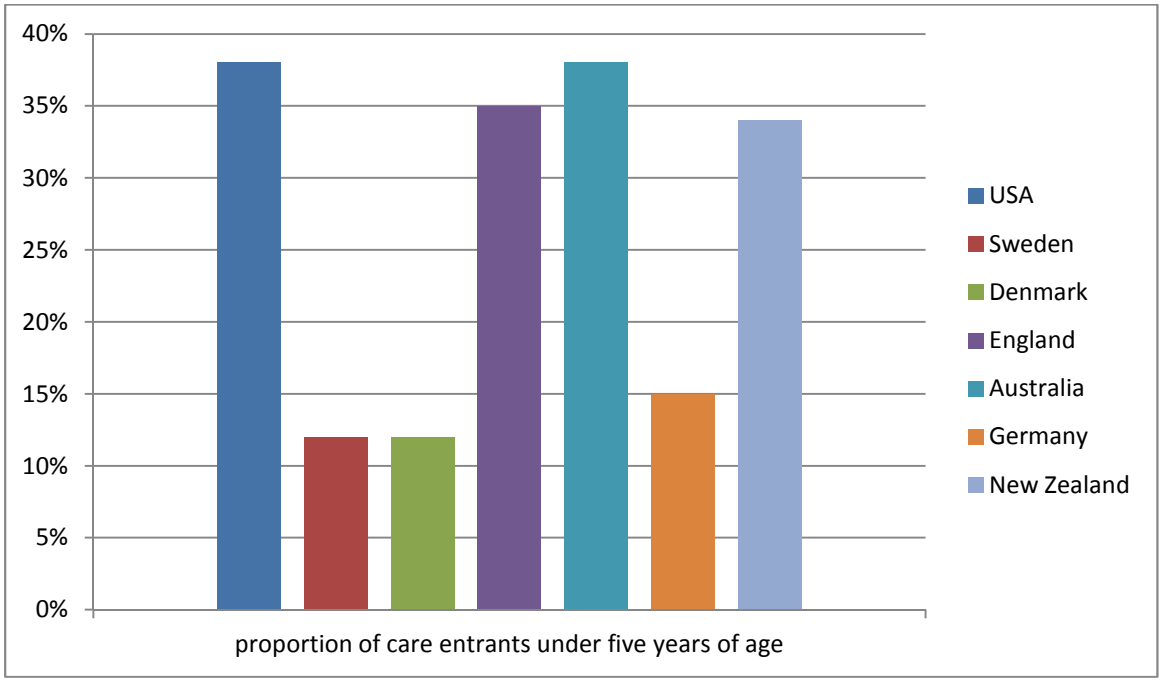
Entry into care

Thoburn (2009) compared the number of children entering care in a 12-month period between 2004 and 2005 in 13 countries.[1]



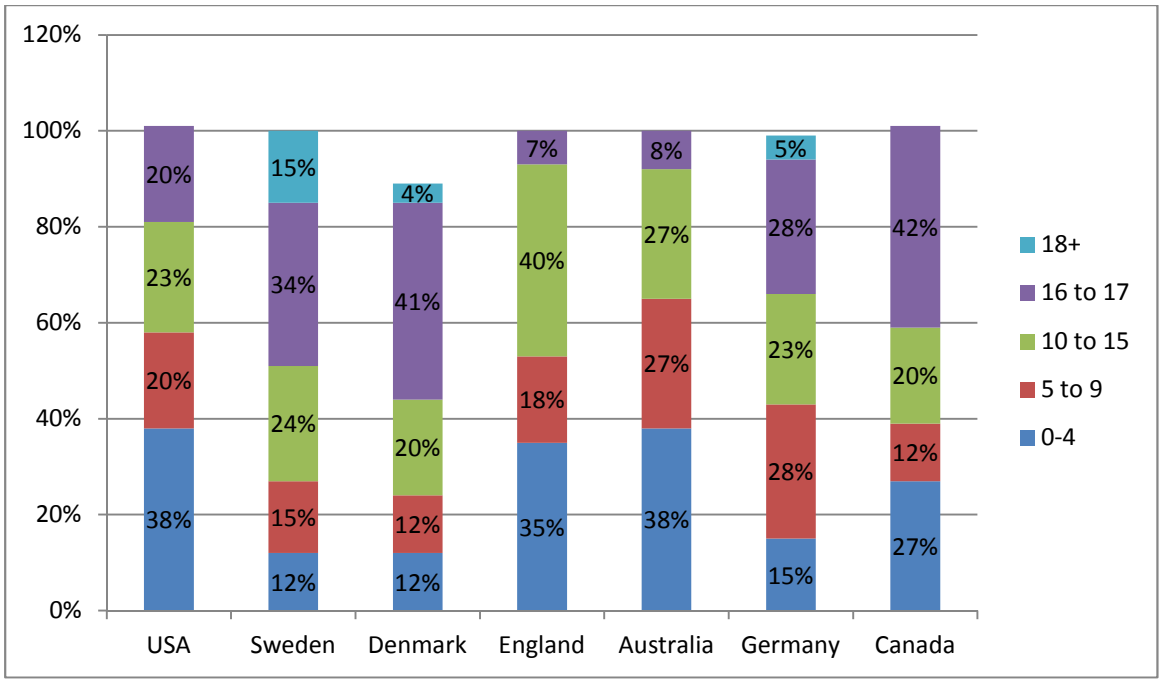
[1] The countries were Australia, Denmark, France, Germany, Ireland, Italy, Japan, New Zealand, Norway, Spain, Sweden, UK, USA.

There are some marked differences in the age that children enter care. The proportion of care entrants under the age of five is much higher in Anglophone countries than in Europe:

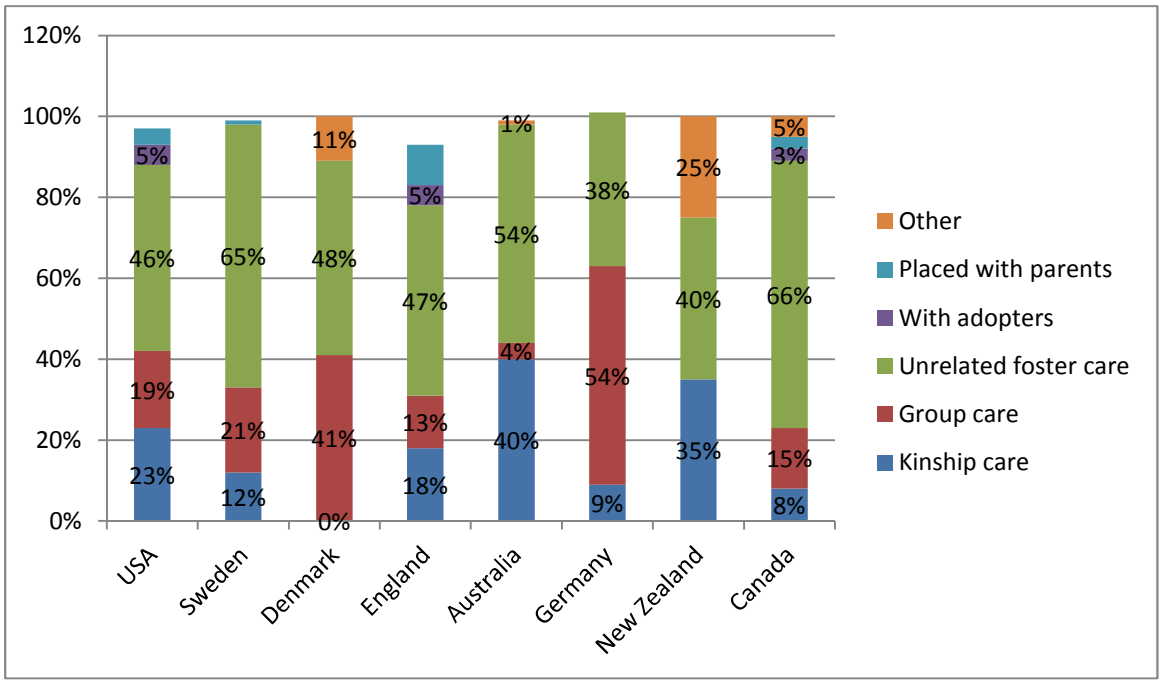


Around 50 per cent of care entrants in Norway and Sweden were over 15 years of age, including some who entered care when over the age of 18 years. Much of this difference can be accounted for by the policy in Scandinavia whereby young offenders are considered as young people in need of welfare rather than justice services. Also of interest is the fact that a young person in France, Norway, Sweden and Denmark can enter care up to the age of 21 or 22 years, as well as remaining in care until that age.

Age at entry to out of home care



Placements of children in care



In terms of placement, Australia was the only country that rarely used group care. In Australia, kinship care was the most frequent placement. Children in New Zealand were also frequently placed in kinship care. Unrelated foster care is used for the majority of children in most countries, with the exception of Japan, although the proportion of placements differs between nations. For example, 65 per cent of children in care in Sweden are with unrelated foster carers, 48 per cent in Denmark and 47 per cent in England.

What influences placement practice?

