Evidence Framework

Feb 2017 - Feb 2020

Independent Care Review

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The Independent Care Review Evidence Framework

Introduction

Between 2017 and 2020, the Care Review heard the experiences over 5,500 care experienced infants, children, young people, adults and members of the paid and unpaid had of Scotland's 'care system', and their vision for making Scotland the best place in the world to grow up. Their voice was the cornerstone of everything the Care Review did, providing the direction and an ongoing sense check for all research, data and evidence gathering undertaken over the same time period.

In order to ensure that all the work done by the Care Review to collate and commission research and evidence was shaped by voice, it was closely intertwined with the processes which ensured voice was heard at all times. An iterative process was designed and deployed which began with the voices of those who told their story. Their experiences formed the baseline for subsequent evidence gathering which in turn was used to identify gaps which existed in the research and data evidence bases. Once identified, the Care Review sought to fill these gaps by commissioning discrete research which served to consolidate and expand the existing evidence on what works, and what does not, for those who have experience of the 'care system'. The findings and outputs of this work then fed back into the processes and structures designed to enable people to share their stories and experiences. More information and detail about how this was done

can be found in the Participation and Engagement section of this resource.

This process was repeated many times throughout the lifetime of the Care Review to ensure the voice of lived experience was deeply embedded at each and every stage and reflected in the evidence base. However, the voices the Care Review heard and the stories they told are not published in this Evidence Framework. Confidentiality and safety were prioritised above all else in the Care Review and this extends to the use of its work after its conclusion. Many of the voices the Care Review heard shared details which made them identifiable even after anonymising personal details. Whilst it was important that the work of the Care Review was led by those with experience of the 'care system' at all times, there was a careful balance to be struck between the work and direction being led by those with lived experience, and the onus being put on them to identify all issues and detail. Within this, avoiding the use of personal stories as a research tool was key. More information on the steps taken to create Composite Stories to strike this balance and reflect what the Care Review heard can be found in the Participation and Engagement section of this resource.

This resource provides a detailed outline of participation and engagement undertaken, a full summary of the outputs of the Care Review's commissioning processes and a bibliography of sources consulted. The work undertaken drew on an extensive body of research from academics and researchers nationally and internationally, across all sectors. It explored independent work and evaluations undertaken by public, third and academic sectors and pulled together all the knowledge and expertise from all those involved in the Care Review itself. At all times, it remained informed by the iterative process which held voice at the centre, ensuring understanding of the issues was constantly broadened and deepened.

The Evidence Framework is not intended to capture everything the Care Review learnt, but rather to provide a platform to help navigate the vast amount of research engaged with and undertaken, with its cross-cutting

themes and intentionally broad definition of the 'care system' as a whole. Its contents are presented here to help signpost to relevant reports, documents, websites and organisations, facilitating a more in depth look at a range of issues which were highlighted during the different stages of the Care Review.

Orientation

The 'root and branch' review of the Scottish care system was announced by Nicola Sturgeon in October 2016 and the Independent Care Review commenced on 17th February 2017 with the appointment of Fiona Duncan as Chair. The first stage of the Care Review was called Orientation and focused on the role, purpose, methodology and position of the work programme. It resulted in a clear set of values and principles on which all Care Review activity has been based, the cornerstone of which was participation of the care experienced community, establishing that the Care Review must meet their needs.

Discovery

The second stage, Discovery, launched on 30th May 2017 and aimed to define the vision and scope of the Care Review. During Discovery, the Care Review engaged with as many people as possible to answer two broad questions:

1. What would the best 'care system' in the world look like?
2. What should a 'root and branch' review look at?

The evidence and data produced at this stage provided the broad background information for these questions, examining the 'care system' in Scotland as a whole, giving context to what the Care Review heard. The participation work led to the creation of a key internal Voice report which outlined what the participation activity had heard so far and therefore, what areas the Care Review still needed to hear more about, both through further participation activity and through a programme of data and evidence commissioning.

Journey

The third stage, Journey, commenced on 1st June 2018. The Journey stage evolved the findings of Discovery into deep dive structures, led by 10 workgroups and voice, to look outwards, locally, nationally and internationally, to broaden understanding of system structures and impact, and to develop knowledge of what works/what doesn't work, within policy and practice.

As the Care Review progressed, participation and engagement methodologies evolved from asking broad, open questions, to testing out ideas and potential solutions developed by the Care Review's 10 work groups. In parallel, the research and evidence work developed from exploration of reference materials designed to give broad overview and insight into the 'care system', into detailed evidence reviews looking at the national and international evidence base to answer specific questions, identified in collaboration with the Care Review's 10 work groups. Work was undertaken during the Journey stage to identify, and make explicit the interlinkages and cross cutting themes. These included:

- Adoption
- Attachment
- Children's Hearings System
- Data use in Child Welfare
- Foster Care
- Independent Advocacy
- Inspection and Regulation
- Intensive Family Support
- International Models of Care
- Kinship Care
- Language used in the Care System
- Parents' Experiences of the Care System
- Poverty, child abuse and neglect
- Residential Care

- Respite
- Rights of Workers vs Protection of Children
- School and Education
- Secure Care
- Sharing Information
- Siblings
- Social Work Perspectives
- Structure and Commissioning
- Trauma

An extensive cross-checking process was undertaken to analyse each research output, extract the cross cutting themes identified by the stories the Care Review heard and collate evidence from across the entire evidence base under each of these themes. This process was used to better understand how issues related to one another, identify any gaps and support commissioning of further research. The aim was the production of evidence which could be understood as a single evidence base, mapped to the voices heard, and exploring all the issues identified throughout the lifetime of the Care Review.

How to use this resource

This resource is a tool to help navigate the huge amount of research, data and evidence collation undertaken by the Care Review.

There are links throughout the Evidence Framework to help you move back and forth, and find specific documents or references:

- The main Evidence Framework contents page at the start of this document has links to the first page of each Part, and each individual report.
- In the header of each individual report is a link to take you back to the beginning of that report.
- At the foot of each page is a link that will take you back to the main Evidence Framework contents page.
- A search for specific words can be made using the 'find' function by pressing 'ctrl' and then 'f' which will identify instances of the word you are looking for and enable you to jump to its location across the entire resource.

The Care Review prioritised confidentiality and anonymity at all times so reports which included direct quotes and material which may have made individual participants identifiable have not been included within this document.

The Framework is split into five parts which are outlined below.

Part One - The Participation and Engagement Report

The first part outlines the work done to hear the voices of those with lived experience of the 'care system' and contains a summary of everything the Care Review heard over 3 years of participation and engagement between February 2017 and February 2020. This summary has been pulled together

from the experiences shared by over 5,500 care experienced infants, children, young people, adults and members of the paid and unpaid workforce to ensure the key themes can be shared whilst protecting identifiable and sensitive detail to ensure anonymity and confidentiality.

Part Two – Discovery Evidence

The second part of the Evidence Framework contains the data and evidence documents produced during the Discovery phase of the Care Review, again with the exception of those which included direct quotes or identifiable material. These are presented chronologically, in the order they were produced and include statistical baseline reports, overviews of policy and legislation, advisory groups and other reference materials which supported the work of the Care Review at this stage.

Part Three – Journey Evidence

The third part contains evidence reviews, which were commissioned as part of the Journey Stage of the Care Review. The evidence reviews were intended to dive deeper into the issues that were heard from voice during the Discovery stage and to help inform and shape the conclusions and recommendations of the Review by providing up-to-date and robust evidence about a wide range of issues relevant to the care system in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with the Care Review's workgroups. More information about the work groups and methodology of the Care Review can be found in the Participation and Engagement section of this resource. The reviews have been clustered into two groups and ordered alphabetically. The first group are evidence reviews which corresponded directly to specific work groups. These were then built on to identify and explore cross-cutting themes with further work which straddled workgroups and work areas commissioned. The outputs from this are presented in the second group of evidence reviews.

Part Four - Destination

The fourth part includes a report which was commissioned after the rest of the evidence reviews to provide reflections on the evidence reviews in part three, highlighting questions and 'food for thought' designed to support the Care Review in reaching its conclusions and making recommendations. A number of other current policy and practice initiatives in Scotland, which have relevance to the Care Review are outlined towards the end of this reflective review which is followed by some brief summaries of other promising approaches in Scotland, set out alphabetically. It also contains a report produced by the Care Review's Stop:Go Team outlining the work undertaken to engage with local and national stakeholders to deliver a programme of change within the lifetime of the Care Review and the impact made. It builds on the commitments made in 'The Promise', preparing the ground for a seamless transition into implementation.

Part Five – Bibliography and Acknowledgements

The final section is a bibliography which aims to capture the diversity of the other sources that have contributed to the conclusions and recommendations of the Care Review, from academic journal articles and policy documents to websites and newspaper articles.

Part One: Participation and Engagement

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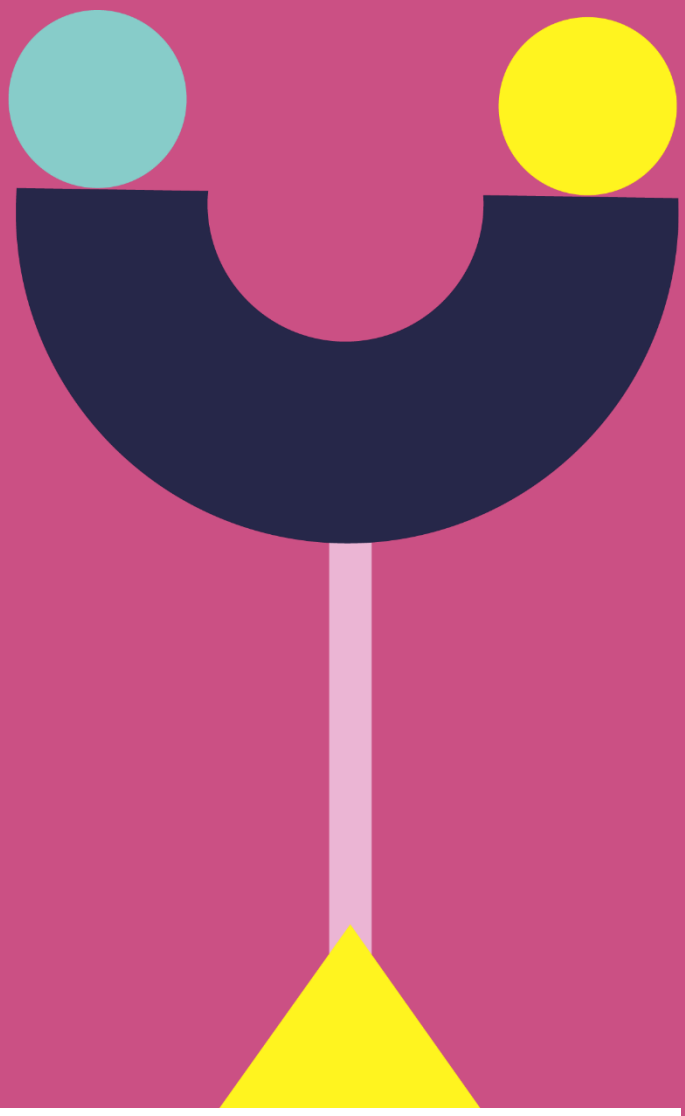
Participation and Engagement Report



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1. Introduction

This report details the methods used by the Independent Care Review (Care Review) to hear the voices of those with lived experience of the 'care system' and contains a summary of everything the Care Review heard over 3 years of participation and engagement between February 2017 and February 2020.

During this time, over 5,500 care experienced infants, children, young people, adults and members of the paid and unpaid workforce spoke up and got involved to make sure their voice was heard and the Care Review was shaped the way it needed to be. The work of the Care Review and the publication of The Promise was only possible because they did.

Although the Care Review heard many stories about the positive difference that carers, the paid and unpaid workforce, family members and friends had made in their lives, many more spoke out about the harm done to them by those trusted to look after them. Whilst nothing can ever make up for what happened, the need for redress is clear, and for that redress to be shaped and informed by the people who need it.

There were a wide range of opportunities to engage throughout the Care Review's Orientation, Discovery and Journey stages. The Care Review prioritised confidentiality and anonymity above all else in each, ensuring that safe spaces where people felt most comfortable were always available, travelling all over Scotland to meet people where they were.

However, the need to strike a careful balance between protecting identities and ensuring the work was led by lived experience was always at the forefront of planning for the Care Review work programmes, with an early decision taken that no stories or experiences would be shared externally, nor would membership of the various workgroups and peer

groups. Instead, the Care Review began an extensive process of documenting methodologies as well as a thematic analysis to take everything heard and translate it into a narrative that could be shared.

The voices of the care community led everything the Care Review did and all subsequent work done to gather research, data and evidence was based on what was heard from those who shared their stories. As a result, the work done to hear voice became the cornerstone of all research and evidence activity and the processes became closely intertwined, and carefully deployed.

This report is the result of working through these processes to create a narrative which could be shared. It was written as a way of explaining the processes and methodologies of the Care Review, and enabling the voices of those who shared their stories and experiences to be heard by a wider audience but still ensuring identities could be fully protected. It contains detail on the peer review processes followed and the work done to hear voice broken down by the different stages of the Care Review and links into the methodology of the wider data, research and evidence work, which was outlined in the introduction to this Evidence Framework.

2. Participation and engagement throughout the Care Review

The Care Review existed because children and young people with care experience called for a 'care system' which prioritised their need for a happy childhood, characterised by love, which results in positive experiences and outcomes.

All work was underpinned by the principle of lived experience at all stages. Children, young people and adults with experience of care decided what the Care Review needed to do, drove its activity and formed its understanding then delivered its conclusions to Scottish Government on 5th February 2020. This marked the Care Review's Destination.

The foundations for this were laid early, with one of the primary aims of the Care Review being to hear as many voices, stories and opinions of people who live and work in the 'care system' as possible. To maximise diversity and be able to reach all areas of the sector and experience, it was always clear that a number of methodologies of participation and engagement had to be adopted.

Membership of all governance groups within the Care Review aimed to be at least 50% care experienced. It was important that as many people as possible were involved to ensure different voices and experiences could play their part. The Care Review aimed to ensure as many sectors, groups of people and types of organisations as possible were represented and made significant efforts to build relationships to ensure this happened. It was also important to ensure any potential over-representation of one area over another was limited; no more important than in the representation of people with care experience and professionals. It was important to hear from those who work in the 'care system' professionally, those who are paid to provide care and the unpaid workforce.

For those who shared their story with the Care Review, engagement always prioritised the person. It was deliberately designed to be flexible, responsive and interactive and offered a broad spectrum of participation and engagement opportunities from light-touch to in-depth conversations, and always at the pace of the person telling their story. In all cases, the Care Review sought to offer people a safe space to have their voice heard, in the way that they wanted to. Staff and carers were asked to leave the room wherever it was appropriate and safe to do so to ensure those sharing their voice could speak freely and confidentially. The voices heard includes those with experience of care, their families and the views and practice experience of the care workforce, both paid and unpaid from a wide and diverse range of experiences and backgrounds.

Participation and engagement of the care community was the cornerstone of the Care Review however the task was challenging; reviewing a failing 'care system' requires in depth involvement and leadership of those who have lived experience of it but this must not become their responsibility. All engagement remained person led at each and every stage, but it was important to ensure the onus was not on participants to deliver all aspects of evidence required by the Care Review. To broaden understanding of the contributory factors of influence to this experience, the context in which it exists, and to underpin it with a robust empirical evidence base, extensive work on data, research and evidence was progressed in parallel to participation. More information on how participation was carried out in each of the stages of the Care Review is detailed below.

Orientation

The 'root and branch' review of the Scottish 'care system' was announced by Nicola Sturgeon in October 2016 and the Care Review commenced on 17th February 2017 with the appointment of Fiona Duncan as Chair. The first stage of the Care Review was called Orientation and focused on the role, purpose and position of the work programme, including:

- Being clear on why the Care Review is needed, what it needs to achieve and who for, determining the governance
- Planning the methodology and recruiting the people needed to begin the work
- Identifying who the Care Review should involve and speak to
- Organising meetings and activities to begin conversations with the people and organisations who wanted to be involved

The methodology was developed to create a well-organised and thoughtful Care Review that children, young people and adults with care experience would want to be part of, and that offered lots of choices and opportunities for them to be involved. This resulted in a clear set of values and principles on which all Care Review activity has been based, the cornerstone of which was participation. A key part of this was the design of the brand identity. It was important this reflected the opinions of those it sought to represent and so virtual brand workshops with 40 care experienced children and young people were held. Many adults involved in, or with experience of, the 'care system' input to the design process. All comments, key words and creative responses were analysed for sentiment and tone to identity the key principles which went onto inform everything now recognised as Care Review branding – from the colours and shapes used to the key messages, tone and imagery.

After the branding work, an easily accessible website was created and a suite of materials including newsletters and presentations. The domain www.carereview.scot was purchased and to make it as easy as possible for the whole team to be contacted, email addresses with firstname@carereview.scot were set up, as were Twitter and Instagram accounts and a Facebook page.

Work was undertaken in Orientation to align participation and engagement methodologies to the planned stages of the Care Review. Who Cares? Scotland's 1,000 Voices team were commissioned to work

closely with the Care Review's Participation Lead to design and deliver an extensive programme of participation, and analyse what was heard.

Discovery

The second stage, Discovery, launched on 30th May 2017 and aimed to define the vision and scope of the Care Review. This programme of work was multi-level and sought answers to the questions from extensive participation and engagement, national and international research analysis and policy mapping. It was initially undertaken with care experienced children and young people, led by the 1,000 Voices team. As engagement grew, this was expanded to care experienced adults and a parallel project was established by the Care Review Secretariat to hear from the paid and unpaid workforce.

The participation approach aimed to ensure anyone with experience of living or working in the 'care system' could share their experiences and ideas with the Care Review. This ensured that experiences of care underpinned and shaped the work of the Care Review from the very beginning. During Discovery, the Care Review engaged with as many people as possible to answer two broad questions:

1. What would the best 'care system' in the world look like?
2. What should a 'root and branch' review look at?

The participation work led to the creation of a series of key internal Voice Reports to reflect what was being heard. The Discovery Voice Report helped inform the methodological design of the subsequent Journey stage participation as it outlined what the participation activity had heard so far and therefore, what areas the Care Review still needed to hear more about. Findings from this work identified 34 suggested areas for change which either focused on practice which was detrimental to the lives of care experienced infants which should 'stop', as well as on identifying the positive practice across Scotland which should to be introduced

everywhere and/or could be accelerated. These 34 areas became known as the Stop:Go list.

Within the Discovery stage, all of this was overseen by the Chair who was supported by a Discovery Group.

To ensure that the Discovery Group gave due consideration to, and reached conclusions informed by how it feels to be in (as opposed to deliver) the 'care system', recruitment of its members was carefully planned with the aim of 50% of its members being care experienced.

Key stakeholder organisations were identified that would understand the breadth of the scale of the Discovery task and a 'nomination and representation process' deployed.

All organisations were sent a Terms of Reference for the Discovery Group that focused on the task and the values of the Care Review and asked to identify suitable people. Half of the organisations were asked to nominate someone with care experience and the other half asked to nominate a representative of the workforce. This would make sure that all members of the Discovery Group would have knowledge and expertise relevant to the lives of infants, children and young people. The process resulted in five of the 12 members being care experienced, with some organisations approached feeling unable to commit to talking in the public domain about experiences of care.

Methodology evolved as lessons were learned and a Participation Hub was created for the Journey stage to provide a one-stop-shop for anyone who wanted to contribute to the Care Review. This required a different approach to joint working by the 1,000 Voices team who were based at Who Cares? Scotland and the Participation Team at the Care Review Secretariat.

At the conclusion of the Discovery stage before the Journey stage commenced, a peer review process was established to sense checked and

challenge the Care Review's intentions and plans for the Journey stage. A Go-To group of 62 children, young people, and adults all who had care experience – with 60% having no previous relationship with the Care Review - provided feedback, again in ways that worked for them.

Journey

The third stage, Journey, commenced on 1st June 2018. The Journey stage evolved the findings of Discovery into deep dive structures, led by workgroups and voice, to look outwards, locally, nationally and internationally, to broaden understanding of system structures and impact, and to develop knowledge of what works/what doesn't work, within policy and practice.

The workgroup methodology involved two appointed co-chairs, at least one with direct lived experience of care and between 8-20 members for each of the 10 workgroups. The Journey stage in its entirety was driven by over 150 workgroup members, over half of whom had lived experienced of care.

Due to the nature of workgroup engagement, the priority was to ensure a balance of lived experience was reflected in workgroup membership. To achieve this, the Care Review used a purposive sampling methodology. This means certain demographics and experience were prioritised before any invitations to workgroups were sent out, and agreement was reached with the Chair about what these should be. Ultimately, the Care Review aimed to achieve 50% representation from people with care experience, and 50% representation from the workforce. Other factors of consideration were gender, experience of certain areas of the 'care system', organisational balance, geographical spread, protected characteristics and sector representation.

To begin the process of populating the workgroups, direct approaches were made to individuals who had previously been involved with the Care Review, often with very specific experiences and who wished to continue,

champions of key issues and subject-matter specialists. To ensure representation from individuals not previously involved, a number of organisations that had engaged across the Care Review were asked for a maximum of 3 representatives or nominees of both those with paid professional experience, and the unpaid workforce. Once this process was complete, the membership of workgroups was analysed to determine the gaps in representation of the previously identified key demographics and experience. Approaches that were then made to individuals referred back to the key factors of representation they were trying to meet.

Owing to the content of the work programme, and the likelihood of discussion on sensitive and potentially upsetting topics, members of Care Review workgroups were all over the age of 18, the age which legally signifies adulthood in the majority of spaces in Scotland and recognised by the UNCRC. Above this, it was also important there was representation from people with care experience of a variety of ages. As the process progressed, constant analysis of the number of people who had accepted their invitation revealed a number of gaps in representation of the identified key factors. Depending on the point in the process this was undertaken, different gaps were identified therefore the approach to filling these has varied, but remained rooted in the identified demographics and experience needed at all times.

The workgroup co-chairs, in addition to chairing their group's monthly meetings, also attended another set of monthly meetings, called Journey Group. The Journey Group replaced the Discovery Group and provided support to the Chair in oversight of all Care Review activity.

The Journey stage brought significant change to what the Participation Hub was asked to explore with those who wanted to take part. It focused on deep dives into themes and issues that were highlighted through the findings of the Discovery stage. The issues discussed were often difficult ones, and the breadth of voices heard meant that the content could often be challenging to personal views or values. Together as the Participation

Hub, the 1,000 Voices team and the Participation team at the Care Review Secretariat worked to ensure care experienced people as well as anyone who could have an impact on a child (families, carers, teachers, health workers etc.) could take part in the Care Review.

The Journey stage created three distinct phases of participation. The first phase involved widening the reach for people across all 32 local authorities to engage with the Care Review and share their experiences. By design, this opened up more challenging conversations about the difficult issues around care. Many of these issues are complex and multi-faceted, requiring a significant amount of debate and consideration. Staying true to the principles of the strategic approach, the participation in Journey created room for dialogue and discussion where everyone's contribution was valued.

The engagement sessions were shaped by questions produced through the Care Review's 10 workgroups, so that the deep dive work could be informed regularly and effectively by what the care experienced voices said mattered. This ensured the key issues raised throughout the participation programme shaped the activities and discussions within the workgroups. Using structured questions, the team was fluid with the materials it used and adjusted the engagement methods to suit the audience without compromising the consistency of data.

As the three phases progressed, the participation approach evolved from asking broad, open questions, to testing out ideas and potential solutions developed by the work groups. This enabled the Care Review to sense-check the Care Review's understanding of particular aspects of the 'care system' and sense-check the provisional conclusions from the workgroups – similar to the purpose of the Go-To group during Discovery. None-the-less, flexibility was embedded in the design of any sessions, so that people who had not engaged with the Care Review previously could answer the bigger, broader questions.

Time was built into the engagement sessions to listen to what else, in addition to the responses to the questions, mattered to the care community and the Voice Reports captured these issues under 'exception reporting' to make sure that nothing was overlooked.

3. Principles of participation and engagement

Participation is, by definition, a choice. In the Care Review, participation methodologies were designed to ensure that no individual faced a barrier to their engagement.

No one should be forced into participating in something they do not feel comfortable in and the Care Review made sure to respect people's choice *not* to participate. To support those who did want to participate, however, the approach was designed on the following principles.

1. **Fun:** Participation and co-design should be an enjoyable process. Each activity was firstly designed to be an enjoyable and developmental opportunity for those taking part. Importantly, each session was tailored to the specific requirements and needs of the person or group sharing their story, from the method of engagement, where it took place, how it was recorded and what it was focused on.
2. **Asset-based:** Using an asset-based approach, the Care Review sought to recognise all the skills, qualities and experiences that people bring with no one feeling limited to speaking only about their individual experience of care, or their story; instead, the Care Review respected all the contributions each individual could offer. This meant providing space for the depth and flexibility of conversation
3. **Safe:** Ensuring that the Care Review was mindful of the circumstances that participants may be living in, so the team could anticipate and be ready to respond to any negative impact on their wellbeing. Every session was designed as an asset-based engagement to avoid re-traumatisation. To support this, the participation questions were designed to take in different ideas and

views – not dwell solely on individual experiences. This was especially important to value and safeguard vulnerable participants who may have been disappointed by 'the system'. Above that, free and confidential counselling support was made available for all participants, if they would like to speak to someone after contributing to the Care Review.

4. **Relationship-based:** Relationships matter. Positive trusting relationships are integral to people feeling safe and relaxed enough to share their views. Participation was designed to build on existing relationships that people had, whether they be directly via the Care Review or partner organisations.
5. **Person-centred:** Encouraging those participating to take the lead in participation activity helps create an environment where they know their voice will be heard. The Care Review's participation was designed to allowing for creativity and flexibility to best suit the individual needs of groups that will be engaged.
6. **Flexible:** Whilst wide varieties of engagement methods were provided, no one was forced to participate in the Care Review. Activity could be paused, postponed or withdrawn by those participating at any point. Throughout all engagement, conversation content, focus and pace was entirely led by those participating with only the inputs people wanted to give being sought.
7. **Clear:** Every person contributing to the Care Review was made aware of what was being asked of them, and why. This was done through an informed consent process that was carried out at the beginning of every participation opportunity. Confidentiality and anonymity were key components of the approach. Personal details were not collected and information was always secure.

The Participation Hub developed a targeted participation and engagement strategy designed to boost involvement from under-

represented groups, whose contributions are often not heard. This included people with disabilities and mental ill-health; LGBTI+; BAME, travelling communities, unaccompanied children and young people; and people affected by homelessness. One of the members of the Secretariat Participation team was appointed to specifically focus on establishing relationships and organising engagements with young people with experience of secure care or the youth justice system.

4. Confidentiality and anonymity

The methods of the participation approach were also designed to ensure that the Care Review could hear from as wide, varied and inclusive a population as possible but prioritised keeping people, and their stories, safe.

Telling, and often re-telling, your story is not an easy experience and one which should never be taken lightly. The Care Review recognised this and sought only to hear the information people wanted to give, recording it in the way they wanted it recorded and sharing it only with those they were happy to hear it at every stage. All reports created from the participation and engagement evidence were completely anonymised and aggregated in a way in which sensitive information and identities could be fully protected.

Pseudonyms were not used as many of the stories told to the Care Review were identifiable simply by their content. Nonetheless, it was important that those who shared their story with the Care Review had their voices heard by those in positions of power and decision making. To ensure confidentiality and protect anonymity whilst still ensuring stories can be told, the Care Review created composite stories to share what it had heard.

Composite Stories

The composite stories were created by carefully analysing every story and voice, grouping and sorting each into different types of experiences and outcomes to piece together stories which represented everyone and no-one, all at the same time. Key experiences and outcomes were reflected in these stories but identities and individuals were not. The composite stories reflected the experiences of care experienced people of all ages and names for the people in them were chosen using the most popular names in Scotland for those years of birth.

Before being finalised, all composite stories were tested with a wide range of groups and people to check they felt reflective of real life experience.

Young people who took part in testing the composite stories said they had found them easy to read, that they were moving, that they covered all ages and stages, and that they could see themselves or others they knew in the stories. Some commented that this would make others reading or listening to the composite stories feel less isolated, knowing others had similar experiences. In particular it stood out to some that problems with not getting enough information were shared by adults as well as children. It also struck young people that each story presented opportunities for intervention in the child's life and the lack of voice children had was captured in the stories. Feedback was largely positive with some helpful amendments suggested. These changes were made which improved the stories ready for publication.

5. Methods

Undertaking a national review with the scale and ambition to be truly led by the voice of those with experience of care was no simple task, therefore it was essential that the participation was underpinned by a well-considered strategic approach and model.

In being true to voice, any strategic approach none-the-less needed to be responsive to the needs of those who participated, requiring flexibility and choice at all times.

The Care Review's participation and engagement design drew on a number of models, including UNICEF's Ladder of Participation[1], the "Double Diamond" model (Design Council, 2017[2]). The former aimed to ensure all contributions of all children and young people in all settings could be meaningfully sought and included; and reflect the challenge made to the Chair that reviewing a failing 'care system', designed and delivered by adults must not be the sole responsibility of children and young people. The latter model is based on valuing people's experiences to explore problems and issues in order to design solutions that work.

Having a diverse suite of engagement methods was key to ensuring the Care Review could reach as wide and inclusive a population as possible.

The Participation Hub adopted diverse methodologies to respect the varied needs of different audiences, be accessible, and ensure engagement is safe and supportive. Methods that would appeal to

[1] https://www.unicef-irc.org/publications/pdf/childrens_participation.pdf
[2] https://www.designcouncil.org.uk/news-opinion/what-framework-innovation-design-councils-evolved-double-diamond

different audiences, from young children; adults; people with disabilities; care workers; or people who English wasn't their first language.

These methods included:

- Workshops or focus groups
- Interviews (phone, face to face)
- National events
- Art, music, graphic facilitation and other creative-based participation
- Oral history and case studies
- Blogs, poems, raps and other written submissions

This diversity of methods was to ensure that any individual could feel that they could contribute, whether it be a drawing from a very young child about made them happy, to a comprehensive written submission by a care experienced adult on a topic that was important that them.

Every opportunity was framed as a continuous conversation, with the Participation Hub encouraging repeat engagement from participants; providing an 'open-door' policy of engagement and supporting continuous, layered dialogue, rather than static or tokenistic consultation.

What you are about to read

The following sections of this publication have been structured as per all the values, principles and approaches you have just read. People are not named, nor identified. An extensive analysis was undertaken on all participation and engagement evidence to identity key themes, outcomes and experiences and summarise them. It is a high level version of this summary of key themes you will read here. These key themes reflect all the stories and voices heard over three years of participation and engagement with care experienced infants, children, young people, adults and those who form the paid and unpaid workforce in the 'care system'.

Quotes are not used as often the details in them were identifiable, even with personal identities removed. The words used below have been kept

as close as possible to what people actually said. This means system words, like 'placement', 'respite', 'siblings' and 'transition' do appear. The Care Review heard repeatedly from children that using these words, and system language like them, often compounds a sense of being different and is stigmatising. However, as the stories told to the Care Review are reflections on the experiences and impact of the current 'care system', the words used by that system are replicated here to avoid creating confusion with alternatives. This does not prevent the Care Review from challenging the use of these terms.

6. What the Care Review heard

Loving, stable and trusted relationships

Throughout the Care Review, people shared the impact that individual relationships had on their lives. They spoke about the central importance of relationships to almost every aspect of their lives and many spoke of the lifelong positive effects of good relationships that had supported and sustained them, and enabled them to feel hopeful about their futures. The Care Review heard again and again that relationships with people who show affection and love was fundamental to individuals' sense of wellbeing, happiness and safety.

When asked about their best experience of care, positive and loving relationships were almost always central to those experiences. There were many stories about staff, carers and adults in positions outside of formal caring roles, such as school staff, who had made them feel special and had gone 'above and beyond' for them. Those who had experienced these sorts of supportive relationships, generally spoke more positively about their experiences of care, and viewed love as being something people could and should be able to express within the 'system'.

Adults shared their concerns with the Care Review about the impact of disrupted and lost relationships on children, describing how re-traumatising, unnecessary and unfair this often seemed. Many shared extremely painful memories of the first time they were removed from their families and placed in care, and reflected on how traumatic this experience was for them. The voices the Care Review heard often felt that more could be done to mitigate against the impacts of this, by creating more trauma-informed approaches.

The Care Review heard frequently that children and young people really valued effort being made to support and nurture the relationships that were important to them with family members, friends and others. Children and young people, as well as carers and professionals, shared their sense of

loss and sadness when meaningful relationships were lost due to moves, and many expressed a desire to continue contact with carers and professionals beyond the confined timescales of placements.

Some adults the Care Review spoke to also reflected on the importance of what children and young people were told about why adults were not in touch and how information was managed. Adults, as well as children, often found these experiences very painful and, for children, a lack of appropriate information or understanding contributed to loss of identity and feelings of shame and self-blame.

Children and young people spoke about the importance of their friendships in helping them to overcome feelings of isolation, improving their mental health, developing their sense of identity as well as having fun. Friends and peers were seen as having a significant impact on overall wellbeing by enabling children and young people to connect with others, including those who had also grown up in care or who had similar experiences.

The importance of love

Love, and how love was experienced was a particularly important theme within the Care Review. Love was discussed in relation to every aspect of care experience and outcomes later in life. Feelings of being loved had a significant bearing on the emotions and aspirations of those who spoke to the Care Review. When the topic of love in care was discussed, the views offered varied greatly, but usually related in some way to individuals' experiences of relationships within their care journey.

For many of those who had not experienced love, there was a sense of hopelessness and inevitability about the lack of love in the current 'system' and the existence of barriers which prevented love from being possible. Many of the people who contributed to the Care Review had experienced a high number of moves during their time in care, and described how this had prevented them from being able to form meaningful or lasting

relationships whilst in care. For some, this experience had left them wary of forming relationships or of giving and receiving love later on in life too as adults.

Being loved and told they were loved, receiving physical affection and having lifelong support were all a normal part of life for those growing up around them, but for many care experienced people, these experiences were largely absent from their lives. This lack of love served to highlight a broader pattern of stigma, which singled them out as different from their peers. The Care Review heard about the sense of isolation and loneliness many care experienced people felt, along with low expectations of life and difficulties in being able to look positively to the future. This also affected children's view of themselves, and a great many spoke of their feelings of shame and self-blame, and that they were undeserving of love or the same opportunities as others. Feelings of pride, confidence and trust were all heavily impacted by experiencing a lack of love while in care.

The Care Review spoke to care experienced adults who reflected on the way an absence of love in their childhood had affected their identity, mental health and overall wellbeing through their whole lives. Some recounted that their need for (and absence of) love had made them very vulnerable (including vulnerability to domestic abuse, sexual exploitation and sexual abuse) with no one in their lives to pick up on this. The Care Review heard from professionals that this issue was particularly acute in rural areas, where domestic abuse, grooming and sexual exploitation remained somewhat hidden due to a lack of support services, a lack of adequate public transport, and that close knit communities were less likely to report crimes to the police due to knowing one another. This all served to leave children and young people more vulnerable to this type of abuse. A mistrust of reporting this to anyone meant that they had been left alone to deal with the consequences without support. Without trusted, caring relationships, they had no model for positive relationships and nobody to identify and address these issues with them.

Definitions of love

There were many different ideas about what love looked or felt like, but there was broad agreement from everyone the Care Review spoke to, that love was an important part of growing up, and was not present enough in the 'care system'. For some, it was necessary to clarify that the kind of love being discussed was not exclusively, or even related to, romantic love. The need to provide clarity on this was in many cases reflective of age, but in some cases, it also highlighted the diversity of individual understandings of love. Many made the point that the definition of love that matters is that which is applied by the person receiving it rather than the person giving it.

A distinction was frequently (but not always) made between love and care.

Many people the Care Review spoke to described love as having characteristics such as being a 'natural' and unconditional feeling that is given consistently and unwaveringly, no matter the circumstance, that lasted a lifetime and had no time constraints. Love was described as an unbreakable bond which involved sharing in one another's happiness and sadness, wanting the other person to do well and be happy and safe, and missing each other when they were not there. Many felt that love should be reciprocal, mutual and never forced.

Care, on the other hand, was sometimes understood as something limited, bounded and professionalised, which derived from a sense of professional duty or obligation, rather than a choice or natural emotion. For those who struggled to recount positive relationships, providing care was felt to be associated with job role obligation, or a 'tick box exercise', rather than coming from an authentic place. This view was reinforced by positive examples where care experienced people felt that workers and carers had gone 'above and beyond' their duties to show love. These stories were often told within the context of varied care journeys with multiple placements, and were most often presented as exceptional instances, rather than as the norm.

There were also those who felt there was little difference between 'love' and 'care', and that separating the two was a source of stigma, singling care out as different. Some people the Care Review spoke to in the workforce felt that the word 'love' should be used by the workforce to ensure that children with care experience were not treated differently to others and grew up being told they were loved. They felt that this was an important way for children to learn about love and loving behaviour and to build confidence and self-worth.

People the Care Review spoke to within the care workforce often spoke about love as being in the seemingly 'small things' such as showing kindness and empathy, or in values such as respect or personal qualities such as reliability and trustworthiness. They spoke about being invested in the lives of those they cared for, and of their positive, warm feelings when they saw children and young people having positive experiences and outcomes. Some in the workforce felt it very natural and comfortable to express love and did so frequently.

There were also many instances where the topic of love invoked feelings of sadness, distress, scepticism or disdain from those whose care experiences had not included feelings of being loved. Some had experienced love being used as a form of control or abuse. For some, their experience of not feeling loved led to determination in later life to show love as much as possible, whilst for others, it had made it much harder to show love and left them feeling more guarded.

Experiences of love

There was a huge range of ways in which those who spoke to the Care Review felt that love could be given, shown or expressed and in how love was experienced or received. Children and young people were able to clearly articulate memories and ideas about what or who made them feel loved, and what contributed to them feeling loved (or not) whilst in care.

In specifically answering the question of 'what makes you feel loved', many people spoke about the importance of feeling safe and of knowing that they are loved by those around them, particularly in reference to residential workers or carers. Many of those who spoke to the Care Review had experienced many temporary or transient relationships through multiple moves in care. The Care Review also heard that the inconsistency of workers within group home settings was also a barrier to gaining access to timely health and wellbeing services, since children were unsure of who to turn to for advice in relation to health and wellbeing concerns. This was mentioned most frequently in relation to residential or secure care settings. Some spoke of experiences of wanting to speak to a staff member with whom they had a close relationship to discuss a health issue, only to be told that the worker was not qualified to do so.

For many, love was shown in everyday actions such as listening and taking an interest; showing kindness and respect to pets or for cherished belongings; sharing food or other treats; and through the creation of loving environments around the person, where they felt supported, important and special.

Children and young people wanted to be involved, for example by being asked to help, as well as being given help. They wanted to be given praise and encouragement for doing things well and told when they were getting things right. For them, love was expressed through reassurance or by taking an interest in how they were feeling or what they were doing.

Others felt it was important to have access to physical affection such as hugging or holding hands. Children and young people sometimes expressed confusion, sadness or frustration with rules that prevented them from receiving physical affection as a normal part of feeling loved. The Care Review heard similar frustrations from some parents, carers and other workforce members who felt that physical contact was an important part of children's healthy development and wellbeing. Some commented that

children needed physical affection to help them learn about safe, positive physical touch.

The Care Review heard about the importance to children and young people of being told they were loved and cared for. Genuine respect and appreciation were spoken about often, especially the importance of being told 'you matter, you're valued, you belong'. For many, hearing this, alongside a sense of never being given up on, was incredibly important in ensuring they felt special and valued. Children and young people told the Care Review that they wanted carers and staff members to take a genuine interest in their lives. The Care Review also heard that love could be shown by people knowing children's strengths and nurturing them by actively encouraging and enabling them to develop those strengths.

Staff and carers reflected on the need for individual choice for children, when it came to accepting gestures of love, as well as respecting individual preference about the ways to demonstrate it.

Love in the workforce

Love was also experienced by children and young people as the qualities and behaviours shown by the people caring for them. Those the Care Review spoke to wanted carers to be understanding, kind, enthusiastic, warm, trusting, nurturing, enabling and encouraging. Staff and carers having patience, not shouting, being consistent, keeping promises and not leaving, were all communicated strongly, with many identifying why this was so important for helping them to build trust and develop mutual respect. For some this was about workers knowing when to talk and knowing when to be quiet and give space. For others it was about empathy and knowing the person well enough to know what they needed, both practically and emotionally. Children and young people expressed that although personality was important, so too were the actions of individuals. For some this meant that workers would 'stick by them',

providing unconditional support which was key in creating trusting, and stable relationships.

For others, it was the approach to building relationships that meant the most, with a strong message about equality within new caring relationships raised as important. There needed to be a sensitive approach to learning about someone, which was mindful of the importance of building trust through time and space. Similarly, the Care Review heard that it was important that the process of getting to know one another be two way, acknowledging that relationships are mutual.

Some voices spoke about how consistent support built up self-belief, while others felt consistent support had helped them to feel a sense of belonging. Conversely, a lack of patience and consistency had left some feeling unsupported and alone. Many spoke about how inconsistency and people leaving, mostly due to changing jobs or placement breakdown, was the greatest challenge they had faced while living in care and beyond, ultimately making it difficult to develop trusting relationships further down the line.

Children who had experience of residential care spoke about their frustration towards staff rotas and the use of 'relief staff', because it had made it difficult to build the kind of meaningful relationships they wanted. The Care Review also heard repeatedly about social workers and others in the workforce having unmanageable caseloads, and the resulting impact this had on children's experiences of feeling loved and valued. Children expressed that they felt uncared for and that there wasn't enough time dedicated to them to build proper relationships. Communication was often felt to be patchy and/or not frequent enough. These experiences of fractured care and support made these relationships feel more transactional and there to serve the purpose of the job, rather than making the child or young person feel wanted. For many, love was felt most completely in environments where communication was effective and regular, and where those providing care were working closely together.

Children and young people often spoke about what they liked about the people that cared for them, alongside things they didn't like. The Care Review heard about instances where children and young people felt they hadn't been shown respect for their wishes or feelings, for example by taking away their personal belongings without their permission. Many children and young people expressed that too much formality was a hindrance to developing good relationships and feeling loved. This included things such as staff wearing their lanyards and ID badges, which were repeatedly mentioned by adults as well as children, as stigmatising, creating a barrier and unequal power dynamics.

Sometimes carers or workers were too strict, which meant that children and young people couldn't joke, laugh and have fun, which was viewed as very important in 'feeling normal' and having loving relationships. Those the Care Review spoke to really valued being treated informally by staff, with less professionalism in their interactions, as this made staff more approachable, so they felt comfortable talking to them if they had problems.

Children and young people also really valued time being spent with them to get to know them and effort being made to build trusting relationships. Furthermore, they wanted those relationships to continue through times of transition or uncertainty in their lives, when they needed support, consistency and reassurance from people they trusted. Some spoke of how much it meant to them when staff showed patience and persistence through difficult or challenging behaviour that was part of how they were coping with transition, and how important it was for workers to understand what was happening to them.

Social workers

Throughout the Care Review, the importance of the relationship between children and their social workers was highlighted. Many children and young people expressed frustration about the lack of support they had

received from their social worker. The Care Review heard from children and young people who highlighted that they hadn't felt listened to, or had their opinions respected or taken into account when it came to important decisions that impacted on their lives. Some children and young people described social workers who had been too busy or not had time for them, who were inaccessible or inconsistent in their communication, or who were perceived as just 'going through the motions'. Others described being either intimidated or patronised by social workers who didn't explain things to them or were too formal. Some felt that they were being judged and could do nothing right in front of their social worker.

On the other hand, the Care Review also heard many stories of the positive impacts that social workers had had on children and young people's lives. Some spoke about social workers who had expressed love for children, even after they had left their post, and had been like a friend or family member. Some individuals described social workers who had consistently been there through chaotic or difficult periods of their life, helping them deal with it all. Others described experiences of being stood up for or fought for by their social worker or of being supported by them with their hobbies, ensuring they had activities they enjoyed built into their lives. Some simply stated that social workers had been useful and helpful, that they liked them or they were nice.

Likewise, parents told the Care Review of the diversity of experiences they had with social workers, with some very negative experiences of feeling blamed, judged, ignored and disempowered, or side-tracked from the lives of their children and decision-making processes. However, there were also many positive stories of social workers who fought for them, who had been a positive support for their children or who had been able to provide them with important information. Some of the positive accounts that the Care Review heard about the role of social workers were told in the context of a particular social worker who had now gone and was missed, or without whom parents felt their support had gone.

Support for families

The need for well-resourced, supportive, accessible and timely support for the entire family, was a strong theme throughout the Care Review. A great number of people, including children, young people, adults with care experiences and members of the workforce, expressed that all too often, support arrived too late and was insufficient in terms of the amount of resource and quality of support on offer.

There was a strong emphasis on better supporting families in order to prevent children from being taken into care. Many voices highlighted the lack of support given to parents or the inefficacy of the interventions that were available. They stressed the importance of getting this right for children and their families. The Care Review heard of the fear that stopped many people from asking for help from services, believing that they would have their children taken away into care. This feeling of fear about potential intervention from services, was also communicated by those who identified as being on the 'edges' of care, recognising the consequences of parents not being supported to make the best decisions.

Many spoke of experiences in the family home which had negatively impacted on their mental health and overall wellbeing, and in some cases led to them coming into care. This recognition that their home environment was detrimental to their health was more common amongst older people with experience of care, or amongst those who had left formal care, whilst younger children were often not easily able to articulate the same correlation or to reflect on issues that were often very painful and current for them.

Many children and young people had taken on carer roles to family members while living at home, particularly to brothers and sisters, when parents were unable to look after them. The Care Review heard many young people talk about having 'raised' their brothers and sisters and their experiences of having to take on the responsibility and emotional impact

that this entailed, often with little or no additional support. Some spoke about the detrimental impact this had had on their mental health.

Additionally, some described the way in which views held by family members about accessing support, had acted as a barrier to them getting the help they needed much earlier in their pre-care experiences.

Whilst the Care Review heard about the need for early interventions to prevent children being taken into care, it also heard experiences of children who felt they should have been taken into care sooner. Some felt that children who ought to have been placed in care had been overlooked due to a lack of family support services around them and because those in contact with the family failed to act. The Care Review heard that the 'care system' needed to improve on the identification of warning signs, and that responses to those signs needed to be faster. For example, when a change in behaviour was noted during a transition, or if there had been multiple hospital admissions and suicide attempts.

Those who shared their story with the Care Review described many instances of warning signs not being picked up on by professionals such as social workers or police. Some believed that this was due to the stigma of care, meaning that those children's needs were dismissed or not fully attended to. It was viewed as very important to ensure that support started as soon as "alarm bells ring". As soon as there was concern about a child in the family home, intensive support should kick in, involving high quality support for parents, including parenting education.

There were detailed examples from those the Care Review spoke to which underscored the need for pre-birth and family support. For some young parents who offered their views on family support through the lens of having their own children removed from their care, the process of social work intervention felt chaotic and confusing, engendering a sense of hopelessness. Many spoke of a lack of knowledge about their rights as parents. Others described the pain of realising their children were likely to

be removed from their care. This pain was not always reflective of disagreement with the decision to remove the children, but instead reflected their lack of knowledge about how to maintain contact, remain in their children's lives, manage their loss or guilt and sometimes how to fight for the children to be returned to their care.

Some parents who had experience of care themselves, reflected on their transition from being the child that was cared for by the state, to young care experienced adults with no support, to parents being assessed and scrutinised with a critical eye. They spoke about feeling judged, anxious about how decisions would be made, and recounted feeling a lack of hope.

Some commented that as young adults, they had felt unsupported by the state and left to cope on their own, but that as soon as they were about to have children of their own, the state intervened. They felt that support services had only served to stigmatise and blame them, and that professionals used young parents' own care experiences against them, rather than trying to supportively build their social capital and strengths as parents. This sense of judgement had sometimes resulted in fear, or hesitation in accepting the support on offer, ultimately affecting the child, and their family life negatively.

Where the Care Review did hear positive experiences, these focused on relationships with workers or carers who had made a difference by offering non-judgemental support, whilst still respecting their role as parents.

Poverty

A recurring theme heard throughout the Care Review was that poverty and care experience are closely interlinked. Some parents articulated that they were unable to provide the basics for their children, and many care experienced people who spoke to the Care Review described the terrible consequences of this for families in poverty, including stories of children being removed from their families as a result of their circumstances. It was continually made very clear that this is not acceptable.

Young people spoke to the Care Review about their experiences of not having enough food to eat, money to wash clothes or buy school uniforms and of how they were perceived by others as a result. Not having the same type of clothes, bags or other items as their peers at school made children and young people feel 'singled out' or embarrassed. They shared their awareness that this had exacerbated their feelings of being different and some had been bullied as a result.

Additionally, young people expressed feelings of sadness and guilt about the sacrifices parents, family members and carers had made in order to try to provide those things for them, and how they carried those feelings of guilt with them for a long time afterwards. The Care Review also heard descriptions of how it felt to go from having little access to food, money and opportunity one day, then almost immediately experiencing the opposite once in foster care.

For some, poverty and debt resulted in them making decisions that ultimately led them to offend and end up in care or prison, often because they had felt a duty to financially provide for their family by any means and to help them out of debt.

Having financial and practical support was seen as a crucial factor in helping families and carers to provide loving homes for themselves and their children, providing the space to focus on loving relationships, as well as being key in overcoming stigma and feelings of difference and isolation. However, in many cases families and carers (kinship carers in particular) highlighted feeling too fearful to ask for support, in case social workers decided that they were not able to cope and took the children away.

Across the different groups of people who talked with the Care Review there was a strong sense of inconsistency, unfairness and inequity in relation to provision of information about their rights and what financial and other support they could access. Additionally, access to support depended on the knowledge, approach and attitude of the person

supporting them. Unclear guidance and 'woolly legislation' which were open to different interpretations by different people were also perceived as barriers. These factors generated mistrust and a lack of faith in the 'system'.

The discretion local authorities had in relation to making and/ or changing payments due to unclear or opaque guidance was felt to be very unfair and added to people's feelings of frustration, of being used and being different. Foster carers, kinship carers and professionals who supported them shared their concerns about the 'postcode lottery' nature of support provision and its quality.

Alcohol and drug use and support for addiction

The Care Review heard from those who had very serious concerns about a lack of support available to young people who had an alcohol and/or drug addiction and who were dealing with complex and interlinked issues of trauma, poor mental health, drug use and poverty. Some were very critical of the lack of residential options and also the length of time that methadone was prescribed. Their experience was that the existing policy, which entailed prolonged use, needed to be reviewed as it was not working. The Care Review heard that in some cases, the lack of appropriate support had ultimately resulted in young people committing suicide.

Some foster carers expressed frustration with the way social workers responded to being advised that a placement was at risk of breaking down due to drug or alcohol use, saying that social workers often seemed dismissive. They described receiving no support for their young people when they had acute need for mental health support and were at risk, and felt there was no sensitivity, understanding or support offered when they started to use drugs and or/ alcohol.

Support for adoptive families

Adoptive families spoke about a deep love for their adoptive children, but also of the challenges that they faced, not least due to the early trauma

that many of their children had experienced, and the impact this had in relation to their children's capacity to experience, understand and accept love.