A combination of social and cultural factors leads to very different contexts in which care systems have developed. A summary analysis of the classification of the various types of welfare regime is provided by Selman and Mason (2005) who cite Gustav Esping-Andersen's (1990) classification of three types of welfare state regime:

Liberal: in which means-tested assistance and benefits are directed mainly at low-income households. The UK is included in this group, along with the USA, Canada and Australia

Social Democratic: where there is a pursuit of equality with benefits graduated according to earnings. Sweden, Denmark and Norway comprise this group

Conservative-corporatist: committed to the 'preservation of status differentials' and usually relying on social insurance, with private insurance and occupational fringe benefits playing a marginal role. France and Germany are classified as Conservative

(http://www.scotland.gov.uk/Publications/2005/06/27140607/07142 accessed 29th November 2012)

Selman and Mason go on to tabulate useful comparative data on poverty, maltreatment, LAC, adoption rates and government expenditure, and to make extended consideration of the characteristics of the looked after children's systems in the nine countries under discussion. This draws out interesting features such as:

- kinship care is favoured in Australia and New Zealand, 'where particular doubts about "stranger" adoption or fostering of children of indigenous ethnic origin has influenced overall policy for both countries'. Kinship care has grown significantly in the USA over the last decade. It is also used in Sweden and common in Norway
- family preservation is paramount in the Nordic countries, via preventative work and strengthening families. Child poverty is far less prevalent and preventative and support services more advanced
- there is an underlying principle in the Nordic countries that the State and the family each have equal responsibility for raising children
- adoption is not currently an option in child welfare policy in Sweden, Finland and Denmark (though there is growing interest in adoption in Norway). Neither Sweden nor Denmark has legislation for the termination of parental rights and there is no concept of 'permanence' in the Swedish system
- in Denmark and Sweden only 3% of care orders are made without parental agreement, compared to 30% in the UK
- in Denmark the nuclear family is paramount and the extended family is not considered as an alternative source of alternative care. The state takes an active role in supporting families, and continues with support after the removal of a child as well as an intense service provision to support reunificationall these countries use foster care as the main provision. 'None provide a model which is clearly superior to the

appropriate use of adoption in providing permanence, but there is much to learn from the successful use of kinship care and specialist fostering and in the stronger commitment to preventive policies compared to Britain and the USA'

- of the nine countries discussed by Selman and Mason, only Canada promoted adoption strongly
- British policy is 'in many ways in advance' of most of the countries reviewed in respect of seeking permanence for looked after children
- 'adoption is just one possible route [to permanence] but one that has proved relatively successful. The danger is that the "costs" of adoption - in terms of loss of links to the birth family - have been neglected and adoption pursued at the expense of a parallel emphasis on improved services for prevention and rehabilitation and on strengthening alternatives such as long-term fostering'
- 'one of the most compelling arguments for adoption is that it is the 'only form of substitute care that can provide a home for life'. It is important that we consider how to provide security 'into early adulthood and beyond' for those not placed for adoption
(Selman and Mason 2005)

Countries where 'rescuing' children or the concept of 'corporate parenting' predominate are likely to have higher rates of children entering care (e.g. USA, UK). In these countries there is a general belief that welfare services should only be used when absolutely necessary and that entry to care is to be avoided where possible. This 'child protection' approach takes the view that child protection is distinct from a wider continuum of services for children with lower levels of need and tends to delay intervention (Thoburn, 2009).

Conversely, Nordic and some other European countries view care as having a positive part to play and consider it as part of a continuum of services to support children in need and their families. These countries also have high rates of children in care. Countries with a predominantly Roman Catholic background (e.g. Spain) have strong pro-family policies and are less likely to endorse state intrusion (18 entrants per 10,000), as are countries with a tradition of extended family (e.g. Japan, 6 entrants per 10,000).

England, the USA and Canada are the only countries that actively support adoption as a route out of care, generally for younger children who are more likely to be adopted than older children. As a result, children who remain in care longer in these countries are likely to have acute problems and be harder to parent. In Nordic countries, adoption is not currently viewed as an option, but is being considered in some locations (Selman and Mason, 2005; Thoburn, 2009).

There have been a number of calls for England to adopt a welfare approach similar to the Scandinavian and European model so that all vulnerable children, whether they enter the 'system' through maltreatment or offending, are treated in the same way (Hazel, 2008; Children & Young People Now, 23.12.12). Hazel argues that the care system is the best place to deal with and have an impact on offenders, and that mentoring and therapeutic foster care may have an impact on this group of young people, who often come from very troubled families and may have suffered from abuse and neglect.

Alternative models of support for young people

The international evidence above looks at placement patterns, but not specifically provision for young people. Research by Boddy et al (2009) bridges this gap by comparing policy, practice and professional skills of the workforce in four European countries (Denmark, France, Germany and England) in relation to supporting young people at or near the point of requiring out of home care.

Therapeutic approaches to prevent a child being placed in care are seen as important in all countries. What differs is how these services are delivered. In Denmark, France and Germany interventions are often designed and delivered by social pedagogues often with input from a psychologist. In these countries, the 'edges' of care are less clearly demarcated in comparison to England. This reflects a different conceptualisation of placement, which is considered as a positive choice among the options for intervention with a child and family.

Short-term accommodation is available in a number of countries and may meet the needs of children who have to move in and out of care within a short period of time, particularly if it forms part of a therapeutic intervention with the family. Respite foster care is available in some local authorities in England and is often linked to other interventions for families and young people. Other short-term placement options available for young people include:

- weekday residential settings in Germany, where children return home at weekends and parents can visit during the week, thereby enabling joint work with children and parent
- extended use of respite provision where young people can self-present and have access to the same respite provider for up to 21 consecutive days in Denmark
- open access emergency accommodation where young people can self-present in Denmark, Germany and France. This is often linked to counselling services and a telephone helpline. The provision is well publicised and is often used by young people running away from their family as well as by those running away from residential or foster care (Boddy *et al* 2009).

Residential care is more readily considered as a first choice in France, Denmark and Germany, although foster care is the preferred option when possible. In contrast to England, where residential care is generally viewed as a last resort, it is seen by professionals in other countries as an intervention for those with complex and challenging needs and who need greater professional expertise. In all these countries there is a graduated range of provision to meet children's needs. Examples include:

- residential boarding care to accommodate people outside the care system (Denmark). However, there was some criticism of these schools' ability to intervene in the difficulties that gave rise to the need for placement
- models of professionalised foster care (Denmark and Germany)
- the *opholdssteder* model in Denmark, which combines professionalised residential care with a home-like environment
- community-based institutions in Denmark, France and Germany to ensure continuity for the young person in relation to involvement in social

networks and school attendance. These provide part-time and respite provision as well as full-time care
- therapeutic institutions in Denmark, France and Germany, and to a lesser extent England, for young people with significant emotional and behavioural difficulties (Boddy *et al* 2009).

One key difference is the lower level of qualifications within the workforce in England compared to other countries (see chapter 4 for a discussion). In addition, the range of professional disciplines in child welfare teams is much wider in Denmark, France and Germany, where they routinely employ psychologists and social pedagogues within social work practice. This approach is being trialled in some local authorities in England (e.g. Hackney).

Based on the findings, Boddy *et al* make a number of recommendations for policy and practice in England:

- strengthening the professional composition of social work teams to enhance the potential for therapeutic interventions with young people and their families, in particular, introducing social pedagogy as a qualification and the use of psychologists within social work teams
- using a child-centred approach when working with young people and their families
- placement of children in care should be seen as part of a continuum of services rather than as a last resort
- there should be diverse models of residential and foster care to address the heterogeneity of the care population, addressing age, placement history and reasons for needing care
- placement services should be therapeutic
- there should be more options available for short-term and part-time placement, including open-access emergency accommodation and respite care.

research
in practice

4. Residential Children's Homes

Key messages

- many children and young people in traditional children's homes in England have very challenging behaviour. Despite the children's complex needs, staff have lower levels of professional qualifications than their European counterparts
- social pedagogy, which takes a holistic view of the child/young person, is used in a number of European countries in a variety of settings. Most pedagogues train for three to four years at first degree level
- the social pedagogy approach permeates child care and education in continental Europe, and plays a key role in the continuum of services for children and families
- differences in the welfare systems between continental European countries and England raise challenges for the implementation of social pedagogy. The evaluation of the piloting of social pedagogy in England highlighted issues including homes not fully adopting the social pedagogy approach, disparity between the professional knowledge and pay of social pedagogues and residential care staff and uncertainty around the roles and responsibilities of social pedagogues. Social pedagogues were, however, generally positively received by young people and staff and families valued the holistic approach
- the evaluation found no significant difference in outcomes for children in homes that employed social pedagogues when compared to those in traditional residential homes. However, these results must be interpreted with consideration of the limited timescales for and contextual challenges to implementation and evaluation
- reforming pockets of practice or airlifting in alternative models is unlikely to be sufficient in itself to improve outcomes; attention must be given to contextual issues that impact on programme implementation and service improvement
- social pedagogy is a promising approach, not just in residential children's homes, but also within wider service provision. The Fostering Network is currently leading on the implementation of the social pedagogy approach for children placed in foster care in a number of UK authorities and agencies.

This chapter summarises evidence on children's residential care in England and then considers alternative models of provision used in other countries.

There has been a steady decline in the use of children's residential care in England, from 32 per cent of the care population in 1978, to 21 per cent in 1986, and only nine per cent in 2010/11 (Berridge et al, 2012). This has been

coupled with an increase in the use of foster care, which accounts for nearly threequarters of all care placements.

Most children's homes accommodate a diverse group of children and young people, with an average age of 15.5 years. Many of the young people in children's homes in England have very challenging behaviour: 33% were assessed as having SEN, 74% were reported to have been violent or aggressive in the past 6 months, with the same proportion reported to have put themselvesat risk (Berridge *et al* 2012). Despite these complex needs, children's homes' staff routinely have far lower levels of professional qualifications than their continental European counterparts.

To address some of the problems associated with children's homes, the Department for Education issued Revised National Minimum Standards, which emphasise the importance of the quality of children's relationships with residential staff (Department for Education, 2011a).

Research suggests that:

- more effective homes tend to be small so problems in managing the group and peer dynamics do not dominate
- staff working with children with challenging behaviour in residential care need to show a clear commitment to young people, be accepting and demonstrate a warm, caring attitude. They should develop relationships of trust and respect, listening to young people and taking their problems and views seriously
- the importance of the staff-resident relationships is consistent with the 'reflexive-therapeutic' approach in children's services in other European countries (Berridge et al, 2012).

Social Pedagogy

In most European countries residential care is used more extensively and residential care work has a higher professional status and requires more professional qualifications than in England. Homes in England tend to be smaller than those in Denmark and Germany but tend to accommodate older children. With residential care seen more as a last resort rather than a positive therapeutic intervention, the length of stay is also shorter in England (Berridge et al, 2011).

Pedagogues work in a variety of social care, health and educational settings, with experienced pedagogues providing training and support services for foster carers. Most pedagogues train for three to four years at first degree level. Others take longer, more theoretically-based, degrees. The training typically combines academic knowledge, with practical, organisational and communication skills and often, the expressive arts, outdoor adventure and environmental activities. Social pedagogues working in residential care expect to have a range of responsibilities within the home as well as between the home and the wider society (Berridge et al, 2011; Cameron, 2011).

Petrie et al (2006) identify the following key principles of pedagogic practice:

- pedagogy builds on an understanding of children's rights
- it focuses on the child as a whole person, and supports the child's overall development
- relationships are at the core of the approach. Practitioners see themselves as in relationships with the child or young person and their training prepares them to share in many aspects of children's daily lives
- there is an emphasis on team work and on valuing the contributions of others such as families, community and other professionals
- pedagogues are encouraged to constantly reflect on their work and to bring both theoretical understandings and self-knowledge to the process

Social pedagogy in England

The social pedagogy pilot evaluation conducted in England between 2009 and 2011 (Berridge et al, 2011) compared 18 children's homes that had recruited social pedagogues from Europe (primarily Germany) with 12 homes that did not employ social pedagogues.

The evaluation investigated placement patterns and key outcomes for all residents placed in the homes over an 18 month period and explored the views of young people living in the homes as well as the views of staff. In some cases social pedagogues had been working prior to the pilot in some of the children's homes, whereas in others they were employed specifically for the pilot to work in a single home. In another group of children's homes, the pedagogues worked part-time in the home as well as taking a consultancy role to increase awareness of social pedagogy amongst the local children's workforce.

The evaluation found that few of the homes fully adopted the social pedagogy approach. One of the challenges was that pedagogues in some homes were expected to undertake the same duties as other residential workers rather than having a specific role linked to their specialist training; in about half the homes with social pedagogues there was no major difference in the SP role compared with other staff.

Pedagogues were generally positively received by young people, staff and managers and most were felt to have contributed to practice improvements in homes. In particular, they had helped to improve behaviour management as well as the engagement of young people and communication within the team. However, children in homes which employed pedagogues did no better across a range of outcomes than children in comparison homes. These results must be interpreted with awareness of the implementation challenges and the short timescale of the evaluation (Berridge et al, 2011). It would be unwise to conclude on the basis of the results of this pilot that a social pedagogy approach to residential care cannot be implemented effectively to improve outcomes for children and young people in England. There is a great deal of interest in pursuing a more systematic and measured implementation of the approach (see below).

In terms of the implementation of the programme, Cameron et al (2011) report that there was a significant challenge in introducing a graduate profession with higher level academic knowledge and professional skills because of the mismatch with the existing workforce, particularly with respect to pay and conditions.

There was also a challenge in relation to the hierarchical organisation of staff in residential homes, which devalued pedagogues' decision making ability. In European residential care, the norm is democratic decision making within relatively flat hierarchies, in which staff take on higher levels of responsibility. Key to success is a constructive and engaging management style. Successful sites were characterised by a commitment to engage with social pedagogic ideas and methods, which was led by the manager and endorsed by staff.

Despite these challenges, Cameron et al (2011) conclude that 'developing and running the pilot programme has helped stimulate interest in social pedagogy, but its introduction into English residential care is not straightforward' (Cameron *et al*: 10). Cousee (2010) argues that what is important is the holistic perspective of social pedagogy rather than the separate role of the pedagogue. Thus, reform of practice is not, in itself, sufficient for major transformations in outcomes. What is of equal, if not more importance, are the social circumstances in which practice operates.

Factors contributing to successful working with social pedagogy include:

- experience, confidence and skills of social pedagogues
- knowledge of social pedagogy among management at all levels and willingness to learn and be challenged
- wide support from the employer organisation and a willingness to invest resources into training, networking, thinking and reflection
- not being wedded to existing approaches to the exclusion of other ways of thinking
- stability of managerial and the staff team, with commitment to debate and reflect and to live with uncertainty as a positive context for the work (Cameron et al, 2011).

According to Cameron et al (2011), there are a number of common factors across countries adopting the social pedagogy approach in terms of family support and early childhood care and education including:

- a well-established practice of providing early childhood care and education services often involving social pedagogues
- a high degree of professionalisation among staff
- work is generally carried out in multidisciplinary teams, with social pedagogues working alongside social workers, psychologists, health and legal professionals and teachers
- a focus on strengths. Services are seen as complementary to children and families own competencies
- there are many possibilities for help, from universal services within neighbourhoods to intensive social pedagogy help. This includes family therapy, individual support worker and options for accessing placements away from home on a short-term, respite or emergency basis. SPs played an important role in all services.

Cameron et al (2011) conclude that welfare systems such as this are more successful at preventing the escalation of family problems. It is not, however, possible to determine the specific value/effectiveness of social pedagogy as it is

not possible to isolate its contribution from that of other services. However, what is evident is that families value the holistic approach of working with children and families. The key principle is offering choice to the family, involving them in decision making and the availability of services staffed by highly qualified experts.

Developments in social pedagogy in England

Interest in social pedagogy continues to gather pace, indicating that the pilot programme has been an important stimulus in developing ways of working with looked after children and young people. Several children's homes have extended their recruitment of social pedagogues to other homes (e.g. St Christopher's Fellowship and Heartwood Care Group).

Derbyshire County Council, in partnership with the University of Derby, have completed an extensive scoping exercise to inform further development and training approaches for social pedagogy (Moore, Jakhara and Bowie 2013). DCC intend to adopt social pedagogy as the underpinning conceptual framework for working with children and young people in care and with other vulnerable young people in Derbyshire.

The Fostering Network's Head, Heart and Hands programme is introducing social pedagogy into foster care in the UK in a number of local authorities (London Borough of Hackney, Surrey County Council, Staffordshire County Council, Orkney Islands Council and Aberlour Fostering- a joint site, and Capstone Foster Care). The programme aims to demonstrate how to successfully introduce the approach and the impact this has on placement stability, educational outcomes and the life chances of children and young people in foster care. It is being evaluated by a team from Loughborough University, the Colebrook Centre and NCAS (National Care Advisory Service). There is also a learning network to share and promote learning across the agencies (www.fostering.net/head-heart-hands).

Other important networks for the development of social pedagogy include:

- Centre for the Understanding of Social Pedagogy (CUSP) at the Institute of Education
- Jacaranda Recruitment, which provides recruitment, consultancy and training services in Social Pedagogy and Social Work and runs the social pedagogy website (www.SocialPedagogyUK.com)
- ThemPra, a social enterprise, formed in 2008, to provide training courses and promote social pedagogy across the UK
- The Social Pedagogy Development Network, led by Thempra in partnership with others. This is a grassroots movement for shaping and developing a UK tradition of social pedagogy.

In addition, the following organisations are developing social pedagogic approaches:

- Essex County Council. Around one third (150) of the county's residential child care staff from all 12 children's homes have undertaken initial six day training courses in social pedagogy. A full-time Development Officer

has been appointed for children's residential services to help support the development of social pedagogy. All practitioners are required to keep a reflective diary
- London Borough of Hackney has recruited social pedagogues , who are located in their Virtual School for looked after children as part of the Head, Heart and Hands programme.
- Walsall Borough Council is undertaking a Social Pedagogy Pilot supported by a training and development programme for children's residential services to improve outcomes for looked after children. At the same time, social pedagogues are being recruited to work locally (Cameron et al, 2011).

In addition, a number of higher education institutions have introduced social pedagogy into degree programmes:

- Aberdeen University and Camphill Schools, follow a social pedagogy curriculum attuned to the practice and philosophy of Camphill Schools
- the BA Youth and Community Work, University of Wales Newport, includes a module on Social Pedagogy
- the BA (Hons) European Social Work, University of Portsmouth, includes a module on social care and social pedagogy in Europe
- the Foundation Degree, Working with Children: education and well-being, Institute of Education, University of London, includes modules informed by social pedagogy
- the MA in Social Pedagogy, Institute of Education, University of London, started in September 2010
- an MA in Social Pedagogy at the University of Winchester (Cameron et al, 2011).

Case Study- Staffordshire County Council

Staffordshire County Council has a history of interest in social pedagogy and employs two social pedagogues from the continent. They have rolled out training and development across children's home staffing teams, delivered by Thempra. There is also:

- social pedagogy leadership training to senior children's home staff
- student exchanges for Danish pedagogues
- a social pedagogy strategy group
- follow-up team reflection days
- 3 day residential course for staff wanting to develop their knowledge of social pedagogy further
- roll-out of introductory social pedagogy training across the wider children's workforce, including foster carers.