Many adoptive parents agreed that 'love is not enough' to make up for significant early years trauma that many children and young people experience. This needed to be recognised, since not acknowledging this had led to feelings of shame and 'failure' in parents. The Care Review also heard repeatedly from these parents about their frustrations with services' lack of understanding of trauma. This was especially so in school settings, where parents felt that teachers often failed to understand, engage with or respond to the complex issues that their children were grappling with as a result of traumatic experiences.

Difficulty in accessing mental health services was raised by many adoptive parents as a significant barrier to the health and wellbeing of their children. This was a major source of frustration among adoptive families. Many described feelings of desperation around the lack of mental health support for their children. Furthermore, parents articulated that the level of support available to them often felt like a lottery and varied between locations and agencies.

Attachment was also a recurring theme from adoptive parents. The Care Review heard from adoptive parents who struggled to form loving bonds with their children, others who felt they had struggled to get the right support for their children and some who had experienced the breakdown of an adoption and struggled to cope. However, many adoptive parents also felt that their experiences had ultimately made the bond with their adopted children stronger.

Many adoptive parents spoke about feeling daunted, intimidated or frustrated by the adoption matching panel process. This was spoken about as being one of the most important decision-making processes in their lives, yet they often felt powerless and distanced from the process.

Furthermore, people spoke about the emotional impact of lengthy delays in the adoption process and the negative impacts these delays had on the mental wellbeing of children and families.

The disparity of support between adoptive children and 'looked after' children was a recurring theme too. Many adoptive parents felt deeply unhappy with the lack of follow up or formal review of their circumstances and needs, once their adoption order was finalised. Many adoptive parents spoke to the Care Review about feeling abandoned, like they needed to fight at every stage of the process to get any help and that this felt emotionally and mentally exhausting, discriminatory and isolating. They spoke of an adversarial relationship with professionals and processes, where they felt judged and unheard. Parents spoke about feeling drained or marginalised by a 'system' which should have been there to support them. A lack of advocacy support for adoptive families was also highlighted.

The Care Review spoke with both single and married couple adoptive families; however, many of the married couple adopters described how they felt they could not have got through the adoption processes on their own. Support from partners played a large part in coping, with most adoptive parents feeling that the challenges were so great, it required at home support. Many adoptive parents spoke about feelings of isolation and loneliness, and the importance of peer support, particularly via social media and online support groups, which helped them to cope with their experiences.

The cost of adoption legal fees was spoken about by both adoptive parents and staff working in adoption services as a source of frustration, and perceived socioeconomic discrimination. The impact of adoption on adoptive parents being able to work was highlighted, as was the financial support – or lack of – that they then receive. Adoption workforce members described the situation as creating 'adoption for the rich' by not supporting lower income families with adoption fees. Others spoke about

the financial impact of delays to the adoption process. The impact of Pupil Equity Funding and other socioeconomic factors were also raised. Often parents spoke about feeling 'lucky' that they had the capacity to complete forms, and being conscious that other families would not necessarily be as fortunate.

Support for foster carers

Foster carers articulated in no uncertain terms, that fostering was not just a job to them, that they loved the children they took care of and often said that they saw those children as their own. However, the Care Review also heard many stories of their frustration with the ways that the 'care system' left them feeling unsupported and a sense of injustice at how the children they cared for were treated.

In particular, many foster carers described long-standing and ongoing frustration at the 'care system' which did not appear to put the needs of the children they cared for first. They recounted their experiences of the impact that delays, 'unnecessary' bureaucracy and unhelpful legal systems had on the confidence of the children in their care and on their life chances in the longer term. They were clear that systems and processes needed to be reviewed.

The Care Review heard of the difficulties presented by the 'system', when foster carers were trying to create a loving, family home environment for children. They described the way in which 'over the top' recording requirements had impeded their ability to have a 'normal' life, since daily activities such as going out for a daytrip required formal approval first, and information sharing took too long.

There was particular concern among foster carers (and other practitioners) about a perceived lack of emphasis in the current 'system' on helping a child maintain links, especially with their brothers and sisters but also with their communities and other relationships that were important to them.

Conversely, the Care Review heard about situations that arose when it was not in the best interests of the child to have contact with their birth family, but the children were required to have contact with them because of a legal decision. Foster carers asserted that decisions around contact needed to be based on the individual and specific nature of each child's circumstances.

Foster carers expressed their frustrations at not being treated as part of the 'team' by other professionals; at not being trusted, consulted with or able to contribute to assessment and care planning processes. This made them feel undermined, disrespected and powerless.

Some foster carers said they wanted to be treated as professional staff, with appropriate terms and conditions. The Care Review heard again and again that there was a 'postcode lottery' of support, with different areas of Scotland providing different levels of training and other resources.

Foster carers expressed that they valued peer support and felt the need to 'stick together', as they did not have the right support from social work. The Care Review heard stories about not having the necessary financial support to acquire practical items for children and young people (such as mobile phones, prams and safety equipment), having to give up jobs and having to move home to get the space they needed for the children. The Care Review heard other examples about the 'poverty of experience' for foster children, such as the limitations on holiday options due to cost or due to not having parental rights to access the young person's passport. A lack of support through the provision of respite added to feelings of being left unsupported and alone.

Support for kinship carers

Children and young people highlighted that kinship care was an environment where it was easier for them to feel loved and genuinely cared for. However, for many kinship carers, the additional pressures of

being a carer took a serious toll on their lives with many discussing feelings of isolation and a total lack of support.

The Care Review heard from some kinship carers that they had experienced living in 'abject poverty' in overcrowded housing. Some spoke about grandparents and children sharing bedrooms, a lack of space for young people to play and study and the need to share clothing. The emotional toll and constant worry impacted on their relationships with their children, family, and on their health. They also worried about what would happen to the children when they were gone.

Kinship carers felt trapped and frustrated as they were acting out of love and bonds towards family, yet being refused the help they needed. This also impacted on them emotionally, as they felt they were losing out on the joys of the grandparent/ grandchild relationship and felt disadvantaged in a number of ways, because they could not afford to spoil and treat their grandchildren or take them on holiday.

In many cases Kinship carers spoke of feeling too fearful to ask for support, believing that their children might be taken away from them if social workers decided they weren't coping. Those who spoke to the Care Review were very frequently unaware of their rights and entitlements to financial support or to respite.

Kinship carers also shared their frustration about the lack of information provided to them, and in particular, that they were treated differently from foster carers in relation to financial support. All of these feelings were compounded by a lack of training and guidance offered, alongside the dismissive attitude they felt was shown towards them by social workers and other professionals. Some kinship carers told the Care Review that they were suspicious of records that were kept about them and stated that at times what was written down was unrepresentative of what had happened or what they said. They talked about the stigmatisation they experienced and how they were made to feel 'second class' and judged.

Creating environments where love can flourish

The type of care environment was frequently referred to as an important factor in if or how individuals experienced love and support. Some care settings were seen as being better suited than others to creating an environment that mirrored a loving family home.

Several individuals spoke specifically about the need for love to be embedded in foster care, commenting that it was at risk of becoming 'too commercialised' and 'like a business', rather than focusing solely on creating a loving and caring family home. The advertising that exists for foster carers, particularly where they cited the financial incentives involved when fostering a child was criticised. Some children explained that this framing of foster care as a well-paid job, made it hard for them to feel genuinely loved, believing instead that their foster carers only did it to make money out of them and their circumstances.

For those in foster care, the value of being included in normal family life and not treated differently to other family members, was considered a crucial feature of feeling cared for and loved. Many foster carers emphasised that they considered the children they looked after to be the same as their own, expressing that they wanted to be there for them forever and whenever they were needed. The vast majority of foster carers the Care Review spoke to viewed fostering as more than just a job. However, the Care Review also heard from children and young people who felt as though they were treated differently from foster carer's own children and how this felt unfair, made them feel unloved and isolated.

Some children and adults the Care Review spoke to recognised the challenges that foster carers faced in relation to attachment, given that, having cared for them and grown to love them like their own children, placements often broke down. Sometimes when children moved on from a foster placement, foster carers were unable to contact them anymore. This caused some foster carers, intentionally or unintentionally, to

emotionally distance themselves from children and young people to protect themselves from the pain this caused.

Members of the workforce, carers and individuals described the ways in which they worked to try to create loving environments. These ranged from time and thought given to young people, caring gestures such as thoughtful gifts or remembering to ask about important relationships or interests, making physical environments more comforting, clean and homely, and talking about love with young people and staff in these settings. Further, children and young people articulated the importance of living close to their network of friends, community groups and school.

However, the Care Review also heard many workers and carers express a sense of frustration with rules and restrictions that got in the way of individual staff being able to create loving environments. Many of those from the workforce described having unmanageable workloads, creating a barrier to forming relationships and providing high quality support. Some children and young people were acutely aware of a lack of resources in the 'care system', commenting that processes and protection of resources were often prioritised over the individual needs of children and young people.

Many spoke of a sense of professionals being afraid to love, in the face of rules, restrictions and attitudes that associated love with a lack of professionalism. In some instances, the Care Review heard of carers who had been actively discouraged from showing too much love. People the Care Review spoke to often viewed the 'care system' as being overly professionalised and risk averse to the extent that it dehumanised children and young people, as well as workers.

Care workers and foster carers described being unable to maintain friendships with young people after they had left a care placement or they had stopped 'officially' working with them, in spite of having formed genuine bonds with the children they worked with. The Care Review also

heard instances where relationships had continued and of young people staying connected by phoning or paying a visit.

Policies and legislation were viewed as getting in the way of normal, loving relationships, rather than supporting workers to provide the best possible care. There was a sense that the rules were there to uphold systems and processes and to protect resources, rather than to serve the best interests of children and young people.

Staff in children's residential homes spoke of the need for support from management, and from guidance and policy, to help them feel safe when demonstrating nurture and love towards young people. They felt that they needed high quality leadership and more protection through regulation and policy, in order to feel safer in expressing love in whatever form was appropriate for individual young people.

The Care Review heard from a number of workers who felt that some 'rules' were based on hearsay or attitudes, rather than on actual rules or guidelines, highlighting the need for clarity to make sure that practice was based on specific policies and legislation which were consistently followed and not left open to different interpretations.

A lot of professionals the Care Review spoke to felt that the system focused more on the qualifications of individuals working in care, at the expense of valuing the relational aspect of the work and the importance of personalities, emotions and social skills in providing care.

Some of those the Care Review spoke to reflected that those individuals outside formal caring roles, such as school staff, including janitors and lunch staff, were less restricted by the kinds of barriers that existed on forming meaningful relationships within the 'care system' and were thus in a good position to have a positive impact on children's lives, in spite of not officially working in a caring capacity.

Risk aversion and barriers

When talking to workers, children and adults about their experiences, the Care Review often heard about risk assessments and risk management processes suppressing the ability of children in care to grow up having a 'typical' childhood, where relationships and opportunities are naturally supported.

Those who shared their experience spoke about the use of risk assessments or risk management plans which had the impact of applying over-protective measures, ultimately limiting access to developmental and fun activities. Examples were provided such as going to the beach or hill walking, which were limited, delayed or prevented due to the application of procedures and risk assessments. Workers felt that learning about risk and risk-taking was an important part of growing up, and that the 'system' sometimes responded by managing risk, rather than cultivating and supporting natural, development through childhood.

Children and young people talked about their frustration with too much paperwork that felt burdensome and unnecessary. The impact of this was expressed clearly as feeling unfair and marking them out as different in comparison to other non-care experienced young people and friends. Some felt some rules stopped them from being who they are. Young people spoke about a hierarchy of power and of often feeling like the people who knew them best or were closest to them didn't get to make the decisions. Instead, people at a senior level with whom they had little or no relationship made them.

In terms of relationship development, some people spoke about how the management of potential risk impacted on opportunities to develop or rebuild important relationships. For some, this was most problematic when police checks were carried out on friends or partners, particularly when the potential for staying at someone's house was an opportunity. For others, it was the management of risk within their family which felt

oppressive, with some identifying how the concern over potential conversations was enough for workers to insist on two people supervising time with their brothers and/or sisters.

There were many discussions centring on limited or no access to internet, phone calls and television. For the most part, these conversations took place in relation to secure accommodation and other residential environments. Advocates also highlighted a wide range of different practices across local authorities for these issues. Not only did this feel inconsistent and unfair in terms of how rules were applied, but many also spoke about the impact it could have on developing much needed friendships. Likewise, these rules limited access to popular culture including music and television, limiting the development of their identity alongside friends who were not in care.

All of these issues originated from the 'care system'' and served to make care experienced people feel different from their peers, adding to a feeling of isolation and stigma.

Multiple moves and transitions

The Care Review heard repeatedly about the detrimental impact that frequent and poorly managed moves had on children, young people and adults.

Many had experienced multiple moves over the duration of their care journeys, and these moves were accompanied by feelings of loss, sadness, anxiety and a lack of security. This was expressed by children and young people as well as carers and professionals. The Care Review heard that moves were not always planned and people found it particularly hard when they didn't get the chance to say goodbye. For some, this unsettled and powerless existence had ultimately led to a sense of hopelessness- of giving up caring.

The Care Review heard about the importance of maintaining relationships during and after a move had taken place. Understanding processes and

receiving consistent support throughout these key moments in their life, was fundamental to children and young people having the best possible experiences of transition into and out of care. Children were strongly in favour of being able to keep in touch with the people they had close relationships with during times of transition, both during care and beyond.

Some spoke of the emotional impact that ending relationships with carers and professionals caused children and young people. Others questioned why such practices happen, asking whether there is policy or legislation currently in place that prevented professionals from keeping in touch.

Some young people suggested workers should move with them, to avoid them having to repeatedly invest in new people and relationships.

The Care Review heard from parents who stressed the importance of professionals properly planning transitions in order to protect the health and wellbeing of children, many of whom had experienced trauma which was exacerbated by multiple moves. Workers, carers and parents described the difficulties of doing this effectively within resource constraints and about processes which created barriers. The Care Review also heard the importance of ensuring that transitions were not rushed or put into action prematurely, before the child is ready. Stability was viewed as having an immense impact on the lives and wellbeing of children.

Children identified that they needed support at the start of a new placement to help them settle in and to help them cope with anxieties they had about being moved again. The Care Review heard that children valued having support or a place to go during times of transition, where they could let off steam and air their emotions in a way that was safe and wouldn't risk damaging their placement.

On the other hand, the Care Review heard about the types of support that helped young people to transition out of care, such as the opportunity to learn about budgeting or cooking during at an earlier age. Some people the Care Review spoke to felt this early support had not been available to

them and this resulted in them feeling ill-equipped to leave care. Further to this, some spoke about feeling pressurised to leave due to their age or their lack of financial entitlement.

The Care Review heard from young people in prison settings, who faced particular challenges sustaining their relationships through moves and transitions. Some spoke of feeling as though they had no positive role models growing up, and frequent moves or specific care environments had also limited or removed the potential to have positive role models. They highlighted a lack of support to guide them through the justice system and beyond. Whether this was day to day, while they were serving sentences or after, this lack of support increased their feelings of hopelessness.

Concern was also raised with regards to the challenges of maintaining relationships once they had served their sentence and were trying to forge a new life for themselves. Doubt, mistrust and a sense of constant threat of the Police being called, and in some circumstances of their children being taken away from them, were examples of how the relationships that mattered to them most were made to feel fragile and unpredictable by their experiences of care, underscoring the need for support through times of change and transition.

Respite care

Connected to discussion of transitions and multiple placements was the issue of respite care for carers, children and young people. Confusion and inconsistency in how respite was viewed and used, was felt to be especially frustrating, as well as uncertainty and a lack of choice and control. Examples of individuals being told that they would be in respite for a short time only to find themselves there for extended periods were not uncommon. The Care Review heard examples of disjointed processes and systems meaning that children were forced to go into respite care instead of going on holiday with their carers.

On the other hand, there were also very positive stories about respite care and of children and young people really enjoying the experience. These experiences were usually the result of the positive relationships built with the respite carers. Some individuals spoke about respite carers becoming foster carers over time, with others speaking of maintaining genuine relationships with their respite carers long after they left.

Many carers who spoke to the Care Review had conflicted views on respite. Whilst acknowledging they would benefit from a break, they often didn't feel comfortable with the idea of respite where they did not know the people the children and young people would be staying with and worried if the children they looked after would be safe and happy. Carers instead often relied on their peers for support.

Furthermore, some carers highlighted that respite had not been available to them in any form at times when they needed it, for example when they were ill. The Care Review heard that the support on offer was inconsistent and varied between local authorities and agencies.

Education

While relationships were most commonly referenced as helping with 'being happy and healthy', education was also frequently discussed as a key factor in children's overall health and wellbeing.

The importance of the education workforce was a thread that ran consistently throughout the Care Review, with both care experienced people, carers and families speaking consistently about the need for a trauma-informed, supportive education system, sensitive to the issues that care experienced children sometimes faced. Many explained that it was not necessarily teachers who were the main source of support for a child.

Often it was classroom or teaching assistants, or guidance staff who provided the most support. The Care Review heard many, many positive stories about relationships with teachers or other school staff that had

made an impact on children's lives, showed patience, understanding and who had been there to listen.

Parents and carers, as well as children talked about the need for teachers to be more aware of the impact of a child's particular experiences and circumstances. The Care Review heard many examples of day to day incidents or issues in a child's life, for example a forgotten birthday or emotional phone call, which could impact on their ability to fully engage and participate in school, and many felt that not enough was done to pick up on these things and support children through school. The Care Review heard about the importance of having a variety of support for care experienced people throughout their entire education journey.

There was inconsistency in whether teachers were aware if a child was in care, or of any support needs they may have. The Care Review heard from some kinship carers that it was unhelpful when professionals made assumptions that those in kinship care and lived, for example with their grandparent, must be ok and not need any additional support.

Some care experienced young people reflected the importance of having ongoing support to turn to for advice at about their education at any time. Advocates for care experienced people at colleges were mentioned, as were peer mentoring schemes or other informal supports.

Some students also discussed how beneficial it had been to their educational journey, having their living costs supported during study, helping to alleviate the pressure of having to work whilst in education. However, there were some who discussed these financial benefits and highlighted how the process of receiving sometimes meant having to prove your care experience in order to take advantage of the benefits and entitlements. This in turn meant that some individuals found the process of accessing these benefits to be stigmatising. The Care Review also heard of many young people who were not aware of their entitlements to financial support and that there was a lack of agreement and clarity

between professionals on the criteria for such supports. Again, the Care Review heard that the role played by advocates was really valued by young people in helping them understand their entitlements and how to access them.

Young people said they wanted educational staff and bodies to work collaboratively with care experienced young people, to effectively create and disseminate promotional information and leaflets about opportunities and support available. It was felt that this information should be advertised to and used within different care settings or be disseminated by people working alongside young people in care, through a range of different avenues, to reach as many care-experienced young people as possible.

Additional support for learning

Ensuring that children and young people with disabilities or additional support needs can successfully participate in education has been an area of concern for many of the voices who have participated with the Care Review. Ensuring that children in families could access support more easily and that the support was tailored to the specific needs of the child were seen as particularly important.

Many of the voices heard by the Care Review expressed frustration, anger and sadness at the lack of adequate support for children and young people with additional support needs. Parents described the challenges they had faced in getting their children's needs recognised and addressed, particularly in relation to gaining access to mental health services. Stories about lengthy assessment processes, poor communication and in particular, difficulties in getting diagnoses were heard frequently. The issue of assessment and diagnosis was particularly prevalent and was a key barrier to gaining access to appropriate services and support. Parents spoke to the Care Review about the negative impacts and sometimes severe consequences of this for children, with many describing how children were falling behind on their education, were not getting the help

they needed and ending up isolated and excluded. For some this had contributed to self-harm and suicidal feelings.

The Care Review heard repeatedly that parents and carers felt they had to fight to get the support they needed, and that they were not listened to or believed by professionals. Additionally, many parents felt they were blamed if anything went wrong, even though they had fought long and hard to get support in place for their child. This often led to adversarial relationships between parents, carers and support professionals, rather than cooperative, nurturing and trusting relationships that were needed. In some cases, parents felt that their children's disabilities mean they were discriminated against and/or that their children had been labelled without diagnosis, leading them to feel stigmatised.

Parents expressed frustration at services not working together in a consistent, coordinated way. Challenges in getting children assessed were often described, along with poor communication and long delays in getting results or being allocated any help. Although some had very positive things to say about specific experiences of great support from services, many felt this was too patchy and inconsistent, and sometimes felt like a 'postcode lottery'. Others spoke of good practice, where disabled children and young people were provided with Personal Communication Passports that helped school understand a child's communication needs. Whilst highlighted as good practice, it was recognised that it was not yet mainstreamed.

Additionally, there was often a focus on systems and processes, rather than on the individual needs of the child, meaning that professionals sometimes lost sight of the child. Some expressed a strong dissatisfaction with aspects of practice in education settings, and that there was a lack of accountability for children's wellbeing beyond the educational setting.

Many contributors felt as though the needs of their children were not fully understood by the workforce or accommodated by the system. This led to

inappropriate support and educational settings that didn't fit with children's needs, or in some cases, to no support being provided at all.

The Care Review repeatedly heard of parents and care experienced people feeling powerless in decisions made about them or their children, of not being involved or listened to. Many of them also reflected on power dynamics within education settings and the additional vulnerability of children with disabilities, especially when they were non-verbal.

Professionals also talked about the lack of opportunities for parents and carers to be involved, but this was often linked back to a lack of resources to ensure these could be supported and put in place. The issue of resourcing came up repeatedly during sessions, with a range of people raising the importance of having the right educational settings, professionals, training and services in place.

For children and young people with disabilities, the role of school came across as very important. They described some of the school-based interventions that helped some of them to cope with the school environment, including safe rooms, drawing, craft, aromatherapy, music therapy- as well as being shown flexibility around their needs and particular members of staff at school who helped them. Young people who contributed, particularly those with disabilities, spoke about what helped them with their sense of wellbeing and of feeling in control. Being "outside and playing" were described as something that children wanted more of, relating to these children's sensory needs.

When asked what they needed to grow up happy and healthy children and young people often gave answers relating to their relationships, with many recognising that they need to be supported by a combination of people in order to live happy and healthy lives. Children with disabilities spoke about the important role that teachers and other support staff played in their lives, and the personal attributes and qualities that were important to them, such as 'being gentle', 'kind' and 'understands me'.

Parents and professionals were also asked to reflect on what had worked well or was important in educational settings. Some spoke about the educational environment and often, they talked about the need for additional resources to provide adequate levels of support and specialist services. Others described individuals who had taken extra time and worked with creativity to get results. In thinking about what children need in order to have the best start in life parents described the need for empathy amongst education, health and other professionals.

Community

Many people felt that tapping into communities to offer help and create a sense of belonging would help families to feel more supported. In turn, the Care Review heard that creating more connected communities could also help combat some of the stigma and judgement felt by families accessing support services, and who were involved with social care. There was a consistent view from the voices the Care Review heard that stigma could be reduced if people in communities and across the country were better informed about care experience. Those who expressed this view, felt this would lead to a more accepting, inclusive and equal society for care experienced people.

The Care Review heard that by providing better structure within communities to allow for support to happen in everyday life, there could be more holistic support for children, parents and families. It was recognised by many that family issues were exacerbated within isolated communities, with individuals feeling distanced from those around them and unable to reach out for help from their peers.

Some parents, in particular those who had children with multiple, complex needs and disabilities, told the Care Review that there was a lack of appropriate services available in their local area, which meant that they had to resort to sending children, young people and adults out of area for

treatment or access to facilities, creating a further distance, and isolation from their local communities and families.

Access to good community services was also highlighted by a number of young people as being important to them. For many, being healthy was rooted in a range of factors including accessing local activities, doctors and dentists, sexual health advice, drug and alcohol education and healthy eating skills, amongst many other things.

The need for culturally sensitive and appropriate services was also highlighted, particularly for unaccompanied asylum-seeking children and young people. Many reflected that services needed to recognise the very specific nature of those children's experiences, and to properly support them to maintain important relationships, ties to their heritage and community, whilst helping them to integrate into their new homes, for example by ensuring adequate provision of interpreters. There was also the need to recognise that cultural barriers may also prevent people from some communities asking for the help they need form services, making it harder for them to reach out.

Fun and food

Having fun, developmental opportunities while in care was identified as important across all age ranges. Some expressed that they would not have had the chance to access opportunities, had they not been taken into care and so this was a positive experience, linked to identity shaping and memory building. Children and young people spoke about the importance of being able to be creative, to play, having food, having fun and having freedom on being happy.

Many children and young people articulated that interests and hobbies are important to making up their identity and how they express themselves. The opportunity to try out activities and learn what they were good at or what made them happy was viewed as an important part of childhood.

Things like football, art, dance classes, theatre groups, music, films, gaming, sporting activities, and learning skills like doing hair and make-up or writing poetry and songs, felt important to many of the voices heard.

Group work was also mentioned as being positive in bringing care experienced people together, using this time to learn skills and talk about issues. A number of people spoke about how care, or the organisations supporting them, had provided them with the chance to take part in activities or opportunities that have been important to them.

Staff working in residential care recognised the need for young people to have more opportunities for physical and recreational activities. The need for a wider and more balanced range of opportunities including social supports was highlighted.

Whilst many spoke about the importance of opportunities and activities in developing their happiness, some spoke about how the system can limit or prevent this from taking place by being too risk averse or preoccupied with process. The Care Review heard that in residential settings, shift patterns could interrupt the dynamic of the day or the relationships that were present.

Some felt that the food they were provided whilst in care was not to their taste or preference. For some, it felt as though the food they were offered could feel poor quality, something that wasn't age appropriate or was too unusual, or something that made them feel different. Some spoke about how their introduction to healthy eating came later in life, along with an understanding about how this could positively impact you and that they had not learnt enough about cooking or nutrition before they left care, whilst others said that being taught these skills in care, had prepared them for adult life.

Leaving care

Many spoke about the anxiety they felt about leaving care and living alone for the first time, recounting that this felt intimidating and sometimes

overwhelming. A lack of financial support was highlighted by several as being a huge stressor after leaving care, particularly experiences of having poor budgeting skills and high levels of debt. The link to the risk of poor mental health, addiction and exploitation was recognised.

When discussing housing, the Care Review heard about the fear and people who were leaving formal care felt about accessing safe and stable accommodation. For some, these experiences were very positive because of the level of 'live-in' support they had received as part of their accommodation. For others, their experiences in these types of accommodation had made them feel isolated or unsafe. In some cases, it had exposed them to dangerous situations such as aggressive neighbours, some of whom had had problematic alcohol and drug use issues which had left them feeling intimidated or frightened.

Employment was highlighted as an area which required more support to help with getting jobs and to progress in careers they were interested in. Those with criminal justice experience also spoke about community-based disposals such as curfews, Community Payback Orders and tags, limiting their ability to access work, making it much harder to gain and keep employment.

For some, the current methods for preparing young people did not work in practice, with several young people talking about how they had found 'pathway planning' to be inconsistent and ineffective. It was felt that support needed to be relationship-led and be committed to by a person who knew them, had a relationship with them and had taken care of them. Some spoke about their frustration at their experiences of throughcare work and felt that not enough had been done to prepare and support them.

The Care Review heard about the kinds of safety nets that were important to people in combating their anxieties around leaving care and to assist them in living alone. Learning about life skills and how to apply them were

viewed as important in this respect, recognising the importance of these supports in helping young people to become independent.

Lifelong support

Many people spoke about the need to reconsider the age criteria applied to support and formal interventions, with some people feeling that the age criteria associated with support were too arbitrary and often removed support at an unrealistic and unhelpful point in life. There was unanimous support for the existence of an offer for care experienced adults, of any age and stage, however there were many different opinions on what good lifelong support should look like.

For some, lifelong support should replicate what other people might have access to throughout life; a 'family' type response with people there when you need them, to help with whatever you might need. However, others felt that likening this type of offer to that of family or 'mum and dad' was unhelpful and "disingenuous". Nevertheless, there was a sense that holistic, emotional support should not be limited to the care journey. Some spoke about how they wished for support in maintaining relationships with people that are special to them once they had left care.

For some, the consequences of living in certain care placements meant that they had not been taught life skills such as budgeting. For them, being able to access support for this in later life would be useful. Others, however, spoke more generally about knowing there was someone there that they could access at key moments of need, rather than providing specific programmes of support.

Some felt they would benefit from accessing more intensive levels of support to help them through longer periods of challenge. Likewise, mentoring and support with maintaining relationships were identified as beneficial, in addition to support during crisis or moments of need.

For those identifying practical support, being supported to have a passport and a bank account was mentioned frequently. This issue was raised

across many different backgrounds, though was most frequently raised by unaccompanied minors, who felt a lack of control and certainty over their future after care. Support workers articulated concerns that unaccompanied children and young people were not given enough support, especially beyond the age of 18 when all support usually ceased and it was therefore very hard for them to build a life and sense of security for themselves.

Whilst most focused on the need for intervention or practical support, others spoke about the benefits of also providing informal positive opportunities such as participation or group work offers.

For some of those engaging with this concept however, the priority was to focus on the intensive support needed by those who have recently left care. This often centred on the 'cliff-edge' experience of supports stopping in early adulthood, and the impact of not knowing who to reach out to for help at this point. These discussions highlighted the challenge of leaving care and were reflective of where they were at in their life or where they struggled most.

Some were intrigued by the concept of lifelong support, but concerned about the challenges associated with delivering it. There were those who criticised the lack of investment in aftercare services, believing that other areas were prioritised and that money was wasted on less important issues. Other responses questioned the practicality of offering this type of lifelong support, with some expressing concern that the offer might be taken advantage of more by certain individuals, leaving less support available to others. Others felt concerned around how the general public would respond to this extra help, alluding to the stigma that is already felt by the care experienced population.

Stigma

Experiences of stigma were extremely commonplace in the stories heard throughout the Care Review from children, adults, carers and members of

the workforce. Stigma played a pivotal role in how challenges and opportunities presented themselves to those in care at any given point during their lives. It was talked about in relation to family, mental health, identity, location, housing, the ability to forge and maintain relationships, education and accessing services.

For many care experienced people, being viewed and treated differently had the effect of making them believe they were less worthy of love and opportunities than those not in care. The Care Review heard many accounts of the sense of isolation and loneliness children and young people experienced, along with feelings of negativity, low expectations for themselves and by others, and the impact this had on being able to look positively to the future. The Care Review heard that tackling the negative attitudes and stigma of school years, would have greatly impacted on their lives and potentially prevented them from entering the justice system.

Many had experienced multiple layers of stigmatisation which intersected with and compounded the stigma they felt due to their care experience- for instance, stigmatisation due to race, socio-economic status or disability. Stigma was also sometimes exacerbated by geography. For example, the Care Review heard about stigma being magnified in rural communities where people knew one another. The Care Review also heard about the impact of moves and living in a new area where young people spoke with different accents and where there was a different culture singling them out and making them feel isolated.

Parents of children with disabilities told the Care Review that their children were consistently marginalised, excluded from events and from mainstream activities, and discriminated against. This stigma and discrimination often extended to the whole family. The Care Review heard about the importance of peer support in reducing these families' feelings of isolation and stigma.

There were multiple discussions about the hugely detrimental impact of stigmatising and inaccurate understandings of what it means to be in care, and how it caused others to view and treat care experienced people differently, making them feel isolated and creating barriers and challenges in every aspect of their lives. Some workers reflected on the stigma that they witnessed in the 'care system', saying that they had seen some professionals behaving judgementally towards children and their families, which had a detrimental impact on the way decisions about them were made.

Children talked about the impact of language on them, and the way that language can stigmatise children further. Children said that words such as 'contact' and 'respite' make them feel that they are different from other children and that they feel nervous and stressed about seeing family when they hear those words. Some children were not aware that they were in care and struggled to connect with the language used by professionals, for instance 'care experienced' or 'looked after', to describe their situations with their lived experiences.

Foster, kinship carers, adoptive parents and volunteers also gave accounts of the stigma they faced and how this made them feel judged, different and isolated, mirroring the stigma experienced by the young people they cared for. The Care Review heard particularly from parents and kinship carers of their fear of being judged by others as being 'bad' people. This fear was often so great that it stopped those people from asking for support, for fear of having their children taken away.

Kinship carers described feeling stigmatised by a range of professionals, and treated in ways which made them feel 'second class'. Adoptive parents recounted the stigma they felt from services, who made them feel judged and as though they were 'bad parents' or that they were 'pushy parents' because they needed to fight for support for their children. Those parents sometimes felt excluded from meetings, leading to a sense of frustration and isolation.

Origins of stigma

A consistent message from those who spoke to the Care Review was that care experienced people are too often misunderstood, labelled and judged by the people around them. Many voices expressed that there was a lack of accurate information about care experienced people and the 'care system', which impacted on the level of understanding people had towards them within their communities and across the country. Many articulated that many people fail to understand the vast variety of care experiences, lumping all those different experiences into a single idea of what 'care' means. This resulted in many forms of stigmatisation.

Stigma was viewed as permeating society, influencing individual mind-sets. Discussion highlighted concerns relating to how care experienced people are misrepresented and socially constructed, creating prejudice about expected behaviours and characteristics of care experienced individuals. People told the Care Review that negative or inaccurate portrayals conveyed in media, such as newspapers, television programmes and in books, served to reinforce the views held by the general public and that these views were shared between people, across communities. Some also talked about how this was reinforced by charity portrayals of images that reinforce need to generate income from fundraising and/or serial discrimination in order to campaign.

The Care Review heard that children and young people felt others viewed them as 'bad' and to blame for being involved with the 'care system'. These prejudices, in turn, influenced day to day interactions with the people they came into contact with. The people identified most commonly as perpetuating this narrow and negative framing of care, were seen to be teachers, other pupils, carers and parents of friends. Some identified that older generations have a particular understanding of care which is outdated and unfairly permeates through to younger generations.

Children and young people shared their experiences of being bullied and of being treated differently by professionals. Many spoke of the distress they felt at being made to feel different from other children and young people around them. Many voices identified the cyclical aspect to this. The emotional and mental health impacts of being treated this way, resulted in behaviours, which were then responded to by those around them in ways that made them feel further isolated.

This feeling of difference was communicated with frustration but also with a sense of hopelessness around how to change these attitudes. This was particularly strong for some who felt that those who have never experienced care, will never truly understand it, regardless of training. Others however, felt strongly that there should be a training or education approach to help change the attitudes of those around care, with a particular focus on schools.

The Care Review also heard from unaccompanied children and young people, who felt that the media and government policies had encouraged a 'hostile' environment, reinforcing negative stereotypes and narratives about them and causing them to feel unwanted and isolated.

The impact of stigma on identity

Many of the voices the Care Review heard emphasised the importance of recognising that every person's experience of care is unique, and that there is no single 'care experienced' identity. They talked about what it was that they felt had made them who they were, including having 'a sense of self', of their values, interests, talents and preferences They were clear that care experience was not what defined them. Voices expressed that experiences and relationships at school or with others around them, had a greater impact on their identity than their experiences of care.

Children and young people spoke about the importance of understanding where they came from and of having a connection to their past, either in person or through knowledge, which helps to shape their identity and

understanding of themselves. Others shared that they didn't know who they were until they left care and even then, that information or views held about care experienced people could skew or confuse their sense of self.

Attitudes towards 'care identities' varied, with some young people explaining that they choose not to discuss or disclose their care experience, in some cases because of the associated stigma and the belief that this would affect how they were viewed as individuals; in other cases because 'care experienced' is not who they are but rather what had happened to them, and most often incidences out of their control. Labels and stereotypes had meant that many of them wished to distance themselves from their care identity altogether. The Care Review heard from some people who believed they would not be accepted for who they were and that they would be alone as a result, highlighting the importance of relationships with other people around them, in helping them to feel positive about their identity and sense of self.

Many had the experience of peers excluding them from their social circles due to what their parents had told them about 'care kids'. This underscored the pervasiveness of misconceptions and stigmatising attitudes towards children in care as being 'bad' or 'troubled'.

Addressing stigma

One of the strongest themes relating to stigma was the importance of improving a wide range of people's knowledge of care. Those who shared their experiences spoke frequently and passionately about the need to educate everyone who comes into contact with anyone with care experience to truly understand the impact of care experience. This was felt to be particularly important at school, within communities, and for those who were not in caring roles. Having the space to connect with others who have experience of care was also highlighted as playing an important role in reducing social isolation.

The Care Review heard about the many negative, and/or inaccurate representations of what it means to be in care, through TV programmes or news stories, partnered with the lack of genuine, informative media coverage through documentaries, for example. Frustration was expressed that these portrayals of care in the media contributed to the stigma they faced. Children and young people felt that this could be addressed through a public education campaign alongside more comprehensive training for those working closely with anyone who might be on the edge of, or in care.

It was also conveyed that there needed to be better communication and partnership working between schools and services involved with the child or young person. For example, children articulated that schools needed to be made aware of their situation and to not punish them for lateness, for not having the right things with them or any other things caused by a change in their circumstances. The crucial role that teachers played in children's lives and their ability to engage in school was talked about by many people who spoke of the positive difference made by having a teacher who cared and was aware and knowledgeable about them and their needs.

Experiences of stigma in the care and criminal justice systems

The Care Review heard many examples of young people who felt stigmatised by police, social workers, carers and other professionals such as school staff when they were known to be in care. Young people felt as though they were continually stopped by the police in the street, being checked upon, unfairly singled out and judged more harshly than peers who were not in care.

Several care experienced people described times when teachers, staff or carers had called the police in situations which they believed such actions were unjustified and unwarranted, and that would never happen to their non-care experienced peers. These incidents had resulted in action being

taken by the police such as searching or charging the young person. For many, there was a sense of over-reaction or overprotection on the part of staff, carers, teachers and police, particularly in group settings like residential care.

Many of the young people the Care Review spoke to felt that the processes and people involved in the justice system talked *at* them, rather than genuinely listening to them, and this contributed to a sense of having been unfairly accused and criminalised. The Care Review heard that young people felt a lack of empathy and understanding for their situations, and that other people had low expectations of them owing to their care experience.

In addition to not feeling heard, many talked of stigma and discrimination directly impacting the decisions made by those involved in the formal processes within the 'care system'. Some young people spoke of feeling that actions taken against them were not fair or did not merit what they had done. The Care Review also heard some say that they were blamed for offences that they did not commit, because they were already known to the police.

There was a sense of fear or anticipation that their criminal record would always be held against them and interrupt any future plans. Discussions about being able to look to the future were grounded in concern about how their criminal record or file could impact on it, including integrating back into society, forming and continuing relationships, pursuing education or finding employment.

Some adults with experience of both care and the criminal justice system reflected on their early experiences of the criminal justice system. Strong feelings of frustration were shared about the unfairness of overly punitive treatment including prison sentences and how this had continued to seriously impact upon them into their adult life. People also shared the challenges they faced when seeking welfare rights and employment and

of feeling afraid and unable to apply for jobs because of a criminal conviction. This had very serious repercussions for their overall stability, financially and otherwise and also on their mental health. They described continuing to feel punished by their corporate parents.

Exposure to drugs and associated debt were mentioned frequently as a reason for coming into contact with the justice system. However, for those with experience of prison, it was also expressed by some as being a way of life while serving a sentence. Substance use within prison and the ways in which substances were brought into the prison undetected, was also discussed. While only communicated by a small number of young people, in some instances this was framed with pride and their prison experience viewed as a way of having some status in their communities and among their peers.

The Care Review heard about the immense pressures of poverty experienced by some of these young people, and the impact this had on their families. Some young people explained that they felt it was their duty to support their families by attempting to alleviate this financial strain, and that this meant sometimes resorting to breaking the law.

Being on an electronic tag was spoken of as a barrier to finding and continuing employment. Work hours were spoken of often clashing with electronic tag restrictions, making it difficult to hold a job and not breach the conditions of release. This added to the sense of hopelessness and lack of support, with many feeling that the only foreseeable future was back in prison.

Many of those who shared their experiences of being on an electronic tag spoke about how these conditions and orders did not help them re-integrate back into the community. Some also felt that the electronic tag was used as a weapon to further criminalise and humiliate them. Experiences of how worthless they felt when authorities mistrusted them due to a fault in the electronic tag, were shared. Some also spoke about

genuine errors which ultimately impacted on their community disposal conditions, such as leaving house keys behind and not being able to enter the house in time.

Improving the justice system

There was a strong overall message that the 'system' must stop punishing vulnerable people. The Care Review heard that support needed to arrive earlier in the lives of children and young people at the point at which they started to exhibiting any concerning behaviour and prior to escalation into offending. The support should address underlying issues, such as problematic drug and alcohol use, trauma and poverty, rather than focusing on the offending behaviour. It was agreed that the support needed to be provided to the whole family and not only the child or young person.

Additionally, some felt that the criminal justice system should consider each person's individual level of maturity, as opposed to just their age. There was general agreement that the justice system should not be involved with anyone younger than 18, and that even at the age of 18 the 'system' needed to recognise the complexities of care experiences, individual backgrounds and the circumstances leading up to their offence.

Many workers felt that a criminal justice response was often not the most appropriate and that what was really needed was additional support.

Staff from a number of third sector providers spoke about their frustrations with the inflexibility of justice system in supporting children and young people and meeting their specific needs, and that the 'system' was not child centred enough. The Care Review also heard from parents whose children had various and multiple disabilities, who felt that the justice system created barriers to their children being treated fairly. They felt that the criminal justice system excluded children with non-verbal expression as they were dismissed as 'un credible witnesses' to their experiences. These parents were also concerned that being funded by Scottish

Government could make legal support services unable to be entirely objective and neutral in their support and representation of the family.

Some spoke about how the court system, especially Sheriffs, should be better informed and conscious of the context of someone's offending behaviour. This was especially significant when the context related to pre-care and during-care experiences, recognising the reasons as to why someone had found themselves in the justice system, either historically or currently.

Some expanded upon the need for focused support worker interventions, but that there should be overall responsibility for the young people who fall within both care and justice systems. This discussion highlighted that there needed to be a more senior or national policy focus on those that fall across both systems.

Many felt there was a need to train and educate justice professionals on care experience, taking an approach that de-stigmatises care, but also recognises that many young people enter the justice system having experienced significant trauma. Voices identified key professionals they felt were particularly in need of specialized training, including sheriffs, social workers and police officers, to support them in taking a more trauma-informed approach.

The behaviour of police was spoken about frequently, both in relation to taking children into care and their interactions with young people in care. The Care Review heard that many children felt that the police stigmatised them due to their care experience, as well as multiple stories of police using force and aggression. These experiences served to exacerbate trauma and feelings of fear, and to young people developing mistrust towards the police.

Conversely, a small number of those the Care Review spoke to shared experiences of being treated with respect and understanding by the police, of being given another chance and listened to. The Care Review

heard instances of police officers taking the time to engage with and to understand some of the issues care experienced people faced and this was really valued by those the Care Review spoke to, and had made a difference to their lives.

Secure care

A small number of young people with experience of secure care placements told the Care Review that they had a positive experience of living in a supportive environment with access to staff who were caring, helpful and knowledgeable. However, it was far more common to hear that young people had very negative experiences of being in secure placements, of having their freedom taken away and their rights to do normal activities such as watching telly, making phone calls or going for a walk, controlled. Some felt that this removal of freedoms had been detrimental to their mental health and wellbeing.

Young people sometimes felt they were lied to or misled about the length of time that would be spent in secure placements, or that stays in secure care far exceeded the limit of time they were told they would be there. This was sometimes due to a lack of appropriate placements being available for them to move onto. Some spoke about the anxiety and uncertainty this caused and that the lack of clarity about where they would be living next, made them unable to feel settled and secure. Staff expressed frustration with the lack of information and preparation given to young people coming into secure care, while also highlighting specific instances of positive practice where knowledgeable social workers had been able to give accurate information.

There were also those who felt that the range of needs that secure care was catering for under the same roof was too broad, and some staff felt strongly that there needed to be support that was more tailored according to individual circumstances and need.

For some, being placed with other young people who were in custody was highlighted as a concern, leading to them feeling unsafe or as though they had to 'watch their backs'. There were others who felt stigmatised by being in secure care because it was viewed as a punishment or a 'steppingstone' to prison.

The Care Review spoke to some young people in secure care who felt stigmatised and targeted due to being placed in the same unit as young people housed on sex offence grounds, on account of their vulnerability. This led to them feeling labelled and ostracised by other young people and to feeling isolated, with no opportunity to socialise with others and form relationships.

These discussions also highlighted the additional stigma faced by young people in care who were also in conflict with the law, as their identity amongst their peers and professionals as 'offenders' often led to their vulnerability being overlooked or ignored.

Restraint

Many of the young people the Care Review spoke to felt extremely angry about the use of restraint in care. From some conversations with children in residential settings, it was clear that the use of restraint added to, or created a power dynamic between workers and young people which was experienced as an 'us and them' relationship. This dynamic had the impact of creating unhealthy and unhelpful relationships between young people and the people that are supposed to nurture and care for them.

This dynamic was intensified by the belief that some workers use restraint too often, too quickly and in an inappropriate, forceful manner. The Care Review heard that some members of staff became known by young people for regularly restraining young people and that it seemed to some young people that those staff enjoyed using restraint. There was a deep sense of unfairness about the way that some staff used physical restraint

on occasions where young people were simply arguing or 'being cheeky' but were not doing anything serious or dangerous that could hurt anyone.

The Care Review heard that the experience of restraint not only impacted on those being restrained but also those witnessing it, with some speaking about how frightening it was to see someone being restrained, especially when injuries occurred. Some young people who had witnessed restraint explained that it wasn't necessarily the restraint itself that was traumatic rather, it was the way the incident had been handled by those using it. The Care Review also heard from some staff in secure and residential children's homes who also felt traumatised by the experience of using restraint on young people.

Some young people described the physical injuries that could occur because of the force used. Others identified that restraints should be followed by interviews or reviews intended to scrutinise the use of restraint, however it was apparent that many of the young people the Care Review spoke to were unclear on how this process worked, or were unaware of it ever having been offered to them.

Many asserted that the use of restraint only served to escalate behaviour. Some questioned the purpose of restraint, asking why this type of physical intervention was allowed to be used on children and young people at all, but especially on those with experiences of trauma. A lot of the individuals the Care Review spoke to identified alternative methods which should be used instead of or before restraint including asking young people about their preferred method of support when in crisis, intensively supporting young people to manage their anger and de-escalating the situation, letting them 'walk it off' and spending time talking to young people using trusted relationships.

Some staff members who reflected on the use of restraint expressed that they believed that sometimes young people craved physical touch and so, would try to seek out restraint, when all they really needed was a hug.

It is important to note that a small number of young people expressed that restraint should be used in some circumstances, to keep them safe, especially in instances where young people had the potential to hurt themselves or others.

Experiences of mental health services

The lack of support in place for many young people when they left care had serious impacts on their mental health and overall wellbeing. Carers told the Care Review without support, young people's lives had spiralled out of control due to drug addiction, compounded by lack of mental health support and support with addiction.

Young people distinctly identified mental health in discussions about what they needed to achieve good health and wellbeing. Many discussed the lifelong impact of trauma and the need for better lifelong mental health support and intervention which recognised not only the impact of early life experiences of trauma, but also the impact of a chaotic 'care system' which at times provided little stability and sometimes further traumatised children and young people. Some were keen to speak about how the processes involved in their care could compound this early trauma, by revisiting the detail at meetings, or talking about past behaviours.

Many voices agreed that simply by being in care, children and young people had been subjected to some level of trauma and therefore, to varying degrees, needed some form of mental health support. Some felt that mental health support should automatically be provided to children as soon as they come into care, or prior to being removed from the family home. Many also articulated the importance of mental health support for parents and families who themselves may have experienced trauma throughout their life, which directly impacted their parenting practices.

Voices shared what it felt like in circumstances where non-care experienced friends did not fully understand the impact of their care experience on them; some reflected a feeling of difference between their

experience of mental health, and that of their non-care experienced peers, others spoke about the general lack of understanding that exists about mental ill health – with the combination of these two factors resulting in a more challenging experience of mental health for those with experience of care.

The Care Review heard from many children, parents, carers and workers that current mental health services were not good enough. Some felt that referral processes, meetings and other interactions with health professionals were ineffective and were leaving them without much needed support.

Delays in assessment and placement in permanent, safe and caring environments were identified as creating problems in relation to mental health and child development in the short term and also risking detrimental long-term outcomes. Adults who had left care reflected on the lack of diagnosis and assessment which they had as children and that the negative effects of this on their mental and physical health had carried into their adult life. They described ongoing delays and barriers to getting the support, including therapy that they needed.

Furthermore, multiple moves had an impact on waiting lists for mental health services, meaning that at times of transition, when mental health support was arguably even more important, children and young people faced delays in accessing those services.

Young people described experiences of being seen by mental health professionals and feeling as though there was too much focus on diagnosis instead of staff really listening to them or how they felt. Children and young people expressed their desire and need to be listened to and have their views respected in all aspects of care.

Some also identified that if they did not want to talk, or were not ready to talk, mental health services would terminate the referral to their services. Given the vulnerability and worries held by a child or young person

needing mental health support, this felt unfair to them. Others described that even where they manage to gain access to services, the support was delivered via inconsistent sessions and some explained they were not contacted again after their first visits to services for follow up.

Many spoke strongly about the 'epidemic' nature of the mental health crisis and how there is a severe lack of resource being put into services and workers. Many suggested that specialist training for other professionals involved in a young person's life could help. This was viewed as helping in a number of areas such as capitalising on pre-existing positive relationships, reducing the number of professionals in the lives of young people and lessening the strain on specialist mental health services.

Self-harm also emerged as a complex and difficult issue that young people articulated dealing with in ways that didn't help and felt that they wanted more support with to help them cope with this issue.

However, some people expressed a positive experience of mental health services. Some of those who had engaged had experience of mental health services which offered play therapy, cognitive behaviour therapy, as well as bereavement counselling and support. They valued services that felt safe and were interactive.

The need for a trauma-informed, responsive workforce

There was recognition that while professionals working directly with children and young people should really know and understand how to support the children and young people they work with, there were also high numbers of other people involved less directly or frequently in children's lives, such as Panel Members, Senior Social Workers, GP's and Administrators. Whilst there was no sense of expectation that all these people should know the child, there was a hope that the current situation could be improved upon.

The Care Review heard again and again about the impact that trauma and stigma played in the lives of children, young people and adults with

experience of care. Whilst many agreed that there was a need for professionals to truly understand the child, some were unsure as to how this would work, given the scale of intervention in many of their lives. It was repeatedly suggested professionals could deepen their understanding if the workforce were trained in trauma-informed practice and more aware of the impact that stigma can have on young people's lives; how it lead them to feel isolated, lonely and to fall behind with their education. It was also commonly suggested that teachers need to have much more training and awareness around care-experience in order to combat the stigma and bullying encountered by many care-experienced young people at school.

Rights

First and foremost, the Care Review heard the strong message that children and young people do not understand their rights; what they are and what they mean for their day to day lives, both in and out of care. For some this related to being taught rights in relation to the United Nations Convention on the Rights of the Child. For them, it was difficult to understand how this related to their own personal circumstances and how challenging it would then be to identify their own experiences of rights abuses.

Likewise, some expressed a dissatisfaction at the lack of support and access to opportunities to challenge any abuse of rights that they experienced first-hand. A number provided examples of scenarios where young people were unsure of how to get support if they felt they were experiencing a breach of their rights. For some, the thought of challenging carers, such as residential workers, felt embarrassing and too uncomfortable. They didn't feel that they had a strong enough relationship with another significant adult such as a social worker or children's panel, to raise it with them.

Experiences of rights education were largely negative, with many feeling that professionals were ill-informed themselves and this impacted on how

they taught or modelled rights use to children and young people. Furthermore, it was evident that several young people felt that the language, materials and communication around rights needed to be made more accessible and contain less jargon, ensuring that children and young people would be able to fully understand and engage with their rights, with a particular focus on how this applied to their own lives on a day to day basis. Children and young people wanted to know their relevant rights at the right time, in ways that are accessible and tailored to them.

The Care Review heard that Children's Rights workers needed to have better access to updated training on both rights, and on ways to effectively teach young people about them. Some children and young people suggested having a dedicated Children's Rights worker in every school, to be ready to support any child at a time in which they need it. Advocacy and independent support was another area of importance for children and young people, who recognised the benefit of having a worker who could support them to ensure their rights were upheld and advise them on what to do if they felt that they weren't. Being taught about rights was viewed as 'a good start', but there needed to be readily available specialist support around rights, that was both accessible and child centred.

When asked specifically about rights knowledge, many struggled to articulate what this could mean for them in their day to day lives. For some, they could identify that rights existed, but were unable to explain how this connected to them as individuals or a collective. Others, although aware of what rights are, struggled to describe how their rights were being met in practice. Likewise, some felt frustrated at what they perceived to be adults holding the power over rights.

Those who understood the concept of rights were more likely to be a part of groups that had discussed, or worked on understanding rights. This was a mixture of Champions Boards, local groups and national groups that would explore issues, rights, and entitlements on a regular or semi-regular basis. Likewise, those who did feel they had a firm grasp of their rights, felt

empowered, and as though they had an equal part to play in formal meetings, or decision-making processes.

When people spoke about knowledge of rights, often the discussion focused on the right to information, particularly about their lives and their circumstances. This could be information being verbally explained to them by the workers around them, or access to the records and files that contain information about them. The right to confidentiality of information was also expressed, with young people understanding that security should be prioritised in order to keep them safe.

The ability to keep in touch with family and friends was also noted as being crucial, with it being articulated that in some places this is limited or controlled due to limited or no access to internet.

For some, it was felt that they were never supported to understand their rights or to understand where they could find the needed support. This was felt most noticeably when leaving care, with individuals feeling abandoned and left to find their way on their own.

Many felt their rights were not being respected. Further, some felt there was inconsistencies of practice, culture and approach. Rights were recognised differently in different care settings and applied in different ways. For instance, the use of restraints happening in residential homes rather than in foster care. Some experienced being locked in rooms by residential homes or told they could not go on holiday because they were undeserving.

The Care Review heard that unaccompanied and asylum-seeking children and young people were particularly vulnerable to not having their rights upheld. The need to recognise the importance of language and the extent to which language can act as a barrier to participation and integration within society was specifically highlighted. The lack of interpreters had a detrimental impact on all aspects of unaccompanied children and young people's lives.

Many discussed the need for more recognition and understanding of the depth of trauma that young people may have experienced, the impacts of this, and how these issues were further exacerbated when individuals did not understand what was being said due to language barriers and no interpreter being used, leading to further feelings of powerlessness and isolation for children and young people.

Voices highlighted the specific vulnerability and experiences of young people engaged within a difficult asylum process, against the backdrop of the Home Office's 'hostile environment' policy and racism in wider society. Support workers underscored the need for trauma-informed and empowering support for these young people, which would enable them to feel some level of control over their lives through having proper access to information about their asylum process and feeling able to ask for their rights, entitlements and services.

Feeling in control

Many of the children and young people the Care Review spoke to said they felt of a lack of control in their day to day life. Examples of situations when young people felt they had no control ranged from homework, to rules which they experienced as unfair, to being treated differently from their peers or brothers or sisters, to formal processes in which they felt they had no say.

Those who shared their story talked about the fact that any decisions they made had to go through other people first. In addition to this taking away a sense of control, for some this eroded their confidence and made them doubt their ability to cope alone and to make the right choices. They wanted control over the direction of their lives- not without input and direction from others, but instead with an equal part to play in decision making. It was also highlighted that not having the autonomy to make decisions could have detrimental impact on their future, particularly when learning about how to make important decisions.

Parents and carers also related their experiences of powerlessness and control in relation to formal decision-making processes and meetings, or their experiences of complaining or whistleblowing about instances of restraint and abuse. The Care Review heard that they felt silenced and marginalised by these processes.

Children and young people explained that relationships with people who understand their individual needs and who strive to support young people in difficult circumstances, could help them to feel more in control of their day to day lives. Other things that helped children feel in control included examples of decision-making alongside carers, being listened to by panel members, being supported to maintain important relationships or being given the freedom to leave a session to make a phone call.

Being listened to

The importance of genuinely listening to children and young people while in care and beyond was spoken about passionately. Having a voice, from the moment of coming into care, was crucial as this would have a lasting and continuing effect on how children felt about their care journey. Some professionals told the Care Review that they were very much aware of the need for young people not only to be listened to, but that they also needed to see that action and change was happening as a result of them sharing their views. There was a strong consensus that being listened to could help ensure the child or young person feels cared for and central to the decisions made about their lives.

Some young people could quickly identify key moments when they felt that they had been listened to, but a lot of people could easily identify regular times when they were not listened to, or when they felt people were trying to show that they listened, but then did not act on what they heard. Other individuals spoke about how they have never felt listened to in care, with the entirety of their care journey feeling like decisions were made about them, and without their involvement.

Children and young people felt as though they were not listened to by their social worker and that they would give their opinion but then not have it taken into consideration. For many, the feelings of powerlessness and frustration that came with not being listened to, were compounded by: feeling not heard by the adults in their family and school life, not being involved in the decisions made about them, and then intensified by experiencing delays in responding to asks or requests.

Some felt they were able to identify the reasons why they were not listened to during their care experience, noting the pressures experienced by the workforce. Several spoke about how busy professionals are, and how it is impossible for them to be able to genuinely spend time listening. These discussions showed how conscious young people are of their surroundings and the people supporting them.

For some, the greatest impact of not feeling listened to was how it had the potential to change, and shape their behaviours, and how they felt. It was recognised by some children and young people that they would behave in particular ways to elicit a response from professionals, or through the frustration at not being heard meaningfully.

Children and young people wanted space to talk and discuss, and mutually agree on decisions and they wanted their asks or requests to be responded to within an appropriate amount of time.

Formal decision-making processes

The Children's Hearings System and Looked After Child (LAC) Reviews were mentioned frequently and referenced as pivotal moments in the care journey where children should be involved, listened to and able to influence what will happen in their lives. Children and young people described occasions where they felt in control and listened to at their Hearings and Reviews and how these felt empowering and hugely beneficial to the decisions that were being made about them, helping them to understand and be part of the process.

However, for the majority of those who spoke about Hearings and Reviews, the feeling was generally that they were not heard and that those making decisions were not there to listen to the children or young people involved. It was expressed repeatedly, not only by children and young people, but also by members of the workforce, carers, parents and adoptive parents that individuals could often feel they were being pre-judged within the meetings and this left them feeling powerless and stigmatised. This created a barrier to their voice being included, whilst others were reluctant to attend at all, feeling that it was pointless, as their presence would make no difference to the outcome.

Children's hearings were spoken about as 'dehumanising', 'awkward', 'intimidating' and 'antagonising'. Medical professionals, foster carers and others expressed that professional assessments were sometimes disregarded, leading to children being returned to or placed with adults when it was not appropriate to do so. This served to compound issues with poor mental health, as well as other aspects of child development and presented a risk to children's long-term outcomes and futures.

Some foster carers felt that the current procedural approach significantly undermined the focus on the child's needs as the priority driver, and that children's voices, especially younger children's voices were not being heard. Some carers expressed very strong views about the approach demonstrated by professionals during children's hearings, which she perceived to be inappropriate and disrespectful given the importance and impact on their child's future. Others raised similar concerns about the lack of due process to ensure their child's voice was heard and that they were appropriately represented.

Foster carers spoke of not being asked to contribute to documents which influenced decisions made about children's lives, even though they felt they held key information about them. They reported not seeing minutes of meetings and information not being shared with them at key times, which in turn had an effect on what they were being able to share with the

child. Kinship carers were suspicious of records that were kept about them and stated that at times what was written down was unrepresentative of what had happened or what they said.

Several people referred to Getting It Right for Every Child (GIRFEC) principles and the need to have the child at the centre, and commented that although the concepts were recognised as positive, this was not what was happening in reality.

Advocacy

Advocacy was mentioned regularly, mainly in response to questions specifically enquiring about advocacy, but also generally in response to questions about what services are important and times when individuals felt listened to.

Strong views were expressed about the need for equal access to advocacy for all children and young people across Scotland. Advocates were viewed as being important in helping children and young people navigate the complex and confusing systems around them, with many feeling that an advocate was a critical figure and likely to be taken more seriously than they were.

Advocates, and Children's Rights Workers were mentioned regularly as being important for informing about rights, and entitlements, as well as helping to communicate the views of children and young people without judgement. This was viewed as particularly important in the case of younger children, since many processes were designed with adults rather than children in mind, could be scary and confusing for small children and often overlooked their voice and needs in decision making processes.

The relationships formed with advocates were also mentioned frequently, showing that children and young people placed a lot of value in these figures, and felt safe in the balance of the relationship. Some individuals identified the importance of having someone who is there to only help you

communicate your views, but who does not have the responsibility of other roles or service.

There were some young people who stated that advocacy had its limitations. Advocates were not universally able to resolve issues that had been raised; there was not always a choice of advocate and in some cases (like sexual abuse or exploitation) this was very important; some were not entitled to advocacy because of the type of placement they were in; others felt that advocacy was no longer for them due to their age.

The role and responsibility of the wider community of adults around the young person in standing up for young people was also reflected in the contributions.

Many had never heard of advocacy, did not understand the concept, or heard about the offer too late.

Information

The Care Review heard that children and young people who experience care often had to understand complicated changes to their lives, especially in relation to their rights. They also had to navigate complex processes involving multiple professionals and processes. It was very clear that getting access to the right information was highly dependent on the professionals involved and that having the right person who cared for them, was knowledgeable and proactive really made a huge difference to children and young people, ensuring that they had access to important resources and entitlements such as financial support through further education.

The sharing of knowledge and information was really valued, creating feelings of being more in control of their care journey. Conversely, experiences of not being heard or important knowledge or information being withheld, led to negative experiences, with voices reflecting that they felt controlled by the people, processes and systems around them.

Those from the workforce, families and carers also spoke about feeling 'lost' and voiceless within complex systems.

Young people felt it was very important to share information appropriately and as soon as possible during the process of being taken into care. The Care Review heard multiple stories of care journeys where the processes of going into care were not fully explored and explained and those the Care Review spoke to shared difficult experiences of how this lack of communication and information, during the most vulnerable moment of being taken into care, had served to further compound distress and created uncertainty and confusion.

Further still, many spoke of not being informed about what was happening with family members, or not having the processes of being separated from brothers and sisters explained to them. There was frustration that this information was not prioritised and that decisions were made without taking into consideration the views or feelings of the brothers and/or sisters about whom those decisions were made. Many voices expressed that even when family situations were difficult and complex, the decisions being made should be properly explained and justified to those involved.

Information communicated throughout life in care was also discussed as extremely important but often lacking. For example, a number of individuals spoke of not being aware of the council tax exemption due to poor or inconsistent aftercare and throughcare support services.

Ensuring children and young people are informed of their rights and entitlements, as well as availability of services such as advocacy were seen as crucial in ensuring that individuals in care were informed, supported to challenge decision-making and felt more in charge of their care experience and lives after care.

While the sharing of knowledge and information appeared important, the active involvement of a person to spend time with the child or young

person, explain what their rights were, what was happening and supporting them to speak, was key and highly valued.

The role of advocacy workers appeared to be well understood and valued by those who had experienced it. In speaking about how access to information and rights is obtained, the two areas mentioned consistently were through education (schools, mostly) and advocacy. Many that the Care Review spoke to felt that they did not have any knowledge about their rights or what information they were entitled to until they met their advocate and had these rights explained to them.

Care records

For many, care records documented an experience or a period of time that they could not remember. For this reason, they were viewed as being crucial in helping to explain and 'fill in the blanks' of their life before and during care and in supporting the development of their identity.

The Care Review heard that the language used in reports written by professionals had a powerful impact on how care experienced people felt about themselves and their lives, and how the words used had led to people feeling dehumanised, shamed, blamed and held responsible for the circumstances they had faced as children.

In discussing the purpose of care records, many felt that these were a tracking of incidents and key moments, determined by the professionals around them who write them. There was a call for the purpose to be re-thought, taking a more child-led approach in the shaping of records. There was a clear message throughout that care records should be about the memories and 'journey' of that person. This in turn would combat the frequently raised issue of care records only documenting negative behaviour.

Those who shared their story highlighted that taking an approach that focuses more readily on milestones and positive instances would help

support care experienced people in looking back over their records in the future, helping them to form a more positive identity.

What was heard emphasised the importance of support being available to people when they do access records, regardless of age and stage, highlighting the challenge and pain experienced when reading personal records. Positive experiences of accessing care records were often linked to being part of an engaged continual process, with the child and young person developing a greater sense of understanding, confidence and engagement in their care journey.

Care experienced adults who had gained access to their records reported instances of incorrect, incomplete records with periods of time missing and heavily redacted information. There were also examples where information recorded in their records was untrue or unfounded yet was not removed when challenged or proven wrong. The struggle to gain physical access to records was highly bureaucratic and complex, not user-friendly or trauma-informed, with waiting times to receive records often being lengthy.

The Care Review heard from those who wanted greater care and respect to be shown to the physical records themselves, who had experienced receiving their care records through the post badly damaged, and in torn envelopes, reinforcing a sense that as people, they were not respected and viewed as unimportant. Torn and damaged packaging was also deemed to be a breach of data protection, as confidential and personal documentation can be open for anyone to see.

There was a call for the purpose to be rethought, taking a more child-led approach in the shaping of records. There was extensive engagement around how the process for capturing, accessing and reading care records should work in practice. In terms of access, there was a call for a much simpler process of asking for records, which would reduce waiting times, the expectation for people to list their previous addresses and be universal

in its procedure - avoiding different approaches across different local authorities.

Redress

Experiences of abuse in care placements, and of poor responses to disclosure of abuse, led not only to feelings of mistrust, but also to a feeling of not ever being safe or secure in their environment. The Care Review heard that having high numbers of professionals around them further led to children feeling a sense of mistrust. The unfeasibility of knowing all the professionals involved in a Hearing or Review, coupled with largely negative experiences of these formal spaces, meant that young people were left with feelings of confusion, disrespect or dissatisfaction.

Some people expressed real anger towards professionals that had made mistakes or had done something wrong which had negatively impacted on their lives. They spoke of the need for the 'system' to acknowledge the suffering that had been caused by any mistakes or wrongdoing that occurred whilst being cared for by the state. It was identified as important that someone took the time and effort to genuinely apologise and take responsibility when they or the 'system' had done wrong. In particular, some spoke very passionately about the importance of making sure that the same mistakes were not made again and that nobody else had to go through what they had experienced.

For some, it was felt that this acknowledgement could be an important part of their healing process. Some discussed how this could make a difference to how someone viewed themselves, and in particular, how it could help them to come to terms with their childhood experiences, reducing feelings of self-blame and enabling them to accept what happened as not having been their fault.

Importantly, some felt that the act of apologising for behaviour was something that the 'system' expected children and young people to do regularly, thus it was only fair that this be expected of professionals also.

They felt that the lack of recognition of wrongdoing from professionals, only added to unfair power dynamics.

Whilst the majority who spoke about redress felt that the 'system' should say sorry, some disagreed. However, this disagreement tended to come from a place of mistrust with some individuals expressing that such apologies would not be authentic and would therefore be pointless. Others suggested that seeking an apology would not be worth the time or effort necessary to follow up on this ask, reflecting on how complicated and bureaucratic the processes would be.

Reflections of care experienced adults

Care experienced adults reflected on their experiences of care, which had often been extremely negative and for some had had lifelong impacts.

Individuals reflected on their vulnerability as children and discussed being sexually exploited and abused and that no one picked up on this. Many also articulated that there had been no one in their lives that they could trust to tell. Some care experienced adults talked of severe risks to their safety and recollected relying on their sense of a fundamental need to survive, because they did not have the right support. Given the massive impact of their early lives on their continuing life, some adults had a strong sense that they had been wronged and that their corporate parents, in all professions and organisations had not acted as they should to keep them safe.

Some people commented on living in a state of fight or flight in all stages of care or describing a sense of precarity, or walking on eggshells derived from the experience of living in an abusive family home, and then this being exacerbated further by the lack of stability in care. For many the impact of dealing with these emotions was lifelong and presented itself in a variety of ways, such as eating disorders, addiction, and mental health issues, at various stages in their care journey and beyond.

Care experienced adults reflected on having to identify with, re-label themselves and be reminded of their experiences regularly in order to access support. The Care Review heard about the impact of their life experience on trying to hold down jobs and manage routines. They commented that layers of negative and stigmatising experiences seemed to continue to widen the gap between them as individuals and the rest of society.

However, every care experienced adult spoke passionately and expressed their commitment to finding ways to make sure that others did not have the same experiences they did. For some, the Care Review had been the first opportunity they had to hear about peer support groups and campaigning and advocacy groups that were working to change experiences of care and they felt positive and hopeful for the future and eager to be involved.

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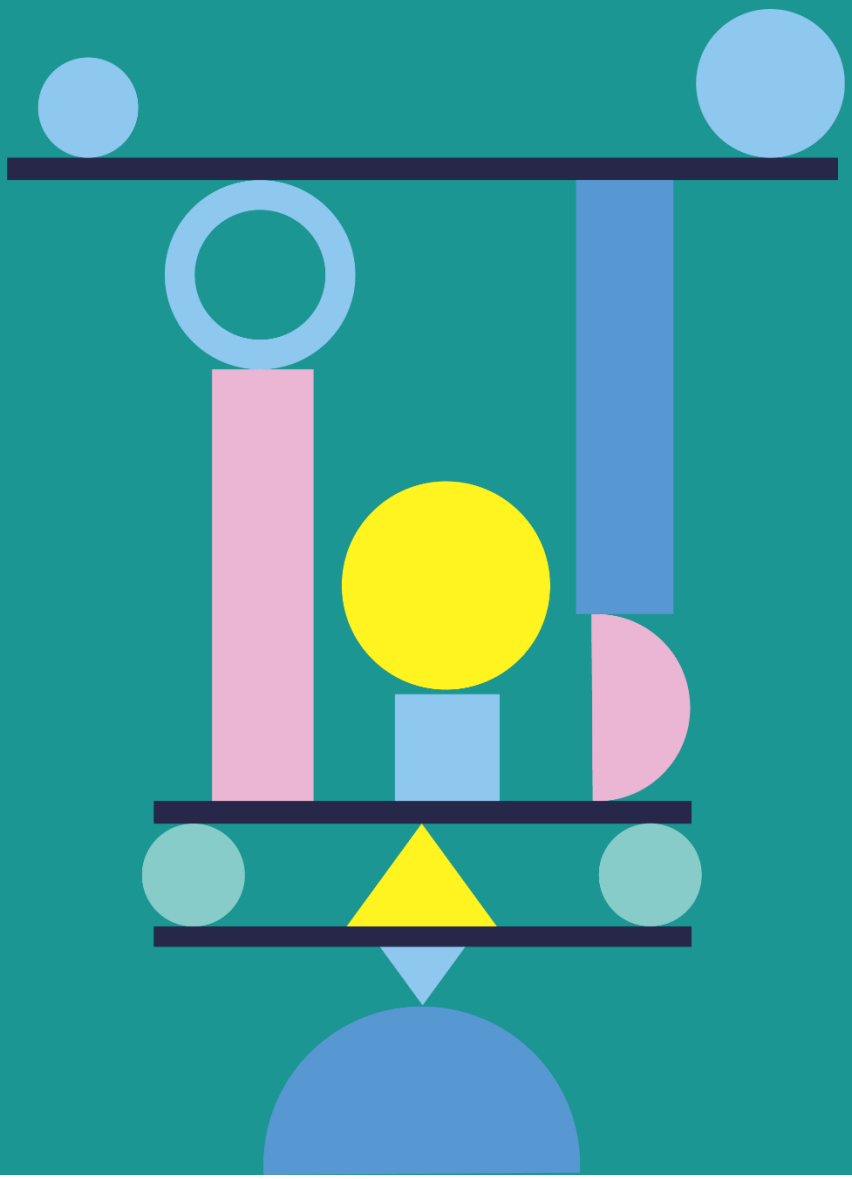

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Produced for the Care Review by CELCIS (Scotland's Centre for Excellence for Looked After Children), at the University of Strathclyde

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1. Preface

This paper has been prepared to facilitate and inform the Care Review's discussions at its Discovery Stage, summarising relevant statistics and other quantitative information.

It provides a comprehensive introduction to the population-level and systems data currently collated and published on Scotland's looked after children and care leavers, incorporating comparative UK and international data where applicable. It is designed to prompt discussion and debate, and to enable the Discovery Group to identify questions for further, more in-depth investigation and consideration.

Context and analysis has been provided throughout, to help explain the strengths, limitations and possibilities of certain data sources and extrapolations. The report also highlights areas where little or no data on the population or system is currently available.

The statistics replicated below are subject to revision by the data owners (i.e. Scottish Government). Links to the original sources are available throughout. A glossary of frequently used terms is provided at Appendix A, and a discussion on what lies behind these key terms (such as 'looked after') is set out in the relevant chapter below. Please note that percentages stated may not total 100 due to rounding.

All errors in this report are the responsibility of CELCIS. Comments and queries should be sent to p.sullivan@strath.ac.uk

Data Sources and Analysis

'Statistics' relating to looked after children and young people have roots in a number of different sources, including official publications, Freedom of Information requests, formal research studies and, on occasion, individual testimonies. Unfortunately, many of the best known and widely cited 'statistics' are unreliable, due either to weaknesses in the original data they are based on (e.g. high error rate collection methods, small sample sizes), poor analysis (e.g. unsubstantiated extrapolations, presentation of data correlation as causation,) or misreporting (e.g. coverage of percentage increases/decreases without reference to the actual numbers, or statements which do not provide wider context and caveats).

This briefing concentrates on data from quality-assured statistical sources, such as the Scottish Government's Children's Social Work Statistics report. These national publications, usually based on secure annual returns from public bodies, and prepared to UK Office of National Statistics standards, can be considered of good quality. However, even in these publications, in bringing together as they do a variety of material from different sources, there are areas of less reliability. This briefing flags these areas, explaining the reasons for caution.

The Scottish Government's annual Children's Social Work Statistics, the main source of national statistics for looked after children and young people, is published each year in spring, presenting data collected over the twelve months up to and including the previous July; i.e. the 2017 publication shows data from beginning-August 2015 to end-July 2016.

Furthermore, to ensure a breadth of commentary across areas the Care Review may be interested in, relevant survey and research data has been included throughout the briefing. Accompanying commentary will assess the strength of the specific sources, and the reliability of conclusions drawn from the specific data, as well as drawing out key trends which the Care Review may wish to consider.

The majority of longitudinal analysis in this briefing will cover the last 10 years for which data is available (2006-2016), in order to illustrate trends and changes; however this has been lengthened and shortened, where appropriate, to accentuate any key messages.

Definition of a Looked After Child in Scotland

To properly understand the statistics relating to looked after children and care leavers, and in particular the strengths and limitations of the data set, it is necessary to have a detailed understanding of precisely who is reflected in the numbers. This comes down to the specific legal definitions of certain groups, such as 'looked after children', or 'kinship care'.

Firstly, who can become a 'looked after child'? Under Part 2 of the Children (Scotland) Act 1995 ("the 1995 Act"), which provides the main legal framework for supporting looked after children in Scotland, a 'child' is defined as a person under the age of 18 (i.e. aged 0-17 years inclusive). All Parts of the Children and Young People (Scotland) Act 2014 ("the 2014 Act") define a child in this way too. Therefore, while it is the case that different definitions of a child exist in other legal contexts, in respect of the 'looked after' system a person can be considered a 'looked after child' at any time from birth up to their 18th birthday. (It is possible for a child to remain 'looked after' by a local authority beyond their 18th birthday, as part of a private arrangement between the family and the local authority. Where this does happen, it is usually due to the child's significant physical and/or mental disabilities, which require the local authority to provide ongoing care.).

Of the population of children, who is considered a 'looked after child' is set out in section 17(6) of the 1995 Act, as amended by the Adoption and Children (Scotland) Act 2007 ("the 2007 Act") and Children's Hearings (Scotland) Act 2011 ("the 2011 Act").

A child is 'looked after' by a local authority when he or she is:

a) provided with accommodation by a local authority under section 25 of 1995 Act; or

b) subject to a compulsory supervision order or an interim compulsory supervision order made by a children's hearing in respect of whom the local authority are the implementation authority (within the meaning of the 2011 Act); or

c) living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities, as a result of a transfer of an order under regulations made under section 33 of the 1995 Act or section 190 of the 2011 Act; or

d) subject to a Permanence Order made after an application by the local authority under section 80 of the 2007 Act.

Please note that the law does not recognise any hierarchy of 'status' within the looked after child system (i.e. a child subject to a Permanence Order is not 'more' looked after than a child provided with accommodation under section 25 of the 1995 Act). The different legal routes do lead to differences in the way a child's care is managed, reflecting the extent to which parental rights and responsibilities are transferred to the local authority and, relatedly, the social work processes (such as reviews) which are mandated. However, in general terms, the duties of a local authority, or any other corporate parent, apply equally to all looked after children in Scotland.

The sections below provide some further detail about what these different legal routes mean in practice, particularly in terms of the child's experience.

(a) Provided with accommodation by a local authority under section 25

Where a child is provided with accommodation by a local authority under section 25 of the 1995 Act, it is done so in agreement with the child's

parent(s), carer, or child themselves. The local authority is not compelled by a court or Children's Hearing to provide the accommodation, nor the child to accept it. This legal route is often referred to as 'voluntary measures' or a 'voluntary arrangement'.

Section 25 of the 1995 Act enables local authorities to offer accommodation to a child if it is in the child's best interest. Local authorities are under a duty to provide accommodation to a child when no one has parental responsibility for him or her, he or she is lost or abandoned or the person who has been caring for him or her is prevented, whether or not permanently and for whatever reason, from providing him or her with suitable accommodation or care. The local authority can also use section 25 to provide respite services for children; if the child is accommodated for more than 24-hours (in a continuous period) then they are considered to be 'looked after' for as long as they remain in that local authority-provided accommodation.

A Scottish local authority has the power to provide accommodation to a person, under section 25, up to their 21st birthday, if the provision of accommodation would safeguard or protect their welfare.

(b) Subject to a compulsory supervision order (or interim compulsory supervision order)

Where a child is considered to be 'at risk', and it is not possible for public services to address that risk in cooperation with the child and/or their parents/carers, a Children's Hearing can make a 'compulsory supervision order' (or an 'interim compulsory supervision order'). This means the child becomes a 'looked after child', with their local authority responsible for ensuring the conditions of the order are implemented, and for providing (and coordinating) the services and support necessary to address the child's needs. A compulsory supervision order (CSO) is sometimes referred to as 'compulsion' or 'compulsory measures'.

A CSO may contain conditions about who the child should have contact with, and where they must live. Where a CSO requires a child to live away from their usual place of residence (e.g. with their parents), the local authority must provide appropriate accommodation to meet the needs of the child, such as with foster carers, kinship carers, or in a group setting (e.g. residential home or school).

Where no condition of residence is attached to a CSO, children become 'looked after' by their local authority but remain living with their parents/carers. This group are often referred to as 'looked after at home'.

A Children's Hearing determines how long a CSO will last, for up to a maximum of one year, or to the child's 18th birthday, whichever comes first. The CSO can be renewed, amended, or ended by a Children's Hearing.

(c) Living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities

The four countries of the United Kingdom maintain a reciprocal agreement, set out in law, to recognise the legal orders by which children become 'looked after' in each of the different UK legal jurisdictions. Therefore, a child living in Scotland may be considered to be 'looked after' if they are subject to an English, Welsh or Northern Irish order which, under regulations made under section 33 of the 1995 Act or section 190 of the 2011 Act, a Scottish local authority has recognised as equivalent to a compulsory supervision order (as made by a Children's Hearing), accepting the legal responsibilities (duties) which come with it.

When a 'looked after child' moves to Scotland, the relevant English, Welsh or Northern Irish authorities must inform the Principal Reporter and the Scottish local authority to which the child is moving. Where appropriate, agreement is then reached to 'transfer' responsibility for the child's supervision, care and education to the Scottish local authority. The child then becomes a Scottish 'looked after' child, with their supervision reviewed and, if necessary, renewed through the Children's Hearing

system. This process also works in the other direction too. If a looked after child (subject to a compulsory supervision order) moves from Scotland to England, Wales or Northern Ireland, the relevant authorities in those jurisdictions recognise the child's legal status as 'looked after' and, where appropriate, will take on responsibility for the child's care and protection.

However, it is possible for a looked after children from England, Wales and Northern Ireland to live in Scotland without any transfer of 'looked after child' duties to a Scottish local authority. For instance, a child may be living in Scotland in a residential unit or with foster carers provided by the private or third sector, and continue to be under the supervision of the relevant English, Welsh or Northern Irish authority. This is also true in the reverse, with Scottish looked after children living with carers elsewhere in the UK. In these circumstances specific arrangements (concerning the child's education, care and health) are made between the placing authority (from England, Wales, Northern Ireland or Scotland) and the relevant local authority and health board/trust in the part of the UK where the child is placed.

(d) Subject to a 'Permanence Order'

A Permanence Order transfers certain parental rights to a child's local authority, including the right to regulate the child's residence (up until the child's 18th birthday). It is a long-term measure of care, used to secure permanence (i.e. physical and emotional stability with one set of carers) for a child who has no reasonable prospect of returning to live with their biological family, but for whom adoption is not appropriate or desirable at this particular time. Once a Permanence Order is in place, a compulsory supervision order, which must be reviewed at least every year, can be removed.

A child provided with long-term accommodation under a Permanence Order is considered a 'looked after child', and all the specific and general duties of corporate parents apply.

Children in other alternative care arrangements

It is important to note that many children in Scotland live in alternative care arrangements (i.e. not with their biological parents) but are not considered to be 'looked after'. This group includes children who have been adopted (under an Adoption Order), those who are living with friends and relatives (either in a private family arrangement or under a Kinship Care Order (Section 11 of the 1995 Act)) and those whose placement is secured by a Residence Order (Section 11 of the 1995 Act). The group also includes children who have been removed to a place of safety under a Child Protection Order.

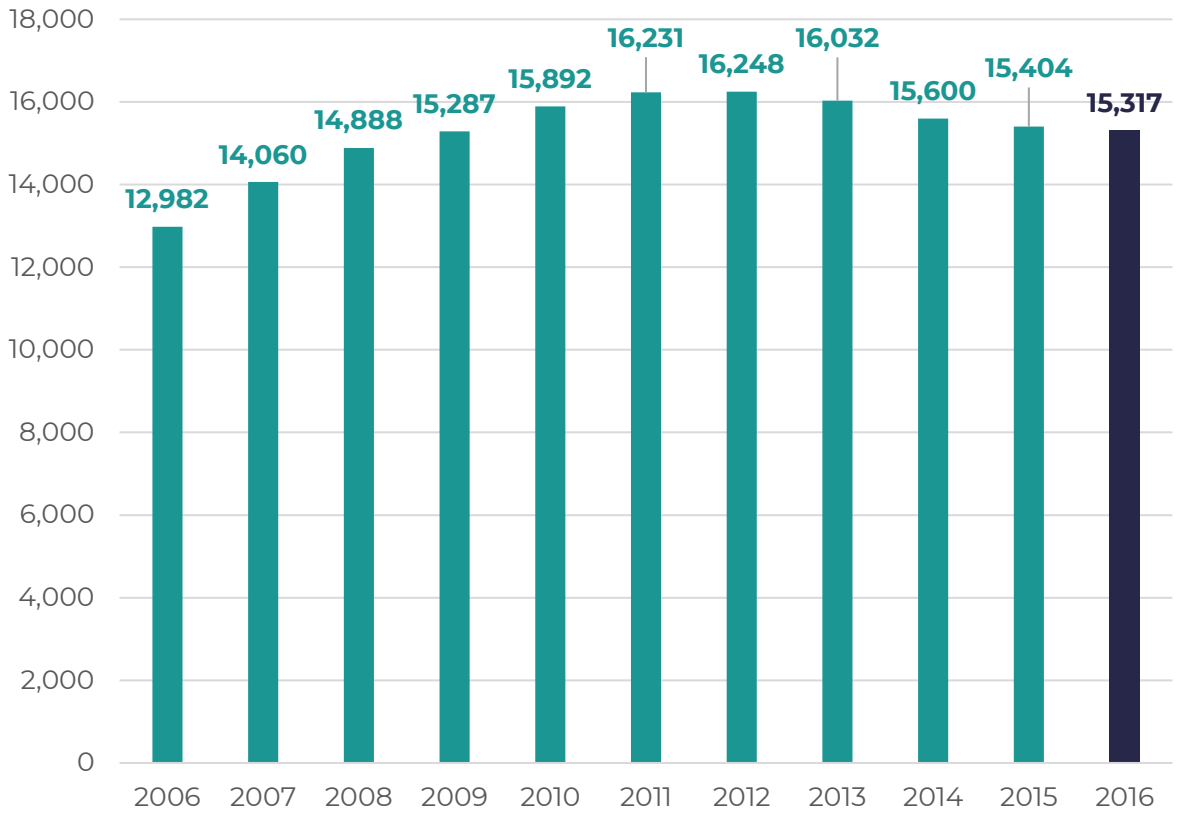
Public authorities are under a number of specific duties in respect of each of these groups. For instance, a child living with family under a Kinship Care Order may be eligible for regular financial support from their local authority. Similarly, a child removed to a place of safety under a Child Protection Order must be provided with accommodation and support by their local authority. However, while the law requires certain public authorities to treat these groups of children as if they were 'looked after' in some circumstances, they are not, under the parameters set out by section 17(6) of the 1995 Act, 'looked after children'. This means they are not covered by the complete range of statutory duties which apply to any looked after child (such as the duties for corporate parenting or Additional Support for Learning), and, critically for the purposes of this paper, will not necessarily be included in the statistics for 'looked after children' or 'care leavers'.

2. Children and young people who are 'looked after': population characteristics

Size of population

On 31 July 2016, the most recent date for which we have national data, the total number of children 'looked after' by a Scottish local authority was 15,317. This total includes children in all types of care setting, such as residential care (including residential schools and secure care), foster care, formal kinship care, and looked after at home. Chart 1 below shows how this total population has changed from 2006 to 2016.

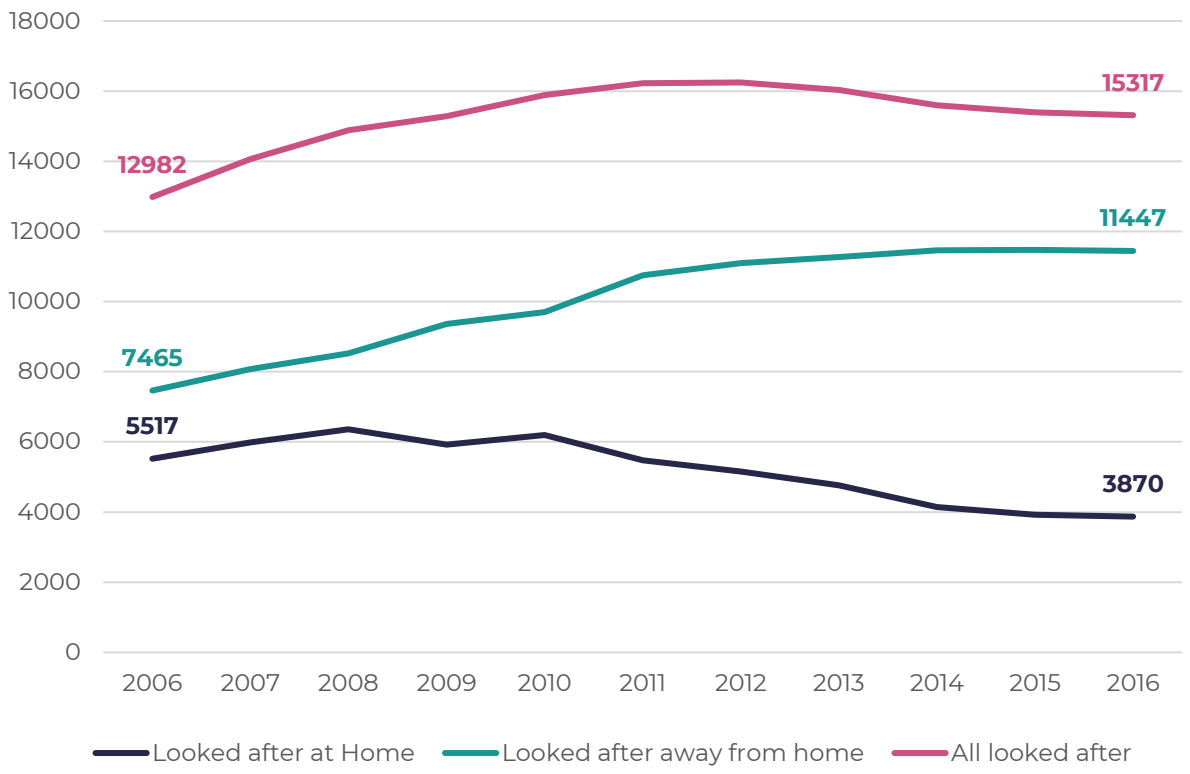
Chart 1: Total number of looked after children in Scotland, 2006 - 2016[3]



[3] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16:, Table 2.1: Number of children looked after, by age and gender, 2002-2016

The total number of children 'looked after' by Scottish local authorities has fallen steadily over the last four years (by 5.7% since 2012); see Chart 2 below. A number of factors will have contributed to this, but the fall does correlate closely with a sharp drop in the number of children 'looked after at home' (i.e. with parents). The reasons for this drop are unclear, but in the four years since 2012 this specific 'looked after' population decreased by nearly 25% (from 5,153 to 3,870 in 2016). Indeed, if children 'looked after at home' are excluded from the total, the number of children 'looked after and accommodated' (i.e. provided with accommodation away from their parents) actually continued to increase up until 2015. (For further detail please see Table 1, and the section below 'Placement Types'.)

Chart 2: Total number of looked after children in Scotland by placement type, 2006 - 2016[4]



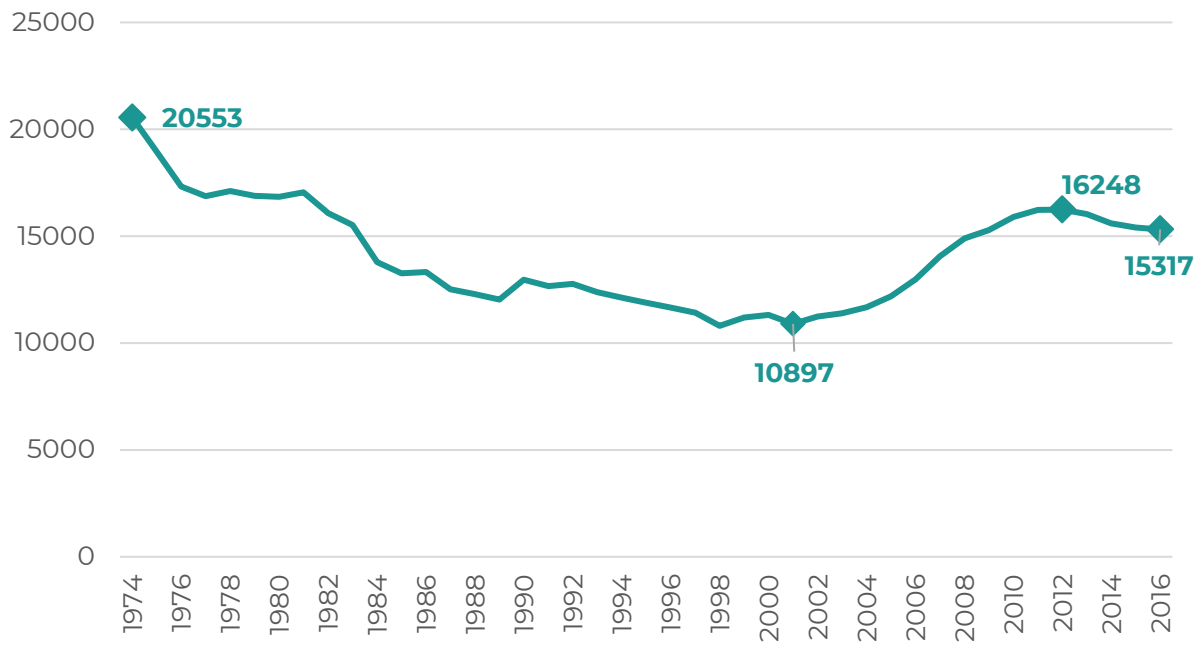
[4] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;, Table 2.2: Number of children looked after by type of accommodation, 2002-2016(1),(2)

Table 1: Number and proportion of children who are 'accommodated'[5]

	2012	2013	2014	2015	2016
Total Looked After Children	16,248	16,032	15,600	15,404	15,317
Total excluding 'at home'	11,095	11,270	11,458	11,477	11,447
% 'accommodated'	68.3	70.3	73.4	74.5	74.7

Viewed over decades, the size of Scotland's 'looked after child' population has fluctuated considerably. As Chart 3 below illustrates, from a peak in the mid-1970s the total number of children 'looked after' by Scottish local authorities fell intermittently until the late 1990's, from which it started to increase steadily again. Between 2001 and 2012 the number of 'looked after children' grew from 10,897 to 16,248; an increase of 49% over twelve years.

Chart 3: Total number of looked after children, 1972 - 2016[6]



[5] CELCIS calculations, based on data from Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;
[6] Scottish Government (2017) Children's Social Work Statistics Scotland, 2015-16;Table 1.1a: Number of children looked after by type of accommodation, 1971-2016(1),(2)

Increases and decreases in the size of the 'looked after' population will be linked to multiple, interrelated factors, including changes in policy or legislation, local government reorganisation, shifting social and political expectations (often in response to high-profile child protection cases) and technical changes in statistical questions or collection methods. Changes in the size of the overall child population may also be a factor, but probably only a very limited one. Between 2001 and 2012, when the 'looked after child' population grew by 49%, Scotland's under 18 year old population (0-17 years inclusive) actually fell by 5.4% (from 1,097,605 to 1,038,464).[7]

[7] General Records of Scotland (2014) Mid-year population estimates: Scotland and its Council areas by single year of age and sex: 1981 to 2013

Chart 4: Total 'Looked after Children' by Local Authority, on 31st July 2016[8]

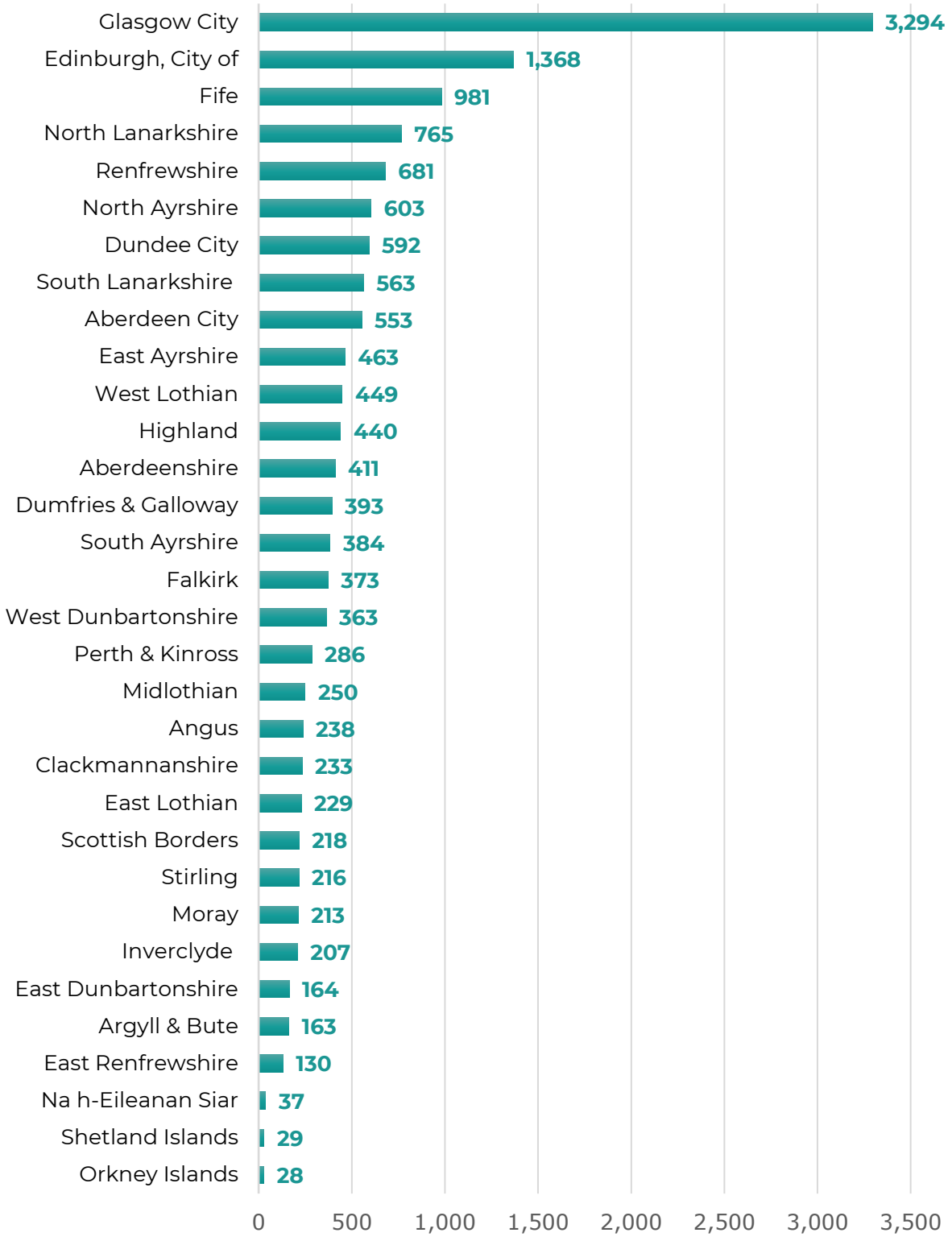
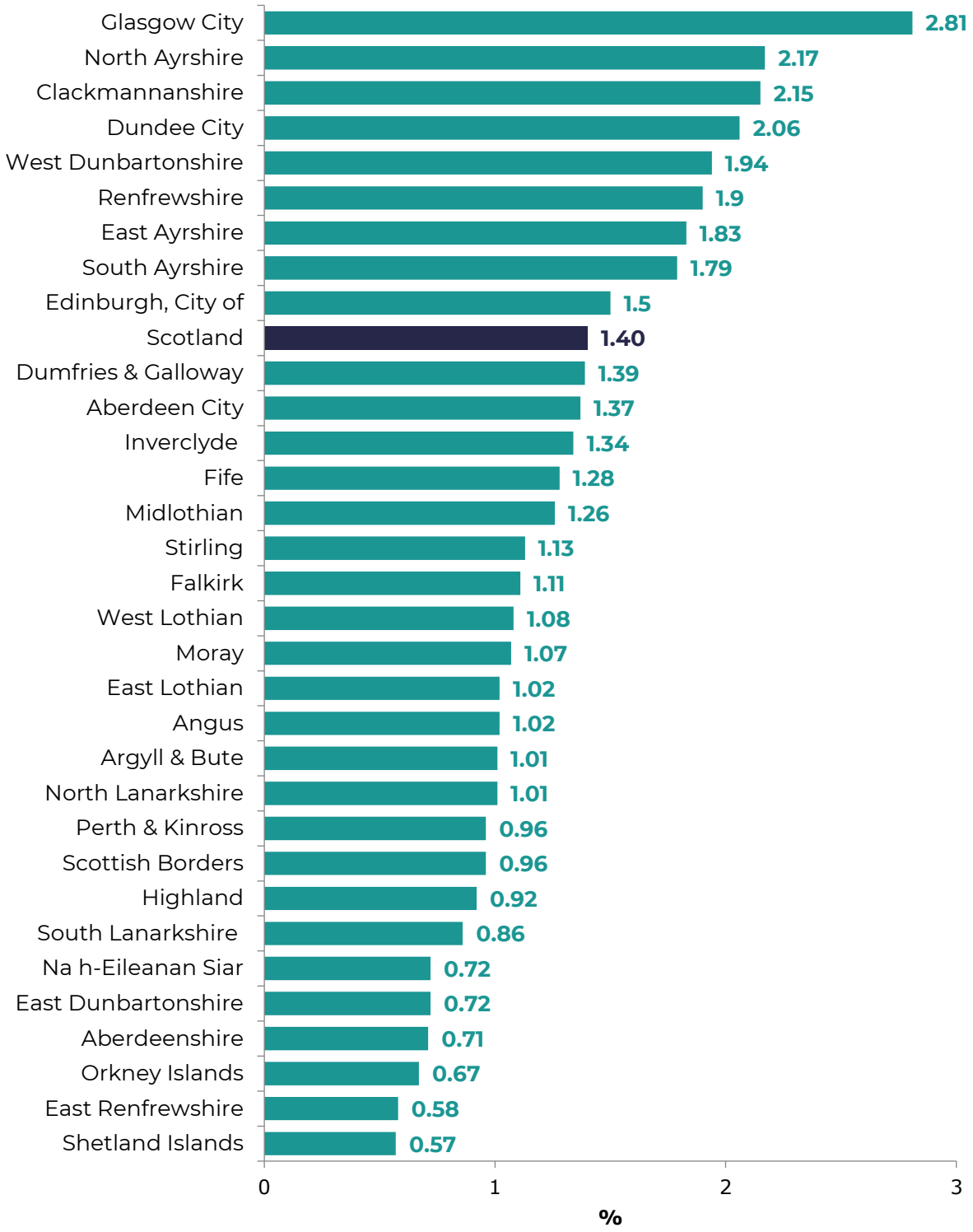


Chart 4 above provides a picture of Scotland's total looked after child population (at 31 July 2016), broken down by the local authority which is legally responsible for them. Unsurprisingly, the City of Glasgow, being the local authority area with the largest population (615,170), also had the highest number of looked after children (3,294). At the other end of the scale, Orkney, Scotland's smallest local authority population, also has the smallest number of looked after children (28).