Although not formally evaluated, positive feedback on the approach from the practitioners' group includes comments such as:

- openness for discussion
- allows questioning
- gives a voice to practitioners
- gives confidence to workers

- breaks down the hierarchy
- creates choices
- staff feel empowered, listened to
- managers to empower staff
- confirmation for some that existing practice is sound
- no need for apologies for getting it wrong
- individual ownership of action/practice

In addition, there is an improved relationship between young people and staff in that the young people want to stay in touch and some say they don't want to leave.

Implementation in Staffordshire is supported by:

- working in partnership with Thempra
- engagement of practitioners and managers with the Social Pedagogy Development Network
- working in partnership with Jacaranda Recruitment and other sites who have an interest in developing practice, in order to recruit qualified practitioners from the UK and the continent.

To mitigate the tensions identified in the pilot between social pedagogues and other residential home staff Staffordshire noted the following:

> *The implementation has been difficult at time with periods of success and failure but the use of training materials has been useful to refresh and reinvest energy in activities and the approach. We have provided structured and unstructured opportunities for practitioners and teams to work through issues and challenges. Practitioners have been supported to self-organise and determine their own goals and opportunities. There is a high level of support for the implementation of this approach from senior managers and leaders within the organisation, and a commitment to invest in the development of our workforce in this sector. We have recognised that cultural change takes investment over time and we, as an organisation, have made the commitment to continue to reinforce SP as a central tenet of our practice. This message is clearly articulated at different levels of the organisation.*

5. Kinship Care

Since kinship care is a naturally occurring family form, it is easy to assume that it is also unproblematic. In fact, research indicates that it is likely to present unique challenges, over and above the 'normal' demands of parenting (Hunt et al, 2008: 162).

Key messages

- around 11 per cent of children in England are formally cared for by a relative or friend. The majority of children (97%) living with kin are cared for informally by their relatives (Nandy et al, 2011)
- children living with relatives or friends (both formally and informally) have usually suffered multiple adversities and can display severe emotional and behavioural difficulties
- grandparents are the most likely relatives to be caring for children not living with their birth parents, in either formal or informal arrangements. Many of the grandparents suffer extreme financial difficulties and health and disability issues. There are also a large number of young people who provide informal care for their younger siblings
- despite these challenges kinship carers receive less support (services and financial) than unrelated foster carers. Informal kinship carers generally receive no support
- children placed in kinship care generally do as well as children in unrelated foster care in terms of the stability of the placement. There are some important age differences in this; disruption is more likely to occur for older children than for younger children
- evidence on the overall well-being of children in kinship care is equivocal
- there is evidence that the sequential assessment of kin carers can lead to delay in finding a child a permanent placement and that relatively few of these assessments lead to children being placed with relatives
- there is an urgent need to increase financial support and provide improved access to universal and specialist services for children and their kinship carers (both formal and informal), in line with the Guidance for Family and Friends Care (Department for Education, 2011c)
- providing support services for kin carers is a viable option when offset against the long-term cost of placing the child in foster care.

Kinship care, also known as family and friends care in England, is a common child-rearing practice throughout the world. There is no single definition of kinship care; it is used to describe a range of placement types with extended family, relatives or friends. It refers to the care arrangements for a child who cannot live with their parents and who is cared for by a member of their family or a friend with whom the child has an existing relationship (Nixon, 2007). In some countries it refers only to blood-relatives, while for others it refers to a much wider group including family friends and neighbours. Kinship care can be

informal (i.e. outside the child welfare system) or formal, where the placement is arranged, supported or approved by the state.

The chapter considers the evidence on both formal kinship care, where the child is fostered with family or friends, as well as informal kinship care. It summarises national and international research evidence with regard to the use of kinship care and the outcomes for children.

Kinship care in England

When children cannot remain with their parents, the Children Act 1989 encourages local authorities to place children with a relative, friend or other 'connected' person. This preference was expressed more fully in *Care Matters,* which proposed a major review in the use of kinship care to address concerns about variation in the use of family and friends placements (Department for Education and Skills, 2006). More recently the Department for Education published *Family and Friends Care: Statutory Guidance for Local Authorities* (Department for Education, 2011c). This guidance sets out a framework for the provision of support to family and friends carers. It also provides guidance on the implementation of the duties in the Children Act 1989 with regard to children and young people who are brought up by members of their family or friends, in particular in relation to the support that carers should receive to safeguard and promote the welfare of children, regardless of whether they are looked after or not. This support should be available regardless of whether or not the arrangement was initiated by the local authority R(SA) v Kent County Council, 2011).

In England, kinship care covers a variety of situations:

- an informal arrangement within the family without any involvement of children's services
- registered private foster care
- local authority foster care with family or friends
- kin care following a court order obtained by the carer (residence, special guardianship or adoption orders) (Argent, 2009)

Latest statistics on the number of children in formal kinship care in England show that 11 per cent of children (over 7,000), who were looked after at 31 March 2012, were fostered by a relative or friend (Department for Education, 2012a). The number of children formally being cared for by family and friends is likely to be higher than this figure suggests, as a number who were previously looked after by family or friends will have ceased to be looked after as a result of their carer being granted a residence order or special guardianship order. Eight per cent (over 2,000) of those who ceased to be looked after during the year ending 31 March 2012 did so through a special guardianship order, a further five per cent (1,290) were granted a residence order. Thirty seven per cent of children who ceased to be looked after in this period returned home.

These data only provide figures for the number of children/young people who are cared for under formal kinship arrangements. Analysis of 2001 census data indicates that in the UK, 173,200 children/young people were living either formally or informally with relatives without their parents present in the

household. Of these, 143,367 were living in England, with 97 per cent (136,497) living informally with relatives (Nandy et al, 2011). Given the large number of children living informally with relatives, it is important to consider the characteristics and support needs of kin carers and children in both formal and informal arrangements.

How does England compare to other nations in use of kinship care?

Table one below provides a comparison of children in kin and non-kin care in a selection of countries in 2004-05.

Table 1: Comparison of kin and non-kin foster care

Country	Kin care (%)	Non-kin foster care (%)
Australia	40	39
New Zealand	35	40
Italy	26	24
USA	23	46
England	18	47
Germany	9	38
France	7	46

(Thoburn, 2009)

Australia placed the largest proportion of children in kinship care followed by New Zealand and Italy. In the USA, 23 per cent of children in care are in kinship arrangements; however, this figure masks the number of children exiting this form of care through adoption by kinship carers. In the same time period in England, 18 per cent of LAC children were in kinship care compared to 47 per cent in non-kin foster care[2]. In France only seven per cent of children in care are placed in kinship care, similar to Germany.

In Australia, it has been suggested that recent increases in kinship care have come about as a result of greater demand for out of home care, coupled with an insufficient supply of foster carers. The Aboriginal Child Placement Principle facilitates culturally appropriate placements for aborigine children. This is likely to have a significant impact on the numbers of children in kinship care as the

[2] This was before the introduction of special guardianship orders.

rate of out of home care for indigenous groups is nine times that for non-indigenous groups (Boetto, 2010).

In New Zealand, it has been suggested that the high proportion of children in kinship care is a consequence of the widespread use of the family group conference (FGC), a process introduced in New Zealand in 1989, which developed out of traditional Maori restorative justice practices where professionals and families work together to address concerns and agree a plan for the child. Family group conferences engage family groups at an earlier stage in the investigative process where child maltreatment is suspected (Doolan and Nixon, 2003).

A study on the use of FGCs in four pilot projects in England showed that children were more likely to be placed with extended family and that the placement was more likely to be stable when there was a FGC. Some resistance to the use of FGCs was noted, as well as concerns about the willingness of the extended family to adhere to plans. Similarly, there was a lack of follow-through and service delivery by social workers and other agencies post-conference. On the other hand, children participation in FGCs was more evident than in other forms of meeting leading to a greater say about their placement needs (see Nixon, 2007). According to the Family Rights Group website, threequarters of local authorities in England and Wales run or commission family group conferences, although only a small minority routinely offer this before a child is taken into care. The Family Rights Group has recently issued guidance on the use of FGC for children who are in, or are on the brink of care proceedings (Family Rights Group, 2011). However, it is not always appropriate to use FGC, for example where there is history of domestic violence.

Another country with a high proportion of children in kinship care is Spain, where kinship care accounts for 85% of all foster care. The predominant type of care is 'administrative foster care', usually within the extended family and which is arranged with the consent of all parties involved. The tradition of a family based culture may explain this, and in fact many kinship placements are spontaneous situations that are later formalised as family foster care (Palacios and Jimenez, 2009).

Characteristics of kinship carers and children

Nandy et al (2011) found that older children (13+ years), and particularly those aged between 15 and 17 years, were the most likely to be living with relatives, either formally or informally. A follow up study of children aged between 8 and 18 years who had been living informally with relatives for at least six months found that:

- 30% moved in under the age of 3 years
- 30% moved in aged 3-7 years
- 30% moved in aged 8-13 years
- 10% moved in aged 14 and over

(Farmer et al, 2013)

The census data showed that there were three distinct groups of relatives caring for children: grandparents, siblings and other relatives such as aunts, uncles and cousins. In England the majority of kinship carers were grandparents (just under 45 per cent); however, the proportion of children living with siblings in England was only slightly lower than the proportion living with grandparents (just under 40 per cent) (Nandy et al, 2011). This is slightly different to the findings on the characteristics of caregivers of children formally placed in kinship care; here, 62 per cent of children were placed with grandparents and 26 per cent with aunts and uncles (Lutman et al, 2009).