[8] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16:, Table 3.3: Children looked after by type of accommodation and local authority; National Records of Scotland (2017)

Chart 5: Looked after Children by Local Authority, as proportion of Local Authority Child (0-18 years) Population, July 2016[9]



[9]Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;, Table 3.3: Children looked after by type of accommodation and local authority; National

However, as Chart 5 above illustrates, a large population number does not necessarily equate to high numbers of looked after children. North Ayrshire, for example, is home to 29,772 people aged between 0-18, placing the area near the population median among Scottish local authorities (i.e. in a biggest to smallest population ranking, it is 15th). But it has the sixth largest population of looked after children, at 603. Similarly, while Clackmannanshire has the smallest general population among mainland local authorities, at 51,350, and 10,845 0-18 year olds, its 233 looked after children means it has the second highest proportion, per head of total population, of all local authorities. (The reasons for these variances are explored in sections further below.)

In addition to local variance, it is also important to note that: (a) the total number of children 'looked after' by a Scottish local authority is not an accurate measure of how many looked after children actually reside in a local authority area, as children are frequently placed outwith their home local authority (i.e. with foster carers or in a residential school); and (b) the total number of Scottish looked after children is not necessarily equal to the number of looked after children living in Scotland. At any time a number of Scottish looked after children will be placed in other parts of the UK, and similarly English, Welsh and Northern Irish children will be placed in Scotland. No published data is available on the number of looked after children currently residing in geographical or administrative (e.g. local authority, NHS Health Board, etc.) areas.

Records of Scotland (2017) Mid-2016 population Estimates Scotland;, Table 3: Estimated population by sex, five year age group and administrative area, mid-2016

Gender

On 31 July 2016, 54% (8,280) of all looked after children were male, and 46% (7,037) female. As Table 2 below shows, these proportions hold fairly consistent across all age brackets. Within the total Scottish population of 0-21 year olds, 51% (662,642) are male, suggesting that males are slightly more likely than females to be in the 'care system'.[10]

Table 2: Children looked after on 31 July 2016, by age group and gender[11]

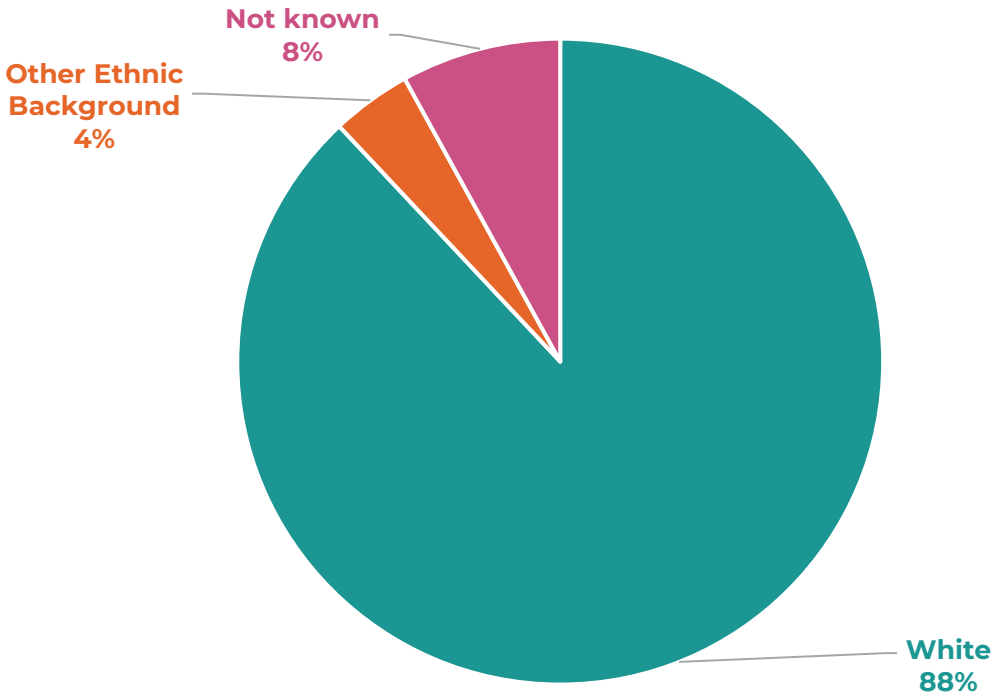
	Under 1	1-4	5-11	12-15	16-17	18-21	Total
Male	225	1,397	3,057	2,598	861	142	**8,280**
% Male	*52*	*53*	*54*	*55*	*53*	*54*	***54***
Female	204	1,239	2,602	2,100	771	121	**7,037**
% Female	*48*	*47*	*46*	*45*	*47*	*46*	***46***
Total	**429**	**2,636**	**5,659**	**4,698**	**1,632**	**263**	**15,317**

[10]National Records Scotland (2017) Estimated population by age and sex, Scotland, mid-2016
[11]Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16; Table 1.1

Ethnicity

In respect of their ethnicity, on 31 July 2016, over 88% of looked after children were recorded as 'white'. A further 4% (577) were recorded as having other ethnic backgrounds, including 'mixed ethnicity' (1.7% / 264), 'black, black Scottish or black British (0.7% / 101) and 'Asian, Asian Scottish or Asian British' (0.7% / 101). For 7.8% (1,202) their ethnicity was recorded as 'not known'.

Chart 6: Children looked after on 31 July 2016, by ethnic group[12]



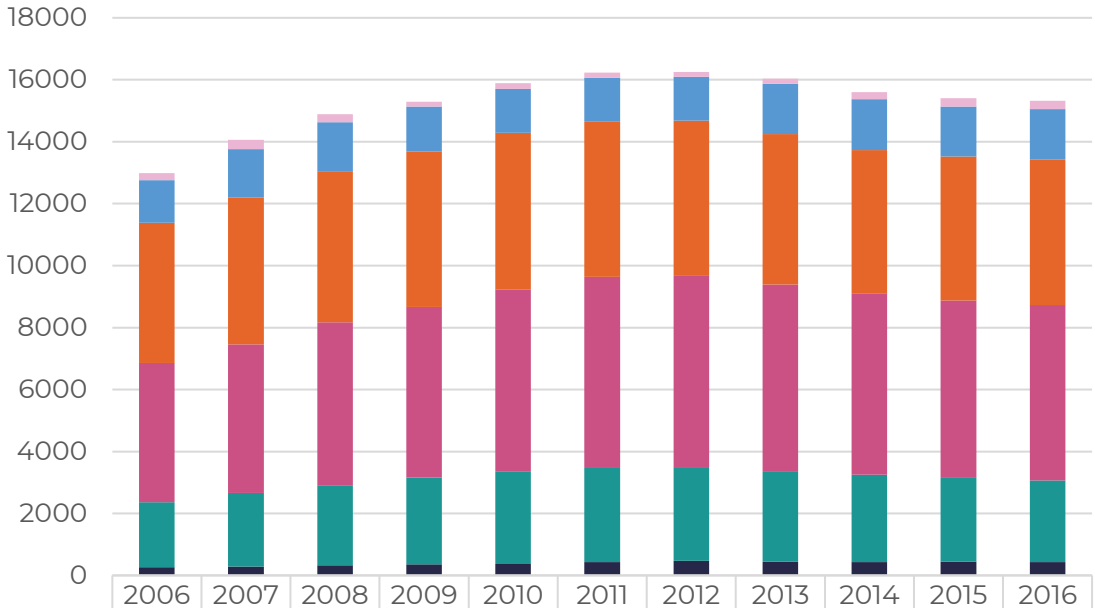
Across Scotland as whole, 97% of the population (all ages) were recorded as being of a 'white' ethnic background (including all white ethnic categories)[13] When contrasted with the data for looked after children, this may suggest that children and young people from 'non-white' ethnic backgrounds are disproportionally represented in the 'care system'.

[12]Ibid; Table 1.2
[13]Scottish Government (2017) Ethnic Breakdown of Scotland

Age

On 31 July 2016, 20% of the looked after population was aged 0 – 4 years old (pre-school); 37% was aged 5 – 11 (primary-school age); 31% was aged 12 – 15 years old; and 12% were aged 16 – 21. Children of compulsory school age (5 – 15 years old) comprised 68% (10,357) of the total.

Chart 7: No. of children looked after by age, 2006-2016[14]



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
18+	220	296	258	146	184	167	155	161	226	260	263
16-17	1379	1558	1605	1457	1423	1407	1413	1626	1644	1617	1632
12-15	4524	4746	4858	5017	5047	5021	5007	4851	4639	4648	4698
5-11	4495	4794	5255	5510	5897	6167	6204	6031	5834	5722	5659
1-4	2098	2382	2586	2800	2968	3036	3001	2919	2823	2712	2636
Under 1	266	284	326	357	373	433	468	444	434	441	429

Chart 7 above shows the total number of looked after children, by age, at the statistical 'year-end' (i.e. 31 July)[15] of 2006 to 2016. Although proportions in the various age brackets have remained broadly consistent over this time, it is interesting to note that the number of infants (under the age of 1), although a small group in terms of numbers, has gradually increased since 2006, rising from 2% (266) in 2006, to 3% (429) in 2016. Over the same

[14]Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16:, Table 2.1: Number of children looked after by age and gender, 2002-2016
[15]Up until 2008-09,

period the proportion of children aged 12 – 15 has fallen slightly, from 35% (4,524) to 31% (4,698).

The number of young people aged 18 and above who remain 'looked after' beyond their 18th birthday has consistently been a relatively small proportion of the total, sitting at just 2% (263) in 2016. But while the total number of looked after children has fallen over recent years, the numbers in this age group have actually risen, from 161 in 2013 to 263 in 2016. This may reflect policy changes introduced by Scottish Government through the Staying Put Scotland[16] guidance and the Children and Young People (Scotland) Act 2014[17].

Disability

On 31 July 2016, 1,797 (12%) of looked after children were recorded as having a disability, 10,994 (72%) had no disability recorded, and for 2,489 (16%) the disability status was not known.

Unfortunately it is not possible to provide a more detailed picture of looked after children's disability. Due to recent changes in the statistical return provided by local authorities to Scottish Government, the data for 2015-16 is not comparable to that collected in previous years. Furthermore, current disability data is not broken down (in a published form) by age, gender or placement type (apart for secure care, where 39% were recorded as having at least one disability).

The changes aim to bring Scottish statistical reporting into line with the rest of the UK, using the definition of 'disability' set out in the Equality Act 2010. From 2015-16, local authorities report on the question: "does the young person have a mental or physical impairment which has a substantial and long-term adverse effect on their ability to carry out

[16] Scottish Government (2017) Staying Put Scotland
[17] Scottish Government (2016) Children and Young People (Scotland) Act 2014: National Guidance on Part 12: Services in relation to Children at Risk of Becoming Looked After; Part One:Services In Relation To Children At Risk Of Becoming Looked After And The Legal Framework

normal day-today activities?" In previous years the statistical return asked local authorities to report on the additional support needs of those looked after children with a recorded disability; a confusing approach, which led to wide variance in the numbers reported between local authorities (due to differences in how 'additional support need' and 'disability' are understood, assessed and recorded). In 2014-15 data indicated a total of 13% of looked after children with a disability had an 'additional support need', with one local authority reporting 3% and another 44%. Such significant discrepancies between one local authority and another, in a context when every looked after child in Scotland is considered to have additional support for learning needs unless assessed otherwise[18], places a question mark over the reliability of such findings. Particularly, when the figures for Scotland are contrasted with data for English looked after children, which identifies 57% (20,220) of looked after children as having 'special educational needs'[19]. According to UNICEF data, of the 604,847 children in residential care in Eastern Europe and Central Asia, almost half (291,493) were recorded has having a disability[20].

Care Plans

Every looked after child or young person must be provided with a care plan by the local authority. This care plan should include important information for the child or young person's care, including areas such as care, education and health needs, as well as family links like sibling contact[21].

[18] Under the Education (Additional Support for Learning) (Scotland) Act 2004, as amended by the Education (Additional Support for Learning) (Scotland) Act 2009.
[19] UK Government (2017) Outcomes for children looked after by LAs: 31 March 2016; Table 4a: Number of children who have been looked after continuously looked after for at least twelve months, children in need and all children with special educational needs
[20] UNICEF (2010) A Home or in a Home?; Table 8.1 Children with disabilities in residential care in 2000, 2005 and 2007
[21] Scottish Government (2015) Getting It Right For Looked After Children And Young People Strategy;, Better outcomes for looked after children and young people

Table 3 below shows the number and percentage of looked after children and young people with and without a care plan, on 31 July 2016, broken down by type of care. Those children looked after at home or in kinship care were more likely to be without a care plan than those in foster care (92% and 87% for looked after at home and kinship care respectively, compared to 98% and 99% for foster care and residential care respectively). Overall, 94% of looked after children had a care plan in place. One reason why a child may not have had a care plan in place is timing; if they became looked after in the fortnight preceding the collection of statistics, their status as a looked after child would be recorded, but a care plan not yet prepared.

Table 3: Children looked after with and without a current care plan, at 31 July 2016[22]

Accommodation Type	With a current care plan	Without a current care plan	Total	With a care plan (%)	Without a care plan (%)
Looked After at Home	3,561	309	3,870	92	8
Kinship Care	3,712	567	4,279	87	13
Foster Care	5,309	83	5,392	98	2
Residential Care	1,459	18	1,477	99	1
Total	**14,041**	**977**	**15,018**	**94**	**6**

Placement type

As suggested in sections above, there are a variety of distinct 'types' of care placement. The statistics divides these into two broad groups: 'in the community' (looked after at home; kinship care; foster care; prospective adopters; and, other community) and 'residential accommodation' (all forms of residential care and education). Within these broad groups the

[22]Scottish Government (2017) Children's Social Work Statistics Scotland 2015/16;, Table 1.2: Children looked after with and without a current care plan, at 31 July 2016

numbers are then sub-divided further, between specific types of care, such as foster care, kinship care, residential schools and secure.

In 2016, children in 'foster care' represented the largest placement type, comprising 35% (5,392) of all looked after children (15,317). 'Kinship care' and 'looked after at home' were the next largest placement types, at 28% (4,279) and 25% (3,870) respectively. Within residential care (constituting 10% of the total, or 1,477 children), 7% (717) were in some form of residential home, 2% (376) in a residential school, and 0.05% (60) in secure care.

Table 4 below also shows that the proportions of children in various placement types varies considerably when further subdivided by children's age. In 2016, over 99% (8,572) of children under the age of 12 were in 'community' placements (e.g. foster care, looked after at home, kinship care). Of the 60 looked after children in secure care, all were between the age of 12 and 17.

Over the past 15 years, the proportions of the population in the two broad groups ('community' and 'residential') has remained broadly consistent, with approximately 90% considered 'in the community' and 10% in 'residential accommodation' in any given year. But beneath those heading, the proportions of looked after children in the various, distinct placement types has changed considerably. For example, between 2012 and 2016 the proportion of children looked after at home fell by 24%, from 5,123 to 3,870. At the same time, increasing numbers of children were looked after in kinship care, which grew from 4,076 to 4,279. The 2015-16 year actually saw a small decline in the number being fostered, but looked at over a longer period, foster care has expanded dramatically in Scotland; between 2002 and 2016 the number of children in foster care increased by 70%, from 3,170 to 5,392. As a proportion of the total 'in care' population, foster care grew from 28% to 35% over this period[23].

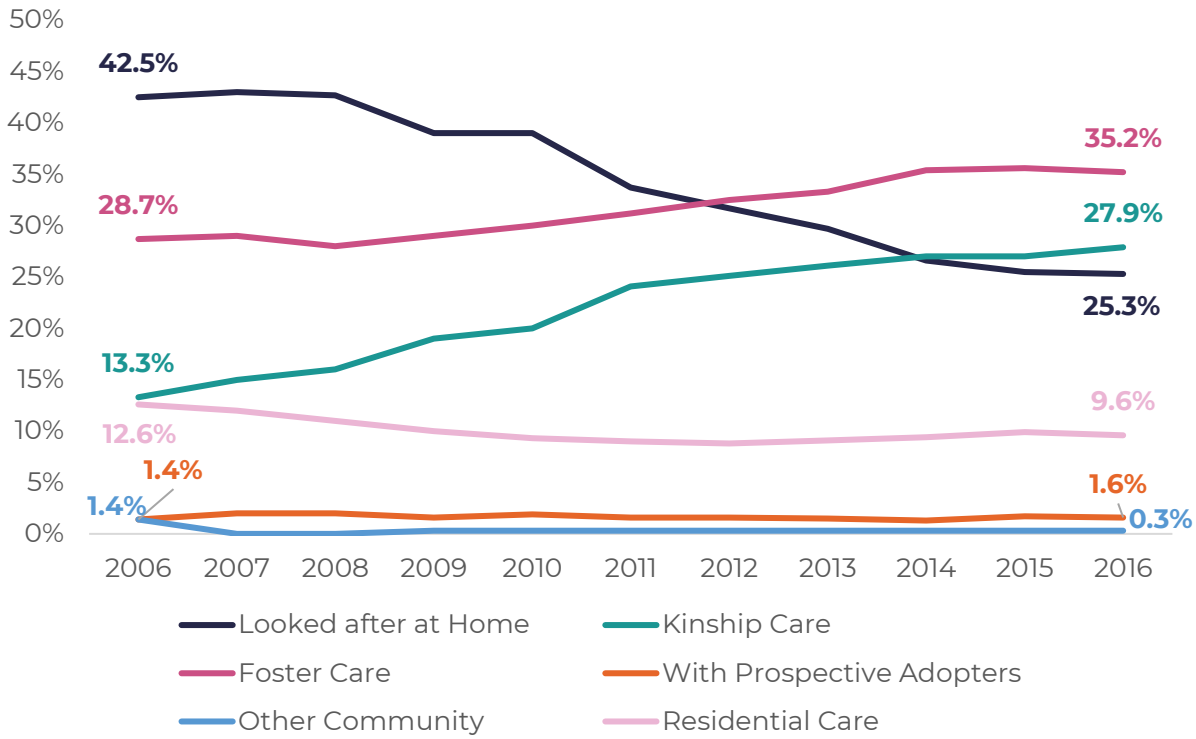
[23]Scottish Government (2017) Children's Social Work Statistics Scotland, 2015-16; Placement Type

Table 4: Children looked after on 31 July 2016, by placement and age[24]

Type of accommodation	Age Group					
	<5	5-11	12-15	16-17	18+	Total
In the community:	**3,060**	**5,512**	**3,898**	**1,185**	**185**	**13,840**
Looked after at Home	784	1,520	1,277	272	17	**3,870**
Kinship Care (with friends / relatives)	920	1,924	1,081	309	45	**4,279**
Foster Care provided by Local Authority	1,037	1,349	964	390	86	**3,826**
Foster Care purchased by Local Authority	0	649	569	178	0	**1,566**
With prospective adopters	179	67	0	0	0	**251**
In other community	0	0	0	35	5	**48**
Residential Accommodation:	**5**	**147**	**800**	**447**	**78**	**1,477**
In local authority home	0	35	308	201	35	**581**
In voluntary home	0	20	71	42	*	**136**
In residential school	0	59	229	84	0	**376**
In secure accommodation	0	0	33	27	0	**60**
In other residential	0	0	159	93	36	**324**
Total looked after children	**3,065**	**5,659**	**4,698**	**1,632**	**263**	**15,317**

[24]Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16; Table 1.4: Children looked after at 31 July 2016(1),(2) by type of accommodation

Chart 8: Looked after children by placement type (% of total), 2006-16[25]



Within foster care and residential care specifically, there is a further subdivision: (a) children accommodated with carers provided by the local authority, or (b) children accommodated with carers purchased through an independent agency (such as Kibble, Care Visions, Barnardo's, Aberlour, Harmeny School, etc.). As the data in Table 4 above shows, in 2016 the proportion of foster carer placements provided directly by Scottish local authorities was 71%, and those purchased from independent agencies 29%. In residential care (excluding residential schools, secure, etc.) the proportions were 81% in local authority provided homes, and 19% in homes purchased from independent agencies.[26] Foster care purchased by the local authority has grown significantly over recent years, from 20% to 29% of all foster care between 2009 and 2016.

[25] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;, Table 2.2: Number of children looked after by type of accommodation, 2002-2016
[26] At the time of writing (October 2017) X secure units provide care and protection in Scotland, of which only one (St Mary's, Edinburgh) is operated by a local authority.

Table 5: Proportions of children in local authority or purchased placements, foster care and residential care, 2009 – 2016[27]

	2009	2010	2011	2012	2013	2014	2015	2016
Foster care total	**4,499**	**4,697**	**5,068**	**5,279**	**5,333**	**5,522**	**5,478**	**5,392**
With Foster Carers provided by LA	3,594	3,651	3,871	3,946	3906	4002	3891	3826
% of total	80	78	76	75	73	72	71	71
With Foster Carers purchased by LA	905	1,046	1,197	1,333	1427	1520	1587	1566
% of total	20	22	24	25	27	28	29	29
Residential Home total	**749**	**702**	**703**	**654**	**687**	**696**	**697**	**717**
In Residential Home provided by LA	611	620	615	564	575	579	564	581
% of total	82	88	87	86	84	83	81	81
In Residential Home purchased by LA	138	82	88	90	112	117	133	136
% of total	18	12	13	14	16	17	19	19

Unfortunately there is no data currently published on the number of placement moves that a child or young person experiences over their full time in care (although it would be possible to generate such figures for a significant proportion of looked after children). From the available data, which relates only to placement moves within a year, 79% of looked after children remained in the one care placement in 2015, 15% had two, and 6%

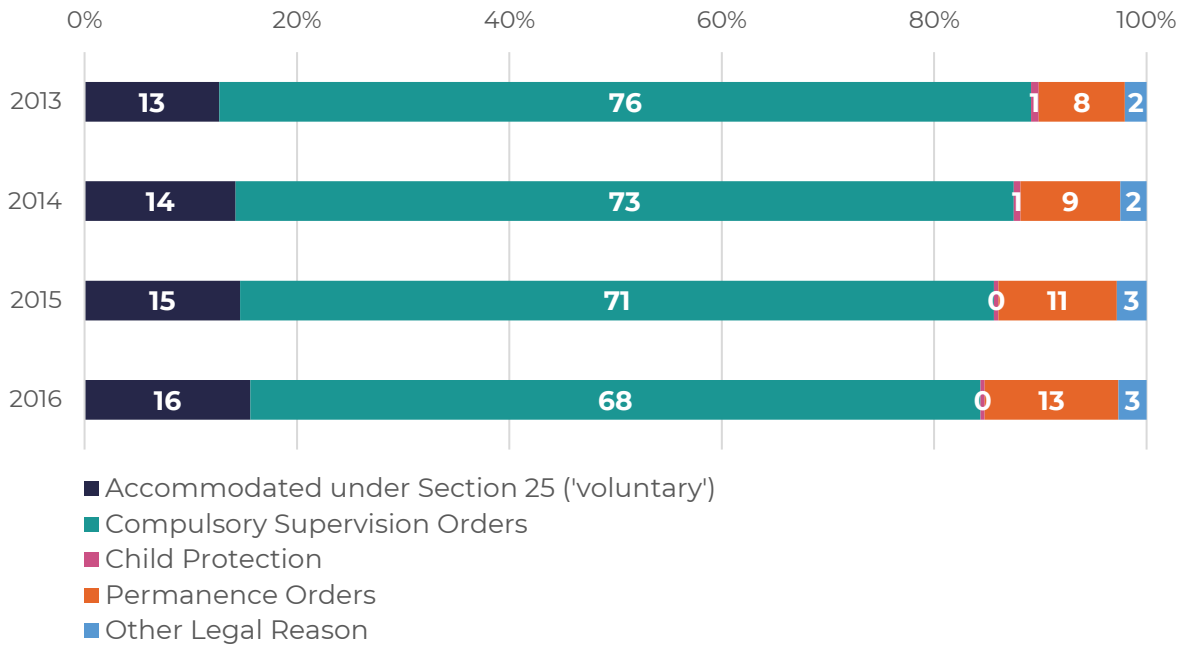
[27] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16:, Table 2.2: Number of children looked after by type of accommodation, 2002-2016

with three or more placements.[28] English data for 2017 shows that, within their population of looked after children, 65% remained in one placement, and 35% had two or more placements in 2017.[29]

Legal basis on which child is looked after

As outlined in the 'Definition of a Looked After Child' section above, children and young people enter (and remain in) the 'care system' through a variety of legal mechanisms. On 31 July 2016, of all the children who were 'looked after', 68% (10,545) were subject of a Compulsory Supervision Order issued by a Children's Hearing. Less than 1% (61) were looked after by means of a Child Protection measure. Over 16% (2,394) were looked after under Section 25 of the 1995 Act (i.e. on a voluntary arrangement between family and local authority), 13% (1,931) were on Permanence Orders, and another 3% (408) were looked after under 'another legal reason'.

Chart 9: Children looked after by legal reason, 2013-2016[30]



[28] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;,Table 2.6: Number of looked after children by number of placements during the past year(1), 2012-16(2)
[29] UK Government (2017) Children Looked after in England including adoption: 2016 to 2017; Table A2: Children looked after at 31 March by placement
[30] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;, Table 2.2: Number of children looked after by type of accommodation, 2002-2016

As Chart 9 above illustrates, 'compulsory measures' (such as compulsory supervision orders or child protection) are the most common legal basis for a child or young person being 'looked after'. However, it is of note that the proportion of children subject to compulsory measures has dropped by nearly 9% since 2012, offset by increases in the number of children secured in care placements by means of a Permanence Order, and by children being provided with accommodation under Section 25 of the 1995 Act.

In addition, please note that in a small number of cases children may have more than one 'legal status'. Such situations are rare, but an example would be a young person with a Permanence Order, but who is later subject to a Compulsory Supervision Order because they've committed an offence. This may explain why the total 'legal reasons' on 31 July 2016 (15,339) is higher than the total number of looked after children (15,317).

Data published by Scottish Government shows the legal status of looked after children on 31 July of each year, therefore showing us only their legal status on that day, and not, for example, the legal reason by which they became looked after, or the various legal reasons they have been subject to while in care. Although this data is not published, the Children's Looked After Statistical return from local authorities is provided at an individual child level, and it should be possible to provide such figures on request.

Unaccompanied Children

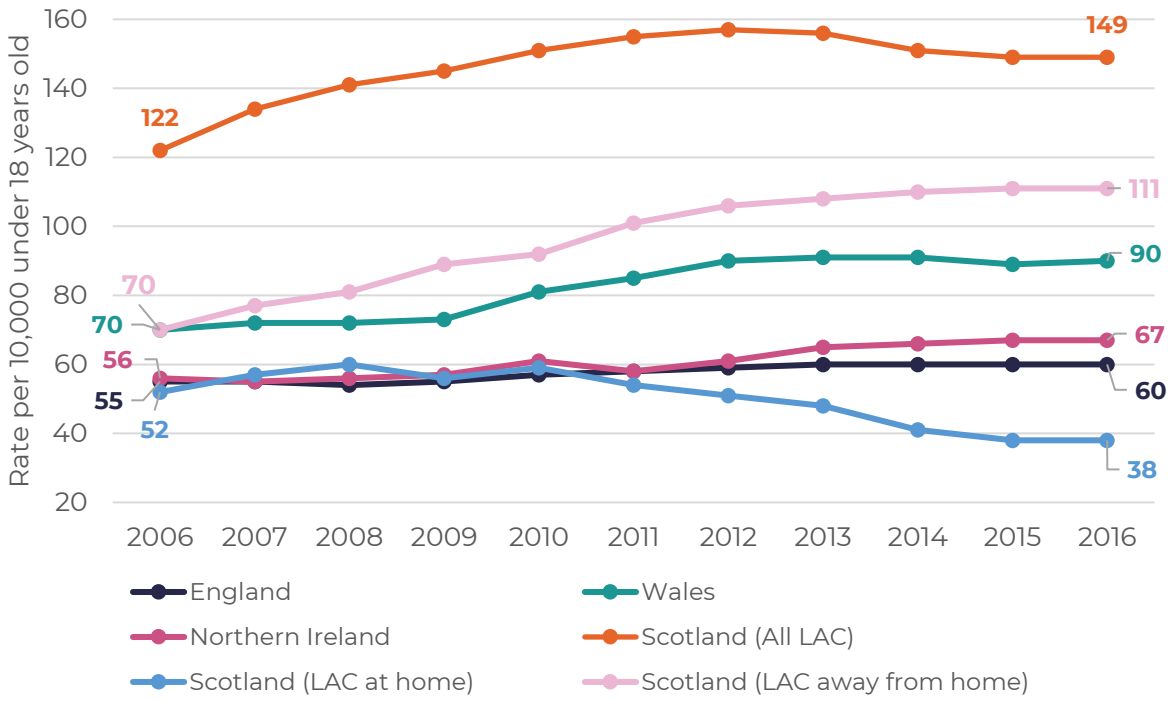
Current statistical data does not distinguish those children who are looked after due to their status as 'unaccompanied children' (e.g. refugees, or abandoned by parents who were illegal economic migrants). The Scottish Government estimate that as approximately five unaccompanied children arrive in Scotland each month[31]. By comparison, Kent local authority (which incorporates Dover, is the nearest English local authority to the Calais 'Jungle' refugee camp) received over 1,000 unaccompanied children

[31] Scottish Government (2017) Refugees and Asylum Seekers; Unaccompanied Children

in 2015.[32] However, whilst the numbers in Scotland are relatively small, the specific needs of such children present local authorities with particular challenges, in terms of care placements and integration, ensuring their culture and beliefs are respected and catered for.

UK Comparison of number of looked after children

Chart 10: Cross-UK comparison of rate of looked after children per 10,000 of the population of 0-18 year olds, 2006-2016[33]



How does Scotland's population compare, in terms of size, to other parts of the UK? Chart 10, above, shows the rate of looked after children per 10,000 under 18 year olds (in the general population). Like Scotland, the rate of looked after children in England, Northern Ireland and Wales increased over the past decade, but has remained relatively static over recent years. In Scotland the rate decreased slightly from 157 per 10,000 in 2012, to 149 in

[32] The Home Office (2015) Letter to Council Leaders Areas on Dispersal of Unaccompanied Asylum Seeking Children;
[33] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;, Table 2.9: Cross UK comparison of the number looked after children and rate per 10,000 children under 18, 2005-2016

2016, while Northern Ireland and Wales saw small increases (see Table 6 below).

Even when children 'looked after at home' are excluded from the Scottish total (as it is a placement much less common in the rest of the UK), the rate per head is still significantly higher than other countries in the UK: 111 out of every 10,000 Scottish under 18's were looked after (and accommodated) in 2016, compared with rates of 90 for Wales, 67 for Northern Ireland and 59 for England.

Table 6: Number of looked after children, 2012 – 2016, UK comparison[34]

	2012	2013	2014	2015	2016
England	67,070	68,060	68,810	69,480	70,440
Wales	5,730	5,770	5,745	5,615	5,660
Northern Ireland	2,640	2,810	2,860	2,875	2,890
Scotland (All LAC)	16,360	16,170	15,625	15,360	15,330
Scotland (LAC at home)	5,300	4,950	4,255	3,935	3,880
Scotland (LAC away from home)	11,060	11,220	11,370	11,425	11,450

Table 7: Rate of children looked after per 10,000 children under 18, 2012-2016

	2012	2013	2014	2015	2016
England	59	60	60	60	60
Wales	90	91	91	89	90
Northern Ireland	61	65	66	67	67
Scotland (All looked after)	157	156	151	149	149
Scotland (looked after at home)	51	48	41	38	38
Scotland (looked after away from home)	106	108	110	111	111

[34] Ibid

However, any such cross-border or international comparison of statistics must be treated with caution. Within the UK alone there are key differences in looked after children's legislation, decision making structures, and other critical process. Whilst the available statistics do show higher numbers of looked after children in Scotland than the rest of the UK, what they do not show is the differences in how kinship placements are managed and recorded between different UK countries, or the varied approaches to securing permanence for children. But even within this mix, Scotland's system is particularly distinct. The Children's Hearings System[35] has access to legal orders with no ready equivalent anywhere else in the UK (such as Permanence Orders), and the significant majority of care placements are provided directly by public authorities (rather than purchased from the third or private sector). In England, 'friends and relatives' who are potential carers are (in theory) assessed as foster carers, or for residence / special guardianship orders; in Scotland it is rare for 'friends and relatives' to be assessed and approved as foster carers, remaining instead in their own category (found only in Scotland) of 'kinship care'. (Kinship care exists extensively across the UK, but only in Scotland is it a formal placement type for looked after children, distinct from foster care.)[36]

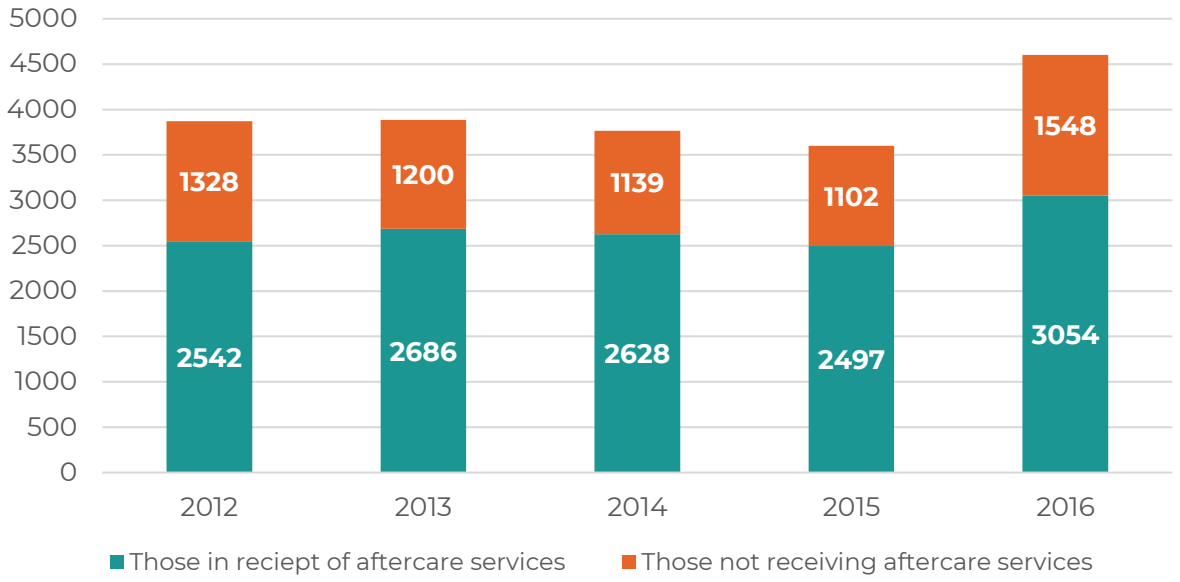
[35] Children's Hearings Scotland The Children's Hearings System
[36] Scottish Government (2017) Looked After Children

3. Young people who are 'care leavers': Population characteristics

Numbers

On 31 July 2016, there were 4,602 young people (aged 16 – 25 inclusive) who were 'care leavers'. These are young people who, under the current provisions of Section 29 of the Children (Scotland) Act 1995, are entitled to advice, guidance and assistance (i.e. 'aftercare') from a local authority.

Chart 11: Number of young people eligible for aftercare services, by receiving / not receiving, 2012 - 2016

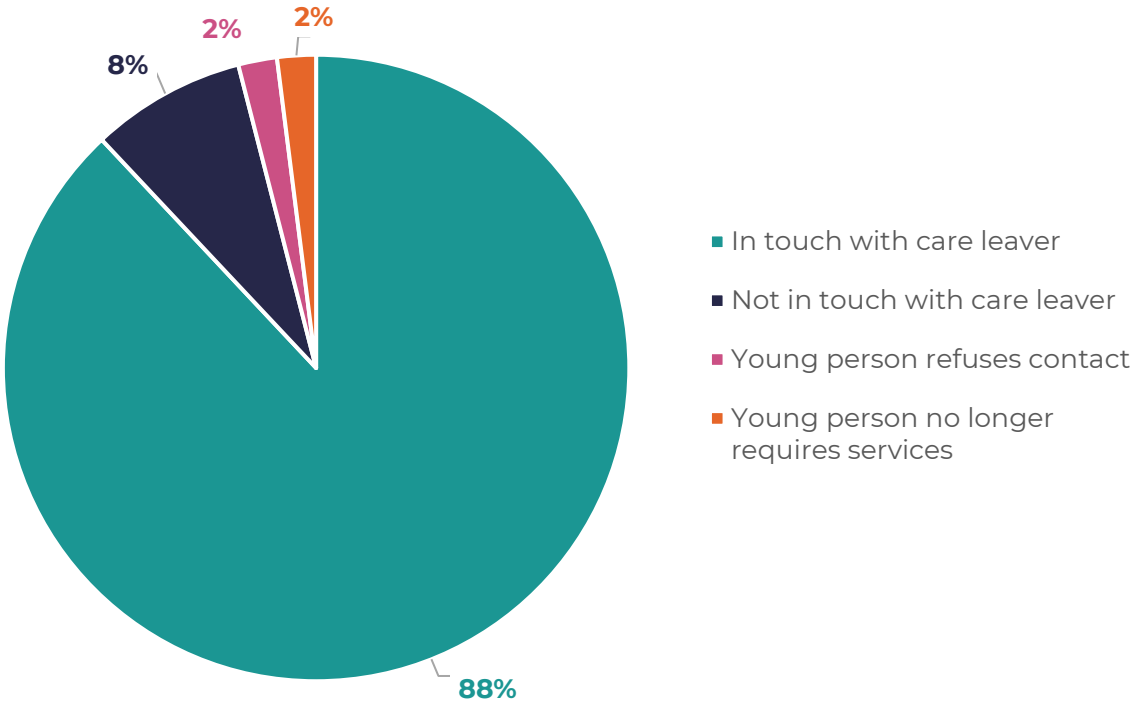


After a period of gradual decline in the number of care leavers, 2015-16 saw a significant increase on the previous year (up 28%). This is likely to be due to the expansion of aftercare eligibility in the Children and Young People (Scotland) Act 2014, which raised the age up to which young people were entitled to assistance from their local authority, from their 21st birthday to 26th birthday.

Chart 11 above also provides an insight into the numbers of eligible young people who are in receipt of aftercare services. In 2016, 66% (3054) were in receipt of some form of aftercare support from their local authority. The remaining 34% (1548) were not receiving services, but this does not

necessarily mean they are out of contact with the local authority, or that support is not available to them. However, it is interesting to contrast the Scottish picture with that in the other parts of the UK. Their statistics focus on whether the local authority is still in contact with the care leaver, providing more detail on the relationship. In 2016, 88% of English care leavers were reported to be in contact with their local authority, a further 10% had either rejected contact or were out of touch, and 2% were no longer in need of support (see Chart 12 below). In Wales, 93% (465) of their 495 care leavers were reported as still being in touch in with statutory services[37].

Chart 12: Proportions of English Care Leavers 'in contact' with their local authority, 2016,[38]



[37] Welsh Government (2017) Care leavers on their 19th birthday during year ending 31 March by local authority and number or per cent in touch
[38] UK Government (2017) Children Looked after in England including adoption: 2016 to 2017; Table F1: Care leavers now aged 19, 20 and 21 years old by gender, contact with the local authority and activity

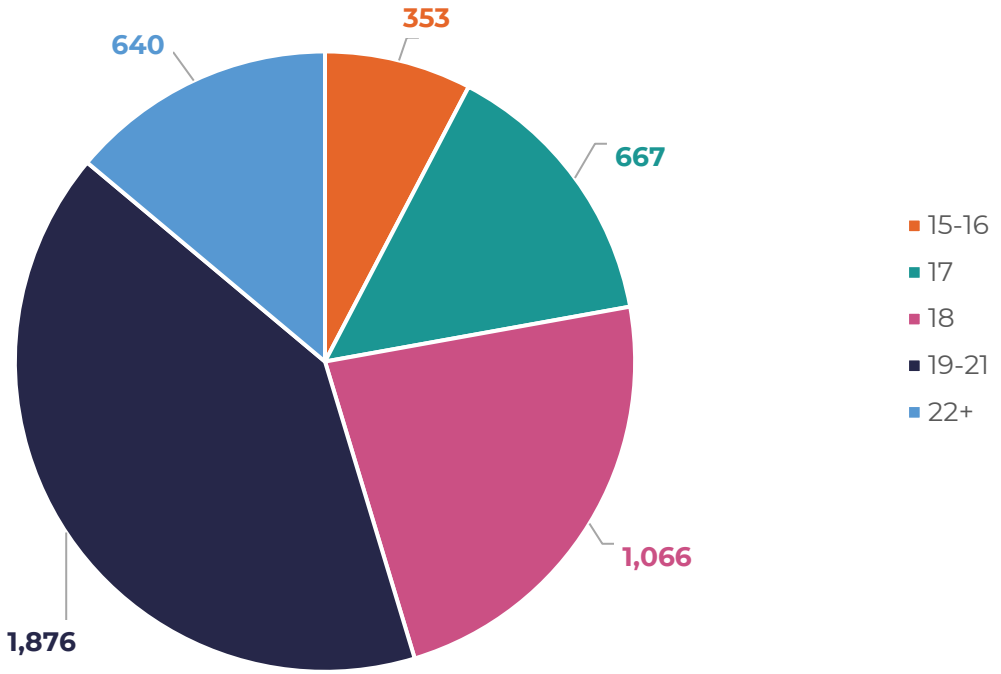
Gender

The gender split of young people eligible for aftercare mirrors the gender proportions of the looked after children population. On 31 July 2016, 53.8% (2,475) were male, and 46.2% (2,127) were female.

Age

Young people become eligible for aftercare if they "cease to be looked after" (i.e. leave care) on or after their 16th birthday. In a small number of cases, a young person may cease to be looked after just before their 16th birthday (by virtue of their Compulsory Supervision Order's end-date); local authorities will usually treat these young people as if they left care after their 16th birthday.

Chart 13: Young people eligible for aftercare, by age, on 31 July 2016[39]



[39] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16:, Social Work Stats Additional Tables - Table 1.18-20

Accommodation

On 31 July 2016, of the 2,659 young people eligible for aftercare for whom their current accommodation was known, 45% (922) were living at home with parents, or with friends and relatives. Another 61% (1,246) were living either their own tenancy or some form of semi-independent living. A further 10% (209) were living with former foster carers or in residential care (a number which should increase in future years, following the introduction of 'Continuing Care'). 6% (125) were officially homeless, and 4% (75) were in custody.

Table 8: Young people eligible for aftercare, by age and current accommodation, on 31 July 2016[40]

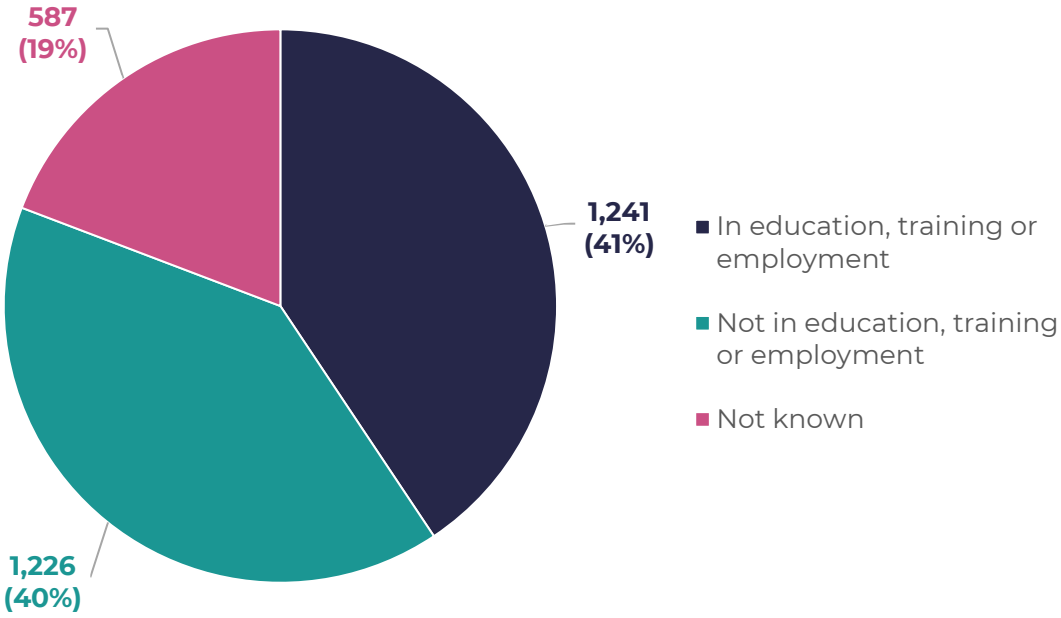
	15-16	17	18	19-21	22+	All ages
Home with biological parents	79	106	96	233	35	549
With friends / relatives	38	67	91	162	15	373
Own tenancy / independent living	21	70	147	405	89	732
Supported accommodation	22	66	114	258	54	514
Former foster carers	0	13	40	62	0	125
In residential care	11	7	27	33	6	84
Homeless	7	27	29	53	9	125
In custody	0	12	11	38	0	75
Other destination	5	13	20	35	9	82
Not known	32	78	121	145	19	395
Not receiving aftercare	132	208	370	452	386	1548
Total	**353**	**667**	**1066**	**1876**	**640**	**4602**

[40] Ibid

Employment, Education and Training

On 31 July 2016, of those young people who were in receipt of aftercare services from a local authority (total = 3,054), nearly 41% (1,241) were in education, training or employment. Of these, 287 were in higher education (HE), 299 were in education other than HE (including school and college), and 655 were in training or employment.

Chart 14: Employment, Education and Training status of Scottish young people in receipt of aftercare services, on 31 July 2016[41]



Of the 40% (1,226) recorded as not being in education, training or employment, a significant number (131) were not able to be due to illness or disability, and a further 111 were looking after family members.

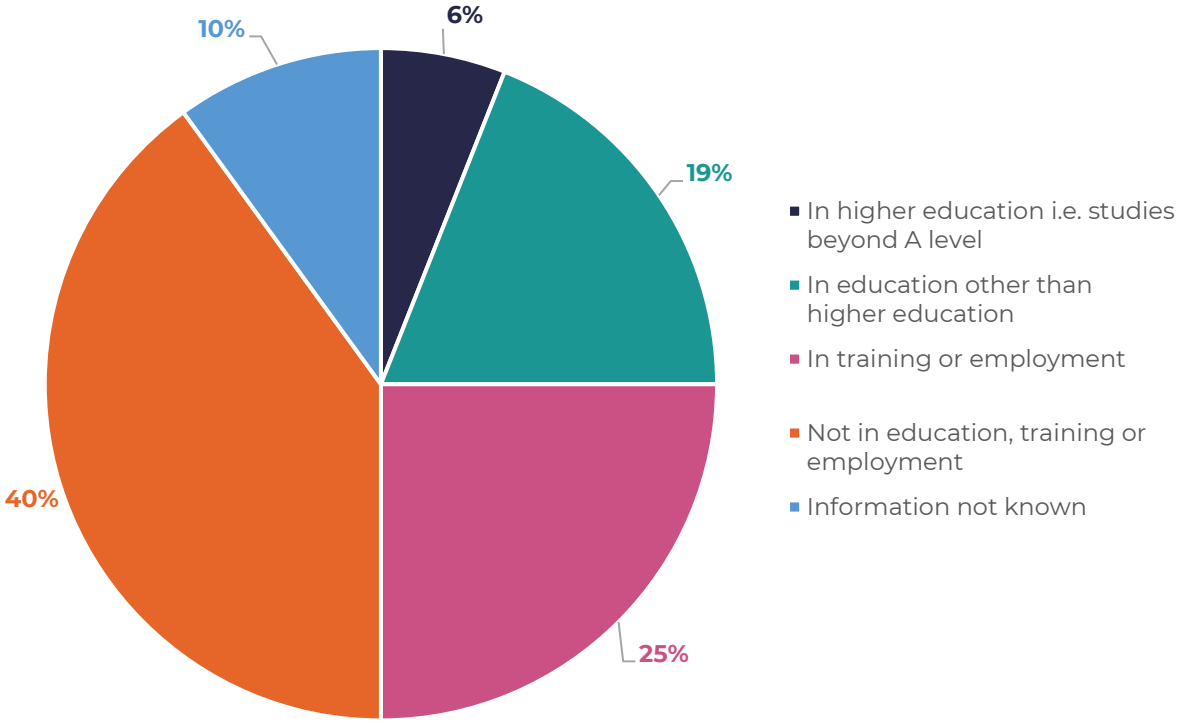
For 19% (587) of young people in receipt of aftercare services, their activity/status was "unknown". This number can be added to the 1,548 young people who were not receiving aftercare on 31 July 2016, and for whom, therefore, we have no indication of their education, employment

[41]Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16:, Social Work Stats Additional Tables - Table 1.18-20

and training status. This means we do not have data for over 50% of care leavers.

Scotland's numbers are similar to those from England (see Chart 15 below), which show for all care leavers aged 18-21 years old in 2015, 40% were not in any form of education, training or employment.

Chart 15: Education, Employment or Training status of care leavers in England, 2015[42]



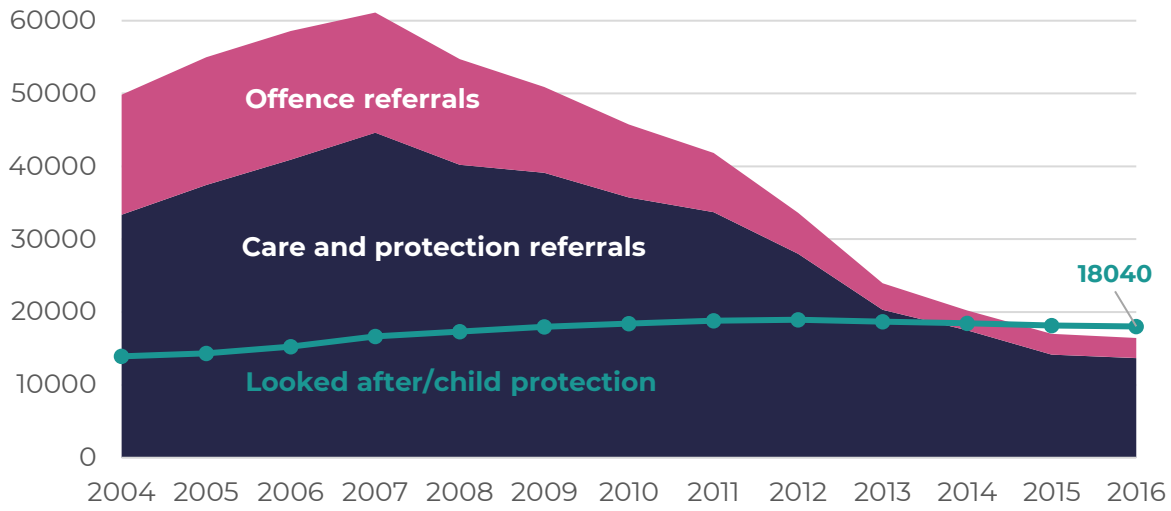
[42] UK Government (2017) Children looked after in England Including Adoption: 2016 to 2017:, Table F1: Care leavers now aged 19, 20 and 21 years old by gender, contact with the local authority and activity1,2

4. Care pathways

Coming into Care

Children and young people come into the 'care system' for a number of different reasons. A child's complex additional support needs (e.g. disability), issues at school and offending behaviour are all reasons why a child can become 'looked after'. But, in the majority of cases, it is the need to secure 'care and protection' for a child which constitutes the principle (if not exclusive) reason for bringing a child into care.