Interviews with carers in a study of formal and informal kinship care undertaken for the Family Rights Group indicated four main reasons for children living with kin carers:

- parental drugs or alcohol misuse (60%)
- abuse or neglect (59%)
- parental mental illness (28%)
- domestic violence (27%)

(Hunt and Waterhouse, 2012)

These figures are consistent with other studies which have found that children living under formal arrangements with family and friends carers had usually suffered multiple adversities before being placed with their carers and that the level of adversity were at least equal to that experienced by children entering the care system (Hunt et al, 2008; Farmer and Moyers, 2008). Of particular note is the finding that 88% of the children living in informal kinship care were thought to have been maltreated (Farmer et al 2013). This study also found that one in three of the children had moved in with a relative because of the death of a parent and one in four had been actively rejected or abandoned by their parents. Selwyn et al's (in press) study on informal kinship care found that over a third of the children had emotional and behavioural difficulties that were in the abnormal range, particularly in their ability to manage and express their emotions.

A consistent finding in the research on children in both formal and informal kinship care is that kinship carers have fewer financial and material resources. Farmer and Moyers (2008) found evidence of financial difficulty in 75 per cent of formal kin placements, compared to 13 per cent in non-kin placements. Nandy et al (2011) found that a substantial number of children (in formal and informal kin care) were living with families whose characteristics were associated with increased risk of poverty: single female carers, dependent on benefits, workless households, higher prevalence of long term illness or disability and over representation of ethnic minorities. The majority of children living in kinship care were living in the poorest 40% of areas and many were in the bottom 20% of areas.

Farmer et al (2013) found that very few informal kin carers had sufficient income to meet minimum income standards, often as a consequence of caring for the children. This study comprised of interviews with 80 children and 80 kinship carers, predominantly grandparents, many of whom lived only on their pensions and had a longstanding health condition or disability (Selwyn et al, in

press). In addition, over a third of the carers' lives were restricted by pain while almost two thirds were clinically depressed. This was particularly the case when the child's parents had died, when they experienced chronic pain or when their social network was small.

The Family Rights Group study found that carers' working lives were severely disrupted by becoming carers. Some had to give up work or reduce their hours in order to be more available for the child. Others had to increase their work commitments in order to manage financially. Only one in eight was able to continue working as before. Forty-four per cent said that they had received no practical help from the local authority (Hunt and Waterhouse, 2012).

Outcomes in kinship care

A consistent finding is that children placed in kinship care generally do as well as children in unrelated foster care, particularly with regard to the stability of the placement (Hunt et al, 2008; Farmer, 2009; Nixon, 2007). Hunt et al (2008) followed up a group of 113 children placed with members of their family over a number of years. They found that 72 per cent of placements were continuing or had ended having lasted as long as needed. A further 28 per cent had ended prematurely and 16 per cent were continuing but vulnerable to disruption. This compares to an average rate of disruption for unrelated foster care of around 43 per cent. These findings contrast with other research, which has found similar disruption rates for kin and non-kin placements (18% and 17% respectively) (Lutman et al, 2009).

There are some important differences in stability with regard to the age of the children placed in kinship care:

- the children whose placements disrupted were significantly older at the end of care proceedings (mean age 8 years) than those whose placements were not disrupted (mean age 4.1 years)
- sixty per cent of children aged between 10 and 14 years at the end of care proceedings had disrupted kinship placements compared to 11 per cent of children under 5 years old
- importantly, over half the children in the study were under five years old at the end of care proceedings. The younger age of children at placement may provide a partial explanation for the lower rate of disruption (Hunt, 2009).

Disruption and the quality of care also vary across local authorities. For example, in one local authority, 49% of kin placements were judged to be of poor quality compared to just 8% in another. There are also significant differences in disruption rates between authorities (Farmer, 2009).

However, not all disruptions are negative; from the children's viewpoint half of the 'disruptions' were a result of them wanting to move and more than half of the children moved back with a parent or went to live with another relative, with the carer often retaining a positive relationship with the child. This supports the evidence from other studies that kinship care is likely to be a less disruptive experience for children than moving into unrelated foster care. This is because they already have a connection with the person, many will be placed with

siblings and contact with birth parents is more likely than in non-kin care. Many also remain in the same neighbourhood and school (Hunt, 2009).

Kinship carers show a strong commitment to the children and tend to persevere in looking after children with high levels of difficulty beyond the point at which non-kin carers would do so (Farmer, 2010). This is a key factor in terms of stability of the placement, but it also means that many kin carers continue to care for a child when they are under considerable strain, which can result in a poor quality placement. Farmer and Moyers (2008) report concerns about the quality of care in 34 per cent of placements (compared to 27 per cent of unrelated foster carers); family and friends carers were more likely than unrelated foster carers to have poor parenting skills with more of them struggling to cope. Despite these difficulties, kinship carers are less likely to receive support services than non-kin foster carers (Nixon, 2007).

Measures of longer term emotional and behavioural outcomes for children in kinship care are equivocal and, to date, there have been no longitudinal studies into adulthood of children placed in kinship care (see Nixon, 2007 for a fuller discussion).

In Farmer et al's (2013) study of informal kinship arrangements, most of the children were found to be securely attached to their kinship carer. However, a considerable number had unanswered questions about their past and why they were living with kin. This was particularly the case for children who had suffered bereavement and wanted more information about parental death. Some of the children also had a small social network and saw few relatives or friends. This was particularly the case for children living with older carers. Often, a mutually dependent relationship developed as the children became involved in caring for their grandparents and helping them with household chores.

Despite this, 97% of the children believed that living with their kinship carer was a good thing, and 73% said they would choose to live with their kinship carer. However, more than one third of the children reported that there was a stigma attached to living in kinship care and said that there had been hurtful remarks directed towards them. As a consequence, only 14% were totally open with their friends about their living arrangements, particularly those that had parents with drug/alcohol misuse problems or parents in prison.

Hunt's (2009) study of formal kinship care found that positive outcomes are more likely when:

- the child is placed with kinship carers at an early age
- the child has few difficulties when placed
- the child has lived with the carer before
- the carer instigates the placement
- the carer is a grandparent
- the carer is a sole carer
- there are no non-sibling children in the household.

The support needs of kinship carers and children

Given the characteristics of kinship carers and the children they care for, it is not surprising to find that they have a range of support needs. Farmer et al (2013) found that threequarters of the informal kinship carers had asked children's services for help, but only a quarter received help. This is consistent with findings from the Family Rights Group, who found that the amount and type of support carers receive from local authorities bears no relationship to the child's or carer's needs (Hunt and Waterhouse, 2012) and that kinship carers get less support than non-kin carers, even when they are approved as foster carers (Hunt, 2009).

In some cases, informal kinship carers have been told that if they could not manage alone the children would be removed for fostering or adoption (Selwyn et al, in press). As a consequence they rarely asked for help again. One of the issues identified was that Children's Services often viewed the arrangements as private when carers had stepped in quickly to care for the children and later turned down their requests for help, often without any assessment of need. This was true even in some cases where social workers had asked kin carers to take the children, but still claimed it was a private arrangement.

It is not just grandparents who struggle in this situation; kinship carer siblings and young aunts are also disadvantaged (Selwyn et al, in press).The census study showed that siblings are the second largest group of kinship carers (38%). In Selwyn's study, this group proved difficult to find and involve. However, in the majority of cases where siblings were informal carers, they had taken on the care of children only a few years younger than themselves, very often following the death of their mother. None of the sibling carers had prior experience of bringing up children and all scored as depressed on the measures used. They often lived in overcrowded conditions and were managing on a very low weekly income (less than £200 per week).

The strain of caring for some of these children cannot be overstated. Despite high levels of commitments, kin carers struggle to cope with the children they care for significantly more than unrelated foster carers (Farmer, 2009). Furthermore, there were many reports on file of family and friends who were close to breaking point. In the cases where carers were showing signs of strain, placement quality was poorer, in both related and unrelated foster care, although kin carers were more likely to continue the placement than non-kin carers.

Another area where support may be needed is in accessing bereavement counselling as a considerable number of children move in with their kinship carers following the death of their parents. Both grandparents and children can struggle to cope with the bereavement and experience a prolonged grief reaction. In such cases, carers need to be signposted to bereavement services for themselves and the children (Selwyn et al, in press).

Although the evidence shows that there is a gap between the support needs of kinship carers (in both formal and informal arrangements) and what is actually provided by local authorities, some local authorities have focused on children in need who are not looked after, offering informal kinship care support for up to a

year. The Kinship Care Team (KCT) in the London Borough of Greenwich offered support in the following areas:

- advice on welfare rights and legal options
- emotional support and counselling
- advice on managing difficult behaviour and attachment issues
- help to access other services such as CAMHS
- supervised contact
- payments for bedding, furniture and clothing and occasionally a small weekly allowance (Saunders and Selwyn, 2008).

The carers in this study were generally very positive about the services provided, although not all kinds of help were needed. In particular, they appreciated being listened to, having emotional support and knowing there was someone they could turn to. They were also very grateful for both financial and practical support. Most of the carers also said that if they had not stepped in the child would have been taken into care.

Reducing the need for a child to be looked after by the local authority represents a substantial financial saving. Figures for 2006 show the unit cost of providing an in-house foster placement was estimated at £633 per week. In comparison, the cost per child of having the kinship care service was around £140 per week (Saunders and Selwyn, 2008). This cost comparison shows that offering much needed support to kin carers is a viable option when offset against the long-term cost of placing the child in foster care.

Assessment of kinship carers

The quality of assessment of formal kin carers is key in terms of positive placement outcomes. A number of researchers and carers have expressed concern around the suitability of the assessment process. There are three main challenges:

- whether there should be a difference in assessment standards for kin and non-kin foster care
- whether intergenerational transmission has occurred and whether kin carers have the same issues as birth parents
- kinship assessments can be difficult for both families and workers (Child Safety Services, 2011).

Many potential kin carers acknowledge the necessity of assessment but feel resentment about the attention given to risk. At times the assessment and approval process is long and drawn out, while at other times, especially in an emergency, it may be too rushed (Hunt, 2009).

Farmer and Moyers (2008) found that placements tended to be more stable when carers had been assessed as foster carers, while Hunt et al (2008) report better placements where there had been a pre-placement assessment (not necessarily a full assessment). The key factor in assessment is parenting capacity, which is linked to better placement quality.

One area of concern in terms of delay in the family justice system is that potential kinship carers are often assessed sequentially, contributing to delays in finding a permanent placement. Some evidence suggests that social workers are instructed by the courts to undertake more kin assessments, even though they are unlikely to be successful (Thomas, 2012).

Selwyn et al's (2010) study found that over threequarters of children had relatives assessed for their suitability to care for them. There was wide variation in kin assessments with London boroughs conducting significantly more kin assessments (75%) than the northern authorities (50%) and the Midlands (69%). In this study, 81 extended family members were assessed for 61 children; 21 children were placed with kin (around 20% of the sample). Of these, five placements broke down. In many cases kin were assessed sequentially, sometimes because family members came forward one after the other and social workers wanted to check the suitability of each relative before moving on to the next assessment. This often resulted in delayed permanence for a child, particularly when assessments were undertaken outside the UK. In one case, "the birth father insisted that the social worker must wait until his father arrived from Pakistan" (Selwyn et al, 2010: 55).

What would help kinship carers and children?

A number of recommendations have been proposed to improve the outcomes for children in both formal and informal kinship care and their carers:

- financial support and practical help, including assistance with equipment and clothes as well as transport and accommodation
- information, advice and advocacy to navigate legal, benefits, education and social service systems. This should include signposting to independent sources of information and advice
- bereavement counselling where children have suffered from parental death
- access to a variety of universal and specialist services through multi-agency working, including therapy and counselling
- access to social work and peer group support
- involving children and families in decision making through offering all families a family group conference prior to a child becoming looked after (or in an emergency, soon afterwards)
- a new approach to assessing kinship carers, which recognises the difference to non-kin foster carers.

(Hunt, 2008; Nixon, 2007; Hunt and Waterhouse, 2012; Farmer et al, 2013)

Organisational support is also important in terms of:

- the suitability of family members as potential carers should be established at the pre-proceedings stage. Evidence to show that all suitable candidates as kinship carers have been assessed should be concise and robust. This would mitigate the introduction late in proceedings of distant relatives with no real connection to the child

- the culture and management of social workers exploring kinship care as the preferred option
- a dedicated kinship care placement team or at least one experienced kinship worker
- the routine organisation of FGC or other family meeting for full involvement in decision making
- a specially designed assessment procedure and preparation course for kinship carers
- the financial and placement support provided
- the availability of an information pack specifically designed for kinship carers
- the availability of legal advice for those who want to apply for a court order (Argent, 2009).

research
in practice

6. Evidence Based Interventions

Key messages

- there are a number of evidence-based programmes that have been found to be effective in improving outcomes for young people either in care or at risk of being placed in care or custody. These include Multi-Systemic Therapy, Multidimensional Treatment Foster Care and Functional Family Therapy
- at the core of all of these programmes is an approach based on working intensively with the young person in the context of their birth or carer family situation
- the programmes share a number of other features including: engagement with the child and parents/carers; developing positive family relationships; promoting pro-social peer relationships; improving parenting skills; and providing clear and consistent behavioural boundaries
- the intensive interventions are delivered by professionals who have been specifically trained, and include techniques such as cognitive behavioural therapy and family therapy
- frontline practitioners have limited case loads and access to high quality, frequent and regular supervision
- although these interventions appear costly, they are generally comparable to the longer term costs of placements for children with similar needs
- it is important to maintain some level of service after the intervention ends to ensure that positive changes are sustained.

There is growing attention at national policy level to the value of evidence based interventions for looked after children and children on the edge of care or custody. The Department for Education supports a range of interventions in partnership with the Department of Health and the Youth Justice Board. These include Multi Systemic Therapy (MST), Multi-dimensional Treatment Foster Care (MTFC), KEEP (parenting skills for foster carers) and Functional Family Therapy. In 2011 the DfE invited local authorities and partner agencies to apply for funding to deliver intensive services to this group of children (Department for Education, 2011b). DfE have also commissioned analysis of the 'issues for success' in implementing model programmes (Wiggins et al 2012).

More recently, the Department launched a prospectus for local authorities and their partners to bid for financial and other support to implement a further tranche of evidence based programmes (Department for Education, 2013). In addition to MTFC, MST, KEEP and FFT, this includes the AdOpt programme for new adoptive parents; the RESuLT training programme for children's homes' staff; MST- FIT(Family Integration Therapy) to support the safe return home of children in care aged 11-17; and a programme for babies and very young children in foster care.

This chapter summarises the evidence on the effectiveness of four interventions for adolescents (MTFC, MST, KEEP and FFT) and summarises the additional

interventions aimed at adolescents being trialled in the Department for Education's most recent prospectus.

Interventions for Looked After Children

Multidimensional Treatment Foster Care

MTFC was developed for children and young people experiencing significant levels of difficulty in several areas of their lives - at home, school and socially, providing a wrap-around multi-modal intervention for these children. It was initially developed for use with young offenders and has recently been used for children and adolescents in the care system. There are three MTFC programmes: MTFC-A (for adolescents); MTFC-P (for children under 6 years) and MTFC-C (for children aged 6-11 years).

MTFC-A differs from routine foster care by offering treatment as well as substitute care. It includes the provision of individual and family therapy, social skills training and support with education. Young people are placed in short-term foster care (for around 9 months), followed by a short period of after care. The programme is delivered both by a highly trained professional team and by highly trained and supported foster carers.

The key principles of MTFC-A include:

- Provision of a consistent reinforcing environment in which young people are mentored and encouraged
- Provision of a clear structure, with clearly specified boundaries to behaviour and specified consequences that can be delivered in a teaching-oriented manner
- Close supervision of young people's activities and whereabouts at all times
- Diversion from association with anti-social peers and help to develop positive social skills.
  (Biehal et al, 2012)

International and national evidence on MTFC-A

The US RCT evidence has found significant positive findings for those in MFTC compared to peers in standard foster care or residential placement. MTFC reduces the likelihood of youths at risk being placed in custody as well as reducing externalising behaviour in young people with conduct disorders who are at risk of being removed from their family (see Biehal, 2012). The young people are more likely to have stable placements and be less likely to be re-arrested, run away or misuse hard drugs. They also show better school performance (Asmussen et al, 2012). As well as the USA and England, MTFC is being implemented in New Zealand, Canada, Sweden, Norway, Denmark, the Netherlands, Ireland and Scotland (Wiggins et al, 2012).

There have been two evaluations of MTFC in England - the Intensive Fostering evaluation, which is aimed at persistent young offenders, and the MTFC evaluation for adolescents at risk of being placed in out of home care (MTFC-A). The Intensive Fostering evaluation found that the young offenders receiving this intervention were less likely to be reconvicted during the initial follow-up period

(one year after they entered their foster placement) than those not on the programme. They were also more likely to engage with education and training, more likely to be living in the community and less likely to be associating with anti-social peers. However, the year after the MTFC group left their Intensive Fostering placement they moved from a situation of intensive support to very little support and the gains made while in MTFC faded and reconviction rates rose sharply. (Biehal et al, 2010, 2011).

The evaluation of MTFC for adolescents (MTFC-A) in England tracked the first four years of the pilot programme for adolescents across 18 local authorities using a randomised controlled trial (RCT) embedded in a non-randomised comparison study (Biehal et al, 2012). These young people were looked after children who were at risk of repeated placement breakdown and had complex difficulties, including mental health and behavioural problems. Most of the young people had experienced considerable placement instability, nearly all had experienced abuse or neglect and two-thirds had mental health difficulties. Over half had statements of special educational needs and 36% had recently committed a recorded offence.

In comparison to a similar group of young people in standard foster care, there was no overall benefit of MTFC-A for the young people on the programme in terms of social adjustment, education outcomes and offending. However, in a subgroup with serious antisocial behaviour problems, there was a reduction in these behaviour problems over usual care and also in overall social adjustment. By comparison, the young people who were not anti-social did significantly better if they received a usual care placement. Young people's engagement in the programme was a key issue and some did not like the structured nature of the programme. However, development of strong relationships with foster carers facilitated engagement. These findings support those from other studies, which have found that MTFC is a promising intervention for children and young people who are at risk of a range of adverse outcomes particularly those with conduct disorders and delinquency (Biehal et al, 2012).