Chart 16: Children Referred to the Children's Reporter and numbers looked after/on child protection register, 2004-2016[43]



Interestingly, as the graphic above illustrates, the number of children and young people referred to the Children's Reporter has decreased dramatically over the past decade, by almost 67% (from 49,850 to 16,449)[44]. The decrease is reflected in both offence and non-offence referrals. (An offence referral would constitute the children or young person committing an offence, whereas a non-offence referral would specifically be focussed on concerns around the welfare of the child.) The reasons for this fall are

[43] Scottish Government (2017) Children's Social Work Statistics Scotland, 2015-16;, What are the trends in other children's social work data
[44] Scottish Government (2017) Children's Social Work Statistics Scotland, 2015-16;, What are the trends in other children's social work data

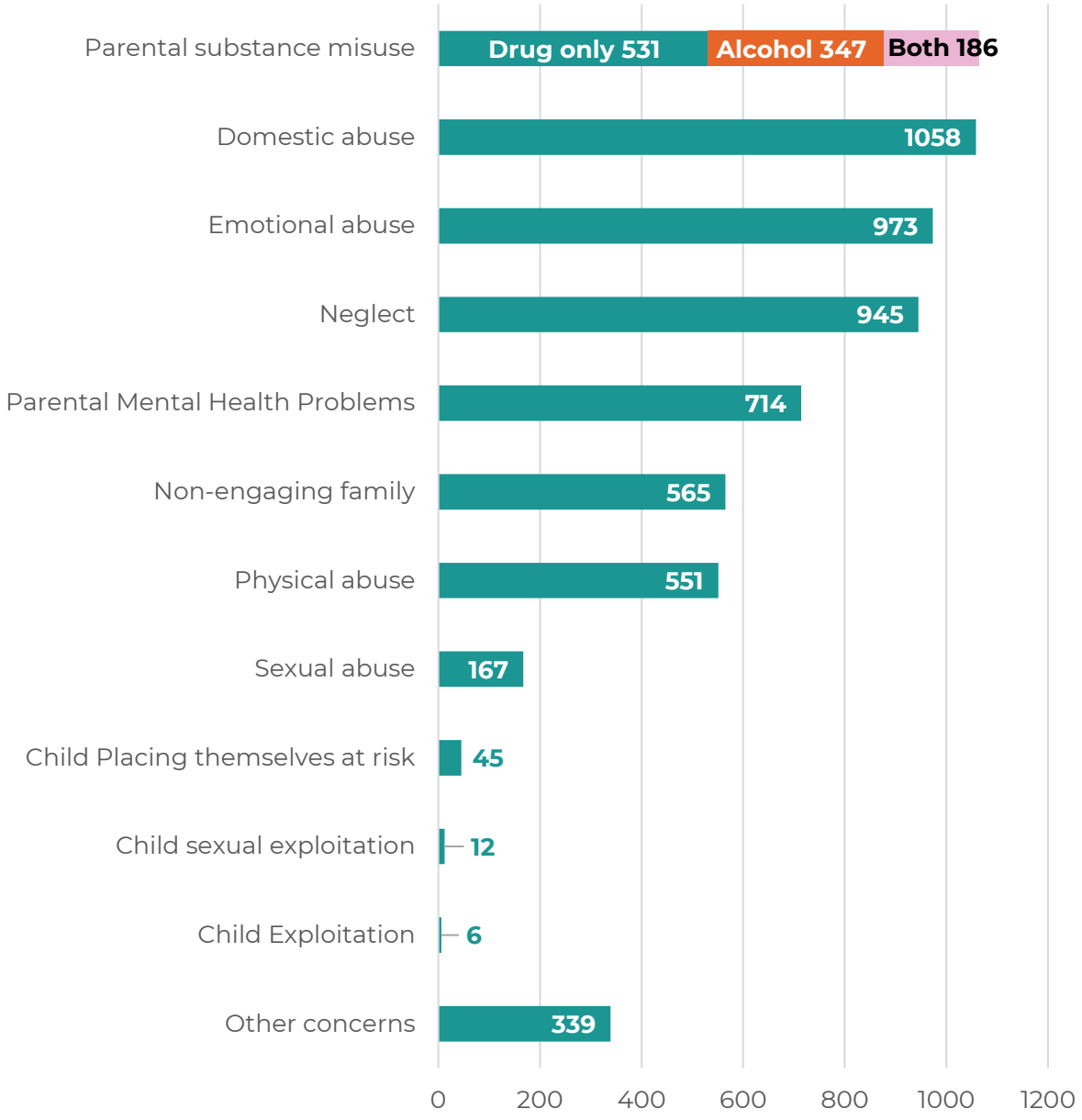
various, but the outcome is that, of the children being referred, a much higher proportion now progress onto a Children's Hearing, and potentially some form of legal order which brings the child into care.

Child Protection

Child protection data provides a useful window into the reasons why children may require to become looked after (although it is important to note that not all children who are subject to child protection concerns are or become looked after). Chart 17 below provides an overview of some of the main concerns identified at the case conferences of children who were on the child protection register. Parental substance misuse, domestic abuse, emotional abuse, neglect and parental mental health problems comprise 74% (4,765) of concerns raised in child protection cases, whereas other serious concerns such as child exploitation and sexual abuse are cited in 3% (179) of cases. Parental substance is shown as the issue most likely to be raised in many child protection cases, being referenced in 17% (1,064) of cases. (Please note also that any one single referral can have multiple reasons attached to it (e.g. a child could be experiencing both physical and emotional abuse). The 'other concerns' noted at the bottom of the table, a new category, introduced in 2016, which includes children at risk of trafficking.

Chart 17 below illustrates the breadth and complexity of the issues leading to child protection concerns. Particularly when it is considered that child protection concerns are likely to be interconnected; for example, the likelihood of neglect, (defined as "the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development") could be seen to increase as a result of serious parental substance abuse.

Chart 17: Concerns identified at the case conferences of children who were on the child protection register, 2016[45]



[45]Scottish Government (2017) Children's Social Work Statistics Scotland 2015/16:, Chart 5: Concerns identified at the case conferences of children who were on the child protection register (2016)

Children's Hearing

For those children who either progress onto, or are referred directly to, a Children's Hearing, another data set becomes available which can shed light on why some children become 'looked after'.

Chart 18: Children & Young People Referred to the Children's Reporter, 2015-16, by grounds for referral[46]

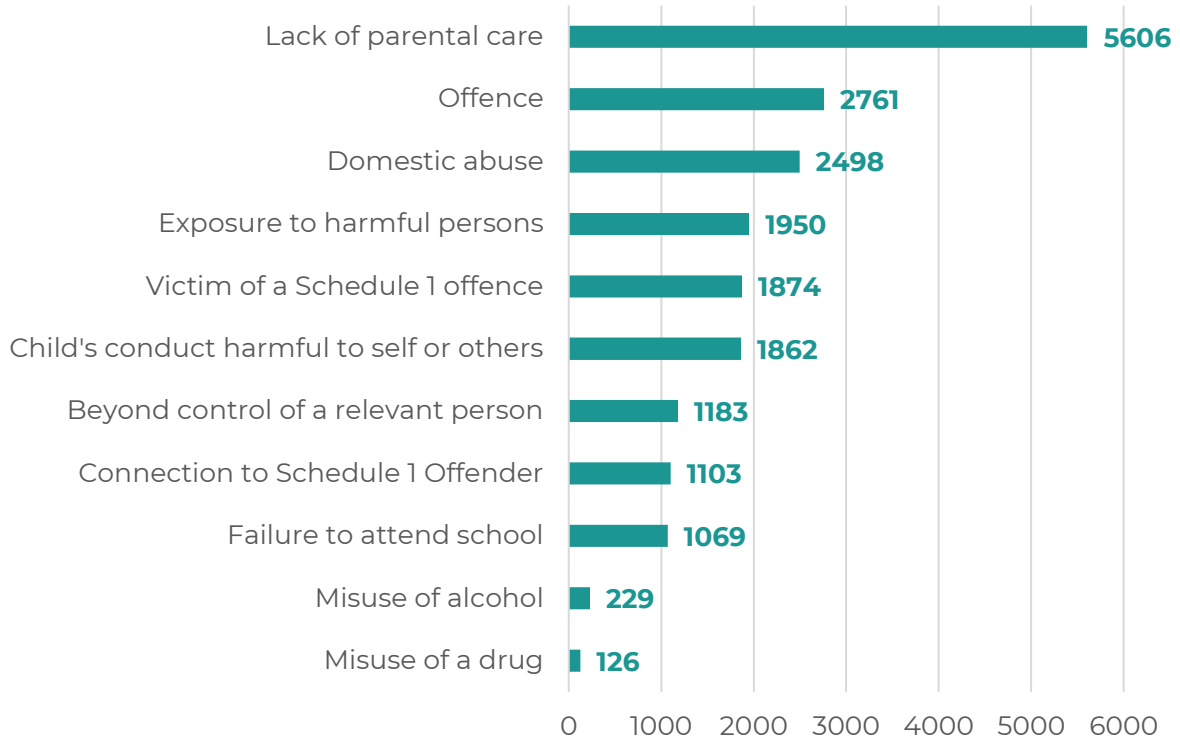


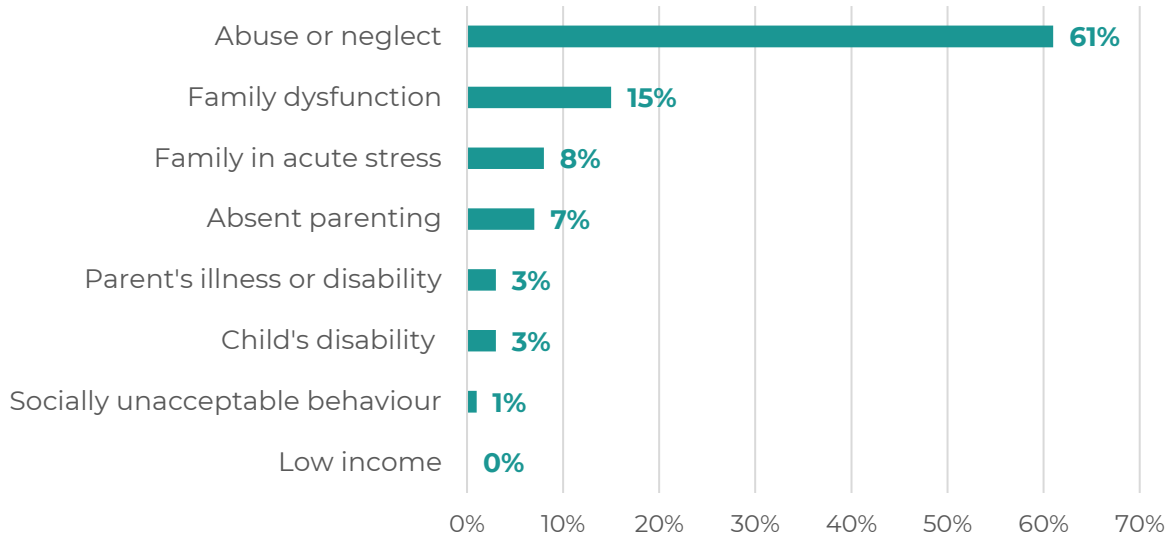
Chart 18 above details the 'grounds' on which children and young people are referred to the Children's Reporter in 2015-16. Lack of parental care was the most frequently cited ground for referral, used 5,606 (27%) times. Being a victim of, or exposed to, a Schedule 1 offender (anyone convicted of an offence against a child listed in Part I of the Criminal Law Scotland Act 1995[47]) is also referenced in 14% (2,977) of cases, whilst committing an offence accounts appeared in 13% (2,761) of cases. (The proportion of

[46] Scottish Children's Reporter Association (2016); Statistical Analysis 2015/16;, Table 1.4 Number of children and young people referred in 2015/16, by section 67 ground and Compulsory Supervision Order status at the point of referral
[47] National Objectives for Social Work Services in the Criminal Justice System: Standards Throughcare;

referrals citing offence grounds has dropped significantly in recent years, from a high of 33% (16,741) in 2003-04). Misuse of drugs or alcohol accounts for only 1.7% (355) of cases.

While grounds for referral to the Reporter are a useful guide to why children become looked after, they are a limited one. In particular, they exclude all those children who become looked after by a means other than a Children's Hearing. Unfortunately, the available statistics in Scotland do not provide details of the reasons children become actually looked after. But the English looked after child data set does, and it is reasonable to assume that the reasons leading English children to be taken into care are broadly similar to those in Scotland.

Chart 19: Children looked after in England on 31 March 2017, by category of need[48]



Why children become looked after: An international perspective

The process by which children and young people become 'looked after' varies between individuals, and between different jurisdictions (as noted above). However, the reasons why children become looked after also varies

[48]UK Government (2017) Children looked after in England including adoption: 2016 to 2017; All children looked after at 31 March by gender, age at 31 March, category of need, ethnic origin, legal status and motherhood status, 2013 to 2017

considerably between countries. Recent international research by CELCIS[49] highlighted that, in Europe, protecting children from abuse, neglect and exploitation are now the principal reasons for children being brought into care. The same can be said for South American countries. In African and Asian countries, removing children from situations of material destitution (i.e. extreme poverty) remains a significant driver, and across a range of societies cultural factors can also play a part (for example babies born to the very young and/or unwedded mothers). In some cases external factors, such as conflict or natural disasters (including disease epidemics) can lead to many children being brought into care.

Stein (2014) finds that in African, Asian and South American countries and in some post-communist European, an estimated 2 million children and young people are living in large institutional care - this is mainly a result of poverty, disasters, war, famine and disease on families and communities[50].

Any international comparison must be heavily caveated, the challenges of differing definitions, cultural norms and socio-economic systems making robust analysis difficult. But the data and available research is strong enough for us to conclude that different countries' 'care systems' are, in some cases, orientated towards different social needs and objectives. Even if, ultimately, they are all focused on addressing issues related to 'poverty', and the risks it presents to children.

Links between deprivation and coming into care

The relationship between poverty and children and young people becoming looked after has been well documented elsewhere. Within Scotland, Chart 20 below illustrates the correlation between child poverty levels in a local authority area and the percentage of looked after children and young people (as a percentage of the 0-17 year old population). If we

[49]CELCIS (2017) Towards the Right Care for Children: Orientations for Reforming Alternative Care Systems; Africa, Asia, Latin America (Part 2: Why Are Children in Formal Alternative Care Settings?

[50] Stein (2014) How does care leaver support in the UK compare with the rest of the world?

accept a hypothesis that reducing poverty levels can have an influence on the rates of children and young people coming into care, reducing pressure in families and thereby reducing incidents which lead to intervention by social work services, recent political developments in Scotland (including Child Poverty legislation and the Scottish Poverty and Inequality Commission) hold promise.[51]

Naomi Eisenstadt, the Scottish Government's Independent Advisor on Poverty and Inequality, and author of "The Life Chances of Young People in Scotland: A Report to the First Minister" [52], recognised how young people's life chances are shaped by deprivation, other forms of disadvantage, and protected characteristics. The six characteristics are defined as: Living in a deprived area; Ethnicity; Disability; Caring responsibilities; Being 'looked after' and leaving care.

Children and young people who are looked after could be affected by a number of these issues - or all of them - at any one time. Eisenstadt's report confirms, for example, that a poorer state of mental health is associated with greater socioeconomic disadvantage for the majority of indicators. Children and young people living in more deprived areas are also more likely to be affected by poor mental health than those living in less deprived areas.

Eisenstadt finds:

> *"Young people from the most deprived areas are also more likely to experience fragmented post-school transitions than those from the least deprived areas: they are less likely to stay on at school, and more likely to experience multiple post-school transitions, to be unemployed when they leave school, or to move into a short-term training programme."*

[51]Scottish Government (2017) The Poverty and Inequality Commission
[52]Scottish Government (2017) Independent Advisor on Poverty and Inequality, The Life Chances of Young People in Scotland, A Report to the First Minister

Young people from the most deprived areas, as with those from a looked after background, are more likely to go on to study at college and less likely to go on to university than those from the least deprived areas. Physical health is affected as well, with rates of regular smoking significantly higher amongst young adults living in the most deprived areas compared to the least deprived areas, with 10% of 15 years olds in the most deprived SIMD quintile smoking regularly, compared to 5% in the least deprived quintile in 2015.

In a Joseph Rowantree Foundation study[53], Paul Bywaters (et al) finds a similar link between being looked after and poor socioeconomic outcomes:

> *"Studies provide evidence that being looked after as a child has a sustained impact on a number of socio-economic outcomes including: reduced income, lower socio-economic status, reduced educational attainment, increased homelessness and unemployment. However, it is not possible from these studies to disentangle the effects of maltreatment from the effects of being looked after."*

Chart 20 on the next page could be seen to reinforce this, showing a correlation between the percentage of children in poverty and the percentage of the population of 0-17 year olds who are looked after.

These findings will be expanded on, with direct reference to the outcomes for looked after children and young people, in the "Outcomes" section of this paper.

Age of Children and Young People Becoming 'Looked After'

Children and young people enter the Scottish 'care system' at all ages. In 2016, 38% (1574) were under aged 0 – 4; 32% (1321) were aged 5 – 11; 29%

[53]Joseph Rowantree Foundation (2016) The Relationship Between Poverty, Child Abuse and Neglect: An Evidence Review; The impact of child abuse and neglect on adult poverty

(1,175) were aged 12 -15. Only a very small number became looked after aged 16 or over. (Please note that these numbers may count the same child twice, as they may have more than one 'care episode' in a year.)

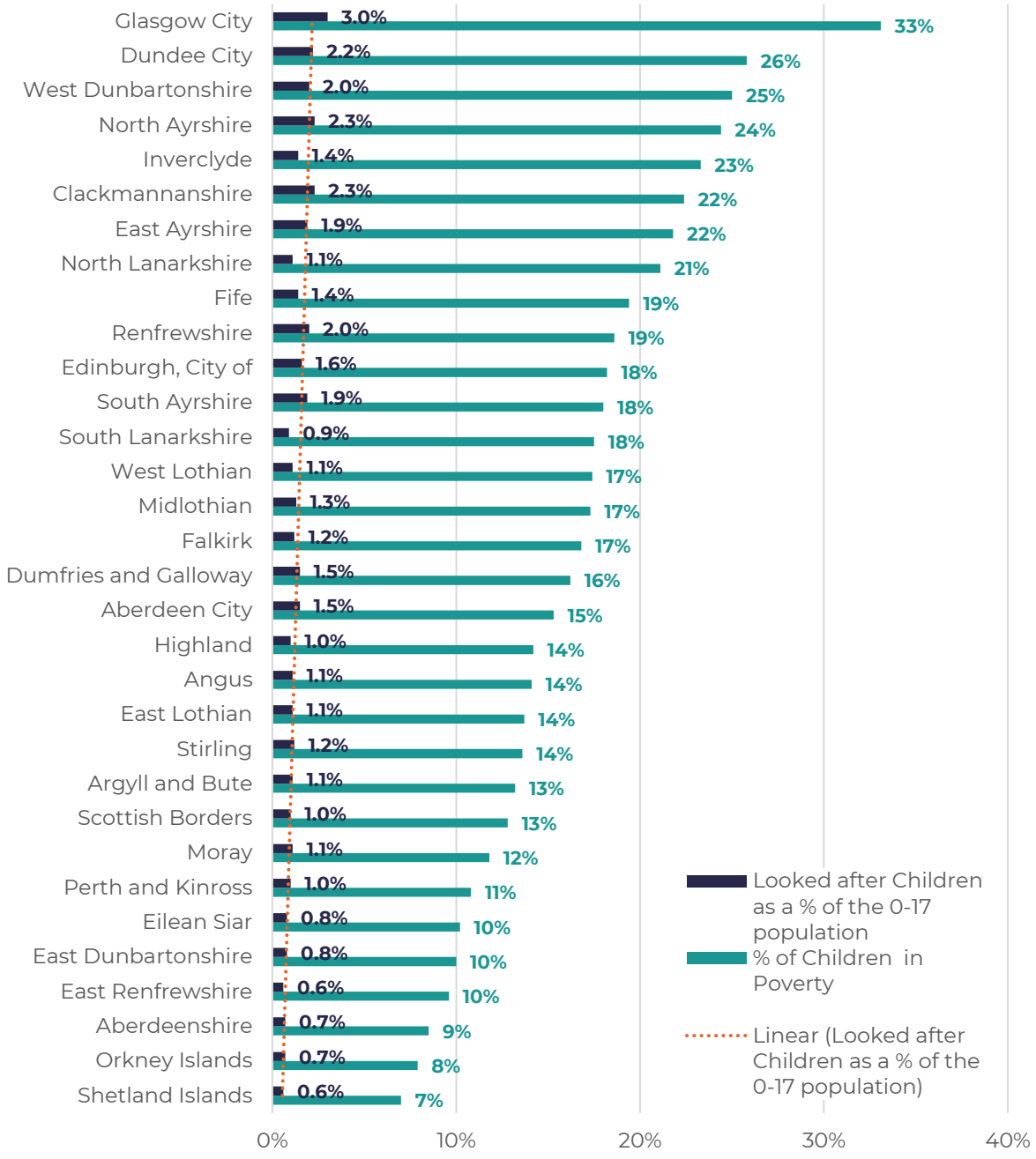
Table 9: Children starting to be looked after, by age proportion, 2012-2016[54]

	2012	2013	2014	2015	2016
Under 1	16	16	16	16	16
1-4	23	23	24	22	22
5-11	31	31	30	31	32
12-15	29	29	28	29	29
16-17	1	1	1	1	1
18-21	0	0	0	0	0
Not known	0	0	0	0	0
Total	**100**	**100**	**100**	**100**	**100**

As table 9 above shows, over recent years the ages at which children 'start' to be looked after has changed relatively little. But if the timeline is extended further, there have been some interesting shifts.

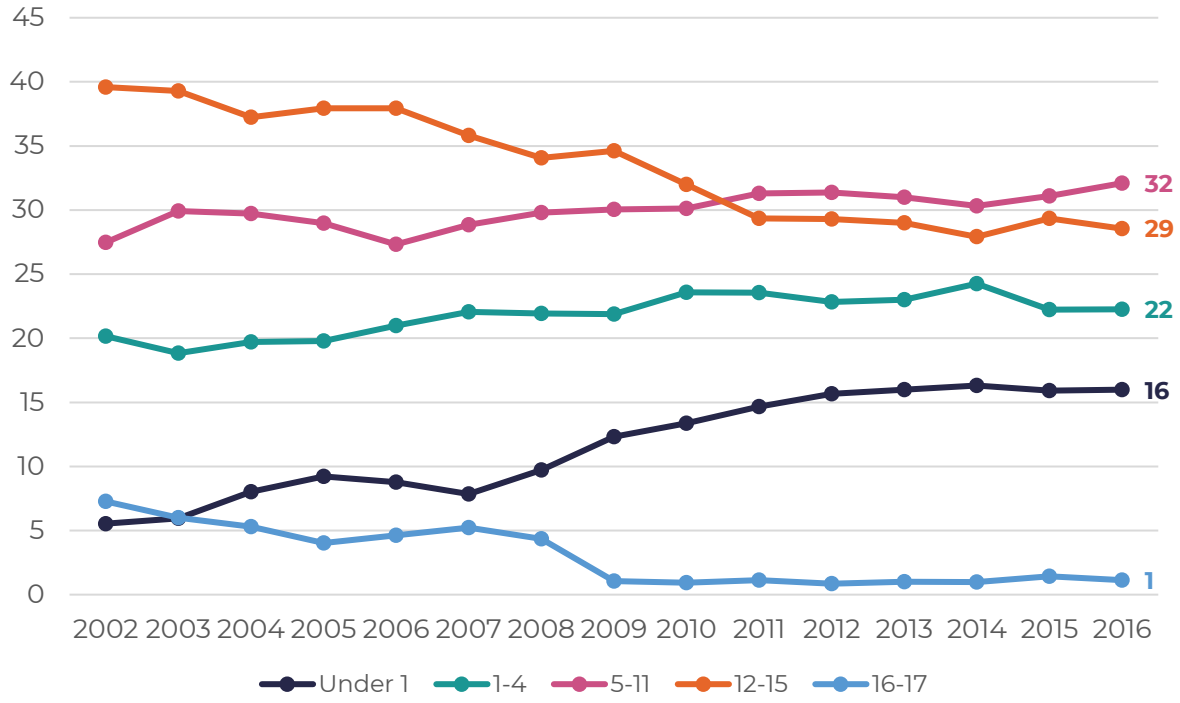
[54]Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16; Table 2.1: Number of children looked after by age and gender, 2002-2016(1),(2)

Chart 20: % of Children in Poverty compared to % of LAC, by Local Authority Area, 2015-16, as of 31st July 2016[55,56]



[55] Scottish Government (2012) Local authority Level Child Poverty data from HMRC
[56] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16; Table 3.1: Children starting and ceasing to be looked after, by local authority, 2015-16

Chart 21: Children starting to be looked after, by age proportion, 2002 - 2016[57]



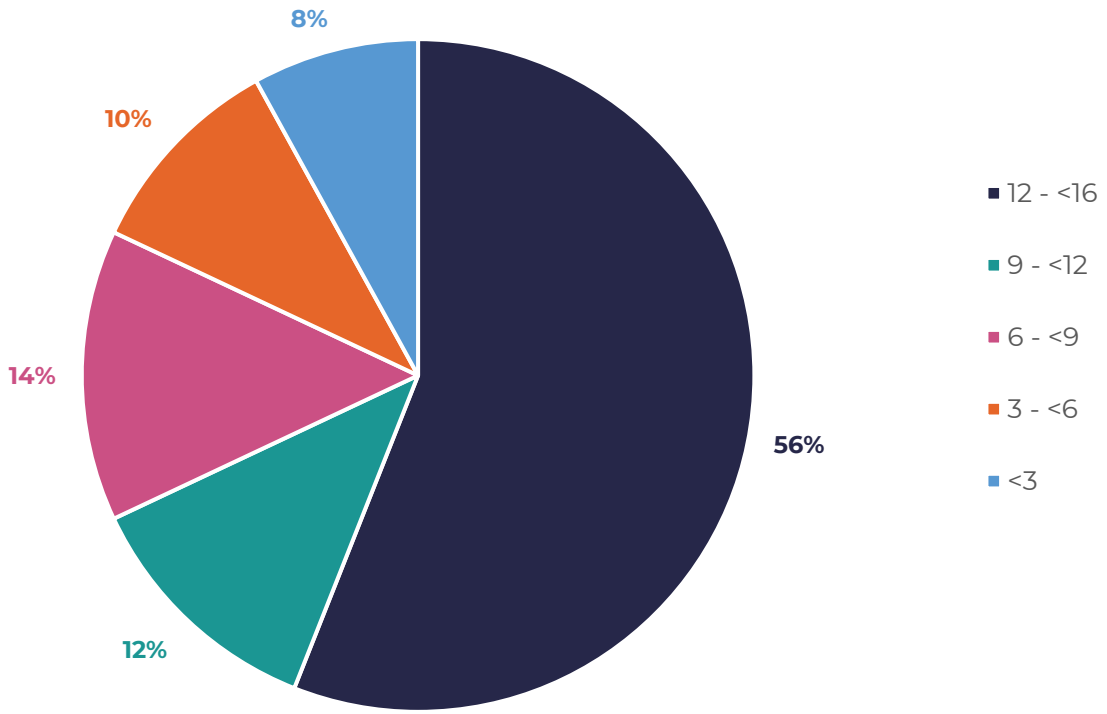
The main point of interest is the rise in infants (under 1) becoming looked after, showing an increase of 57% over this timeframe (from 183 in 2002, to 429 in 2016). Children between the age of 1-4 and 5-11 both show an increase of 33%; from 1,768 and 3,781, and 2,636 and 5,639, respectively.

Certain factors are worth bearing in mind when considering children's care pathways, and the age (and reason) at which they come into care. For example, with no child beneath the age of 12 able to be prosecuted for an offence (due to legal convention, the minimum age of criminal responsibility being 8)[58], it follows that the 12 – 15 year old age bracket should see an increase in the proportion of the general population coming into care, as some children will now be coming into care on offence grounds.

[57] Ibid
[58] Scottish Government (2017) A Nation With Ambition: The Government's Programme for Scotland 2017-18

Chart 22 below describes at what point children and young people became involved in the Hearings System. It shows that over half of children and young people (63, 56%) were aged between 12 and 15 when they were first subject to compulsory supervision order (CSO). Of the 105 young people who took part in the study reflected in Chart 22, 20 (18%) of them had been on CSOs for at least 10 years at the time of their Hearing.

Chart 22: 16-17 year olds, and age comparison when Compulsory Supervision Order first made[59]



Length of Time Children and Young People are 'Looked After'

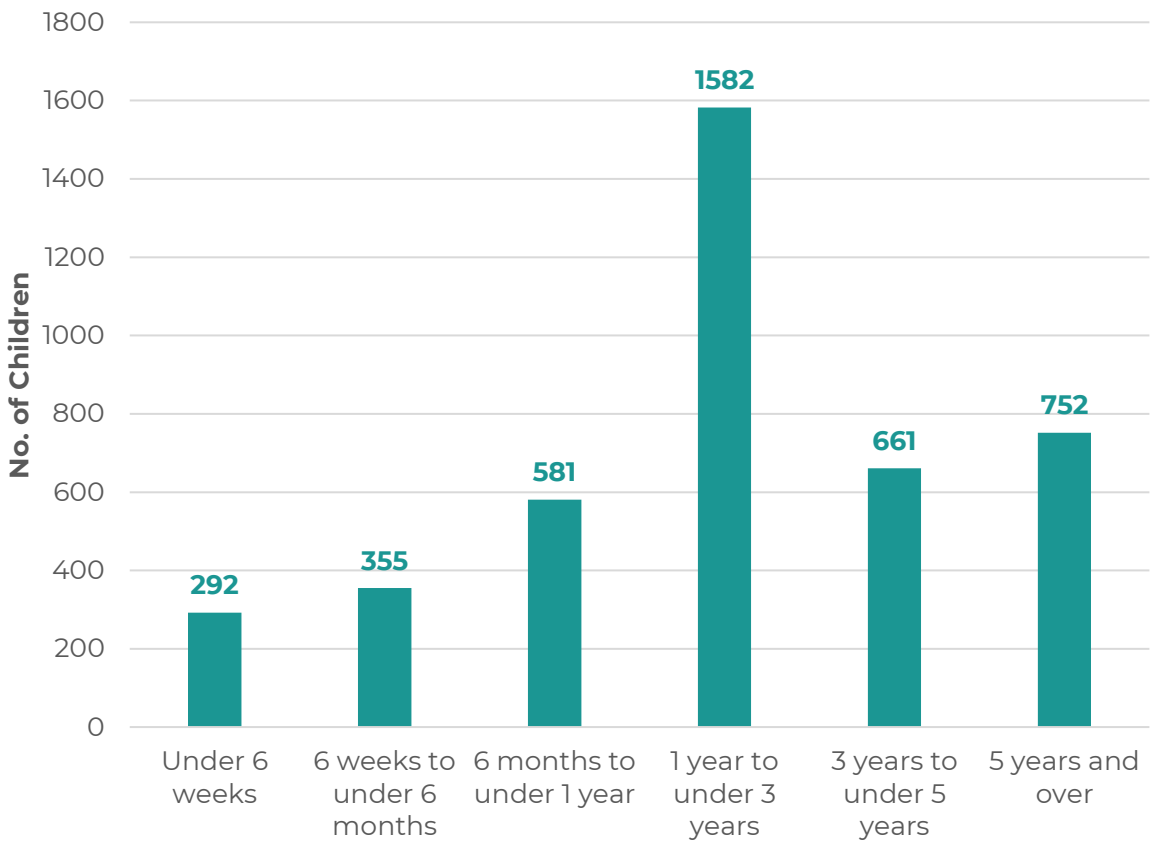
Charts 23 and 24 below provide an illustration of the length of time a child or young person remains 'looked after'. The data shows that, in general, the time a child or young person is 'looked after' has remained fairly consistent over recent years, with a significant majority in care for 0 – 3 years. Over a third were in care for between 1 – 2 years. This suggests that, for most

[59]Scottish Children's Reporters Administration (2016) 16 and 17 year olds in the Children's Hearings System;, Figure 1. Age when CSO first made

children, care is a relatively medium-term intervention (i.e. a period of their life lasting under 3 years); albeit some may cease to be looked after due to adoption or residence orders. However, it is also true that the number of children and young people being looked after for five years or more has been increasing steadily, rising from 674 in 2012, to 752 in 2016. One reason for this may be introduction of Permanence Orders, which secure a child in their placement until adulthood, but which do not remove a child's looked after status.

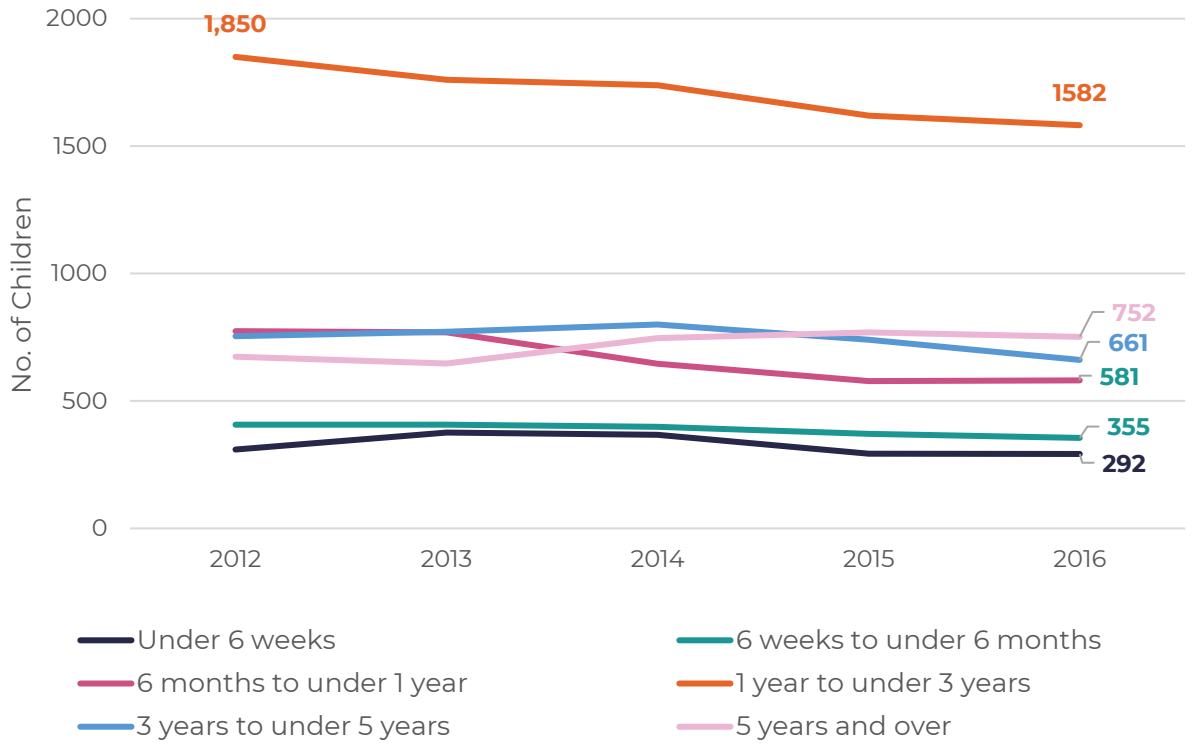
(Please note that this data does only relate to children and young people who ceased to be looked after in 2015-16; children who remained in care throughout the year are not counted.)

Chart 23: No. of children ceasing to be looked after by length of time looked after, 2016[60]



[60]Scottish Government (2017) Children's Social Work Statistics Scotland 2015/16;, Table 1.4: Number of children ceasing to be looked after by length of time looked after and age, 2003-2016

Chart 24: No. of children ceasing to be looked after by length of time looked after (2012-2016)[61]



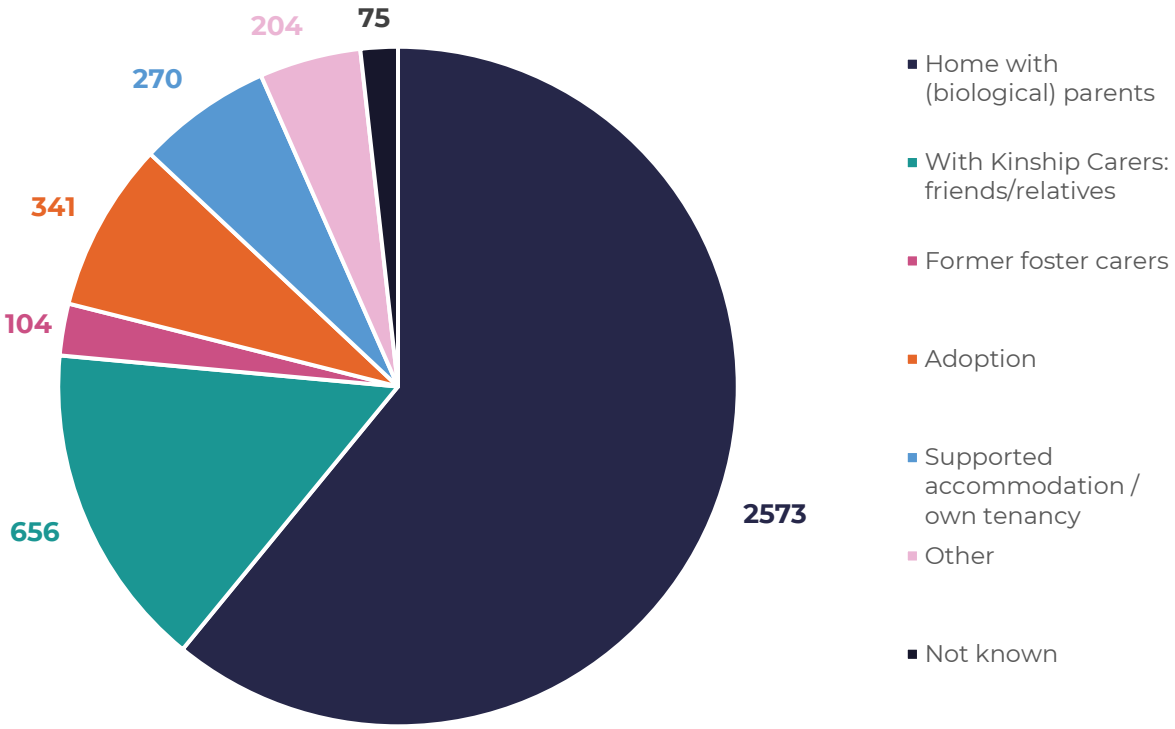
The length of time children remain in care is important because it provides an indicator of how 'care' is used, and should therefore inform how services are designed and delivered. For example, in 2015-16 only a small proportion (647) of children ceased to be looked after less than six months after their care episode began, in contrast to the 1,582 children who had remained in care for a year or two. Combining this with knowledge that the majority of looked after children leave care to return to their parents, this may suggest that attention should be focused on ensuring parents receive the support they need in order to safeguard and promote the wellbeing of the child when they cease to be looked after. Indeed, the trends in the data showing numbers of children remaining in care for longer, is perhaps one driver behind the Scottish Government's permanence agenda, developing a 'care system' which has the capacity to provide permanence for children.

[61]Scottish Government (2017) Children's Social Work Statistics Scotland 2015/16:, Table 1.4: Number of children ceasing to be looked after by length of time looked after and age, 2003-2016

Destinations on Leaving Care

In 2015-16, of those children and young people who ceased to be looked after, 61% (2,573) returned home to live with biological parents. This is across all age ranges, and includes young children who are being rehabilitated with their families (and may be subject to alternative care and protection arrangements in the future), and older children who may be leaving care permanently, as 'care leavers'.

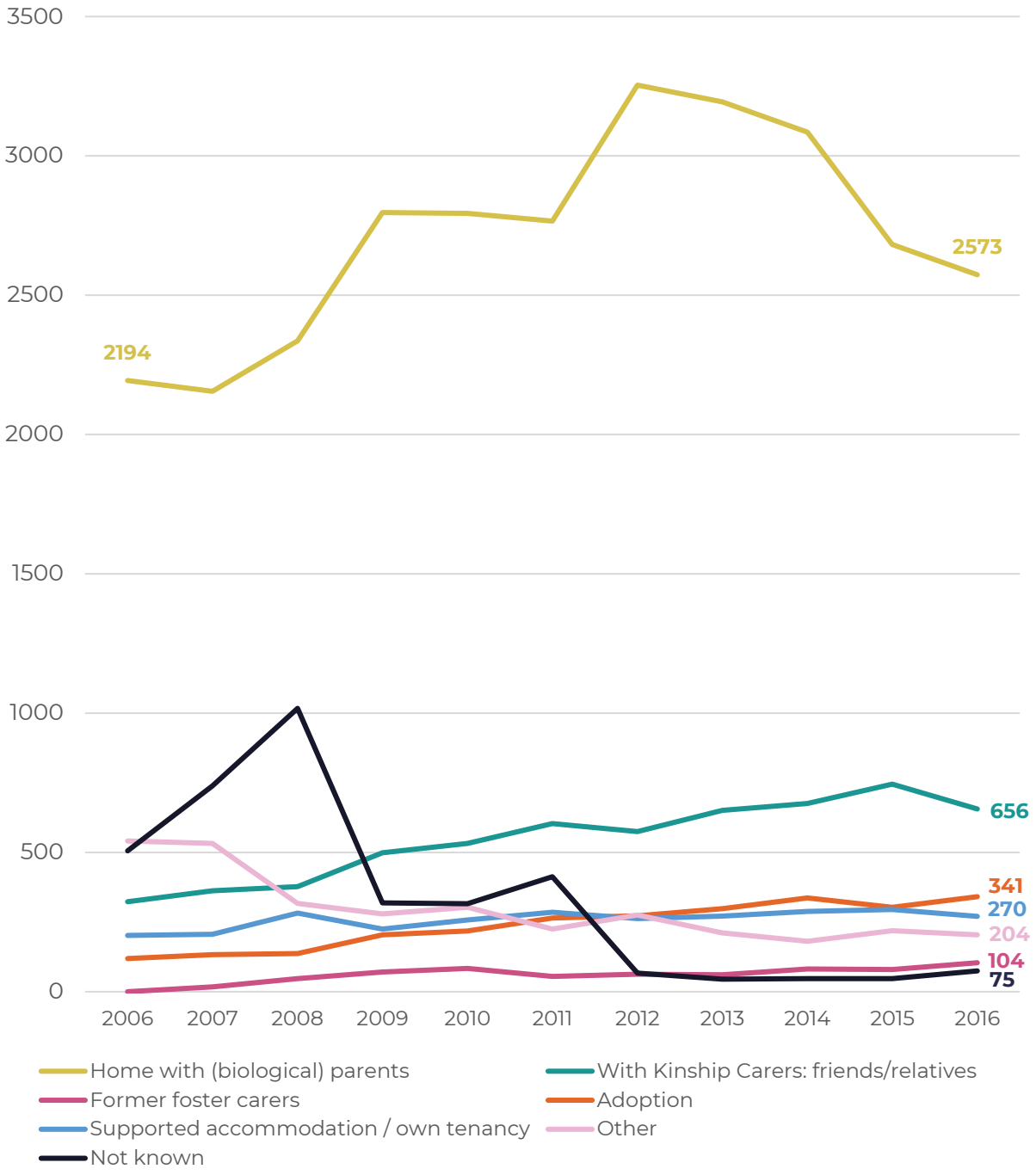
Chart 25: Number of children ceasing to be looked after, by destination, 2016[62]



As chart 26 below shows, while there has been some variance in the total numbers over recent years, overall the proportions have remained relatively constant, averaging at 62% 'returning home to parents' over the last 10 year period.

[62] Scottish Government (2017) Children's Social Work Statistics Scotland 2015/16;, Table 1.5: Number of children ceasing to be looked after, by destination, 2002-2016

Chart 26: Number of children ceasing to be looked after, by destination, 2006-2016[63]



[63] Scottish Government (2017) Children's Social Work Statistics Scotland 2015/16;, Table 1.5: Number of children ceasing to be looked after, by destination, 2002-2016

Sibling Contact

Sourcing accurate information in relation to sibling contact can be difficult; however, there are some academic studies and international research which can be referred to as an introduction to the issue.

A study between the SCRA and the University of Strathclyde[64] found that:

> *"Sibling networks of looked-after and accommodated children can be large, diverse in age and spread over multiple households and care types (kinship, foster, residential care and adoption). This creates challenges in terms of supporting sibling relationships."*

"Children who were accommodated and subsequently placed permanently away from their birth parents experienced a high degree of estrangement from siblings. 58% of these children had biological siblings who were 'stranger' siblings and 68% of children were living apart from at least one of their 'familiar' biological siblings."

Attachment, defined as a "deep and enduring emotional bond that connects one person to another across time and space"[65] is said to be critical to a child's personal development, and, if a sibling – or any other care-giver – has been removed from that child's life, then it can have a damaging impact on their personal development. Children in care generally want to be placed together with their siblings, and when this is not possible, they want frequent contact and information about their siblings[66].

The Government of South Australia held an inquiry in order to find out more about sibling contact for looked after children. Their "Report on the inquiry into what children say about contact with their siblings and the

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[64]University of Strathclyde, School of Social Work (2017) Supporting Sibling Relationships of Children in Permanent Fostering and Adoptive Families;
[65] John Bowlby (1969) From Psychoanalysis to Ethology: Unraveling the Roots of Attachment Theory
[66] Herrick, M. A., & Piccus, W. (2005). Sibling connections: The importance of nurturing sibling bonds in the foster care system. Children and Youth Services Review, 27(7), 845-861

impact sibling contact has on wellbeing" (2011)[67] delved into the issue in some depth, finding that:

- In 48 cases (of the 66 they investigated) there was no documented information that sibling separation was in the best interests of the child or young person.
- In 16 cases there was no explanation for the separation of siblings.
- In 45% of the cases, the child or young person's views about residing with their siblings was documented in the preceding 12 months. The child or young person's views would not have been available in 15% of cases due to the child's age and/or capacity to contribute their views. Therefore, 40 per cent of files did not document the child or young person's views in the preceding 12 months where the child or young person was capable of doing so.

This mirrors the findings of the SCRA and University of Strathclyde study[68] which found that "Children's contact arrangements and wishes in this regard were frequently not recorded as part of the hearing process or recorded in piecemeal fashion throughout a child's file".

Often, the reasons for separation of siblings are justified as in the 'best interests' of the child. For example, a child or young person may express a strong view during a Hearing that they do not want to live with their sibling; carers may not have the capacity to accommodate large sibling groups; or, they may be at risk of abuse from the sibling (however it is important to note that this equates to a small number child protection cases).

[67] Australian Government (2011) Report on the Inquiry into what Children say about Contact with their Siblings and the Impact Sibling Contact has on Wellbeing;
[68] University of Strathclyde, School of Social Work (2017) Supporting Sibling Relationships of Children in Permanent Fostering and Adoptive Families;

5. Outcomes for looked after children

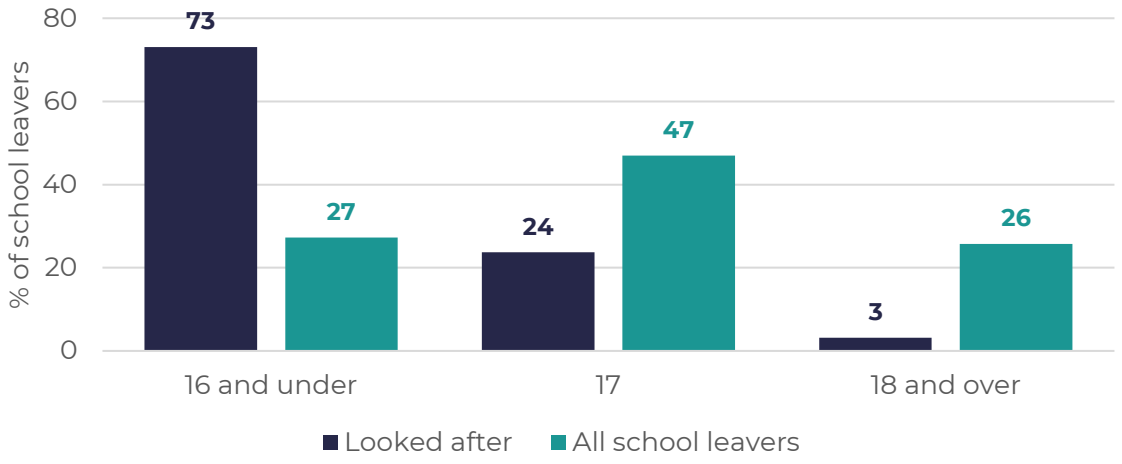
Education & Post-School Destinations

Outcomes data for care leavers in Scotland is limited, with the Education Outcomes for Looked After Children report, published annually by the Scottish Government[69], providing the majority of data.

Chart 27 below shows that, in the year 2015-16, 73% (342) of looked after children left school aged 16 or under, compared to 27% (19,964) of their non-looked after peers. Only 3% (15) of looked after children left school at age 18 or over, compared to 26% (13,470) of all school leavers.

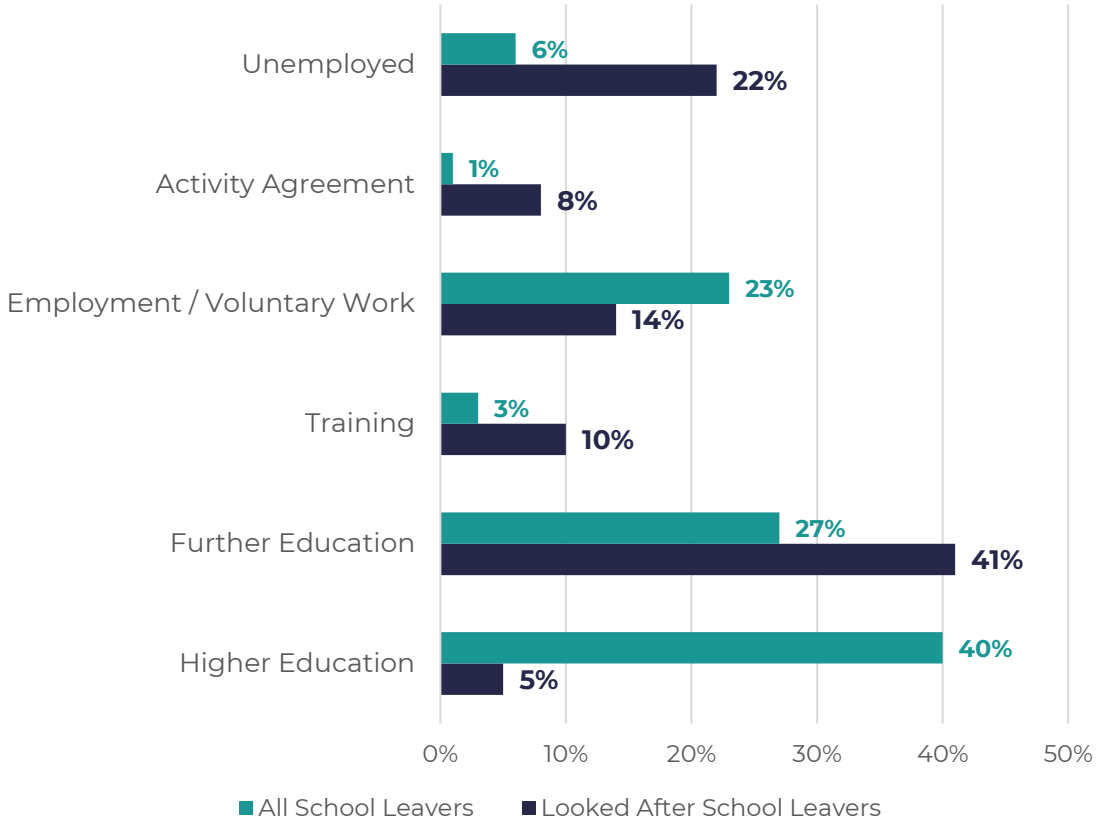
Chart 28 and 29 show that attainment levels remain lower than the national average; likely to be because looked after children tend to leave school earlier than their peers (thereby restricting the level of qualifications they can attain). This may also explain why, of those looked after children who left school in 2015-16, only 5% went directly into higher education, compared to the national average of 40% of school leavers. 23% of all school leavers are recorded as entering employment or voluntary work upon leaving school, compared to just 14% of looked after school leavers.

Chart 27: School Leavers' ages - 2015/16[70]



[69]Scottish Government (2017) Education Outcomes for Looked After Children 2015/16;
[70]Scottish Government (2017) Education Outcomes for Looked After Children 2015/16:, Chart 1: Age of all school leavers and those who were looked after, 2009/10-2015/16(1)

Chart 28: % of school leavers by initial destination, comparing all school leavers with those who were looked after, 2015/16[71]



It is likely that these educational outcomes are affected by the higher rates of school exclusion experienced by looked after children (shown in Chart 32 below), as compared to the average pupil: 218 cases per 1,000 looked after pupils, compared to 27 per 1,000 in the general school population. The relevant Scottish Government statistical publication explicitly highlights a link between exclusion and lack of educational attainment, showing that only 5.7% of pupils who had been excluded in 2015/16 went on to achieve Level 6 or above in terms of qualifications, whereas 57.7% of pupils who had no exclusions, achieved Level 6 or above[72].

[71] Scottish Government (2017) Education Outcomes for Looked After Children 2015/16:, Table 2.1: Percentage of school leavers by initial destination, for all school leavers and those who were looked after children, 2009/10 - 2015/16
[72]Scottish Government (2017) Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions:, Section 5 - The Impact of Exclusion on Children and Young People- Included, Engaged and Involved

The data available also suggests a correlation between care placement type and educational attainment, shown in Chart 29. For example, foster care (which is a significantly more intensive and specialist intervention than 'looked after at home') is associated with higher educational attainment levels, with 93% of looked after children in foster care going on to achieve SCQF level 4 or better, compared to 56% of children looked after at home. Indeed, 24% of children looked after at home go on to leave school with no qualifications.

Chart 29: Highest level of attainment of looked after school leavers, by placement type, 2015-16[73]

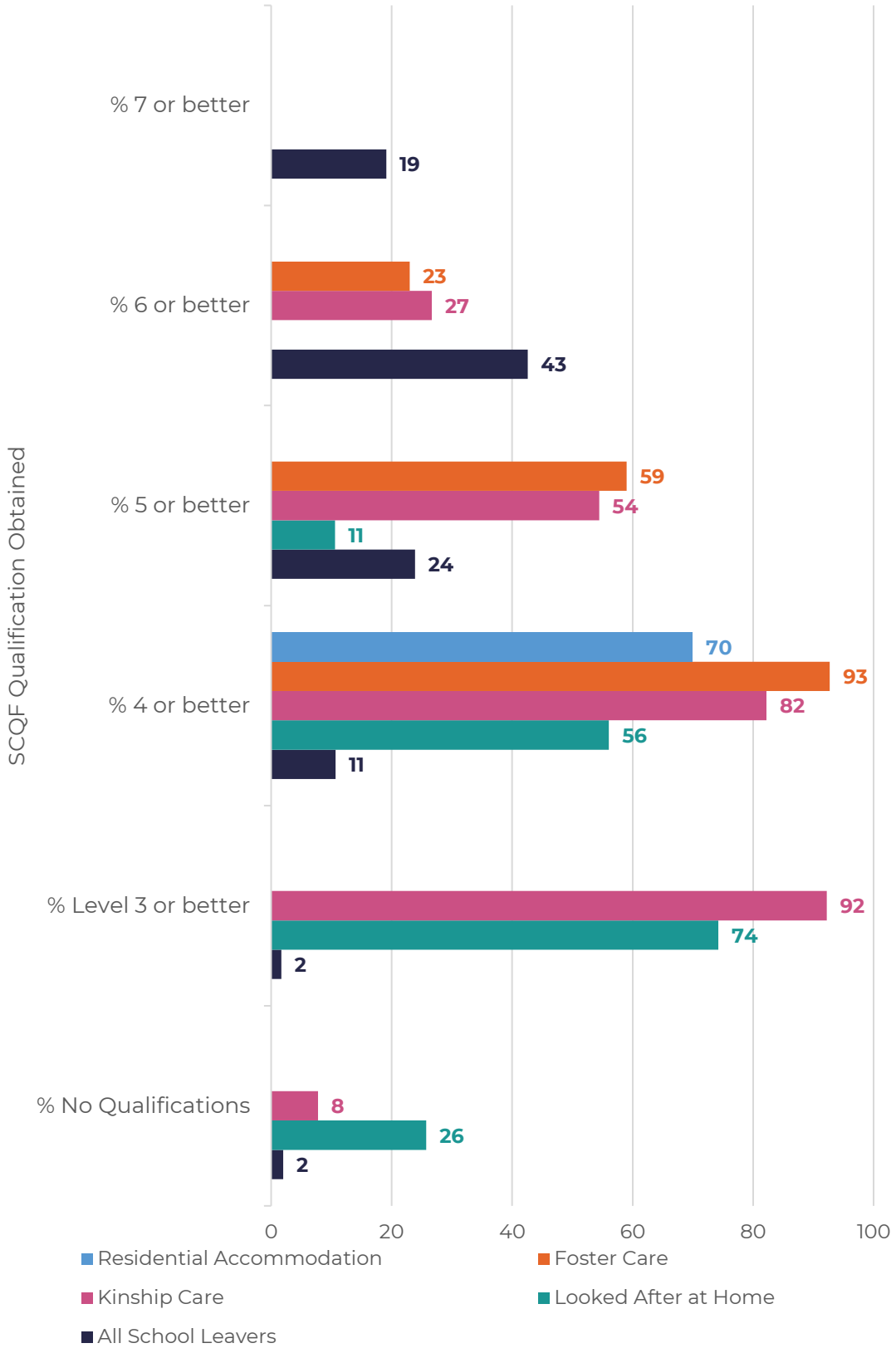


Chart 30 below shows that 58% (66) of looked after at home school leavers went onto a 'positive destination', compared to 92% (157) of school leavers from a foster care placement. A positive destination is defined as education, training or employment. (Please treat such conclusions with caution though, as the numbers on which there are based are small, and subject to revision in future years.)

Table 11: Percentage of Primary 1, Primary 4, Primary 7 and Secondary 3 children looked after for the full year, achieving the Curriculum for Excellence (CfE) level relevant to their stage, by number of looked after placements they experienced in 2015-1674

	Reading	Writing	Listening & Talking	Numeracy
1 placement	*52*	*46*	*58*	*50*
2 placements	*51*	*45*	*58*	*50*
3 placements	*55*	*46*	*57*	*43*
4 or more placements	*59*	*59*	*59*	*50*
All looked after for entire school year	**52**	**46**	**58**	**50**

[73]Scottish Government (2017) Education Outcomes for Looked After Children 2015/16;, Table 1.2: Highest level of attainment of looked after school leavers with one placement for the year, by the accommodation type of that placement 2009/10 to 2015/16

[74] Scottish Government (2017) Education Outcomes for Looked After Children 2015/16;, Percentage of Primary 1, Primary 4, Primary 7 and Secondary 3 children achieving the CfE level relevant to their stage(1), by accommodation type, 2015/16(2); Table 4.1 Looked after for the full year

Chart 30: Positive initial destinations among looked after school leavers with one placement, by placement type, 2015-16[75,76]

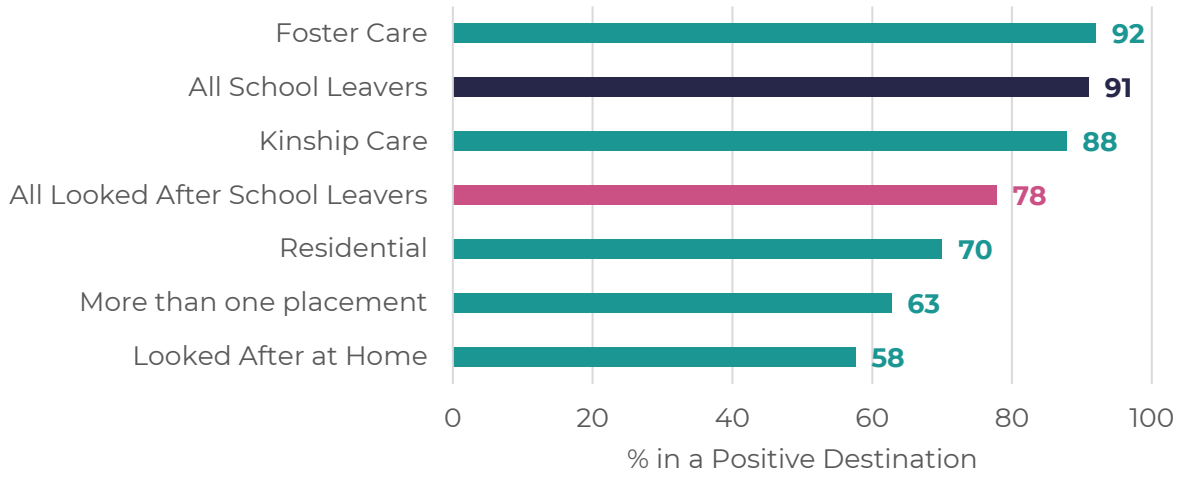
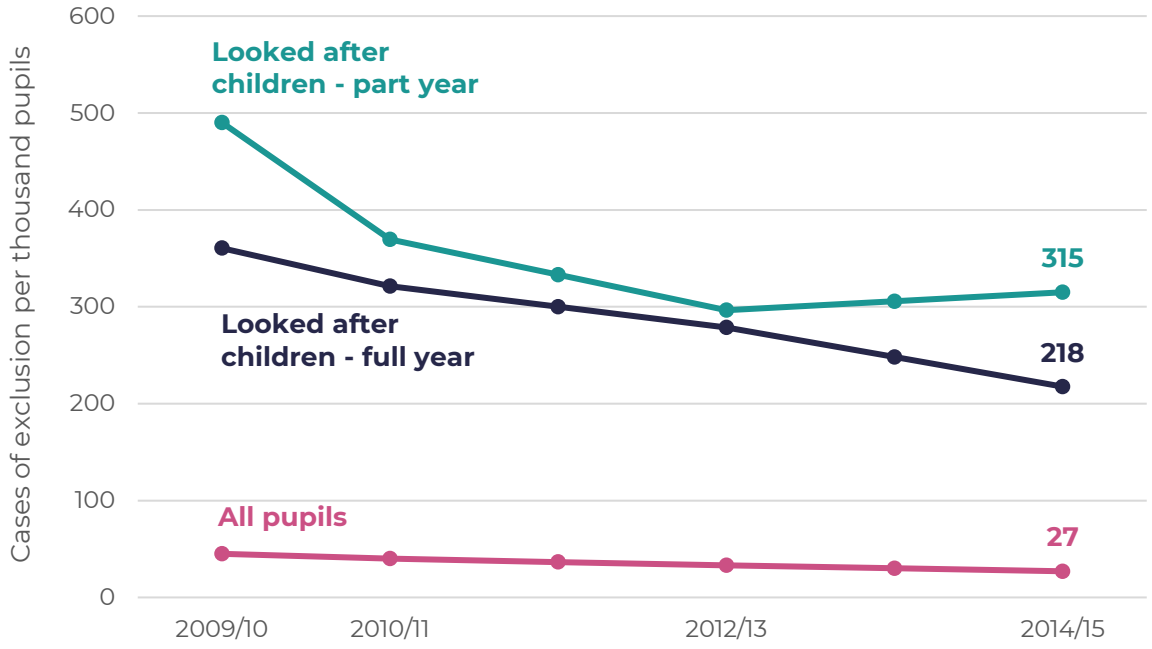
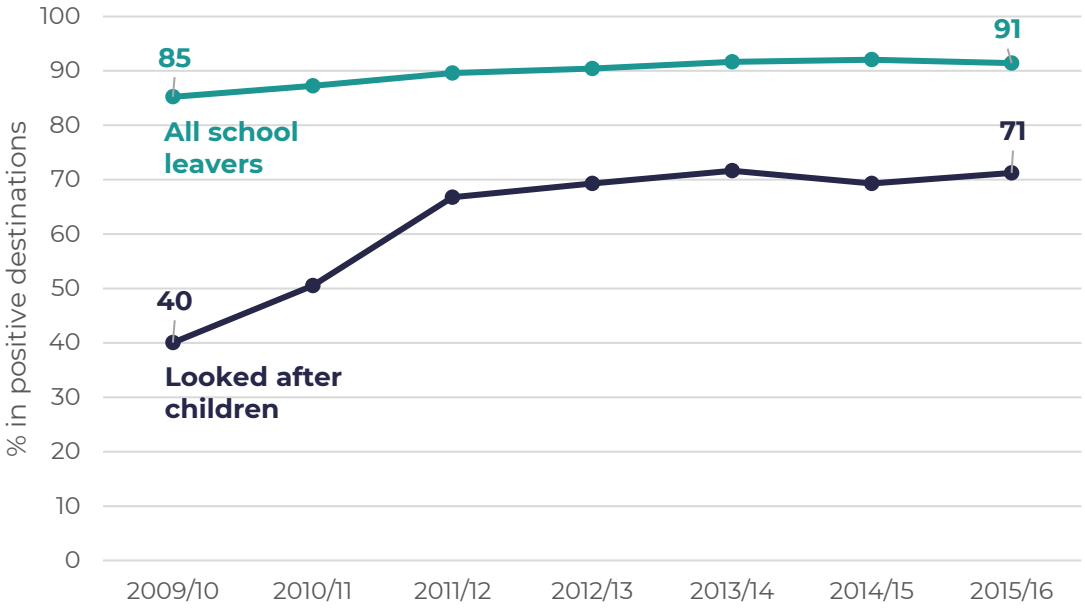


Chart 31: Exclusion rate per 1,000 pupils by all pupils, looked after children, 2009-10 to 2014-15[77]



[75]Scottish Government (2017) Education Outcomes for Looked After Children 2015/16;, Table 2.3: Positive initial and follow-up destinations among looked after school leavers with one placement, by placement type, 2015/16
[76] Scottish Government (2017) High Level Summary of Statistics Trend: Destinations of School Leavers
[77]Scottish Government (2017) Education Outcomes for Looked After Children 2014/15;, Chart 5: Exclusion rate per 1,000 pupils by all pupils, looked after children, 2009/10 to 2014/15

Chart 32: Looked after children in positive destinations nine months after leaving school, 2009-10 to 2015-16[78]



English data shows that over 10% (30,720) of looked after pupils (in England) had at least one school exclusion, compared to less than 2% of all children. The number of looked after children excluded goes up at secondary school stage, with 16% of English looked after children being excluded at least once[79].

[78] Scottish Government (2017) Education Outcomes for Looked After Children 2015/16; Chart 3: Looked after children in positive destinations nine months after leaving school, 2009/10 to 2015/16

[79] UK Government (2017) Statistics on schools, post compulsory education, training, qualifications and spending; Table 6: Exclusions by type of school for children who have been looked after continuously for at least twelve months1,2, children in need and all childrens

Premature Death

Table 12: Causes of death of looked after children 2009 - 2011[80]

Cause of death	Numbers of children
Life limiting conditions	8
Other health (includes sudden death, complex health conditions, illness)	7
Suicide	5
Accidental death	5
Murder	1
Drug/alcohol related	3
Unknown/unascertained	1

Table 12 details the causes of death of the 30 looked after children in Scotland who died between 2009 and 2011. The data, published by the Care Inspectorate, identified health conditions as the main causes of death, associated with 50% of cases. (Perhaps unsurprising when it is remembered that some children become looked after due to their health conditions.) Suicides and accidents each accounted for five deaths and three young people died from substance misuse, linked either to chaotic lifestyles or not fully realising the risks involved.

[80]Care Inspectorate (2013) A report into the Deaths of Looked after Children in Scotland 2009-2011Table from Care Inspectorate report: Causes of death of looked after children 2009 - 2011

Homelessness

Chart 33: No. of homeless applicants formerly looked after by the LA in Scotland, 2007-08 to 2016-17

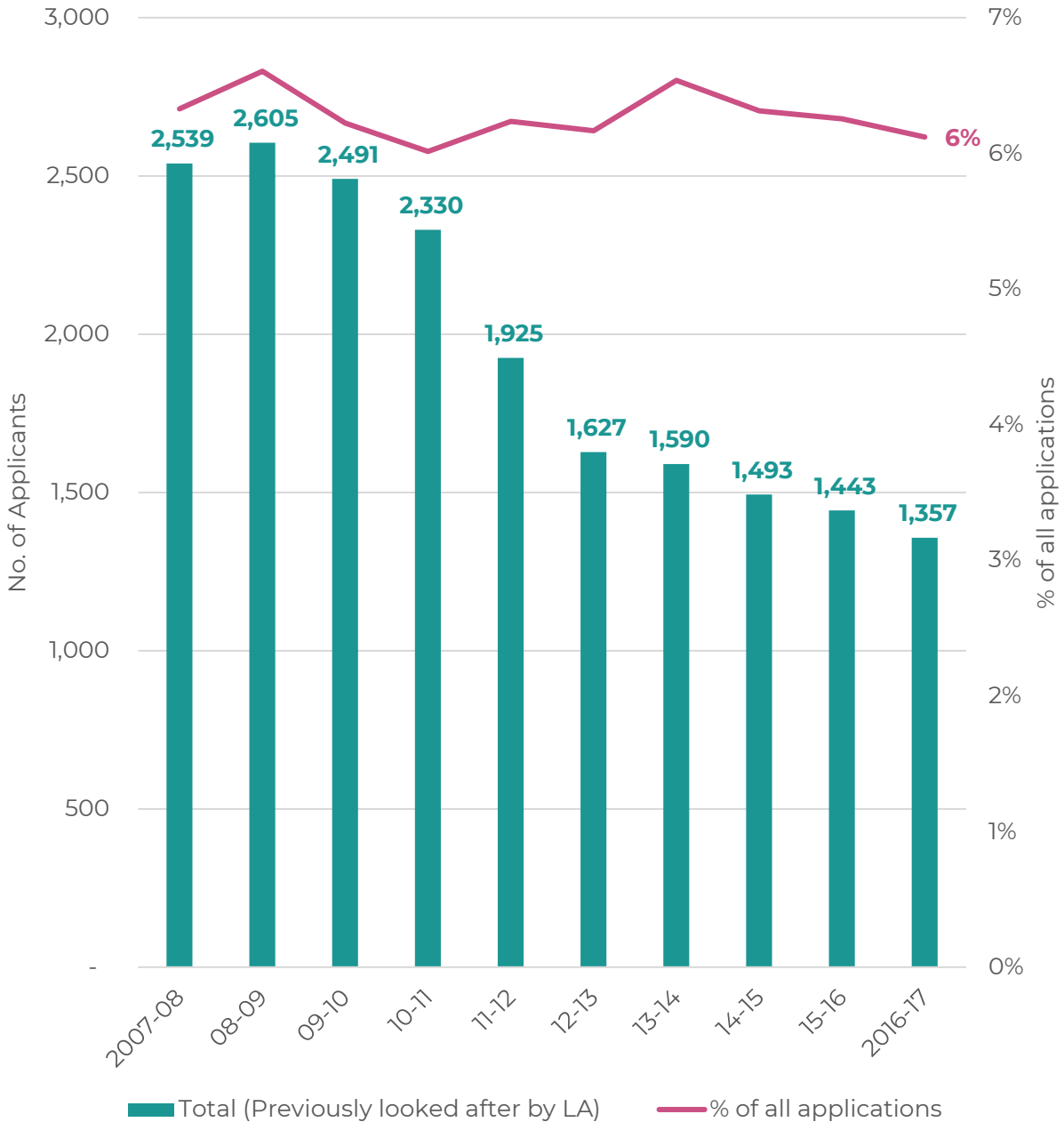
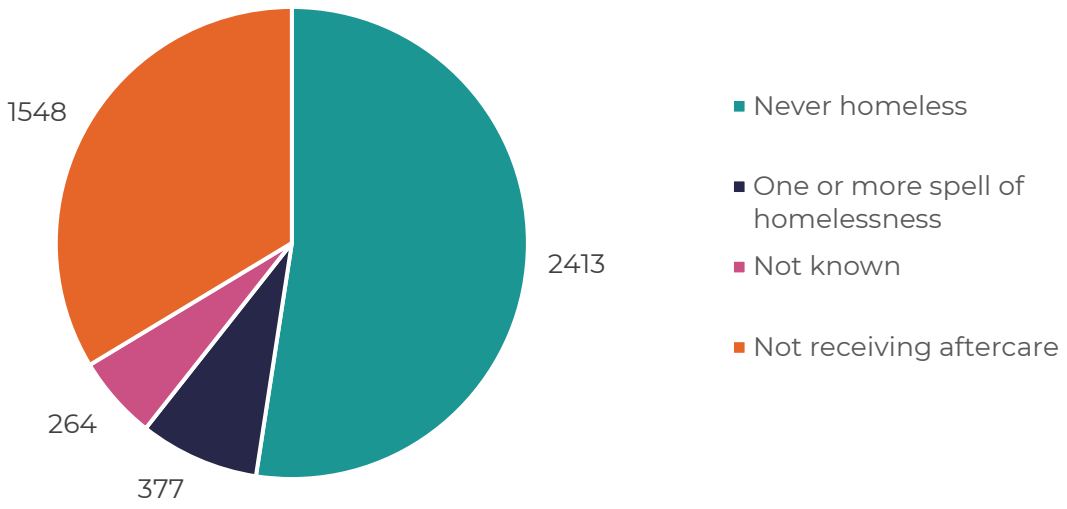


Chart 34: Young people eligible for aftercare services - episodes of homelessness since becoming eligible for aftercare services, 31st July 2016[81]



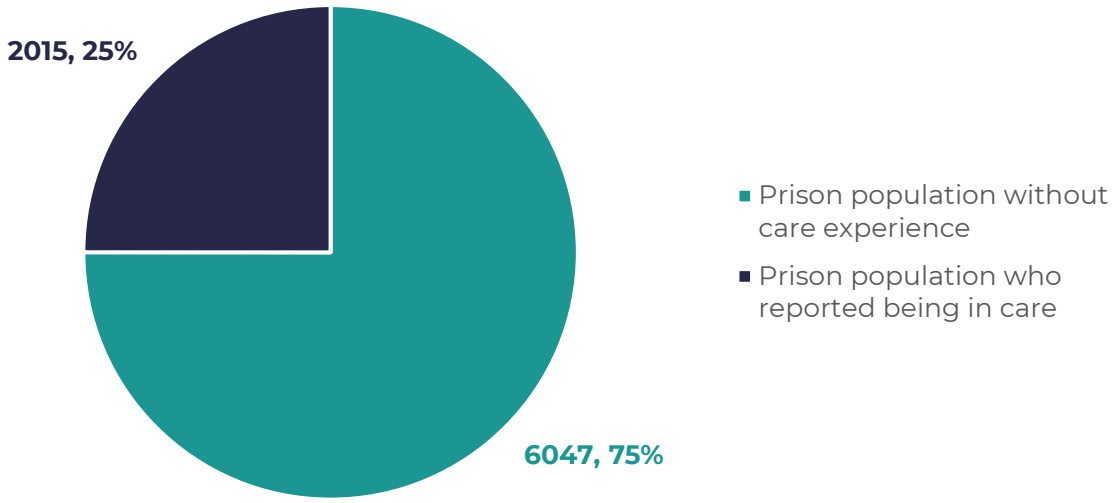
Link between Care Experience and Prison

The link between care and prison is often cited in the media, but robust data on the relationship is limited. The proportional figure, shown in Chart 35 below, refers to a joint analysis of data by the Scottish Centre for Crime and Justice Research and the University of Glasgow. The study cites figures from the Prison Reform Trust, showing that 25% (2015) of prisoners reported that they had been in care at one point. This differs slightly from reports by the Scottish Prisons Trust in 2015[82], who recorded 31% of adult prisoners as having been in care. In addition, of the 327 young men under 21 in HMYOI Polmont who responded to the Scottish Prison Service's Prisoner Survey, a third (33%) reported being in care at some point in their childhood, and a quarter reported being in care at the age of 16.[83]

[81] Scottish Government (2017) Children's Social Work Statistics Additional Tables 2015-16;, Table 1.19: Young people eligible for aftercare services on 31 July 2016(1) - episodes of homelessness since becoming eligible for aftercare services
[82] Scottish Prison Service (2015): Prisoners Survey 2015 - Young People in Custody
[83] Centre for Youth and Criminal Justice (2017) Children and Young People in Scotland: Looking Behind the Data;

While such statistics demand attention, it is important to bear in mind how such information is collected. Data in relation to prisoner's care experience is often collected via a survey, where each individual is asked whether they have been 'looked after' or not. There is not always explanation or background given alongside this question, leaving significant latitude for error (in both directions) in how prisoners understand the question.

Chart 35: Proportion of Prison Population with care experience, 2015 (from total of 8,062)[84]



However, research studies provide a check on national survey figures, and broadly the numbers found are consistent. In a recent study of 103 young offenders at HMYOI Polmont (Cesaroni, 2017), three out of every five young people who were interviewed indicated that their family had been involved with the Children's Hearings system and one third (33%) reported being removed from their family and placed in supported accommodation.

[84]University of Glasgow and Scottish Centre for Crime & Justice Research (2015) Who's in Prison: a Snapshot of Scotland's Prison Population 1.2.1 Care experience and contact with Children's Hearings System

Measuring Happiness

Measuring the 'happiness' (general wellbeing) of any group is a complex task, requiring consideration of a number of subjective factors. But, in the wake of growing inequality[85] in many countries, and in trying to gain more nuanced understanding of systems such as children's 'care', organisations have been exploring new measures, which can provide a picture of how individuals and groups are feeling about their lives. The head of the UN Development Program, among others, has spoken up against what she called the "tyranny of GDP"[86], (alongside which could be sat a range of other 'output' measures), arguing that "paying more attention to happiness should be part of our efforts [...]."

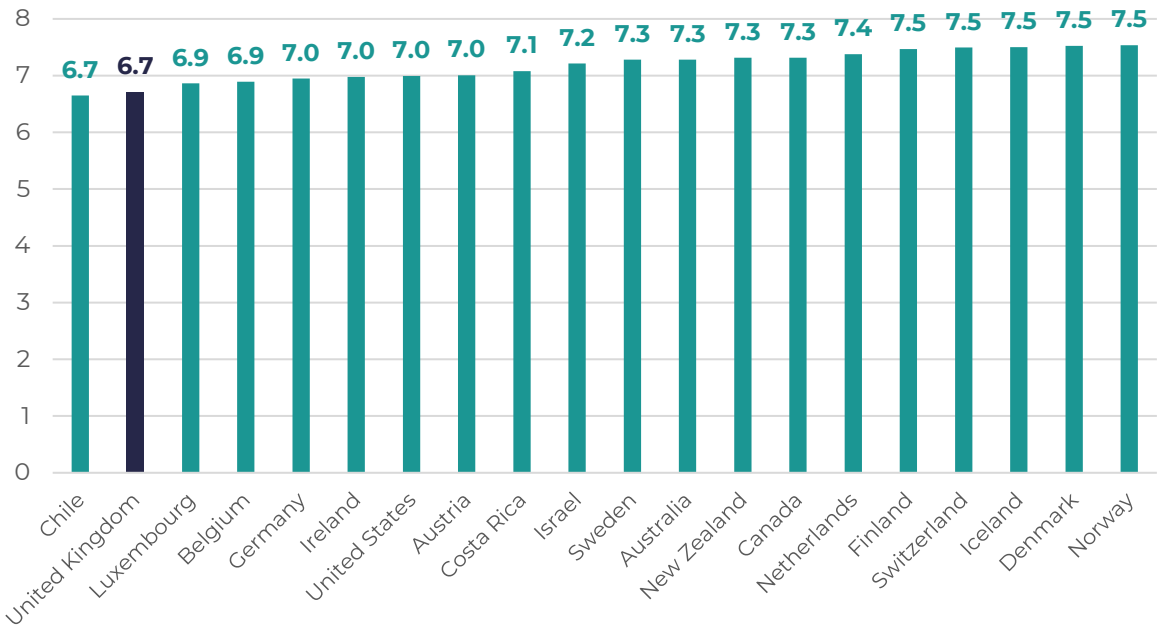
The World Happiness Report is a measure of happiness, published annually by the United Nations Sustainable Development Solutions Network. The World Happiness Report asks people to evaluate the quality of their current lives on a scale of 0 to 10) for each country, averaged over the years 2014-2016. Key factors include economic variables (such as income and employment), social factors (such as education and family life), and health (mental and physical). These countries are surveyed on GDP per capita, social support, healthy life expectancy, social freedom, generosity, and absence of corruption.

Within this report, in the three Western societies (United States, Britain and Australia), mental illness was identified as more important than income, employment or physical illness in determining 'happiness'. In every country, physical health was found to be important, yet in no country is it more important than mental health. The study also finds that the key

[85]Oxfam An Economy For the 1%: How privilege and Power in the Economy Drive Extreme Inequality and How This can be Stopped
[86] World Happiness Report (2017) World Happiness Report (2017), Chapter 1: Overview (John F. Helliwell, Richard Layard, and Jeffrey D. Sachs)

factors for the future adult are the mental health of the mother and the social ambiance of primary and secondary school[87].

Chart 36: Top 20 'Happy' Countries, compared with happiness explanation variance[88]



The Happiness Report's calculations are illustrative rather than conclusive. But even within their significant limitations, their strength is to shift the debate from measuring the performance of a system to its impact on the people the system exists for. To give a very simplistic example, if most people in a country are rich but also unhappy, should it be considered that the system(s) are working well? Looked after children data is not only limited, what we do have is focused overwhelmingly on measuring inputs and outputs, not experience or wellbeing.

The Scottish Government aims to capture data on health and wellbeing indicators as part of their realigning children's services programme. The Government has developed entirely new surveys to capture this data,

[87] World Happiness Report (2017) World Happiness Report (2017), Chapter 5: The Key Determinants of Happiness and Misery (Andrew Clark, Sarah Flèche, Richard Layard, Nattavudh Powdthavee, and George Ward)
[88] World Happiness Report (2017) World Happiness Report (2017), Figure 2.2: Ranking of Happiness 2014-2016

which includes surveying children and young people directly using questions such as “How often do you feel you have a good life?” and “How often do you feel happy?”[89]. This development may lead to a broader, more holistic data set for children in the future.

[89] Scottish Government (2017) Children's Wellbeing Surveys;

6. Data gaps

This paper has presented some of the existing data that exists for looked after children, young people and care leavers in Scotland. However, it is not an exhaustive and completely comprehensive review; instead it focuses on areas which the Care Review has expressed an interest in, and for which there is reliable data.

Moreover, very significant gaps in the data remain. We cannot say, for example, how many care experienced people there are in Scotland, or how many care experienced young people are currently at university.

The current data sets, and the lack of linkage between them, also make it very difficult to map children's 'care journeys'. Information is available on how many children's panel hearings there were in a year; how many children and young people have had two placements or more; and, how long children had been in care at the time of leaving. But, at present, it is not possible to draw out the care journeys of individual children. The information exists within systems, but without significant effort (involving much technical work), it remains fragmented. For example, the information from SCRA and local authorities is not currently linked, precluding a wide range of analyses around the operation of the Children's Hearings system and the implementation of Compulsory Supervision Orders. Nor is looked after child information linked to UK or Scotland-wide administrative data sets, which would allow journeys to be mapped pre and post care. No such linkage is simple, and many practical and ethical considerations would need to be worked through, but if the resources and willing were available, Scotland would be able to say much more about the drivers into, experiences within, and outcomes of, its 'care system'.

There also continue to be issues with data quality in some areas, with discrepancies between data providers over definitions and local practice. Opportunities exist to build capacity in local authorities and other potential data providers, improving the quality and consistency of the available information.

It should be recognised too that most of the available data only shows a 'snapshot' of the 'care system', a picture taken on a specific date (in most instances, 31 July). Indeed, the Scottish Government itself has identified a large number of gaps in the data which are either outwith their ability to collect or are more appropriately measured by in-depth qualitative studies[90]. They have presented these gaps as questions, which include:

- What are children's situations prior to becoming looked after?
- How suitable are placement types for children?
- Are placement endings planned?
- Why do children choose to stay in their care settings?
- What impact does the extension of aftercare have on young people?

Additional gaps/areas in need of further development of data collection and reporting include:

- The role of domestic violence
- Intergenerational and recurrent cycles of care
- Homelessness and direct link to leaving care
- Involvement in crimes / Youth Justice
- LGBT and other protected characteristics
- Care placement moves

[90] Scottish Government (2015) Looked After Children Data Strategy

7. Appendices

Appendix A: Glossary of terms

Term or Phrase	Explanation
Adoption / adopted	Process by which all parental responsibilities for a child are transferred to an individual(s), by means of an Adoption Order.
Asylum Seeker	An asylum seeker is a person who says that he or she is a refugee but whose claim for refugee status under the UN Refugee Convention to a state that has signed that Convention has not yet been definitively settled.
Care experienced	This term has no basis in legislation or statutory guidance. Therefore no fixed, universal definition is available. In general, the term is used to describe persons who are, or have been at any time, 'looked after' by a local authority. To manage eligibility for support, individual organisations have chosen to develop their own definitions. For example, the University of Strathclyde, uses the following definition of 'care experienced': • Currently a 'looked after' child or young person; • Currently or were a UK 'care leaver', (i.e. eligible for aftercare support from a UK local authority); • Were looked after by a UK local authority for three months or more during the years of compulsory school education (5-15 years old).
Care leaver	A person who 'ceased to be looked after' on or after their 16th birthday, but who has not yet reached their 26th birthday. (This includes persons who were 'looked after at home' and 'looked after away from home'. All 'care leavers' are, subject to an assessment, eligible to 'aftercare' support from their local authority. Corporate Parenting duties (Part 9 of Children and Young People (Scot.) Act 2014) apply to all care leavers.

Term or Phrase	Explanation
"in care"	Child is currently 'looked after' by a local authority. (For further information, please refer to main text of briefing above.)
Corporate Parent	An organisation or individual listed, or within a description listed, of schedule 4 of the Children and Young People (Scotland) Act 2014. These organisations and individuals are subject to all the duties set out in Part 9 of the 2014 Act.
Kinship Care	Term used to describe a child who lives with, and is cared for by, a relative or friend of the family. However, the term is frequently used to describe three similar but legally distinct groups: • *Formal kinship care*, where the child is 'looked after', and so living with relatives or friends under the supervision of a local authority. • *Informal kinship care*, where the child is living with relatives or friends on the basis of a private agreement with the child's parents, and is not 'looked after' by a local authority. • *Subject to a section 11 order* (referred to as a 'residence' or 'Kinship Care Order'), where the child lives with relatives or friends to whom certain parental responsibilities have been transferred by a Court. These children are not 'looked after' by a local authority, but may be eligible for a range of support from publicly funded organisations.
Kinship Care Order	A legal order, made by a Court under section 11 of the of the Children (Scotland) Act 1995; this transfers certain parental responsibilities to a named individual(s). If the child meets certain criteria (e.g. they were, or were at risk of, being 'looked after'), the section 11 order may be referred to as a Kinship Care Order. This entitles the child and carer, under Part 13 of the Children and Young People (Scotland) Act 2014) to support from their local authority. A child subject to a 'Kinship Care Order' (aka a 'section 11 order') is not 'looked after' by a local authority.

Term or Phrase	Explanation
Looked after child	A child to whom a local authority is providing a level of care and protection, as an outcome of either an agreement with the child's family, or a legal process (which transferred certain responsibilities for the child's welfare to the local authority). A child for whom a local authority has a duty to safeguard and promote their welfare and wellbeing (and which shall, in the exercise of their duties to him/her, be the local authorities' paramount concern); A child eligible to the support and assistance of all 'corporate parents', as appropriate to their function.
Looked after at home	Child is subject to a Compulsory Supervision Order (CSO) with "no condition of residence". Child lives with their parent(s), or other family member, under the supervision of the local authority. Child is 'looked after' by the local authority for the duration of the CSO.
Looked after away from home	Child is either: • subject to a Compulsory Supervision Order with a condition of residence; • provided with accommodation under section 25 of the 1995 Act; • subject to a Permanence Order; or • living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities. Child lives with carers 'away from' their parents or regular carers, under the supervision of the local authority, in kinship care, foster care or some form of residential care (including secure care).
Formerly / previously looked after	A child or young person who was, but is no longer, 'looked after' by a local authority. This could apply to a person of any age, including children who went on to be adopted, those who returned to the care of their parents after being accommodated elsewhere, care leavers, etc.

Term or Phrase	Explanation
Refugee	A refugee is someone whose individual application for asylum has been granted. They have been recognised as needing protection under the 1951 UN Refugee Convention
'Section 11 order' (also known as a 'Residence Order' or 'Kinship Care Order')	A legal order, made by a Court, under section 11 of the Children (Scotland) Act 1995. The order transfers parental responsibilities (including decisions over residence) to a named individual(s), such as a grandparent, aunt, etc. A child subject to a section 11 order is not 'looked after' by a local authority.

Appendix B: Grounds for referral to a Children's Hearing

Section 67 of the Children's Hearing (Scotland) Act 2011[91] sets out the grounds on which a Reporter may refer a child to a Children's Hearing. These are:

a) the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care,

b) a schedule 1 offence has been committed in respect of the child,

c) the child has, or is likely to have, a close connection with a person who has committed a schedule 1 offence,

d) the child is, or is likely to become, a member of the same household as a child in respect of whom a schedule 1 offence has been committed,

e) the child is being, or is likely to be, exposed to persons whose conduct is (or has been) such that it is likely that—

   i. the child will be abused or harmed, or

   ii. the child's health, safety or development will be seriously adversely affected,

f) the child has, or is likely to have, a close connection with a person who has carried out domestic abuse,

g) the child has, or is likely to have, a close connection with a person who has committed an offence under Part 1, 4 or 5 of the Sexual Offences (Scotland) Act 2009 (asp 9),

h) the child is being provided with accommodation by a local authority under section 25 of the 1995 Act and special measures are needed to support the child,

[91] Children's Hearing (Scotland) Act 2011 [http://www.legislation.gov.uk/asp/2011/1/contents]

i) a permanence order is in force in respect of the child and special measures are needed to support the child,

j) the child has committed an offence,

k) the child has misused alcohol,

l) the child has misused a drug (whether or not a controlled drug),

m) the child's conduct has had, or is likely to have, a serious adverse effect on the health, safety or development of the child or another person,

n) the child is beyond the control of a relevant person,

o) the child has failed without reasonable excuse to attend regularly at school,

p) the child—

   i. is being, or is likely to be, subjected to physical, emotional or other pressure to enter into a marriage or civil partnership, or

   ii. is, or is likely to become, a member of the same household as such a child.

Narrative Comparison of Care Experienced Data Analyses

Jean Gordon, Research Consultant
Moira Dunworth, Research Consultant

3rd November 2017

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1. Introduction

The Care Review was launched in February 2017. Aiming to explore the underpinning legislation, practices, ethos and culture of the 'care system' in Scotland, the Care Review is being driven and shaped by care experienced young people.

The first, or Discovery, stage aims to reach a consensus on the vision and scope of the Care review. A large number of care experienced children, young people and adults have contributed their views about the current 'care system' and how it could be improved. The aim was to answer two key questions:

- What does good care and protection look like for children and young people in care?
- What should the scope of the Care Review be?

The responsibility for seeking the views of care experienced individuals was split between two organisations, Who Cares? Scotland and members of the Care Review Secretariat team.

Data from the two consultations were analysed and reported upon separately.

The purpose of this report is to discuss the differences and similarities between the two analyses and their conclusions. The approach taken by both teams will be summarised briefly before comparing, in turn, the approach, participants and methods of data analysis employed, and the key themes generated.

The two final sections of the report address the significance of the comparison's findings and identify learning that will contribute to the next, Journey, stage of the Care Review.

2. What approaches were taken?

The contribution made by the voices heard by Who Cares? Scotland to the Care Review forms part of a wider, future focused project, *1000 Voices*, 'a way for care-experienced people to share their views, ideas, hopes and dreams about how Scotland can provide the most stable and loving environment to enable children and young people to thrive' (Who Cares? Scotland, 2017a).

1000 Voices aims to ensure that at least 1000 care experienced people's voices are heard by the Care Review, thereby creating a community of empowered individuals and structures to ensure that their voices continue to be heard long after the Care Review concludes (Who Cares? Scotland, 2017a).

This ambition informed the approach employed to engage with care experienced people (Who Cares? Scotland, 2017b). The consultation design and process were underpinned by the participation values and ethics of the organisation, which is owned and governed by care experienced people. The organisation was able to build on its pre-existing relationships with care experienced young people, for example, through their participation groups, to involve and support Care Review participants. Care experienced people could contribute to the Care Review in a range of ways, from individual (phone, online, face to face) contact, through small focus groups to larger workshops and events. Facilitation methods included:

- Audio recording through a podcast project
- Visual records e.g. drama, journey mapping
- Graphic facilitation e.g. using a 'root and branch tree'
- Creative and artistic methods e.g. photography

Who Cares? Scotland also made a commitment to work with partners to ensure that care experienced people would be supported by known and trusted adults to take part in the Care Review (Who Cares? Scotland, 2017b).

A range of different approaches were also employed by researchers from the Care Review Secretariat team. Similarly, care experienced participants could contribute individually, or through small or larger group meetings and events. An important difference between the engagement methods is that the Care Review were also consulting with the wider audience of parents, professionals and carers. In some cases group events included a mix of these participants, for example, young people were interviewed with a residential social worker, or a care experienced adult was interviewed with his or her birth mother.

Care Review consultations partly took place in facilitated group events, or during small group or individual interviews. An online survey attracted 39 responses from care experienced people, but none went further than inputting their status into the survey. Two child-care organisations also gathered views by means of Discovery postcards, completed by a total of 233 contributors. This body of data provided brief verbatim written responses from care experienced participants whilst the meetings and interviews were recorded in note form by facilitators. This is an important difference between the two analyses, since many of the methods used by Who Cares? Scotland enabled them to access the unmediated words of care experienced people.

3. Whose voices were heard?

Who Cares? Scotland engaged with 373 voices during the Discovery stage.

The largest contribution was made by young adults (15-19), and 18% were over 19. Just over half identified themselves as female. Nearly 60% of the voices heard were from a child or young person resident in a children's home (38%) or in foster care (19%). Other voices came from young people in secure accommodation and residential schools, with just 16 (7%) living with kinship carers (Who Cares? Scotland, 2017c).

The Care Review Secretariat engaged at least 349 care experienced people[92]. Participant ages were mostly not recorded, but, of the ages given, at least 47 (13%) of these were recorded as adults or over 18 year olds. Participant gender was not recorded, and only limited information about location was available, so has not been reported on in the analysis of this data (Gordon and Dunworth, 2017).

[92] Numbers were not recorded at all group events analysed, and some events did not include a breakdown of stakeholders involved, so this is an under-estimate.

4. How was data analysed?

In early October 2017 it was agreed that the analysis of the two datasets would be conducted separately, but both would employ a form of thematic analysis developed by Braun and Clarke (2006).

The approach adopted was inductive; in other words, the themes identified were to be data-driven, generated by the voices of care experienced participants themselves. This form of analysis has some similarities to grounded theory (Glaser and Strauss, 1968; Strauss and Corbin, 1990). However, since the focus of the data analysis was on the two Discovery questions, there was no intention to engage in theory development, the intended outcome of a full grounded theory approach.

Data was coded and then grouped into themes for each of the two Discovery stage questions by both analysis teams. The teams devised similar ways to quality assure their analysis by double coding a sample of the data. This involved two researchers independently making coding decisions, discussing similarities and differences and, where necessary, making improvements to the coding framework. Comparing the codes generated from Who Cares? Scotland and the Care Review data, there are some striking similarities. Examples of codes used in both analysis include: 'listening', 'communication', 'carers', 'stability', 'transition(s)', 'mental health', 'education', 'trust', 'respect' and 'relationships'. Where differences existed, these often appeared to be related to the more unmediated access to the actual words of care experienced participants in the Who Cares? Scotland data. So, for example, Who Cares? Scotland included in their schema many codes directly related to the day to day lived experiences of young participants. These included: 'running away', 'pets', 'blame', 'what I enjoy', 'punishment' and 'informed'. Overall there were more similarities than differences in the codes generated, and it was often possible to see how

words used by young participants, such as 'leaving care', for example, in the Who Cares? Scotland framework had become translated into the more 'adult speak' of 'throughcare' and 'aftercare' in the Care Review codes.

5. How different are the analyses?

Both analyses grouped codes generated from the data into themes.

Who Cares? Scotland analysis identified 9 'Recurring Themes' that span both Discovery questions (see Appendix 1). The analysis of the Care Review data identified different, but overlapping, themes for each of the two questions. Seven themes were identified in relation to care experienced people's vision for care and protection in Scotland. A further seven themes address the question of what the Care Review should consist of. This distinguished between themes about who should be involved, what should be reviewed and how the Care Review should go about its work (see Appendix 2).

Taking a very broad overview, the accounts of participants of their care journeys and experiences on which the two analyses draw have yielded some very similar themes. For example, both emphasise the importance of continuity, of stability, of being included in communities and wider society, of compassionate caring, of contact with birth families (especially siblings) and ongoing support as young people move into adulthood. Importantly, however, this broadly similar content is expressed and organised in different ways in the two analyses. To some extent, this is inevitable; however rigorous a qualitative analysis, there will always be differences in how researchers will code and theme the same data. In these analyses the identified themes are highly inter-related so that there were continual choices to be made about how best to reduce the very rich data to thematic form.

However, there are also some more fundamental differences about the approach taken. Firstly, as could be predicted from the data sources available to the two teams, the Who Cares? Scotland themes are significantly more centred on the child's experience. The words used in

their recurring themes are those of the care experienced participants they spoke to (Discussion at data analysis meeting, 31.10.17). Their analysis has been able to draw on detailed accounts of the lives and experiences of participants and records, for example, individual's personal feelings about making relationships, or being restrained. The Care Review data is mostly less detailed with fewer verbatim contributions and, apart from the Discovery Postcards, had already been summarised into more adult language by meeting facilitators and interviewers. An example of this difference is evident in the Who Cares? Scotland Recurring Theme 9, 'The importance of knowing who I am'. This theme reflects statements from young people about their perception of 'sense of self', which is reported as coming across strongly in the data collected. This was not the case with the data from the Care Review. There was no equivalent in the Care Review data codes for, for example, 'identity' and 'identity/ belonging', both of which occur in the Who Cares? Scotland data. However, the Care Review data analysis picked up the constituent components of this recurring theme in other ways. So, Vision Theme 3, 'care experienced people will be treated as the equals of other children', arose from data that spoke to care experienced people's concerns about stigma, discrimination and exclusion. Recurring Theme 9 refers to the importance of loving and stable relationships, which also emerged in the Care Review data analysis Theme 4. It is beyond the scope of this report to explore the precise equivalence of every theme in the two analyses in this way. However, a broad reading of both draft data analysis reports finds similar correlations between interweaving themes, however differently the themes themselves are sometimes expressed.

6. Conclusion

Overall, the two analyses do not tell dramatically different stories about care experienced people's vision for good care and protection, or about what the Care Review should encompass.

As far as can be determined from the socio-demographic data available, there is no evidence that the data sets have been drawn from differing populations of care experienced people. Data analysis has been conducted using the same theoretical framework, and has been undertaken systematically and transparently. Nevertheless, there are marked differences in the emphasis and presentation of the two analyses which mostly appear to relate to differing approaches to hearing and recording the voices of care experienced people.

A particular strength of the Who Cares? Scotland analysis is that it draws explicitly and immediately on the voices of care experienced people, and aims to speak to what matters most to them. The Care Review data, which was generally less detailed, and sometimes more mediated by professional and researcher voices, generated an analysis that goes some way to translate that vision into what care and protection will need to do to make this vision a reality. Its analysis of data related to the Care Review's scope should also help to begin to flesh out and plan for the 'who', 'what' and 'how' of the Journey stage. Summarising, the two analyses can be seen as holding up two different but related lenses to the same child 'care system'. They are best regarded as complementary, separately and together making an important contribution to the Discovery stage of the Care Review.

7. Further learning

At the end of the analysis process representatives from the two analysis teams met to review progress and discuss their findings.

The use of the same thematic analysis framework was thought to have worked well for both teams, as well as making it easier to understand and compare the completed analyses. Some of the same challenges arose for both teams, including a difficulty in prioritising the themes identified. Unlike Who Cares? Scotland, the Care Review data analysers have chosen to prioritise their themes, but acknowledge that their method, which identifies themes on an event-by-event basis, is flawed because it lends equal weight to views expressed by a single individual in an interview and a group of 20 or more people. Important differences between engaging professional stakeholders and care experienced people were also highlighted. Care experienced participants need to feel safe and supported before they are likely to feel confident to engage, and their responses will be about what is most relevant to them and their lives. One of the skills of data analysis is therefore paying attention to and trying to understand participants' varied stories about their care journeys, which may not, at first sight, provide the answers to the questions that adults have devised for them to answer.

Looking to the future, it is important to note that, although the focus of both analyses was necessarily for the two Discovery questions, the data collected goes far beyond this aim. Amongst the data are many individual stories about care journeys. They are not told in the Discovery stage analyses, which necessarily fragmented the data to answer the Care Review's two questions. It will be important for the next stages of the Care Review to consider a range of research methods, such as case study designs, that will ensure that these stories are not lost. Lessons can also be

learned from the experience of dividing data collection and analysis between two teams at the Discovery stage. Should a similar approach be used in the future, it will be important for analysers to work closely together and agree common approaches from an early stage. This collaborative approach would ensure that the theoretical and practical basis for data analysis is integral to decision-making about research design and that researchers are able to benefit from each other's expertise from the start.