Care should be taken in interpreting these findings because of the limitations of the evaluation in England, in particular in relation to the sample size and problems with fidelity to the model. Furthermore, half of the young people were still in their MTFC placement at follow-up. Thus, the authors conclude that it is not possible to tell whether or not MTFC has a long-term benefit in the English context. The authors also suggest that young people with complex needs, for whom reunification is not the plan, should remain in an MTFC placement over a longer period in order to sustain improved outcomes. Training existing foster carers in elements of the MTFC programme (see KEEP below) would help keep the costs down. MTFC-A teams could act as mentors for other carers in order for the approach to reach more young people (Biehal et al, 2012).

Costs of MTFC-A

The estimated placement costs for adolescents in MTFC are comparable to agency foster care (approx. £70k per annum) for a child with complex needs and considerably less than a children's home (£120k-165k) (Department for

Education, 2011b). US cost calculations suggest that MTFC-A has the potential to return $43 in the long-term for every dollar invested (Asmussen et al, 2012).

Standard local authority foster homes are not generally able to support children with the extensive needs of the MTFC population and that these children are more likely to be cared for in a specialist foster or residential placement. Such placements are often provided by the independent or voluntary sector, and tend to be expensive and in short supply and may only be found outside the area of the commissioning local authority (Holmes et al, 2009).

Holmes et al (2009) found that although the costs for MTFC are substantially higher than local authority foster care, they are comparable or lower than the costs of placements that are often used for children with similar needs - agency foster care and residential care. The ongoing cost to maintain a child in MTFC was less than placements in the residential units that were the alternative placement type for some of the children. The authors were not able to calculate the set up costs of MTFC; however, they argue that there are lower costs associated with moving children from high cost, out of authority, residential units into MTFC, and that this can be offset against the costs of setting up the service.

Lessons from the implementation of MTFC:

- the implementation of MFTC was delayed when local authorities experienced changes in senior management and structural reorganisation
- challenges once local programmes got underway included: changing financial priorities and concerns about budgets in the short-term; withdrawal of backing from health partners; difficulties in recruiting and retaining appropriate foster carers; and lack of appropriate referrals of young people into the programme
- there is need for strategic long-term planning to embed the programme into standard services, including utilising multi-agency partnerships and making sure that the programme is part of local strategies. (Wiggins et al, 2012)

The 2010 annual report from the MTFC project reports the following key messages for implementation:

- the differing needs of boys and girls who are referred to the programme - there should be earlier referrals for girls
- the benefits of timely, quality pre-placement assessments and taking a developmental perspective
- early planning for post-MTFC placements to ensure timely decisions about children's futures
- ensuring the strategic and operational linking with existing services such as health, education, social work

This national programme team suggests that the greatest challenges facing the programme are: sustaining MTFC programmes; post-MTFC placement planning; and recruitment and retention of foster carers (Wiggins, 2012).

KEEP (Keeping Foster and Kinship Parents Trained and Supported)

KEEP is a 16-week training programme which is based on MTFC. It works as a prevention programme to increase the parenting skills of foster and kinship carers of children aged 5-12 years. It aims to decrease the number of placement disruptions, improve child outcomes, and increase the number of positive placement changes (e.g. reunification, adoption). It promotes positive behaviour and relationships as well as children's' social and emotional development (Department for Education, 2011b). It is delivered to groups of foster carers (7-10 per group) on a weekly basis for 3 hours over 16 weeks. Foster carers get additional support and individual consultation before and after the group sessions (Asmussen et al, 2012).

Evidence from an RCT of 700 foster and kinship carers in the US demonstrated fewer child behaviour problems and increased rates of positive parenting methods by carers. Reunification rates were also higher and disruption rates lower compared to the control group. Improvements in behavioural problems, emotional well-being, and carer stress have been reported from audit data of the programme in England. Both kinship and mainstream foster carers report high levels of satisfaction and positive benefits for themselves and their children's development (Department for Education, 2011b).

The set up costs of KEEP are approximately £13k per site, which includes initial training, equipment and staff costs. In year one, running costs are between £2.5k - £3k per foster or kinship carer, on a four month course plus follow up support groups for 8 months (Department for Education, 2011b).

Fostering Changes

Fostering Changes is an evidence-based training programme for foster carers providing care for children aged 2-12 years. The programme enables foster carers to respond more appropriately to children and young people, particularly in forming positive relationships with the children and managing challenging behaviour (Department for Education website). It is delivered to groups over 12 weekly sessions.

Research suggests that Fostering Changes is effective in improving children's behaviour and the quality of attachment between the child and carer. Foster carers were unanimous in their praise of the course saying that they were more confident, had greater self-esteem, were less stressed and felt that they had improved their skills and knowledge (Briskman et al, 2012).

The Fostering Changes Training Centre has been set up in England with a DfE grant to train 3 workers working in Fostering Services in all local authorities, who will then deliver the Fostering Changes course to the foster carers in their area.

Interventions for young people at the edge of care

> *Less than one-sixth of all children that come to the attention of local authority social services are taken into local authority care (Ward, et al. 2008). Children who receive support services to prevent a care placement are often referred to as children at the edge of care.*

Children at the edge of care typically include:

Children at risk of out-of-home placement due to parental abuse or neglect

Children who are in high conflict with their families and are difficult for their parents to manage

Children whose parents suffer from poor mental health, a severe disability or substance misuse problems

Children who have offended or at serious risk of offending (e.g. children excluded from school)

Children who have previously been looked after (Asmussen et al, 2012: 9).

Multi Systemic Therapy (MST)

Multisystemic Therapy (MST) is intensive family intervention for children and young people aged 12-17 years and their families, where young people are at risk of out-of-home placement, in care or custody and families have not engaged with other services. It aims to:

- increase the skills of parents and caregivers
- increase young people's engagement with education and training;
- promote pro-social activities for the parent and child
- reduce young people's offending behaviour
- increase family cohesion; tackle underlying health or mental health problems in the young person or parent.

(Department for Education, 2011b)

MST draws on theories of social ecology and uses techniques such as cognitive behavioural therapy and family therapy. In contrast to services for adolescents that focus on professionals working directly with young people, the emphasis is on supporting families to make changes. The MST therapist is on-call 24 hours a day, seven days a week, and provides intensive support in homes, neighbourhoods, schools and communities, over a period of three to six months. The MST therapists are professionals from a range of disciplines such as psychology, social work and family therapy. The MST therapists hold small caseloads of four to six families (Wiggins et al, 2012; Bowyer, 2009).

Key organisational elements for implementing MST:

- setting up the team as set out in the MST model
- adherence to the model. This keeps practitioners focused and avoids them being pulled into families' agendas
- weekly group supervision for practitioners and weekly group consultations with supervisors in the US by phone
- flexible working arrangements (because of the 24/7 nature of the programme)
- IT support for remote working.

(Bowyer, 2009)

A number of methodologically rigorous RCTs have been carried out in the US and other countries by the programme developers. These have found that MST is significantly more successful than normal services in improving family

relationships and reducing both the short and long-term rates of re-offending amongst serious young offenders. Studies have also shown that MST is cost effective in the long-term: £5 (in projected future costs on prison, crime health services etc) is saved for every £1 invested in the programme (Bowyer 2011). MST costs £7-9k per average intervention. An MST team consists of a supervisor and three or four therapists. The operational cost of running an MST team is approximately £350k per annum. The average per unit intervention cost is significantly lower than the average per unit yearly cost for mainstream foster care (£35k) or residential care (£120-£165,000) (Department for Education, 2011b).

Fidelity to the programme is important and the originators have developed very strict treatment protocols. MST has been implemented in the UK, Australia, New Zealand, Canada, Denmark, Ireland, Netherlands, Norway, and Sweden (Wiggins et al, 2012).

A recent RCT was carried out in England with an ethnically diverse sample of 108 families who were randomized to either MST or usual supportive Youth Offending Team services (see Wiggins et al, 2012). Results showed that, compared with the control group, at 18 month follow up, MST provided significantly reduced non-violent offending, youth-reported delinquency and parental reports of aggressive and delinquent behaviours. Qualitative interviews carried out with parents and young people assigned to MST approximately three months after the intervention finished, showed that the intervention was valued and acceptable to families, and that they credited it with improvements in offending and relationships between the parent and young person. However, there was a sense that the intervention had come to an end too soon for some (Wiggins et al, 2012).

MST-CAN (Multisystemic Therapy for Child Abuse and Neglect)
This programme is a variant of MST for families where there is evidence of child abuse and neglect. MST-CAN teams typically involve two to four therapists as well as access to a psychiatrist who is assigned to the team on a part-time basis.

MST-CAN therapists aim to:

- stop the parent from abusing and/or neglecting his or her child
- eliminate the need for an out-of-home placement
- teach parents effective parenting skills
- improve family relationships
- improve the parent and child's mental well-being
- improve the family's network of informal supports.

Therapists are available to families on a 24/7 basis for a period of around six to nine months. They generally meet with family members three times a week through home visits. These meetings include individual therapy sessions with the child, and with the parents as well as group sessions with the entire family (Asmussen et al, 2012).
The evidence for MST-CAN is good, involving one recently completed RCT demonstrating significant reductions in abusive and neglectful parenting

behaviours, as well as out-of-home placements. In addition, parents participating in MST-CAN were significantly more likely to report improved mental well-being and increases in their informal family support networks in comparison to families participating in the control group. Significant improvements for children included reductions in PTSD and other anxiety related symptoms (Asmussen et al, 2012).

Functional Family Therapy

Functional Family Therapy (FFT) is a family therapy intervention for young people (10 – 18 years) with a history of offending or with violent, behavioural, school and conduct problems. It aims to address problems in children's behaviour by changing family interactions. It uses family behavioural therapy over a three month period, delivered in a variety of settings – home, juvenile court, institution or clinic. FFT therapists come from a range of professional backgrounds such as mental health workers, probation officers and behavioural therapists. The focus of FFT is the engagement and motivation of the family in treatment, problem-solving and behaviour change through parent-training and communication-training. Families with moderate need typically require between eight and 14 sessions while families with more complex needs typically require between 26 and 30 sessions delivered over a six months period (Wiggins et al, 2012; Department for Education, 2011b).

In the short-term, it is expected that:

- The young person will remain at home with his or her parents
- The family will experience improved family functioning
- The young person will demonstrate improved behaviour and emotional well-being
- The young person will engage in less drug and alcohol use (Asmussen et al, 2012: 33).

Rigorous RCT evaluations have shown reduced recidivism in offending youth and improved family communication, while other evaluations have not found significant differences. FFT has been implemented in New Zealand, the Netherlands, Norway, Sweden, Belgium and England. In England, it is being implemented in community youth offending services in Brighton and is being evaluated through an RCT, the SAFE trial, being carried out by the Institute of Psychiatry (Wiggins et al, 2012).

The costs per case are £2,239 in a working team of 3-8 therapists. Each therapist will work with between 30-50 cases per year (Department for Education, 2011b).

7. Leaving Care

Key Messages

- care leavers move to independent living much earlier than their counterparts in the general population
- care leavers are a vulnerable group and are at high risk of homelessness, social exclusion, mental health problems and exploitation
- the Right2BCared4 and Staying Put pilots were set up to improve the transition of care leavers to adulthood and independent living
- not all young people in care want to remain with their carers beyond the age of 16 or 18. Those that do want to stay tend to have a good relationship with their carer
- the main benefit for young people who stay with their carer up to the age of 18 or 21 is that it provides them with greater control over their transition to independent living.

The transition from care to independence has been identified as a period of high risk for care leavers. Care leavers are a particularly vulnerable group and are at high risk of:

- homelessness;
- experiencing mental health problems;
- social exclusion;
- teenage parenthood;
- spending time in prison;
- exploitation;
- fractured links with families and communities.

(Bowyer 2009)

In the general population, transitions for young people to independence take place over a period of time and are generally supported by their families. The average age for leaving home is around 24 years (Bowyer, 2009). By contrast, care leavers leave "home" much earlier. Recent data shows that over a third of care leavers were under the age of 18 years. Young people leaving care from children's residential homes were even more likely to leave before the age of 18; more than half leave before they are 18 compared to around a third leaving foster care (Department for Education, 2012b).

In 2010 the government strengthened the duties of local authorities towards care leavers through regulations and guidance. The principles of this framework are that young people should:

- usually remain looked after until their 18th birthday unless there is a good reason to change their status
- be listened to in the development and implementation of their Pathway Plans
- be supported into education, training or employment

- be provided with accommodation which is suitable and safe
- be given information and advice, as well as practical and financial support to make the transition into independent living

(Department for Education, 2012b).

Analysis of SSDA903 data shows that the older a person is when they leave care, the more likely they are to be in education at the age of 19: 40 per cent of young people who ceased to be looked after at 18 or over were in education compared to 26 per cent who left at 16. Young people who had stable placements were also more likely to be in education, employment or training (Department for Education, 2012b).

This chapter summarises the evidence from two recently evaluated pilot programmes aimed at improving the transition from care to independence: Right2BCared4 and Staying Put.

Right2BCared4

The Right2BCared4 pilot began in October 2007 in 11 local authorities and is based on the following principles:

- young people should not be expected to leave care until they reach 18 years
- they should have a greater say in the decision making process preceding their exit from care
- they should be properly prepared for living independently (Munro et al, 2011).

The evaluation found that professionals became more proactive in encouraging young people to remain looked after until legal adulthood. A higher proportion of those in the pilot authorities were looked after until they reached legal adulthood compared to those from comparator authorities. However, not all young people want to remain in care for longer; White British young women, especially young mothers, tend to leave care early, as do those who have experienced multiple placement changes (Munro et al, 2011).

Over half of those who moved into semi-independent or independent living arrangements were positive about their transitions. However, around a quarter said that moves had been rushed and abrupt. Findings from both pilot and comparator sites acknowledged that age related eligibility conditions resulted in some young people continuing to leave care before they are necessarily ready to do so; around a third of young people from pilot authorities felt that they did not have a choice about the timing of their transition from care to adulthood.

Young people reiterated the importance of consistent and supportive relationships with social workers and personal advisers to assist them in preparing for and navigating the transition from care to independence. Many rated their workers highly in this respect and young people welcomed flexible and responsive contact.

The researchers suggest further consideration is needed in relation to the following:

- exploration of the role that birth family may play in young people's lives during the transition period; for some family will offer support whilst for others contact may lead to disappointment and disillusionment
- attention should be given to young people's health and emotional behavioural and development needs
- a number of young people were anxious about managing their finances and budgeting. Statutory guidance on transitions to adulthood for care leavers outlines local authorities' responsibilities in respect of supporting looked after children to develop financial literacy and financial capability over time (Munro et al, 2011).

Staying Put

The Staying Put pilot ran from July 2008 to March 2011 in 11 local authorities across England. It aimed to improve outcomes for young people making the transition from care to adulthood and was targeted at young people who had 'established familial relationships' with their foster carers. It offered them the opportunity to remain in their placement until the age of 21. The key objectives of the pilot were to:

- enable young people to build on and nurture their attachments to their foster carers, so that they can move to independence at their own pace and be supported to make the transition to adulthood in a more gradual way
- provide the stability and support necessary for young people to achieve in education, training and employment; and
- give weight to young people's views about the timing of moves towards independence
  (Munro et al, 2012).

The evaluation found two models for Staying Put were adopted. Eight local authorities adopted a model for where young people remain with their former foster carer, with whom they have an established relationship, post-18 ('familial model'). This model attempts to replicate the experiences of young people in the general population. A 'hybrid' model was adopted by three authorities. This model removes the pre-condition that young people need to have an established relationship with their carer prior to the age of 18 to be entitled to stay put. Although this model potentially maximises the opportunity that young people can stay put, in practice, this did not increase uptake of staying put placements. Four out of the six local authorities who were studied in-depth, required young people to be in education, employment and training to be permitted to stay put. This is of concern as it is likely to exclude some of the most vulnerable (Munro et al, 2012).

The majority of foster carers (31 out of 36) were willing to offer staying put placements, primarily because they viewed young people as 'part of the family'. Twenty-three of these young people took up the offer. The young people who had a strong, secure base and who were close to their foster carers tended to stay put. Four young people expressed a desire to remain with carers who were

either unable or unwilling to offer a staying put placement. The most common explanation young people provided for not wanting to stay put was poor quality relationships with their carers or others in the placement. Other key factors were the desire to be 'free' and 'independent' or to return to live with birth family. There were various reasons why foster carers decided not to offer young people the opportunity to stay put; in three cases it was because of young people's behaviour and in two cases the carers were concerned about the young people's ability to develop the skills needed for adulthood if they were to remain in their placement for longer.

Once young people made the transition to independent living arrangements their support networks tended to contract; over half of care leavers revealed that they had a network of just three people who they could turn to for support and advice. This is of concern given the challenges associated with making the transition from care to independence.

The total cost to social care of providing a staying put placement is estimated to be £14,278, although it might be anticipated that once the programme is embedded into practice this would fall to around £13,068 (includes case management process costs and placement fee/allowance). This compares to an estimated annual cost of providing a foster placement to young people below 18, of £25,828. However, the costs of staying put may be offset over time by improved outcomes.

8. Conclusions

This paper has reviewed a wide range of evidence on models of care for adolescents. It has considered the impact of maltreatment on early brain development and the consequences of this for adolescence and adulthood. It has explored international models of care provision and various models of care including kinship care, social pedagogy and various evidence-based intervention programmes.

Care should not be a 'last resort'. It should be the means for safeguarding and supporting those whose birth families, having had access to coordinated targeted early intervention and focused family support, are not adequately safe places in which to grow up. We need to develop a range of services to address the heterogeneity of the care population.

In countries that adopt a 'welfare' rather than 'child protection' approach (e.g. Denmark, Germany and France) care is seen as a positive option within a continuum of services, and children and families have a key role to play in deciding which is the most suitable option for their circumstances. These countries also offer care on a part-time basis, often through self-referral. Adopting a model such as social pedagogy, with its holistic view of the child and family, requires not only a change in practice but attention to the contextual challenges to implementation and embedding in an English system.

Kinship care is suitable for some young people. However, it is important to ensure that there is adequate and timely assessment of carers' parenting capacity in relation to the young person's history and circumstances. Without this, carers might have difficulty managing a young person's challenging behaviour. Using kinship care as a 'cheap option', without providing sufficient support services and financial assistance, is unethical.

Well-implemented evidence-based programmes such as MST, MTFC and FFT can mediate the adverse consequences of earlier maltreatment and neglect through interventions delivered by well-supported professionals working intensively with young people and their families/carers. Consideration of effective 'step down' from such intensive support is vital to ensure that the positive gains are sustained over time. The costs of these interventions should be considered in comparison with the longer term costs of alternative care provision for children with similar needs, for instance residential children's homes.

It is timely that ADCS asks the question 'what is care for?' in England in the twenty-first century. If we wish to provide a care system that provides stable relationships, the therapeutic support to allow young people to develop and maintain such relationships, and the extended sense of permanence and 'home' that such relationships facilitate, then it is on providing the structures to support these relationships that our work should focus across all and any models of care provision.

research
in practice

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