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9. Appendices

Appendix 1: Who Cares? Scotland data analysis: Recurring themes

Recurring theme 1: The importance and impact of power/control

Recurring theme 2: The importance of educating others on care

Recurring theme 3: The importance of good support, early on and as early as possible

Recurring theme 4: The importance of stability

Recurring theme 5: The importance of lasting relationships

Recurring theme 6: The importance of looking to the future

Recurring theme 7: The importance of more information

Recurring theme 8: The importance of good wellbeing and mental health

Recurring theme 9: The importance of knowing who I am

Appendix 2 Analysis of Care Review Secretariat data: Themes

A vision of the best child 'care system'

1. The child or young person will always be at the centre of care and protection
2. There will be continuity, stability, security and consistency throughout the care journey
3. Care experienced people will be treated as the equals of other children
4. Everyone who works with young care experienced people will be compassionate, caring and understanding
5. Children and young people will be included in all decisions that affect them
6. Services will be reliable, effective and work together to provide the best possible standards and continuity of care and care worker
7. Care environments will be homely, safe, warm and nurturing, and offer opportunities for activities, fun and self-fulfillment

The scope of the Care Review

1. **Who:** The views and experiences of care experienced people should be central to the Care Review
2. **Who:** The Care Review should include many voices
3. **What:** The whole care journey
4. **What:** All kinds of care services, including services for children who live with their birth parents and other relations, foster care, residential care and secure care
5. **What:** The quality, skills and training of care staff, especially social workers, residential staff and foster carers
6. **What:** Decision making and the legal system
7. **How:** Learning how to do things better

Historical overview of legislation and policy relating to 'looked after children' in Scotland

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1. Introduction

This paper provides an overview of legislation and policy relating to 'looked after' children and young people and draws out historic trends, illustrating how the current legislative framework came to be.

It sets out the early history of child care law and the gradual move towards children's rights and a child-centred approach being embedded into policy and legislation in Scotland.

Particular attention is given to the 1964 Kilbrandon Report and the founding of the Children's Hearings System which forms the foundation of today's system.

The paper maps the development of the workforce profession and the gradual move away from the reliance on social worker alone to a more integrated approach, extending responsibilities to other professions and universal services.

Further, the manner of care provision and the historic policy move away from residential homes to small family-based care provision is explored, as well as the policy agenda regarding adoption and permanence.

The paper also provides a brief summary of the policy and legislative effort to extend care and support to care leavers and the effort to improve outcomes for looked after children more widely. Throughout, the paper makes reference to the most recent legislative developments, including the impact of the Children and Young People (Scotland) Act 2014.

2. Early history and wider context – the emergence of universal rights and the creation of the UK welfare state

Universal children's rights and child protection is very much a 20th century concept.

It wasn't until the early 1900s that Parliament first passed legislation giving the state authority to intervene in family life by removing children from abusive parents, and making ill-treatment of children a criminal offence[93].

The end of WWII saw Europe as a whole move towards recognition of universal human rights, with the European Convention on Human Rights introduced in 1950[94] and later, the UN Declaration on the Rights of the Child in 1959.

Another 30 years were to pass before the UN Convention on the Rights of the Child came into being; today the most widely ratified human rights treaty in the world.

The end of WWII also became the catalyst for the founding of the UK welfare state with the birth of the NHS in 1948, and the introduction of the National Assistance Act 1948 which extended social welfare benefits to those in society unable to pay national insurance.

[93] The Prevention of Cruelty to, and Protection of, Children Act 1889; Children Act 1908 ('the Children's Charter).
[94] Ratified by the UK in 1951 and transposed into UK law by the Human Rights Act 1998

3. Early Intervention and the Importance of Familiar Relationships

Within the wider context of legislative and societal reform in the aftermath of WWII, the Children Act 1948 was introduced, and for the first time created an explicit duty on local authorities to provide care for destitute children, moving away from care being provided by the church and voluntary sector and establishing the principle of the best interest of the child[95].

The Act also marked a shift towards thinking more holistically about families, and allowed local authorities to do preventative and supportive work, to stop children coming into care in the first place.

The Children and Young Persons Act 1963 further placed a duty on local authorities to provide advice, guidance, and assistance to reduce the need to take children into care, including monetary assistance.

Keeping families together and avoiding children going into care were the core objectives behind the introduction of home supervision orders in the Social Work (Scotland) Act 1968, based on the principle that the most powerful and direct influence on a child remains the home.

A child looked after at home continues to live at their normal residence (usually the family home), but receives regular visits from social workers to ensure that the objectives of the home supervision order are being met. Home supervision orders are still in place today and guidance was published in 2010[96].

[95] Children Act 1948 section 12(1): "*Where a child is in the care of a local authority, it shall be the duty of that authority to exercise their powers with respect to him so as to further his best interests, and to afford him opportunity for the proper development of his character and abilities.*"
[96] Guidance on the Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007

For children for whom living at home isn't a viable option, the Children (Scotland) Act 1995 placed an explicit obligation on local authorities to facilitate and promote the involvement of birth families in the lives and upbringing of children taken into care[97] , and to promote contact with birth parents[98] [99].

The Looked After Children (Scotland) Regulations 2009 extended this to require local authorities to also take into account contact with the family more widely when determining where to place a child in care[100].

The Scottish Government has in place a number of policies specifically benefitting children on home supervision orders, including the Intandem mentoring programme launched in 2016 in response to recommendations made by the Looked After Children Strategic Implementation Group (LACSIG) in 2013[101].

[97] Children (Scotland) Act 1995 section 22(1)(b).
[98] *Ibid* section 17(1)(c)
[99] Parents are defined by the Children (Scotland) Act 1995. The definition of parents has been extended by the Family Law (Scotland) Act 2006 to include unmarried father and by the Human Fertilization and Embryology Act 2008 to biological parents.
[100] The Looked After Children (Scotland) Regulations 2009 section 4(3)
[101] Developing a National Mentoring Scheme for Looked After Children

4. Kilbrandon and the Children's Hearings System

Up until the 1960s, policy in Scotland had developed along a largely similar trajectory to that of England and Wales. However, the publication of the Kilbrandon Report in 1964 marked a decisive change in Scottish children's policy.

The Kilbrandon Committee was set up to look at solutions for dealing with 'delinquent juveniles', although the eventual report took a much wider look at children in need of care and protection, and not just those involved in the justice system.

The Report, which led to the introduction of the Social Work (Scotland) Act 1968 and the establishment of the Children's Hearings System in 1971, marked a decisive change. Scotland moved away from a punitive approach and towards a child welfare centred model by creating the one system for handling matters of child protection and youth justice; the Children's Hearings System.

The Children's Hearings System has undergone significant reform in the past decade, led by the Children's Hearings (Scotland) Act 2011, designed to modernise and streamline the hearings system through a number of structural reforms and the establishment of the public body, Children's Hearings Scotland.

This was in part to reflect the changing nature of referrals during the 1990s which saw a significant increase in referrals on 'care and protection' grounds, and a drop in referrals due to juvenile offences. Also worth noting is the establishment of the Scottish Children's Reporter Administration (SCRA) by the Local Authorities etc. (Scotland) Act 1994.

To help implementation of these reforms, the Children's Hearings Improvement Partnership (CHIP) was established, bringing together a

range of people from organisations across Scotland with a common interest in developing and improving the hearings system.

In 2016, CHIP published 'The Next Steps Towards Better Hearings', comprising research into the views of practitioners and children and young people involved with the hearings system. 'Better Hearings' forms the basis of on-going work to develop service standards for the Children's Hearings System[102].

[102] Children's Hearings Improvement Partnership, *The Next Steps Towards Better Hearings*, http://www.chip-partnership.co.uk/wp-content/uploads/2016/10/Better-Hearings-Research-Report-2016.pdf

5. Regulating the workforce – How it became everyone's job

The Social Work (Scotland) Act 1968 is the landmark piece of legislation for the social work profession in Scotland which introduced social work departments in all local authorities and made the social worker the key professional for children's care and protection purposes.

Since 1968, there has been a significant increase in the regulation of professionals working with children, as well as a political and legislative push to spread responsibility more widely across professions other than social services and universal services.

Over the past half-century, Scottish local authorities have undergone several restructures, and the place and role of social work departments have changed correspondingly.

The Local Government (Scotland) Act 1973 centralised social work and education policy in 9 regional councils, whereas housing and recreation policy was placed with 53 smaller district councils.

The NHS and Community Care Act 1990 saw the UK move towards part privatisation care in certain areas, further complicating the professional landscape and leading to an increase in specialisation of social workers.

The Local Government etc. (Scotland) Act 1994, which created the current day structure of 32 authorities across Scotland, meant another reorganisation of local authorities and a major reduction of social work departments.

The role of the Chief Social Work Officer was introduced and local authorities were given more autonomy over how children's services were delivered, leading to fragmentation in configurations of integration.

An important influence on how the children's social work profession has been regulated has to do with the public perception of the profession over time.

The death of Maria Colwell in 1973 and the child sexual abuse scandals which came to light during the 1980s (which led to the Cleveland Inquiry in England) and the 1992 Fife and Orkney child abuse Inquiries in Scotland, greatly damaged the standing of the profession and led to an increase in regulation of the sector.

The Regulation of Care (Scotland) Act 2001 is the landmark legislation, establishing the precursor to the Care Inspectorate and SSSC. National care standards were introduced for children's care homes, and from 2002 onwards a registration requirement for the social work and child care professions was gradually rolled out[103].

The child abuse scandals of the 1990s also resulted in a political push towards further integration of services, and to the strengthening of the involvement of other professionals in child protection through increased emphasis on early intervention.

The Scottish Executive report from 2001 'For Scotland's Children' introduced the concept of the 'Named Person' – a lead professional assigned as contact person for every child. The Named Person role was to be held by education and health professionals, rather than social work.

The Named Person policy has since become integrated into the Scottish Government's Getting It Right For Every Child (GIRFEC) model, and was included in part of the Children and Young People (Scotland) Act 2014. Further legislation is currently going through the Scottish Parliament to amend part 4 of the 2014 Act and bring the provisions into force.

[103] SSSC's registration timetable: http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications?task=document.viewdoc&id=1485

The role of the wider workforce involved in children's lives was further strengthened by the publication of 'It's Everyone's Job To Make Sure I'm Alright' by the Scottish Executive in 2002. Lastly, to help professionals working with children, the resource materials 'We Can And Must Do Better' was published in 2007 (and updated in 2013).

Over the years, the Scottish Government has gradually introduced more stringent requirements on the level of qualification professionals working with children and young people in care are required to hold.

In 2009, the National Residential Child Care Initiative published 'Higher Aspirations, Brighter Futures' which called for a new Residential Child Care level 9 qualification to be developed. In 2015, the Scottish Government announced it would make this qualification a requirement for the residential childcare force. Implementation is currently pending.

It is also important to note the Social Care (Self-Directed Support) (Scotland) Act 2013 which allows those eligible for social care to choose how support is provided to them. In the context of 'looked after' policy, this has had the largest impact on children with disabilities.

Other important legislation to note is the Public Bodies (Joint Working) (Scotland) Act 2014 which sets the framework for health and social care integration.

Whilst there is no obligation on children's services to be integrated, a number of local authorities have chosen to do so.

6. The evolution of child protection policy and Getting It Right For Every Child

Child protection legislation has undergone constant change over the past centuries, from the early 20th century when child protection was defined by prevention of cruelty legislation, to present day when we have a much more nuanced picture of what neglect is, and what child welfare means.

For example, while the definition of neglect is still to be found in the Children and Young People (Scotland) Act 1937, it has been amended repeatedly over time, including by the Children (Scotland) Act 1995 and the Criminal Justice (Scotland) Act 2003, and a consultation is currently on-going to further review this.

Fundamental to understanding child protection in Scotland is the Getting It Right For Every Child (GIRFEC) policy, and in particular the importance of the Named Person duties in part 4 of the Children and Young People (Scotland) Act 2014 - to be read in the context of data sharing and the Data Protection Act 1998.

The duty to protect and report is set out in Police and Fire Reform (Scotland) Act 2002 while the Children (Scotland) Act 1995 defines the range and scope of Local Authority intervention in family life in order to safeguard children.

The Protection of Vulnerable Groups (Scotland) Act 2007, replaces the former disclosure system and sets out when PVG certificates are required for those working with children.

Most recently, the Scottish Government commissioned the 2016 Review of Child Protection, resulting in the publication of 'Protecting Scotland's

Children and Young People: It's still Everyone's Job' in 2017, and the establishment of the Child Protection Improvement Programme (CPIP).

7. Adoption policy and permanence

Scottish Government policy is underpinned by the principle that permanent, loving, nurturing relationships are what matter most to children, and that this is best delivered by removing children from long-term supervision, where appropriate, and giving them the legal certainty that their relationships are permanent. This is secured either through adoption or through the granting of 'Permanence Orders'.

Scotland has been slightly slower off the mark than other nations in recognising the importance of adoption and permanence. Adoption first became legal in Scotland with the introduction of the Adoption of Children (Scotland) Act 1930 (four years later than in England and Wales) and it wasn't until 1978 that 'private' adoption based on a financial transaction was outlawed in Scotland.

The Adoption (Scotland) Act 1978 also established adoption agencies officially in law and established grounds under which parental rights could be overruled in order for children to be 'freed for adoption'.

In the early 1990s, and following the introduction of the UN Convention on the Rights of the Child, policy started to shift in Scotland towards a rights-based approach, placing more weight on the interest and views of children.

The Age of Legal Capacity (Scotland) Act 1991 gave children over the age of 12 the power of consent to the making of an adoption order, or an order 'freeing' him or her for adoption.

The Children (Scotland) Act 1995 was the first piece of legislation in Scotland embedding children's rights into law and made the

consideration of a child's lifelong interests a paramount concern in adoption decisions.

Between 1990 and 2000, the number of adoptions in Scotland dropped by 50% from 900 to 450 annually, and in 2001 the Adoption Policy Review Group was announced by the Scottish Executive to address barriers to adoption.

The group, which reported in 2002 and 2005, pointed to the changing nature of children's relationships and the detrimental impact 'freeing for adoption' orders were having, as a person losing parental rights also lost all rights to contact with that child.

The group's findings led to the passing of the Adoption (Scotland) Act 2007 (and accompanying guidance[104]) and the introduction of Permanence Orders.

In terms of the measures put in place to ease the process of adoption, since 2011 the Scottish Government has funded Scotland's Adoption Register, which aims to speed up and increase the number of adoptions in Scotland.

The Children and Young People (Scotland) Act 2014 wrote Scotland's Adoption Register into law. Scotland's Adoption Register Regulations 2016 were created to set out the key requirements for supplying, retaining and disclosing information, and from April 2016 all adoption agencies in Scotland use Scotland's Adoption Register to refer both children and adopters within three months of approval.

Lastly, one of the key Scottish Government policy initiatives to note is the Permanence and Care Excellence (PACE) programme, delivered in partnership with the Permanence and Care Team (PaCT) at the Centre of Excellence for Looked After Children (CELCIS).

[104] Guidance on Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007

PACE began in 2014 with the aim of enabling more looked after children to experience permanence. The programme supports local authorities and their partners to develop projects based on improvement methodology that will identify delays, blockages, and difficulties to securing permanence for looked after children.

By December 2018, all local authorities will be using improvement methodology as part of the PACE programme.

8. Large-scale residential care v small-scale family-based care

Across the UK there has been a move away from large residential care providers towards smaller, family-based care provision. Today, only 10% of looked after children in Scotland stay in residential care, and the nature in which residential care is provided has changed dramatically.

From historically being a sector where care was provided by charities, churches and other voluntary bodies, provision of care gradually became the responsibility of the state, up through the 20th century.

In 1946, and in response to a number of childcare scandals, the Curtis Committee in England and the Clyde Committee in Scotland both made strong recommendations regarding the quality of care in residential homes, and that residential care was made more 'family-like'. The impact of these recommendations led to the Children Act 1948, which moved the UK towards a more child-centred approach.

A major landmark in residential care policy came with the 1992 Skinner Report. Much like the lead up to the Clyde Committee, Scotland and the rest of the UK found itself in the midst of a number of residential care scandals.

A comprehensive review of the provision of residential care in Scotland was therefore taken forward by the Social Work Services Inspectorate for Scotland (around the same time of the Utting Report in England).

The final report, 'Another Kind of Home', made fundamental recommendations with regards to how residential care should be provided and established eight principles for high-quality care still relevant today.

In more recent times, the Scottish Institute for Residential Child Care (SIRCC, since incorporated into CELCIS) was commissioned by the Scottish Government to lead a multi-agency National Residential Child Care Initiative (NRCCI) which published its reports in 2009.

In 2013, the Scottish Government published National Guidance for the External Management of Residential Child Care Establishments, and in 2017, the Care Inspectorate published its new National Care Standards.

9. Regulating Foster and Kinship Care

The concept of foster and kinship care is one that has evolved over time from an area subject to little state intervention into one which has increasingly been recognised requires a high level of skill, knowledge, and support.

The emergence of child development theories through the latter half of the 20th century and the importance attached to 'family life' for children's well-being have meant that the number of children in foster and kinship care arrangements has increased hugely over the years.

In terms of significant policy developments in this area, the 2005 Phase II report by the Adoption Policy Review Group was pivotal in promoting models of care which most closely resembled that of a 'regular' family situation.

This eventually led to the publication of 'Moving Forward in Kinship and Foster Care' by the Getting It Right For Every Child In Foster and Kinship Care Review in 2008, setting out a vision for fostering and kinship care in Scotland.

In 2013, a national review of foster care was completed in Scotland with the publication of a final report and six recommendations for improvement.

The Scottish Government responded to the report in 2014, agreeing to take forward all recommendations, the full implementation of which is still on-going.

The key legislation for fostering is the Looked After Children (Scotland) Regulations 2009[105]. Private fostering (i.e. an arrangement where a child is cared for by an adult who is not a close relative or an approved foster carer) is regulated by the Foster Children (Private Fostering) (Scotland)

[105] As amended by the Looked After Children (Scotland) Amendment Regulations 2014

Regulations 1985 and additional practice guidance was published by the Scottish Government in 2013.

Kinship care is regulated slightly differently to foster care in that it was only formalised by the Looked After Children (Scotland) Regulations 2009 which defined a kinship carer as: "a person who is related to the child (through blood, marriage or civil partnership) or a person with whom the child has a pre-existing relationship".

A child can be placed in kinship care by a local authority as a consequence of a supervision order under the Children (Scotland) Act 1995, or as a consequence of a court order under section 11 of the 1995 Act. It is also possible for a child to have an informal kinship care arrangement not established in law, and without the child acquiring legal 'looked after' status.

In 2015 the Scottish Government published 'National Guidance on Part 13: Support for Kinship Care' under the Children and Young People (Scotland) Act 2014, and the Kinship Care Assistance (Scotland) Order 2016, setting out guidance on kinship care assistance under the legislation. A national review of foster and kinship care allowance was announced in 2017 and is currently underway.

10. Secure Care

Secure accommodation is a form of residential care for the very small number of children whose needs and risks, for a particular period in their lives, can only be managed in the controlled settings of secure care.

Such children have been deemed to be a significant risk to themselves or others in the community. Secure care restricts the liberty of the children under the age of 18 placed in their care through the Children's Hearings system or the Courts.

The key legislation for secure care provision is the Secure Accommodation (Scotland) Regulations 2013 which sets out the definition and parameters of secure care.

The Children's Hearings (Scotland) Act 2011 provides the legal framework for consideration and decision making in relation to secure care placements.

There are National Standards (National Standards for Youth Justice Provision, Appendix 1 to the National Youth Justice Practice Guidance), which state that secure care and detention should be used only when it is the most appropriate disposal, and that consideration has been given to alternatives.

Scottish Ministers are responsible for children under the age of 16, and young people aged 16-18 on Compulsory Supervision Orders who are sentenced under solemn procedures and placed in secure care. The Criminal Procedures (Scotland) Act 1995 (sections 205 and 208) gives more information.

The Scottish Government has adopted the Whole Systems Approach programme for addressing the needs of young people involved in

offending. Underpinned by Getting it Right for Every Child, this ensures that anyone providing support puts the child or young person – and their family – at the centre.

Practitioners need to work together to support families, and take early action at the first signs of any difficulty – rather than only getting involved when a situation has already reached crisis point.

This does not mean that crimes committed by children and young people go unpunished. Children and young people can still be prosecuted if the offence is sufficiently serious to be dealt with on indictment or can be dealt with by the Children's Hearings System.

In 2016, a review was undertaken of secure care in Scotland by Secure Care National Advisor, Alison Gough. The final report, 'Secure Care In Scotland: Looking Ahead', sets out the key findings of the project.

As a result of the report, the Scottish Government established the Secure Care Strategic Board to lead the development of a strategic approach to responses to children and young people in and on the edges of secure care in Scotland.

The Board will report to Ministers by December 2018.

11. Care Leavers, Corporate Parents and Improving Outcomes

Children and young people in Scotland who are, or have been looked after, benefit from a number of other policy initiatives, including in the areas of health and education.

Over the years there have been a number of studies into the relatively poorer outcomes for children and young people with care experience which have led to legislative and policy changes.

The landmark legislation in terms of creating obligations on local authorities and other public sector bodies is the Children and Young People (Scotland) Act 2014, but a number of other pivotal developments are worth noting.

The 1973 publication 'Born To Fail' was an eye-opening national child development study funded by the National Children's Bureau, which for the first time, highlighted the adversities of 'disadvantaged' children in almost every aspect of life, including health and education.

In 2006, the comprehensive 'Extraordinary Lives' Report was published, exploring the gap in outcomes, demonstrating best practice in relation to creating positive futures for looked after children and young people.

Following 'Extraordinary Lives', the Scottish Parliament's Education and Culture Committee carried out an inquiry into the educational attainment gap, concluding in 2013 that the educational attainment gap remained 'unacceptably wide'.

In terms of education, the main piece of legislation is the Education (Additional Support for Learning) (Scotland) Act 2004, as amended in 2010 and 2016.

This legislation created a duty on Local Authorities to provide additional support to children with additional needs and, following the 2010 amendments, made children with 'looked after' status a priority group by establishing a presumption that children with experience of care have additional support needs, unless an assessment finds otherwise.

Other important policies to note are:

- Curriculum for Excellence;
- Equally Well (health strategy);
- Early Years Framework;
- Early Years Collaborative.

On a general level, the Children (Scotland) Act 1995 (as amended) set out that local authorities have a legal duty to:

- Prepare young people for leaving care or ceasing to be looked after.
- Provide advice and assistance to young people who have ceased to be looked after on or after their 16th birthday. Local authorities are legally required to provide aftercare support until the care leaver turns 19, and to assess any eligible needs for aftercare support until they turn 26 (or beyond in some cases).

These duties were set out in the Support and Assistance of Young People Leaving Care (Scotland) Regulations 2003[106]. The Scottish Government published guidance on services for young people leaving care in March 2004.

Specific provision was made to improve access to housing and prevent homelessness for care leavers in the 2013 'Housing Options Protocol for Care Leavers: Guidance for Corporate Parents'.

[106] amended by the Support and Assistance of Young People Leaving Care (Scotland) Regulations 2015 to extend the categories of aftercare support provided for by the 2014 Act

Obligations were further strengthened by the Children and Young People (Scotland) Act 2014, by putting into law the policy aspirations of:

- These are our Bairns (2008) – guidance for community planning partnerships (CPPs) on how to be a good corporate parent.
- Staying Put Scotland (2013) – guidance for all corporate parents on ensuring the wellbeing of care leavers, including coverage of Continuing Care.

The 2014 Act introduced legislation in two key areas; Continuing Care and Aftercare.

New provisions in Part 11 meant that a young person born after 1 April 1999 who is looked after in foster, kinship, or residential care is eligible to remain in their current care placement until they turn 21. This is called Continuing Care.

If the placement cannot be maintained, or if it is in the young person's best interests to start an alternative placement, a welfare assessment must be provided showing why staying in their current placement would significantly adversely affect their wellbeing.

Any eligible young person ceasing to be looked after when or after they turn 16 can request Continuing Care under section 60 of the 2014 Act.

A young person receiving Continuing Care will no longer be defined as 'looked after' but will continue to receive the same support. The Scottish Government published guidance on Continuing Care in November 2016[107].

Under provisions in Part 10 of the Children and Young People (Scotland) Act 2014, any young person who ceases to be looked after on or after their sixteenth birthday, and is less than 26 years of age, is eligible (between the ages of 16 and 19) or potentially eligible (between the ages of 19 and 26) for aftercare.

[107] Consultation on Parts 10 (Aftercare) and 11 (Continuing Care) of the Children and Young People (Scotland) Act 2014

This applies to all care leavers regardless of the placement type while looked after.

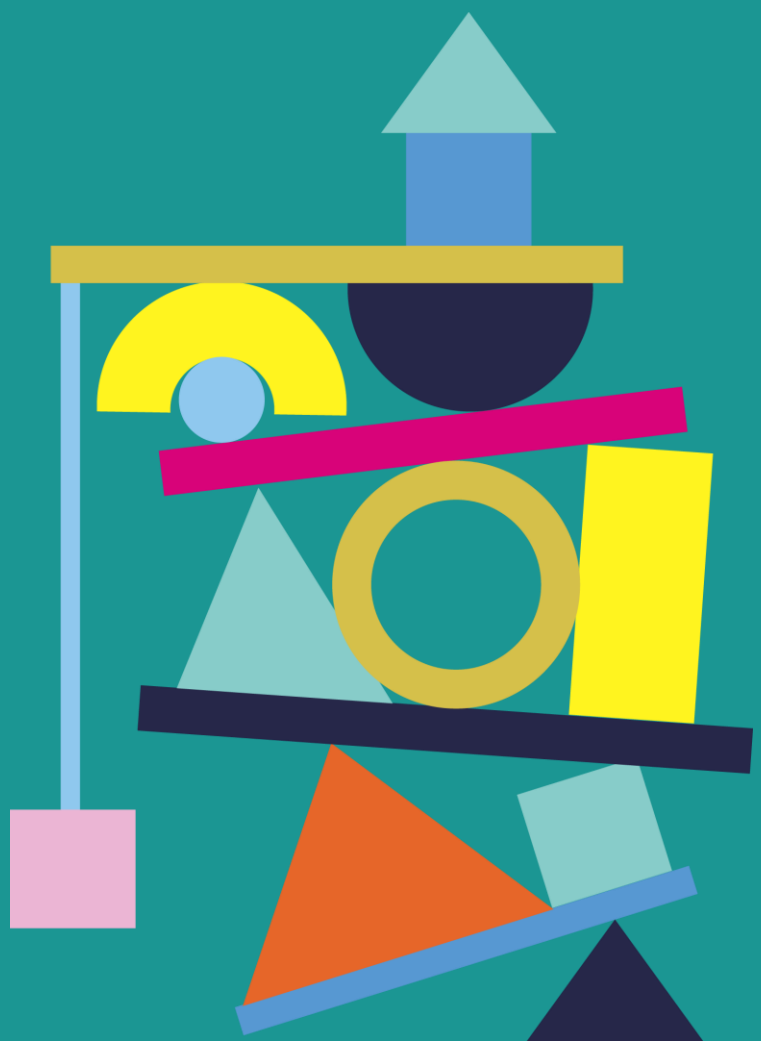
The Scottish Government published guidance on the further extension of aftercare in November 2016[108].

The Scottish Government also published statutory guidance on Corporate Parenting in 2015[109].

[108] *ibid*
[109] Statutory Guidance on Part 9 (Corporate Parenting) of the Children and Young People (Scotland) Act 2014

Literature Review

What would the best care system in Scotland look like to you?



The views of children and young people, their parents, carers and professionals

Dr. Claire Baker

October 2017

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1. Summary

Background

To understand what contributes to quality care experiences we need to hear directly from those who know the 'care system' best: looked after children and young people, their parents and carers as well as the workers who support them. Research captures some of their views and experiences. This report is based on a non-systematic examination of around 80 individual studies and research reviews looking at what these key people said was important to them and the main themes that emerged are summarised here.

Looking across these perspectives there was no one single experience of the 'care system'. Much variation was found; both in terms of the individuals, and their experiences of care. For example, children differed in age, gender and reason why they were looked after. Much was influenced by pre-care experiences and pathways through and out of care. Similarly, carers and workers had diverse backgrounds in terms of how long they had been supporting looked after children, and the role they occupied. Some were kin carers, foster carers or adoptive parents and the workers included in the research studies were from a range of different teams and local authorities from across the UK.

Despite this complexity and variation, there were some common and consistent views throughout the research examined as to what the best 'care system' in Scotland may look like.

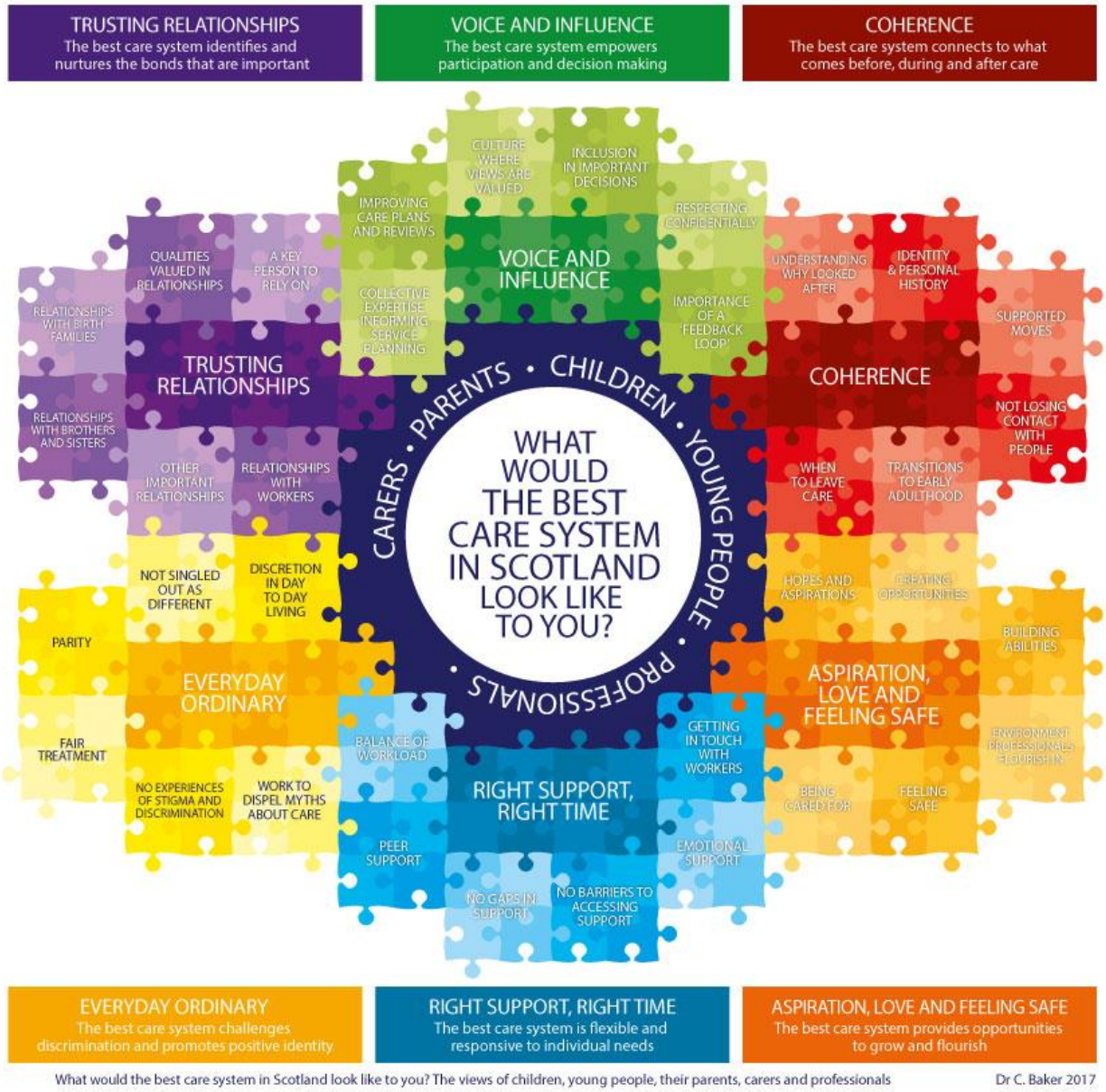
Findings

Based on looked after children, carers, parents and professionals' accounts, a set of six cross-cutting themes emerged as important in building a better 'care system'. Each element had several sub-themes. Figure 1 illustrates these areas.

1. **Vision and Influence** – the best 'care system' listens, empowers participation and decision-making

2. **Trusting Relationships** – the best 'care system' identifies and nurtures the bonds that are important
3. **Everyday ordinary** – the best 'care system' challenges discrimination and promotes positive identity
4. **Right support, right time** – the best 'care system' is flexible and responsive to individual needs
5. **Coherence** – the best 'care system' connects to what comes before, during and after
6. **Aspiration, love and feeling safe** – the best 'care system' provides opportunities to grow and flourish

Figure 1: What would the best 'care system' in Scotland look like to you?



Conclusions

Often, it was adults who shaped the 'care system' and decided what it should look like. This review redressed this imbalance by looking at a wide set of views from children, care leavers, carers, parents and professionals. Collectively they communicated a vision that the best 'care system' in Scotland was one that created opportunities.

- Opportunities to listen to views.
- Opportunities to develop quality relationships.
- Opportunities for parity.
- Opportunities to connect across children's lives.
- Opportunities to be supported.
- Opportunities to be loved and cared for.

The ask based on these views was for the people who mattered to looked after children to have the opportunities they needed to build these relationships, access the resources, support and training they needed and ultimately the opportunity for their views to be heard, valued and included.

2. Introduction

At present limited information is collected at a national level on the 'care system'. Data provides only a partial picture of looked after children's lives.

For example, statistics focus on: where looked after children live and how long they stay there; where they move to when they cease to be looked after, and whether children are in education or training at a point in time (Scottish Government, 2017). None of these data tell us about the care experiences of these children, their parents, carers and workers from their own viewpoints; were they happy, safe and doing well? Were there areas of the 'care system' they would like to change? In their opinion, what in the 'care system' worked well for them?

> *'It's only us who've been through it who can really understand it' (Young person, Rahilly and Hendry, 2014).*

To understand what contributes to quality care experiences we need to hear directly from those who know the 'care system' best. Research captures some of their views and experiences. This report is based on a non-systematic review of research looking at what these key people said was important to them and the main themes that emerged are summarised here. The quotes used in this review are from the children, carers, parents or professionals interviewed or consulted in the various studies.

The review contributes to our understanding of the 'care system' and helps build a picture of how the Scottish 'care system' could be improved. The work forms part of the Discovery Stage of the Care Review and informs thinking about what the best 'care system' in Scotland may look like to these different groups of people.

3. Findings: Cross-cutting themes

1. Voice and influence; the best 'care system' listens, empowers participation and decision-making

Introduction

This section looks at the views of children, care leavers, carers, parents and professionals and what they said about their participation and inclusion in care planning and decision-making. Overwhelmingly, those taking part in research emphasised the importance of services listening to their views on two main levels. Firstly, on an individual level, in terms of how they were involved in arrangements for day-to-day living and planning for their future, and secondly, at a service level, and how their views influenced service development and delivery.

Examining experiences from these perspectives showed that not everyone got the chance to contribute their views. Even when they did, some felt that their opinions were not always valued or acted upon. Children emphasised the important areas in their life where they wanted to have more say about what happened; such as where they lived and who they had contact with.

Carers and parents also expressed a level of frustration at how much their views were taken account of. Sometimes, like children, they too felt left out of important decisions. The arguments made by participants in research for their inclusion in planning and decision-making were compelling but from children, and others', experiences their involvement risked remaining partial. Across views, there was a sense that that the processes for inclusion could be improved.

Culture where views are valued

Many felt that listening and responding to the views of children and young people in care, and those who work and support them, was the foundation

for delivering high-quality services. But, for that to happen, people said that services firstly needed to have a culture that valued these views. Children and young people had to be regarded as active players in their own development and seen as having the capacity to work in partnership with adults (Voice, 2005; Research in Practice, 2015; Whincup, 2010). Young people told researchers they felt that staff and carers did not always give enough time and weight to their views.

> *'I've been in care for a long time and I never get a say in what I would like. It's always what other people would like, and I'm fed up with it' (Young person, Coram Voice, 2015).*

For children to participate fully in decisions being made about them they needed to be aware of their right to have their voice heard. The information they received about this was crucial. Evidence suggested that independent advocacy could facilitate children's participation and help young people take part more, but not everyone knew about advocacy services and sometimes they were not widely available (Pona and Hounsell, 2012; Rahilly and Hendry, 2014; Coram Voice, 2015; Hannon, 2010).

> *'Some things I tell a social worker and they ALL know about it. But if I tell [advocate] and she doesn't think I was in danger, she'd keep it to herself' (Young person, Coram Voice, 2015).*

Mixed experiences of being listened to

Across research children wanted different things: some to live with their siblings; others to be at home; some wished to live in a house with younger children and others preferred to live in residential care. Whatever their individual views, children fundamentally wanted services to pay serious attention to them (Sinclair, 2005a).

Evidence showed there were mixed experiences in how far children and young people were involved in decision-making both on an individual and

at a collective level (Baker, 2017a; Care Inquiry, 2013; Rahilly and Hendrick, 2014; Gough, 2017; Minnis, 2012).

Some young people thought their views made a difference to decisions.

> *'I feel my views are heard and they involve me in decisions. They treat me like an adult' (Young person, Dickson, 2009).*

A few reported that they had been asked for their views but that what they had said did not really count (Minnis, 2012). Other children experienced inconsistent, limited or no opportunity to participate, as this young person explained:

> *'If they'd [the children's home staff] sat down and talked to me, asked me how I wanted to deal with it, it would have shown...I don't know, it would have shown caring, I suppose' (Young person, Coram Voice, 2017).*

Some felt that others, such as carers or workers, dominated discussions about their future, this left them with limited opportunities to take an active role in the planning process (Baker, 2017a).

> *'They need to obviously listen to the young person... I wasn't asked once in that meeting. Everybody was talking amongst. There must have been about six or seven people in that meeting... There were staff members, key workers... So, there was all them and they were all making decisions about me and me sitting there listening' (Young person, Kelly, 2016).*

Some children reported that they were listened to, but explained that the areas in which their views were sought did not necessarily always relate to what was important to them. In a few studies, children highlighted the important things in their life where they wanted more influence over what happened, commonly they talked about:

- where they lived and how they moved to and from there;

- day-to-day issues and plans for their future;
- involvement in planning and review processes;
- and importantly for many, who and how often they saw members of their family (Hung, 2016; Hannon, 2010; Minnis, 2012; Sinclair, 2005a).

> *'It would have helped if I was included in the discussions and decisions that professionals involved made for me. I would have been happier if I had a say and somebody asked me what would I like, where would I like to live. Even if professionals felt that they could not accommodate my wishes for whatever reason, I would feel that my wishes and feelings would be valued, and I would feel listened to' (Young person, Children's Commissioner, 2015).*

There may be some groups of looked after children where there was an increased risk that their views are not regularly sought. For example, in some studies younger children were less likely to feel included and felt their voice was not always listened to due to their age; they thought the best way to hear what was important to them was to spend time with them (Selwyn and Briheim-Crookall, 2017; Research in Practice, 2015). Not all disabled looked after young people in one study had been given opportunities to communicate their views and some were using communication systems that did not meet their needs (Selwyn and Briheim-Crookall, 2017).

> *'The older you get, the more likely they [social workers] are to take note of what you say. Though actually I think a five-year-old knows just as well what they want as a fifteen-year-old' (Young person, Mcleod, 2010).*

Making decisions was associated with growing older and taking on more responsibility. But as this care leaver explained, it was a daunting prospect to leave care and then be in charge of decisions, when previously chances to do this had been limited:

> *'All your life...decisions have been made on your behalf, so now that you've got to suddenly become an adult and make decisions yourself. You think, am I making the right decision, or can I even make a decision, you can doubt yourself' (Young person, Liabo, 2016).*

Overall, a strong message from research was that many children and young people wanted to be more involved in planning and decision-making about their lives (Sinclair, 2005a; Minnis et al, 2012; Coram Voice, 2015; Thomas, 2011; Hart et al., 2015; van Bijleveld et al., 2015).

Why including children is important

From children's viewpoints, the benefits of listening to them were manifold; they talked about the positive influence it had on both their well-being, and on their experiences of being looked after.

Put simply, young people in one research study said, 'being listened to and understood', was 'the most basic requirement for a positive experience of care' (Rahilly and Hendry, 2014). In another survey, the most common comments in response to, 'what is the main thing that would make life better for children and young people in care, and for care leavers?', was 'being listened to' (Children's Commissioner, 2015).

Research with children in the general population has suggested that those who felt they had some control over their lives did better educationally, were less prone to depression and anxiety and had greater resilience in the face of adversity (Children's Society, 2015). Having a sense of some control can be very important to children who have felt out of control in their past due to adverse experiences. Like their non-looked after peers, feeling listened to and taken seriously was also reported to have a positive impact on the well-being (Wood and Selwyn, 2017) and self-esteem (van Bijleveld et al., 2015) of looked after children.

In contrast, those who felt excluded from decisions, or thought their views had not been listened to expressed feelings of disempowerment, low self-esteem and poor confidence (Thomas, 2011). Being excluded from

decision-making could also affect young people's behaviour. One review looking at the experiences of children in residential care found some evidence that children did not always feel they were heard or could talk to staff. In some instances, this had led to their trying to achieve change through running away, or otherwise disrupting their placement (Hart, 2015).

Whilst the benefits of including children appeared clear, research also revealed some of the risks associated with *not* involving or listening to children. It could affect their engagement and how honest they were about their experiences (Thomas, 2011). Talking and listening to children was fundamental to keeping them safe; if children felt they were going to be believed they were more likely to be honest when they were in danger (Warrington, 2017a; Rahilly and Hendry, 2014).

Carers, parents and professionals also felt their views were left out at times

Children and young people placed high regard on 'respect'; this meant others' respecting their views and valuing their contribution. Much of what children had said was echoed by their parents and carers. They also wanted their views to be heard and valued (Brown, 2014) but did not always feel this happened (Care Inquiry, 2013b). Similarly, workers fed back that they did not always feel listened to, senior staff and managers did not always acknowledge or respond to the concerns they raised (Cunningham, 2015).

A research review looking at foster carers' views showed they consistently highlighted the need for better communication with their workers. Carers reported that improved communication and support from their fostering service was one of the top things they wanted to change to help them improve looked after children's lives (Lawson, 2017). Research highlighted that the degree to which carers felt their opinions and experiences were valued by professionals was an important factor in how the placement went (Sinclair, 2005a).

Carers reported occasions where their views had not always been heard, for example, if they were unsure about accepting a new placement they sometimes felt their concerns were not considered and at times felt pressured to take children who they thought may not work in their family.

Others, reported they had not always been given full information about a child. Research found that when social workers had given inadequate information, or not been open with carers about young people, this could affect the placement (Wilson, 2004; Sinclair, 2005a; Baginsky, 2017; Brown, 2014).

> *'They tend to withhold crucial information of behavioural type so that you don't refuse a placement! Then later they disclose it after an incident takes place' (Carer, Lawson, 2017).*

One survey of over 2,500 foster carers across the UK found nearly a third (31%) reported that they were rarely, or never, given all the information about a fostered child prior to placement (Lawson, 2017).

Like others, birth family members often wanted more involvement and information about planning and decision-making processes. Concerns were raised by parents about the level of information they had received, as these parents explained:

> *'I didn't have a choice. I wasn't fully informed. The children were taken from [me] without really knowing what I had signed to and when I asked for information on section 20, I was told to google it' (Parent, Lynch, 2017).*

> *'They didnae even explain half o' what was happening to us...we were having to wait until we got ootside the panel, and my Social Worker was saying to me, "Did you understand everything?", and then I would say to her, eh? I was like that, "No. No this bit. No, that bit. No, this bit". See, they didnae explain everything... They didnae make us*

> *feel as comfy as the last yins, coz I was really at … at ease [with them]' (Parent, Homes, 2014).*

These parents reflected on their experiences and reported they had not always felt listened to:

> *'…if you're not feeling 100%, you can't articulate yourself the way you want to……. I know they can't sit there all day, and sit with you… some – not all – panel members were rushing you, or cutting you up… And the panel I felt sometimes, when I was talking, weren't doing enough to help me or listen to me' (Parent, Homes, 2014).*

Barriers and facilitators of engagement

Across research studies workers were committed to hearing and understanding the feelings and views of their looked after children, but there were barriers to this happening in practice. Research identified structural factors; such as the time workers had available and turnover of staff which inhibited the opportunities to spend time talking and listening (Dickson, 2009). For some workers, there were also factors relating to their own confidence in communicating with children and others. Workers lamented not always having the time needed to plan work in advance, meet with the child, carer or parent and to ensure toys or stickers or other ways to facilitate engagement, where appropriate, were available.

Overall, the degree to which children and others were at the centre of decision-making appeared dependent on the capacity of practitioners to form relationships and focus on direct work with children. To do this they needed to work in organisations that valued and supported children's participation (Whincup, 2010).

> *'Organisational structures, professional responsibilities and resource limitations aren't always the easiest fit with the time, relationship-based practice and commitment needed to involve children and young people meaningfully in decision-making processes… As*

> *professionals we don't always feel skilled and supported to share power and responsibility with those we're charged to care for. What feels right in principle is harder in practice' (Warrington, 2017b).*

Improving processes: plans and reviews

Thomas (2011) found that although both children and adults wanted the views of looked after children and others to be heard, attending official meetings and completing forms were 'imperfect vehicles' for doing this. Across many of the studies children and young people reported that the processes developed to facilitate their inclusion were simply not working well enough for them. Children, and others, recorded ideas for improving their inclusion.

On a simple level, children said they were more likely to feel they had some control over their situations if they were aware of the plans that had been made for them and were kept up to date regularly with what was happening. As these young people in secure accommodation reflected; there should be no surprises to a child about what was in their plans as they should be contributing and consulted throughout (Gough, 2017).

Children sometimes reported that whilst they knew plans about them existed, they were not always sure what they said (Minnis, 2012). At a minimum, they wanted to know what was in their plan.

> *'Having a plan really helps, but they need to involve us; half the time you don't know what's in your plan or you're seeing it at the last minute' (Young person, Gough, 2017).*

Young people also wanted decisions to be explained to them better.

> *'I feel that I was never listened to. At times, it was like my opinion was never heard by the social worker or the children's panel when I tried to express my feeling about moving back in with my mum. They always made decisions regardless of how I felt about it' (Action for Children, 2017).*

Although children may want to attend their meetings to find out what was being said about them and planned for them, children and young people could find the experience intimidating as well as overly long, jargon-filled, alienating, boring, pointless, and stressful (van Bijleveld et al., 2015; Gough, 2017; Hiles et al., 2013).

> *'Nah I walked out them all. Panels are too formal, felt like getting in trouble. Thought oh crikey here again' (Young person, Rohan, 2016).*

> *'I remember going to a court hearing. Everyone was smartly dressed and well spoken. I was a child wearing jeans. Everyone was talking about me and making arrangements for me. Nobody asked my opinion or feelings' (Young person, Douglas, 2017).*

Although in one review about half of children attended their planning meetings, levels of participation and degrees of engagement were highly variable (Thomas, 2011). Simply recording if a child attended a meeting or review did not mean that the child or young person was engaged or participating (van Bijleveld et al., 2015).

There was little evidence that even where the child's perspective was asked, it made any difference to what happened (van Bijleveld et al., 2015)

Some young people were concerned about the number of people attending their hearing or review meetings and it worried some when people they did not know attended. Young people reported difficulties in talking about personal things in front of strangers.

> *'I just dread them. They're just strangers speaking about your life, and they don't actually know you, so I don't like it' (Young person, Rohan, 2016).*

Young people had lots of ideas for how to improve planning and decision-making meetings (Voice, 2005; Homes, 2014; Action for Children, 2015), for example they said:

- Make sure everyone waited till the young people had finished talking so that everyone takes their turn;
- Have an advocate or friend at meetings;
- Do some proper planning (in advance) with young people and make sure it's their independent ideas;
- See if the young people wanted to help chair their meetings;
- Make sure there are no shocks or surprises for young people in meetings;
- Explore whether meetings can be done over the phone or via video link so not everyone had to come together in one room;
- Make sure there are not too many people at the meeting. If the young person decides they want someone and it's not their turn they can still invite them;
- Call them CHOICE meetings not reviews;
- Strangers should never be at your review;
- Help young people to choose where it will happen – comfy chairs, cuddly toys, nice bright, warm room – not too formal;
- Make sure people turn up on time;
- Get bigger, friendlier rooms and have food and drink available that the child likes and check if they want toys or stickers to help them express their views and take part;
- Ensure adults are as smiley and friendly as possible;
- Give better information about all the people who will be there (check it is only the people who need to be, and they don't all have to stay all the time);
- Check young people have the information they want and know about all their rights;
- Help young people ask questions (and support them to do this if it is needed);

- Make sure young people are kept informed about what is happening and what has been decided. And explain decisions more, especially if what is happening is not in line with what the child wanted.

Respecting confidentiality

Young people, parents and carers wanted their personal information to be respected. Children said it was important to be told when information about them was being given to others and to be asked before sensitive or private things were shared (Coram Voice, 2015; Minnis, 2012). Young people wanted to understand more about what would be written down and what would be kept confidential, as this young person described:

> *'I felt really let down because I thought I had been talking to her privately, but I saw she had written it all down in the file for anyone to read. I wouldn't have said anything to her if I had known she was going to do that' (Coram Voice, 2015).*

Dickson et al. (2009), reported some children and young people could be reluctant to talk with, or felt mistrustful of professionals, due to concerns around confidentiality.

Importance of a 'feedback loop'

Children, and others, wanted to see tangible evidence that they had been heard. This was not necessarily about getting everything they wanted but it meant being kept informed, having transparent processes and being told why, and how, their views had been considered (Care Inquiry, 2013a).

Children described that listening was important but ultimately what mattered to them was what happened as a result of listening to them. One review identified that what listening meant to young people was different to how it was understood by workers. Young people saw listening as 'action'; if a worker did not act on what they had heard they had not listened (Minnis, 2012). Young people pointed out that often they did not see evidence they had been listened to or that their input had made a

difference (Gough, 2017; Dixon and Baker, 2016). The most effective way of giving children confidence that they would be heard was to demonstrate that they had been listened to and that, as a result, things had changed.

4. Trusting relationships; the best 'care system' identifies and nurtures the bonds that are important

Introduction

Across the research studies trusting relationships with key adults were of central importance to looked after children and care leavers (Coram Voice, 2015; Care Inquiry, 2013a). Relationships were highly individualised and meant different things to each child; principally they involved their own families, carers and workers.

Children wanted support to maintain and strengthen the relationships which were important to them (Voice, 2015). They wanted loving and stable relationships. From children's perspectives, the 'care system' was not about processes or their plans and reviews but was all about the quality of relationships with carers, workers and family members and these had the greatest impact on their experiences while in care (Rahillly and Hendry, 2014; Care Inquiry, 2013).

But despite their importance to children, research showed relationships were not always prioritised by others (Coram Voice, 2015; Winter, 2015). Many studies highlighted the need to support and nurture the whole network of relationships. Young people wanted to be involved in identifying their key relationships, particularly those within their extended family, and thought that both practical and emotional support was important.

Across studies children broadly reflected on both the availability of the relationships they had and the quality of these relationships. Many felt strongly that it was these factors that should be at the heart of the 'care system' (Care Inquiry, 2013b). The unavailability of these relationships and frequent changes in them, had a cumulative negative impact of children's wellbeing (Rahilly and Hendry, 2014).

A key person to rely on

Much previous research highlights the importance that children in care and care leavers have in their lives trusted adults. A recurring theme from consultation with children, young people and adults who have been in care, is the difference that one individual can make. Trust was the factor cited most frequently by looked after children as important to them in their relationships (Wood and Selwyn, 2017).

Regardless of the type of setting, what appeared pivotal to young people was the quality of the relationship between staff or carers and children. Furthermore, looking at what children talked to researchers about, lots of children spoke not necessarily about what 'role' the person occupied in their life, rather they emphasised what they gave them; unconditional support and access to a consistent person (Wood and Selwyn, 2017).

However, not all looked after children found these relationships. Some children reflected on the difficulties they had faced in trying to establish trusting relationships and the need for better support, as this young person explained:

> *'They can talk and do all the things … but until they adjust their system to fit the needs of the people that need them, we will never be perfect or right. It may suit some people because they might get on with someone they bond with or their foster family but what about those ones that can't bond with nobody' (Young person, Coram Voice, 2015).*

One small scale study with 19 care leavers showed a number of these young adults had missed out on stable relationships with trusted adults whilst in care, they regarded this as a contributory factor in their entering and sustaining poor, and at times abusive, relationships in early adulthood (Hyde, 2017).

'I kind of have been a bit promiscuous but I think it is because I have missed out on love. That is the way I feel. I didn't grow up with it, so I am kind of looking for it now' (Young person, Hyde, 2017).

'And I relied on him an awful lot because I crave love...Because of the stuff we went through, my mam could never show me the love that I wanted from her, so I was always looking for something in a fellow that I couldn't get from my mam' (Young person, Hyde, 2017).

Qualities valued in relationships

What mattered most to children and young people were the qualities and attributes of adults who cared for them and the quality of care they offered rather than the type of placement they lived in per se. Whilst children used multiple adjectives to capture what they wished for, there was consistency about the main things that were important: relationships needed to be above all loving and caring.

Children valued relationships with people who:

- were always there for them;
- loved, accepted and respected them for who they were;
- were ambitious for them and helped them succeed;
- stuck with them through thick and thin;
- were willing to go the extra mile;
- treated them fairly and included them, as part of their family or setting;
- were part of their life, beyond childhood and into adulthood (Care Inquiry, 2013a).

The main qualities that children valued appeared consistent across the different roles that adults occupied. For example, 'stickabilty', was as important to a child in foster care, as it was to a child talking about their social worker. Although, in relation to professionals, children often emphasised additional important factors: accessibility of workers (being

able to get in touch with them easily) and reliability (doing what said would do).

> *'It's not trying to train the professional to be better to the young people, they have already got it – the ingredients to do it. They sometimes just get mixed up between the personal and the professional, but because of my social worker I was really lucky as I had her my whole life. For the first year and a half I refused to have anything to do with her, but she made a point in telling me you can have these tantrums, you can cry, you can shout, you can runaway but I'm here for you I'm not going anywhere. I think it was that she was stubborn and that's what made our relationship what it is, because she took the time to get to know me through my ups and downs and she would text me asking how I was – even if it was at night – it didn't matter' (Young person, Rohan, 2016).*

The quality of the child's relationships was by far the most important influence on the quality of care, and the child's well-being and happiness (Hart, 2015; Winter, 2015).

Relationships with birth families and siblings

Across research studies children and young people emphasised that what was important to them was making sure the contact arrangements they had with birth family members were right for them. For many it was the top priority they talked about when their views were canvassed in surveys about their care experience (Voypic, 2013). Children usually had very clear views about their contacts with birth family members; identifying who they wanted to see, how often they wanted to see them and where they wanted to meet. Looking across studies: some children explained that they wanted more contact with their parents and family members; whilst some had made a choice not to see particular people and other children did not understand why contact was not taking place (Dickson, 2009).

> *'I would like to go somewhere private to see my mum rather than in a public place' (Young person, Coram Voice, 2015).*

> *'You should be allowed to go and see your family unless you are in danger. At the moment my social worker is saying no, but I am still going behind her back and going to see them' (Young person, Dickson, 2009).*

Children often felt that it was very important that brothers and sisters were placed together whenever possible unless it was not right for them (Minnis, 2012; Jones, 2017). Separation from siblings was a common experience (Jones, 2017). Whatever their circumstances children were keen to emphasise that they wanted to spend time with their brothers and sisters. They also sometimes wanted to keep in contact with extended family members (such as aunties or cousins) and close family friends (Minnis, 2012; Coram Voice, 2015). One young person said that workers should:

> *'Try their hardest to keep them together but if they don't, make sure they don't drift apart and become more like distant relatives than brothers and sisters'. (Young person, Coram Voice, 2015).*

Across studies there were high levels of dissatisfaction reported by some children about the level of contact they had and arrangements to keep in touch with the family members they wanted to see (Minnis, 2012). Over time the frequency of contact children had with their siblings could diminish (Jones, 2017).

> *'All my brothers and sisters have been in foster care... Our relationship is kind of awkward because we don't really know each other' (Young person, Baker, 2017).*

Some children explained that they were not allowed contact with some people, though they were not always sure of the reasons for this. Others were unsure why established contact had ended or why a parent seemed

disinterested. Some children said they lived too far away from people and so could not visit.

> *'I would like to see my mum and I would like her to say sorry for being so horrible and to treat me like her actual son' (Young person, Selwyn and Briheim-Crookall, 2017).*

> *'Seeing my mum, it was like, are you really mum? Like it gave me mixed emotions cos I love her but it's difficult because I don't want to show her too much affection for her to just drop it like she did before' (Young person, Baker, 2017a).*

Unlike other children, many looked after children in the studies (especially younger ones) were reliant on adults to enable them to see their family.

> *'I've been let down by contact workers, so I've lost the contact time with my Mum. They should be there when they say, as it makes you feel really upset to miss it' (Young person, Selwyn and Briheim-Crookall, 2017).*

Children thought that the role of their worker in making the practical arrangements, listening to what they wanted and taking the time to explain if their wishes could not be met was crucial. In a review of studies parents stated that they also often wanted support from professionals while their children were in care to maintain continuity in contact with them (Dickson, 2009).

Some young people highlighted that arrangements for seeing family should be kept under regular review as circumstances, perspectives and experiences of relationships could change over time and as they grew older they wanted more control over what happened.

Some children, such as asylum-seeking children, those in secure care or disabled looked after children, could face specific issues in relation to contact with family. Some asylum-seeking children were unsure where members of their family were and wanted help from agencies such as the

Red Cross to help trace relatives (Selwyn and Briheim-Crookall, 2017). Although, a small number of unaccompanied asylum-seeking young people were worried that they would be returned to their country of origin if they asked for help to find, or get in touch, with relatives (Coram Voice, 2015).

Children in secure care emphasised that whilst there could be restrictions on the timing and arrangements for visiting them, they believed they should not be made to feel that contact with family was dependent on their behaviour (Gough, 2017).

Disabled looked after children were at risk of having a lower level of contact and missing out on seeing family (Baker, 2006).

Carers (foster and kinship) also spoke about contacts with birth family members, they identified this as an area where they welcomed help and support (Brown, 2014; Dickson, 2009). Carers who experienced difficult contacts with birth families could be liable to increased stress (Sinclair, 2005a).

Other important relationships

Young people felt that some of the relationships that were important to them (for example, with friends, others they lived with in residential care or other places) were not always recognised or prioritised by adults such as professionals and carers (Hart et al., 2015; Coram Voice, 2015).

Friends especially were highly regarded by young people: in one survey of over 600 children and young people, most (92%) stated that they had at least one good friend (Selwyn and Briheim-Crookall, 2017). Moving placement or school could make keeping friendships problematic. This caused upset.

> *'I am very angry because when I move I always leave my friends.' (Young person, Coram Voice, 2015).*

In studies with children in residential care, children placed significance on the '*relationships within the group of children'*, these relationships could be supportive or volatile. In one study, some young people reported they could feel threatened by, or were in competition with, each other (Hart, 2015). But whatever the dynamics, children thought they warranted attentions from those looking after them.

For some children having a pet was important to them; they said they normalised their experience of care and said animals were non-judgement. Pets sometimes made them feel less lonely (Coram Voice, 2015).

Friends and neighbours were important to carers, but some carers had found that their support networks had reduced since they had become carers (Sinclair, 2005a).

Relationships with workers

Many children and young people viewed their social worker as the most important professional in their lives (Oliver, 2010). Children in many studies wanted positive relationships with their workers (Coram Voice, 2015). Having these positive relationships promoted their well-being (McLeod, 2010). Children saw their worker as a powerful and a strong ally when the relationship was good (Minnis, 2012). Young people in one study emphasised that they saw the role of their worker as someone who actively engaged, involved and advocated for them (Gough, 2017).

When young people felt their worker supported them, they felt well looked after (Minnis, 2012), as these young people explained:

> *'Over the past year the best thing for me has been my support worker with 14+ with all the support she has given me I feel like you have built up a good relationship with her and I feel like if I have any queries I can always go to her about them, so it has been nice to build up a good relationship with someone who I can trust' (Young person, Children's Commissioner, 2015).*

> *'My 16 plus worker is like my mum. I am still in contact with her. Hugs when I've done well, lectures when I've done something wrong … I wish I didn't have her as a social worker, I wish she was my friend'. (Young person, Rahilly and Hendry, 2014).*

Common things young people wanted from their workers included; reassurance at times of stress and practical support (Minnis, 2012; Wood and Selwyn, 2017). Other help children said they received included help staying safe, help getting ready to leave care, and speaking on their behalf (Morgan and Lindsay, 2006).

Children thought that positive relationships with social workers were promoted by not having constant changes of worker; lots of young people said that continuity was essential, as was trust (Minnis, 2012; Wood and Selwyn, 2017; Coram Voice, 2015). In one study of over 600 children the majority (83%) reported they trusted their social worker (all or some of the time) although levels of trust decreased with the child's age (Selwyn and Briheim-Crookall, 2017).

> *'I trust her, she is a lovely person, she helps with everything' (Wood and Selwyn, 2017).*

Young people described how trust was damaged by constant staff changes and workers leaving or being replaced (Wood and Selwyn 2017; Coram Voice, 2015). In one study, around two-thirds (69%), reported they had had more than one social worker during the year (Selwyn and Briheim-Crookall, 2017).

> *'As soon as you were beginning to trust them (social workers), they moved on. Just as you were putting trust in them, if you did put trust in them, they were gone' (Young person, Coram Voice, 2015).*

Like young people, carers were also keen to have stability in their relationships with their workers (Wilson, 2004).

Some children highlighted that they wanted to spend more time with their workers to get to know each other more. Lots of young people argued for a reduction in the amount of work their worker had (Rahilly and Hendry, 2014).

Overall, the message from lots of children was to spend less time on paperwork and more time building relationships with them and getting to know them (Coram Voice, 2015). Social workers expressed the same concerns and often felt work pressure inhibited the amount of quality time they spent with children and others building relationships.

> *'You need a lot more social workers… more social events out of the office… bowling, ice skating… a big day or residential thing. You really get to know people that way. You need to get them the heck out of their offices. You're working with children you're not lawyers!! Be seen as a fun person! not stuffy or intimidating to the young person… loosen up… more child-friendly. (Young person' Rahilly and Hendry, 2014).*

> *'I felt looked after as they had regular one to ones with me and always made sure I was ok. They took us on regular outings like the football and swimming which I enjoyed. They also helped me to get a mechanics work placement which was great' (Young person, Action for Children, 2017).*

> *'Far too many, there needs to be a change. I know people can change jobs and want to do different things, but there needs to be more permanent social workers working with children and young people, it is quite hard to trust anyone if you have a lot of change and people coming in and out of your life.' (Young person, Voypic, 2013).*

Children thought it should be easier to change their worker if things weren't going well (Rahilly and Hendrick, 2014).

'My social worker does not follow through with requests I have made and makes me feel like I am not of importance' (Young person, Selwyn and Briheim-Crookall, 2017).

'Social workers seemed very cold, like they only wanted to get the job done and were only doing it to earn a living. These days I realise that not all social workers are bad. I've learned from some of them, and they have supported me a lot too. But when I was younger I didn't fully understand the situations around me. I never really saw social services be heartfelt or understanding' (Young person, Impower, 2017).

Across studies young people identified the qualities they valued in their professionals these included someone:

- who listened to what they felt and what they wanted;
- worked with them as an individual and did not judge them;
- held positive but realistic ambitions for them;
- demonstrated an interest above and beyond the job;
- was consistent and reliable;
- was friendly, kind, not bossy and had a sense of humour;
- took time to understand what they'd been through;
- acknowledged positive changes they noticed in them; and
- kept them updated and fed back in an appropriate way about decisions (Minnis, 2012; Berridge, 2012, Hiles, 2013, Action for Children, 2017).

Many of these attributes were echoed by carers who appreciated workers who were reliable and available (Brown, 2014; Dickson, 2009).

5. Everyday ordinary; the best 'care system' challenges discrimination and promotes positive identity

Introduction

It was evident that many looked after children wanted their childhood to be as 'ordinary' as possible. Those supporting looked after children were equally keen to 'normalise' experiences and avoid singling out young people as different.

Young people, parents, carers and professionals reported on issues related to 'everyday ordinary'. Firstly, they wanted an appropriate level of discretion in day-to-day decisions and to be empowered in their role supporting looked after children. Secondly, processes and practices that singled children out as different were highlighted and children wanted people to recognise the negative impact of these and to avoid them happening.

Some children and carers had experienced discrimination due to the stigma associated with care and emphasised that this should be challenged and minimised as a matter of urgency.

Discretion in day-to-day living

Research with carers and children showed they wanted to have more discretion over managing day-to-day issues that were usually managed within families. Carers highlighted that their ability to make everyday decisions for children can be hampered and they are not always empowered to parent as they may wish (Baginsky, 2017). Children often agreed that they wanted the people looking after them to have more power to take decisions so that their lives were more 'everyday ordinary'. In one survey, a third of carers looking after children on short-term placements and 15 per cent of carers with long-term placements felt that they were not allowed to make appropriate decisions (Lawson, 2017).

Practitioners also agreed about the importance of 'everyday ordinary'. In one study, most workers agreed that the ultimate aim of services for looked after children should be to provide as 'normal and stable a life as possible', while addressing the specific issues children faced (Toombs, 2008).

Examples given in research studies, where carers and young people reported they would like more day-today responsibility over permissions, included things such as school trips, sleepovers and haircuts. Generally, it was important for those looking after children to feel empowered in their caring role. Currently, not all said this was happening. They thought there was potential for them to have better 'delegated authority'.

In one recent project, Mockingbird Family model, both carers and children welcomed having more control over the provision of 'respite' (young people staying with other carers for a time limited period) which had previously been available only via their fostering service. The MFM model allowed carers and young people to have more say in the arrangement of this support. Evidence showed an uptake in 'respite' and it was said to be easier to arrange. But, importantly carers and children had started to redefine 'respite' and how it was experienced; they had started to make it more ordinary. Some now referred to it as 'sleepovers' and it happened in a more natural way. Through Mockingbird it was usually the same carer who provided the sleepover; everyone, including children, reported they felt more comfortable about this as they knew who they were going to be staying with, they felt familiar with their house and how things were.

> *'It is not respite anymore it is just going to [hub carers] … [the fostered children] see us with [the hub carer] and then they don't mind being with them' (Carer, McDermid, 2016).*

Singled out as different

Children in care and care leavers didn't want to be treated any differently by others because they were looked after. Children emphasised they

wanted people to avoid making them feel different. They wanted their carers and workers to be mindful of how their actions and behaviour could inadvertently reinforce the stigma associated with care experience. But one study of children's views found a significant minority, about 1 in 6 (16%), of young people felt they were 'hardly ever' or 'never' able to do similar things to their friends (Selwyn and Briheim-Crookall, 2017).

Interviews in research with looked after children consistently highlighted the importance of their life and their childhood being kept as 'ordinary' as possible. Overall, children strongly disliked it when they were made to feel different because of being in care. Generally, they wanted to avoid things that made them feel different to their peers who were not in care.

Children felt more could be done by their professionals and wanted procedures and practices to be checked to make sure they did not unintentionally mark them out as different from their peers. They thought it should be a priority for all who supported them to avoid identifying them as looked after children, unless necessary.

> *'Risk assessments have put my friends' parents off.' (Young person, Children's Rights Director, 2009).*

> *'One thing I disagree with is police checking if you are staying with your friends. I have got friends and I have known them for quite a while and I trust them. It annoys me when I have got to get a police check with them because then I feel embarrassed.' (Young person, Social work Agency, 2006).*

Sometimes children reported that they did not want meetings such as reviews to be held at school as they said it could be embarrassing and marked them out as different from their classmates. Children appreciated it when workers avoided drawing unnecessary attention to their looked after status (Wood and Selwyn, 2017) as this young person described:

> *'That's what I love about [name of social worker], when we went out, she didn't wear her badge, so you didn't feel like everyone knew that I was with a social worker' (Young person, Wood and Selwyn, 2017).*

In one study, young people were asked, "*If adults did things that made them feel embarrassed about being in care*." Most (83%), did not experience adults drawing negative attention to their care status, but the proportion who did varied from 6% to 25% in different local authorities (Selwyn and Briheim-Crookall, 2017).

Parity and fair treatment

Children also wanted to be treated in the same way as other children where they lived, and to be treated fairly like other children who lived there.

> *'I always really appreciated and respected the individuals that worked with me. I knew that I could be challenging sometimes, and the individuals were always firm but fair and supported me.' (Young person, Action for Children, 2017).*

> *'Care would be better if your carer treats you the same as their children and doesn't treat you any different' (Young person, Selwyn and Briheim-Crookall, 2017)*

> *'Some of them don't make it like it's your home . . . so you've got to ask to get a drink or ask to have a shower . . . when everyone else just does what they want. And if they've got their own children there, you feel really different to them' (Young person, Dickson, 2009).*

Experiences of stigma and discrimination

> *'We are expected to fail, and it is a stigma. I hated telling people I was in care because it feels like people judge you' (Young person, Become, 2017).*

Stigma and societal prejudice were identified as a significant concern in the lives of children and young people; negative attitudes were common (Dickson, 2009).

> *'The sort of prejudice people have towards care leavers is ridiculous… when you move out of care … whether it's getting a job, whether it's going to find a house, if you tell them you're a care leaver they're thinking negatively unless they've been through it themselves… hence the reason why trying to find a house was so difficult. Everybody had these preconceived ideas that care leavers are partiers. They're criminals, you know, ridiculous things. Yet I'm a quiet person who likes my own company … and don't drink, don't smoke. You couldn't have a better tenant in a sense' (Young person, Kelly, 2016).*

Curiosity and pity were also experienced and strongly disliked by young people.

Negative stereotypes and the stigmatisation of those living or working in the care system also affected carers, parents and workers.

Throughout the research examined, numerous examples were given, whereby people were not treated with respect, or were discriminated against, due to the stigma associated with the care system.

> *'Sometimes. You don't want people to know you're in foster care because some people just judge you, they don't really know why people are in foster care, they think that 'oh maybe you are a bad person' or like your family doesn't want you' (Young person, Liabo, 2016).*

Children were aware of the stigmas that came with their status as looked after children. This status was understood increasingly as they grew older. Being bullied by other children for being in care had happened to some children (Children Rights Director, 2009). Overwhelmingly, they described

negative stereotypes; they said others thought children in care were troubled, different and not likely to achieve (Mannay, 2017).

> *'[People] expect me to kick off all the time' (Young person, Children's Rights Director, 2009).*

> *'Secure care is still seen as being for young people who are in trouble. I haven't done anything wrong, but I was in with someone who had set fire to another person. But then I guess that young person might have had bad things happen to them. We're blaming young people instead of the adults who've hurt them and let them down' (Young person, Gough, 2017).*

There appeared to be a multitude of ways that people discriminated and stigmatised children in care and care leavers without necessarily thinking about it. For example, the use of language by people and systems were not always appropriate; such as the use of acronyms and other abbreviations or too much jargon at meetings; or speaking in derogatory terms about people that mattered to children (Action for Children, 2017).

> *'I hate it when they slag off your mum or your dad. I mean, I can do that because they're my parents, but they don't really know them' (Young person, Coram Voice, 2015).*

The language used when recording information and decisions was equally important: children wanted what was written to be clear, not full of jargon and to talk about strengths not just all the bad things that had happened and to highlight their achievements.

As a result of stigmatising attitudes to children in care and others, some young people said that they preferred to keep the fact that they were in care a secret from people (Rahilly and Hendry, 2014). One survey revealed that half of the care leavers who responded recorded they sometimes, often or always tried to keep it a secret that they were in care (Children's Rights Director, 2012).

> *'I've lost quite a few friends coz they see me as being different and don't want to be friends any more' (Young person, Children's Rights Director, 2009).*

Carers were also at risk of experiencing stigma and social isolation. Kinship carers were particularly at risk of feeling socially isolated (Baginsky, 2017). Research showed this may be because they were too busy with caring responsibilities or too tired to meet up with friends or because friends had concerns about looked after children's behaviour, particularly in public (Baginsky, 2017).

Parents and families whose children were looked after also experienced stigma, negative presumptions and judgemental approaches. These parents described their different experiences:

> *'...these panel members they were, they were alright, they were telling us that we were doing good staying off the drugs and like no me and my partner splitting up.... They were just like talking to us like as if we were human beings, they werenae like disrespecting us and we werenae disrespecting them. They were they would laugh with us like they were smiling at us, eh' (Parent, Homes, 2014).*

> *'Just, like they just treated me, oh because she's been on drugs and 'cause she's doing this, and she's got her wains taken, were taken off her, we'll just talk to her any way ...you're wanting that respect then you need to gi'e me a bit of respect. Doesn't matter what people go through in their life but it means they're still human beings at the end of the day' (Parent, Homes, 2014).*

Work to dispel myths about care

Some young people felt that poor understanding of the 'care system' among the public contributed to discriminatory attitudes towards looked after children. In a survey of children in care and care leavers, half of those who took part thought that '*people think it is children's fault that they are*

in care' (Become, 2017). Young people argued that measures should be taken to educate members of the public about care as poor understanding contributed to discriminatory attitudes (Rahilly and Hendry, 2014).

> *'Nobody seems to understand the 'care system' if you haven't been in or worked with the 'care system'. No-one outside the 'care system' really understands how it works. Especially teachers and things. [...] they make decisions based on what the media tells them, which isn't very true (Young person, Rahilly and Hendry, 2014).*
>
> *'Challenge the labels and stigma. If you're in secure then you've had bad experiences and you need help and support, not to be blamed or seen as 'trouble' (Young person, Gough, 2017).*
>
> *'All people have certain views on people in care. They think we are troublemakers' (Young person, Coram Voice, 2015).*

Young people, and others, have been at the forefront of encouraging a more balanced picture of the 'care system'. A narrative that celebrates the many achievements of looked after children and care leavers and challenges the stigma associated with care. Examples of projects include: Young People's Benchmarking forum positive message campaign; Aspire to More project interviewing successful care leavers; ADCS change the narrative project and the Fostering Network work focusing on achievements of looked after children.

6. Right support, right time; the best 'care system' is flexible and responsive to individual needs

Introduction

As one young person concisely summarised: '*people need other people to cheer them on and support them*' (Young person, Action for Children, 2017). This was true across perspectives. The provision of high quality worker support was important to children and their carers. Having the right support could make a real difference to care experiences.

Everyone was clear that support mattered and that they wanted services to be matched to their individual needs and delivered flexibly. There may be times of stress (such as allegations, placement endings) that require more intense support, flexibility was key to meeting needs (Baginsky, 2017). Different types of support were identified; information, advice, practical and financial help as well as emotional support (Dickson, 2009).

Getting the balance of support right

Some children thought professionals should develop a better balance in their work; between spending time directly with them and all their other tasks (Voice, 2005; Oliver, 2010). Across many studies young people reflected that their workers often seemed stressed and had many demands on their time. Consequently, one of the main areas of reform identified by young people in one study was the need to reduce workloads to increase opportunities to spend time together (Rahilly and Hendry, 2014).

> *'The way no one seems to have time. "Can I ring you back there's a crisis". "Let me finish these reports"' (Young person, Oliver, 2010).*

Cuts in staffing, resources and the impact of austerity led around half (48%) of survey respondents from social services to report that the biggest challenge faced by their sector was funding cuts. Other factors were high

workloads and staff shortages; nearly two-thirds (62%) of respondents reported that they did additional work every week (IRISS, 2017).

> *'I have 6 years to retirement and despair over the lack of resources. I've worked in a variety of roles and have seen many changes. I used to make a difference. Now, I firefight' (Survey respondent from social services workforce, IRISS 2015).*

> *'Life doesn't stop just because the council's skint … that's no use to our kids' (Residential care worker, McGhee, 2017).*

Experience of support

Carers and workers thought that both training and support was needed in order for them to help children flourish (Brown, 2014). It was evident that the extent to which carers and parents were satisfied with the support they had received varied (Baker, 2017a; Rohan, 2016).

Generally, messages from carers summarised that they wanted:

> *'Carers want respect, efficiency, reliable, warm support from social workers, good information on foster children, responsive out of hours services, relief breaks when they need them, information on entitlements, fair remuneration, appropriate training and an 'absence of avoidable hassles' (Sinclair, 2005a).*

Some carers, particularly kinship carers, may be less likely to receive support (Sinclair, 2005a).

In a range of studies children, care leavers and carers described the positive impact their workers and the support they provided had on them in their lives (Barnardos, 2014; Dixon and Baker, 2016; Happer, 2006; Ridley, 2013).

> *'My social worker? I really, really like that guy. He's helped me a lot. I feel like he's thrown another lifeline to me. He used to come and see me a lot and that helped. It's like the social worker goes out the*

window and a father comes in and talks to you and you know that you are going to really get somewhere.' (Young person, Happer, 2006).

'I don't know how to describe it, we're not mates I know we're not mates because she's got to be professional. But, but at the same time like, I know I can talk to her about anything...she's always willing to listen and at the same time she gets in touch with me' (Young person, Ridley 2013).

Gaps and barriers in accessing support

Some carers and young people said they had not always received the support they needed. They felt that services were sometimes too constrained by factors such as the legal status of a placement, age of a child or were simply too determined by what was available rather than what would help (Care Inquiry, 2013a; Barnardos, 2017). At times, those who took part in research described gate-keeping, and recounted occasions where they had to fight to get additional help, struggled to get what they were entitled to, or did not always gain access to specific specialist services.

'Not enough support, more and more work you have to do yourself, lots of paperwork, you don't feel valued, it's a lonely job, can be tough on your own family, you don't get listened to, decisions are made without your input and they won't be explained to you, you don't always get paid expenses even though you put them in on time... it's not about the children anymore it's about budget' (Carer, Lawson, 2017).

Provision of worker support could help to protect carers from stress and strain (Baginsky, 2017). Conversely, studies identified a perceived lack of support from workers as a source of carer dissatisfaction (Wilson, 2004).

Some older young people acknowledged that even when support was available they could find it difficult to accept help. Some young people shared they did not easily reach out to those around them for help and support. Some reflected they did not want to be regarded as not coping, others said their non-acceptance of support could be related to lack of trust or their sense of pride.

> *'I didn't want to say I needed help with budgeting because a lot of the stuff they said about me was negative so then they'd say: "she can't manage living on her own" cos then it's easier that way and they think "B is doing well", it's easier' (Young person, Adley, 2017).*

Sometimes care leavers thought they were offered the wrong type of support or it was 'forced' on them and therefore seen as 'pointless' (Hiles, 2013).

Emotional support

Many looked after children and young people had experienced some form of trauma in their lives, with ongoing consequences for their emotional and mental health. Staff were acutely aware of these issues and identified that successful support for children and young people needed to recognise such experiences (Barnardos, 2017). However, research with care leavers highlighted that they thought their emotional and mental health needs were not always supported well enough, both within the care system, and after they had left care (Rogers, 2011). Practitioners who responded in one research project identified mental health problems as one of the most significant issues faced by looked after children, but they thought support services to help children in this area were less defined, funded and developed compared to some other support services (Toombs, 2008).

> *'When I went into care when I was young there was no emotional support there for me whatsoever and maybe if there was, I would be slightly different to how I am now, cos in my adult life, I do struggle*

with certain things now, I have a lot of emotional stuff trapped inside me now. I think it's very important to have the emotional support when you're younger to prepare you for more serious stuff when you're older' (Young person, Adley, 2017).

'Services tend to focus on practicalities, not emotional stuff...making sure you're ok day-to-day life rather than the core of the issues. That's what I found myself...I've had to deal with it my own way...and I think a lot of kids find that too and because they can't deal with it, it breaks them apart and they get into drugs and stuff or they should sort it out their own way, or else you can't keep going. That support could be provided by a range of individuals and should be easily available' (Young person, Rahilly and Hendry, 2014).

Getting in touch with workers

Everyone wanted to be able to get in touch with their worker(s) easily (Morgan and Lindsay, 2006; Minnis, 2012; Oliver, 2010); experiences of this were not always positive. Children reported that contacting their worker was sometimes difficult for them. In one study, less than half (45%) of the young people reported that their social worker was easy to get in touch with and nearly a fifth (18%) stated that they could 'hardly ever' or 'never' get in touch when they needed to (Selwyn and Briheim-Crookall, 2017).

Apparent in many children's accounts was a sense of frustration in relation to communication with their workers, and a desire that things improved, as these young people described:

'If social services listened to me and didn't say, make an appointment for next week. If I need to see them, it's NOW, not next week' (Young person, Selwyn and Briheim-Crookall, 2017).

'It would be nicer if there is an easier way to contact social services in emergencies and out of hours' (Selwyn and Briheim-Crookall, 2017).

Both children and carers appreciated being informed when their worker was going to be on leave or being able to get in touch with their worker directly (Wood and Selwyn, 2017). A few children said they had to ring a 'customer care centre' rather than being able to contact their worker personally (Wood and Selwyn, 2017). This was described as stressful and impersonal.

Children said it was important to be able to talk to their social worker alone, but they were not always given the opportunity to do this (Minnis, 2012). Children recognised that they sometimes needed to go out of the house to feel free enough to discuss any problems about where they lived and that it should be easy to do this with their worker.

Peer support

Carers stressed the value they placed on support from their peers. Other carers sometimes provided emotional support, practical help and on occasion, positive reassurance. It could counteract the sense of isolation some carers felt. The opportunity to meet with other carers also provided an opportunity to learn from each other, share problems and spend time with people who had a deeper understanding of what being a carer entailed (McDermid, 2016; Luke and Sebba 2013).

> *'You need someone who has been through it, who understands' (Carer, McDermid, 2016).*

> *'Our friends [who are also carers] know when we just need someone to talk to, and they also know how to listen' (Carer, Luck and Sebba, 2013).*

Young people also noted the importance of peer support to them. They echoed much of what carers had said; they valued spending time with, and learning from, those who been through similar experiences to them. They thought this brought an added level of understanding and quality to

the support and friendship they could provide (Baker, 2017a; Dixon and Baker, 2016; Dickson, 2009).

> *'Care leavers should be employed to support young people in the care system and train professionals' (Young person, Care Inquiry, 2013a).*

> *'I found out everything from either being in [participation project] or from my friend who also comes to [participation project], and who's also in care' (Young person, Liabo, 2016).*

Team around the child

Children, young people, carers and parents were helped by a wide range of professionals. Alongside their main worker were often health staff, teachers, youth workers, mentors, advocates and a wide range of other professionals. All had important roles to play. Several evidence sources encouraged a broad conception of the children-in-care workforce; one that included all these professionals and understood the roles that they played (Rahilly and Hendrick, 2013; Care Inquiry, 2013a).

Some foster carers and residential staff felt undervalued and believed that their work had lower status in comparison with other areas of social work. It appeared that carers were not always included as members of the team supporting the child; an apparent tension in terms of how they were viewed in the professional network and whether they were seen as colleagues (Brown, 2014). In one survey of over 2,500 foster carers across the UK (in a non-representative sample), a third recorded that their children's social workers did not treat them as equal team members (Lawson, 2017).

> *'It is rare that a child's social worker will recognise that the foster carer knows the child better than they do, therefore they don't take our opinions and advice into consideration, almost always at negative cost to the child. We are not treated as professional nor*

> *knowledgeable most of the time. And this is at the cost of the child's mental health and ability to develop to their potential' (Lawson, 2017).*

Ultimately, as was emphasised in the section on relationships, support was delivered through people. The nature and type of support experienced varied depending on the quality of the relationships carers, children and workers had with each other (Hiles, 2014).

7. Coherence; the best 'care system' is connected to what comes before, during and after care

Introduction

The 'care system' does not exist in a vacuum. In children's lives, care experiences are inextricably linked to what happened before entering care, what happens during and what will happen after. It was important to children that these connections were made and there was coherence between their care experiences and other aspects of their lives (Sinclair, 2005a). It was also very important to children to understand the reasons they were in care, as well as getting the support they needed to come to terms with this.

For individual young people care lasted for different lengths of time. At some point young people moved on from care. Whatever the individual circumstances young people were keen to know what was planned and that the relationships they had built up would not be lost.

Whilst in care children and carers experienced moves as children entered, moved placements and left the 'care system'. Children had views on what the important transitional points were to them, as well as opinions about what would have supported them better during these times. Fundamentally, they wanted moves and endings to be sensitively handled. But this did not always happen as this young person explained:

> *'It is really tough having to move because they take you into care and then you have to get to know new people and then once you get to know the new people they move you again and it all starts all over again' (Young person, Hyde, 2017).*

Many felt they were not well prepared at times of transition when they moved into, through or out of care. Lots of young people were concerned about leaving care and their transition to early adulthood and thought lots could be done to improve their experiences.

Children and young people explained that they did not always have the information they needed about their rights whilst in care. They were not kept fully informed about important aspects of their life, for example, around the reasons for them becoming looked after, the purpose of the placement, and what to expect. The lack of information could be distressing. Carers could also feel left out of the processes as this carer explained:

> *'The decision [to end the placement] was made by a social worker assistant and I was told I was not a "relevant person" so no details could be discussed with me' (Lawson, 2017).*

Transparency: understanding reasons for being looked after

Some children and young people were confused about what had happened to them and reported they did not have a full understanding of why they were in care. One study of children aged five to 12 suggested two-thirds of them were not fully informed about reasons for their coming into care (Wilson, 2004). In another study, (Selwyn and Briheim-Crookall, 2017) children and young people were asked if an adult had explained to them why they were in care. Most children did understand the reasons for care, for example, nearly three-quarters (73%) of 11-18-year olds replied someone had explained this to them. But the numbers of children who were unclear, or confused, were greater in the youngest age groups. Half of children (4-7yrs) reported someone had either not explained the reason for their coming into care, or had only partially done so.

> *'Why do I live with carer?' (Child aged 4-7, Selwyn and Briheim-Crookall, 2017).*

> *'I would like someone to talk to about my feelings and tell me about my past. I would like to see a picture of my dad, so I know what he looks like. I would like to see a picture of me as a baby. I have never seen a picture of me. I have a lot of questions that no-one answers' (Young person aged 11-18yrs, Selwyn and Briheim-Crookall, 2017).*

For some older young people access to their care records may be something they considered and wanted to pursue. A few reported they hoped that accessing their files would provide answers to their unanswered questions. Research with older carer leavers found the approximate average age for accessing care records was 35.

> *'I've waited years and years to get my file. When you read your file, you have to be at the right stage and have someone supporting you' (Care Inquiry, 2013a).*

Identity: understanding personal history

Developing a positive identity was associated with high self-esteem and emotional wellbeing (NICE, 2013). An understanding of the past was an important aspect in developing identify.

> *'Children need to create a coherent autobiography for themselves to develop their identity and sense of self' (Furnivall, 2011).*

Children wanted support to develop their understanding of their family history. Some children needed help to understand why their family could not provide them with safe or positive relationships (Care Inquiry, 2013b).

> *'I still struggle with childhood issues... I sort of haven't got over them, but I've learned to live with them... I've asked the social worker and she's kind of explained stuff that I didn't really know from early on ... my relationship now with my parents ... is still difficult' (Kelly, 2016).*

A review of what was important to children in care and care leavers found that a sense of identity was compromised by the lack of a sense of belonging (Dickson, 2009).

> *'The thing about being in care is it doesn't matter even if you have the greatest [foster] family in the world, if you don't know where you're from, who you are, you always have that sense of loneliness*

> *and being on your own…you need to be able to feel that you belong, and that people are there for you' (Young person, Winterburn, 2015).*

Like young people, carers sometimes struggled to define their identify in relation to their fostering role. Some carers in research studies focused on what was described as *'role ambiguity';* which arose from the tensions between a 'parenting role', requiring personal commitment to a child, and a 'professional role', requiring training, qualifications and being part of a wider professional network (Kirton, 2007 cited in Baginsky, 2017). While some people managed the two roles alongside each other, others struggled to do so (Schofield, 2013 cited Baginsky, 2017).

> *'For foster carers, however, in very significant ways, their family is their work and their work is their family – so roles are not so clearly separated, and boundaries are not so clearly defined' (Schofield, 2013 cited in Baginsky, 2017).*

Support was important to carers to help them with the ambiguities created by their fostering role. Research recommended that workers considered the ways in which carers viewed their roles and identities and helped support them with this (Baginsky, 2017).

Research with birth parents of children looked after away from home also highlighted identity issues:

> *'The threatened identity as parents in the context of absent children, negative judgements having been made on them as parents, the lack of current parenting roles and responsibilities, and social stigma. Birth family parents adopted a range of strategies for managing their identity and workers needed to understand these to ensure effective work with families' (Schofield, 2009).*

Supported moves; beginnings and endings

It was well documented that care was not static but made up of ebb and flow; some of the movement described was planned and some was not

often arising from crisis. Research seeking young people's views on transition points showed they had experienced a wide range of changes. In their own words, children described transitions points as including:

- Stopping or re-starting contact with birth family;
- Education transition points (moving between nursery, primary, secondary, further and higher education);
- Leaving education to seek employment or training;
- Moving care placements;
- Moving to supported accommodation or moving in into own tenancy;
- Experiencing life changing moments – relationships, getting married or having children;
- Leaving the 'care system' (Action for Children, 2017).

Young people, and others, in many studies said children often experienced too many moves and instability in the 'care system'. Young people thought these moves undermined their sense of belonging and had a negative emotional impact on them (Dickson, 2009). It was an issue that concerned their carers and workers too.

> *'Every time you move, you feel rejected and this affects your self-esteem and confidence' (Young person, Coram Voice, 2015).*

Moves required adjustment to new families and sometimes schools. They could result in the loss of friends and other key relationships. This was often source of sadness for children.

> *'I was always worrying about moving placement. That is my biggest worry. I am happy, I am still there now, but it was just that I was delighted being there, I was happy. I finally found someone who loved me [foster carers] and would be there for me and things like that and I didn't want to be moving…They say you are not supposed to have broken families and they move you constantly. It is not right; I*

> *don't think it is right to move a child the whole time' (Young person, Hyde, 2017).*

Whilst no one argued that children should stay somewhere they were unhappy, there was a sense that moves should be avoided where possible if children were happy and settled. Where this was not possible there were things that could help to mitigate the impact of movement. Of great importance was making sure children had all the information they needed. Young people wanted information before they moved about what it would be like.

> *'Every time a child moves from one living situation to another it involves separation from a caregiver and the likely disruption of an attachment. Changing teachers or schools can also disrupt relationships that have particular meaning for children. Insufficient thought and respect is usually given to the meaning and importance of relationships when change is planned' (Furnivall, 2011).*

Children suggested there were things that could be done to make living in to a new place easier from their point of view. For example, they valued the chance to try out where they were moving to and an opportunity to test it out and see if they would fit in before committing themselves (Coram Voice, 2015). At a minimum they wanted more information on where they were moving to before they moved in (Sinclair, 2005a).

> *'I became a 'looked after' child when I was in primary school. Imagine moving into the home of people you've never met, when you're that young. It was upsetting, distressing, and I felt I didn't belong' (Young person, Douglas, 2017).*

Each place was likely to have different routines and expectations and not knowing about these could be unsettling.

> *'You don't know who your person is going to be – looking after you; you don't know anything about them. You don't know what kind of*

> *food they'll have in that family. You don't know what time they'll eat. You don't know what's bedtime. What's the laundry system' (Young person, Coram Voice, 2015).*

Young people said they didn't always get enough information before moving, commonly they wanted to know about things such as:

- *As they moved into the 'care system'* - why were they not with their siblings; how long were they going to stay where they were; what were the rules in the new house; would people treat them well and like them and what would happen to them while they were in care?
- *When moving from one placement to another* – which other people and children lived in the household; what were the carers' interests; were their pets there?

Some children said it would be useful to see photos of the house and their bedroom, and pictures of the people they were going to live with and information on their school if that was changing too.

Young people in secure care echoed much of what other young people had emphasised. They wanted to be informed and prepared for a secure care placement. They wanted information about their rights, and what to expect on arrival. They explained that arriving in secure care can be an upsetting and stressful experience and wanted all professionals involved to ensure they were sensitively supported through this time (Gough, 2017).

Overall, reassurance was vital: children explained they were likely to be missing their family, confused and upset. It could feel frightening and unsafe to move. Lack of information increased their worries and anxiety about what was going to happen.

> *'… I hated been moved about not knowing where I was going next and who these people were. Sometimes it was quite scary and upsetting, as I could never settle down and was always playing up at school and at home' (Young person, Coram Voice, 2015).*

Losing contact with people that matter

Children said it was upsetting and confusing to lose contact with people just because of 'administrative' reasons such as when they, or their worker had moved from one team to another. They thought this should not necessarily mean they had to end the relationships they had built up (Care Inquiry, 2013). At a minimum, carers, workers and children argued that there should be time to say goodbye and for a high-quality handover to the next person who would support the child (Care Inquiry, 2013a).

Moves could negatively affect aspects of care leavers' lives, such as studying and education, as this young person explained:

> *'It more had an effect on my emotional wellbeing and my education. When I was in foster care I did my first year of A Levels and I got really good grades, I got like A's, B's, C's. But then I moved (mid A-level) and you see in my second year I got like D's, E's, and U's'. (Gill, 2017).*

Both young people and adults urged that moves and endings were handled with greater care (Coram Voice, 2015; Sinclair, 2005a; Barnardos, 2017). This young person described their positive experience:

> *'The way they moved you on was really good. You started off coming (to the prospective foster home) for two hours, and then you spent a day. Next, I came for a weekend. Lee (key carer) stayed here as well. I came for a weekend on my own. I got to walk to school and back during a week here, to get used to it. I went back to The Planes (residential unit) for a week, and then I moved in' (Young person, Coram Voice, 2015).*

Respondents in research recognised the wider impact when a child moved. The 'pain of partings' described by some children, were also commonly experienced by their carers, carers' children and wider family. It was important that the effect of moves were acknowledged and supported more (Sinclair, 2005b).

Some people felt the relationships between the child and others were at times arbitrarily cut off (Sinclair, 2005a). Those taking part in the Care Inquiry (2013b) agreed, and suggested there was a risk of an assumption that 'old relationships must be broken for new ones to be made' (Winter, 2015).

> *'When you are making changes to my life, don't stop what's already there' (Young person, Care Inquiry, 2013b).*

Some carers and children kept in touch after a young person had moved, sometimes that happened unofficially and on occasion such contact was not supported by workers. One survey found some young people who wanted to stay in touch with their foster carers had been unable to do so. For some this was because they lived too far away, others felt unsure if their previous carers would want to see them and a few said that their local authority wouldn't allow them to. Over half of children and young people in care, and care leaver respondents in one survey said their social worker did not support them to keep in contact (Swain, 2016).

> *'I think it is vital for children to keep in touch with foster carers they have lived with because we are human, we grow attachments, we grow feelings and we grow the bond between one another. I think it is also important because some children have been moved around a lot and finding that one family that has made them promises, helped them along their journey and took them in as their own...they should be carried out through their life, it is important because attachments do not go away and as a child who has experienced not being able to do this because of attachment issues it is hard, it sort of has an impact on your everyday life. This is why I think it is important' (Young person, Swain, 2016).*

Leaving care: transitions to early adulthood

Leaving care and progressing towards early adulthood was a key transition highlighted in research. From young people's viewpoints it was

differentially anticipated. Many young people said they had been enthusiastic about leaving care and becoming independent before they left care. Interviewees typically described looking forward to life after care, which they said offered them an opportunity to be more in control of their life such as where they lived and how they spent their time (Baker, 2017a). However, other care leavers explained that they had felt anxious about their move out of care, and that it was a stressful experience.

In many studies young people suggested that the experience of being independent did not always live up to their hopes and plans.

> *'I had this glamorised thought of living on my own and having all my friends around and life being a big party but it wasn't that … I was studying too and coming home and doing homework on my own, there was no mum or dad so I had to come home and cook and do the washing and the laundry … I was basically on my own' (Young person, Adley, 2017).*

For many young people the transition to adulthood can be difficult in care (NICE, 2013). Young people approaching adulthood reported mixed experiences in terms of how fully they felt they had control over the timing and decision to leave care (Gill, 2017; Kelly, 2016; Baker, 2017a; Minnis, 2012).

A lot of young people said that they would have liked to have left care more gradually (Morgan and Lindsay, 2006; Baker, 2017; Hannon, 2010).

> *'You have got to really seriously think about the decision you are going to make it's not a tiny decision it's something that will affect your life, it's really, really lonely in your own place' (Young person, Rohan, 2016).*

Some young people described chaotic experiences of leaving care and felt they had not been adequately supported to cope with this. They argued that instead of imposing arbitrary cut-off points, supportive services should be available to care leavers for as long as they were needed (Rahilly and

Hendry, 2014). Workers agreed that delaying the age at which young people moved on from care was beneficial (McGhee, 2017).

> *'Because I am worried about moving out and having to live on my own without a choice in the matter, people who are not in care get to stay with their parents until they feel ready to move out and I feel that I am nowhere near ready to leave but I don't have a choice in the matter' (Young person, Children Commissioner, 2015).*

> *'I left so someone else could have what I had... If I could do it again I maybe wouldn't be in such a rush. I could still be at home [former foster care placement] now but I'm not ... Someone else is in my place.' (Young person, Devereux, 2014).*

Young people in many studies reflected on their experiences of leaving care; they often thought they were not prepared well enough. Services had tended to focus on the acquisition of practical skills, whilst valued, young people thought there should be more emphasis on emotional readiness (Baker, 2017a).

> *'Emotional support is especially important when you don't see your family. They tell you what you will be doing and tell you you'll be getting a flat, but they don't know how it feels - it's scary, weird things happen in life' (Young person, Children's Rights Director, 2012).*

Some young people reflected that rather than their care experience helping them prepare for adult life it had not given them a chance to try out independence skills, as this young person described:

> *'I was supposed to start cooking in the children's home and the chef there has cooked a meal. I'm not going to start cooking a meal when there is a meal sitting there you know... Like cooking and washing clothes they do try and sort of educate you on but for me the environment was completely wrong... the staff always wash your clothes... And then suddenly about six months before you move out*

> *you are like 'now you want me to do that?'... It needs to be done from the minute you go into residential care' (Young person, Kelly, 2016).*

Care leavers and others urged that transitions from care became less absolute endings and occurred more slowly. After leaving some would have liked the chance to move back to a more supportive environment (Morgan and Lindsay, 2006) if leaving was not working out for them. To be able to make mistakes or try out living elsewhere and to have the opportunity to change their mind and have a second chance would be valued by young people.

Many described feeling lonely and socially isolated after leaving care (Dixon and Baker, 2016).

> *'As a young person, I would like continued support i.e. a flat within the residential unit to enable me to live more independently but still have the safety net of all the support I receive' (Young person, Action for Children, 2017).*

Coping with transitions was easier for care leavers who had a key person to rely on and go to for help. Some care leavers had lost contact with important people, such as former carers, support workers or friends (Baker, 2017a).

Research with young people and those who supported them, identified factors that can significantly improve a young person's transition from care, these included strategies to:

- Delay the age at which young people leave until they feel ready.
- Increase the agency and control young people have over the transition process.
- Provide more flexibility for young people to remain in supported placements or return to them.
- Ensure young people receive quality preparation (which starts early) and support.

- Empower workers to build relationships.
- Focus on approaches to combat isolation and identify and nurture the relationships that are important to young people and ensure young people have lifelong connections, someone who will champion them throughout their life beyond care (Baker, 2017b).

Young people also argued that the variation between services in terms of the help they received when they left care was unfair and should be tackled (Rohan, 2016).

8. Aspiration, love and feeling safe; the best 'care system' provides opportunities to grow and flourish

Introduction

Many respondents identified that a principle role of the 'care system' was to create the conditions that allowed those living, or working within it, to flourish and succeed. Much appeared connected to opportunities to build resilience; making sure children, carers and workers had chances to enhance their abilities and to withstand the difficulties they had experienced.

An important factor in building resilience was creating an environment for learning; for children this may be formal education as well as through play and hobbies. Carers and workers also emphasised that to flourish they needed positive and supportive organisational cultures.

Across perspectives respondents acknowledged the central importance of having high aspirations for both children and young people growing up, as well as high ambitions for the services and supports provided.

At the heart of much of what children talked about as essential for their well-being and future prospects were making sure children and young people felt loved and safe.

Hopes and aspirations

Looked after children and young people wanted to enjoy the same opportunities as their peers (NICE, 2013). A strong message from children and young people was that they had many hopes, dreams and aspirations, just like their friends and peers who were not in care (Action for Children, 2017; Mannay, 2017).

> *'Children in care should not be treated differently with regards to their hopes and aspirations. Some may need extra support to fulfil these and this should be done through supportive and caring*

> *environment. Children in care should have equal opportunities to fulfil their hopes and aspirations as those brought up by their parents' (Young person, Action for Children, 2017).*

Lots of children and young people shared their ambitions; to get a good job, have a nice home, to have their own family and buy a car, to be a nurse or an actor. For many the breadth of their wishes were, as they should be, endless and sky high.

> *'To become a midwife, start a family and travel the world' (Young person, Voypic, 2013).*

> *'My greatest ambition is to finish college, go to university, get a good job, also make my staff, foster mum proud and hopefully to open my own restaurant one day' (Young person, Voypic, 2013).*

However, young people were often acutely aware that they faced barriers to achieving what they desired. They thought that some of these barriers were related to their own self-doubt, stigma from others or unsupportive relationships with carers, teachers or workers. Disrupted or negative school experiences and changes in circumstances such as bereavement, family problems or becoming a parent could be barriers to education and employment for care leavers (Baker, 2017; Mannay, 2017).

Whatever, the individual challenges they faced they wanted people to help them overcome the obstacles and a 'care system' that challenged and dismantled barriers. They talked about inspiring carers, teachers or workers who advocated for them, put up a fight to get what they needed and 'had their back' so that they could achieve their potential. They wanted their achievements to be recognised and celebrated.

> *'My social workers and foster carers and school planned for me to go to university from when I was in first year at school. We talked about it at every review meeting and they helped me think about what I needed to do to get there' (Young person, Social Work Agency, 2006).*

Having an adult who continually encouraged and supported them was linked to better educational experiences. Carers, teachers and workers were all important people who could support and encourage young people and their presence could be instrumental to success, as this young person explained about the support they had received from their carer:

> *'I knew I had the ability to do well and, because they believed in me, they gave me … support me through college. I'm now in University … training to be a social worker' (Young person Coram Voice, 2015).*

Children in care and care leavers didn't always think that the people around them were aspirational enough for them. For example, a recent survey of children in care and care leavers views found that just over half (56%) thought that social workers were ambitious for the children they worked with (Become, 2017).

Creating opportunities and building abilities

When children talked about their experiences they didn't tend to use terms such as 'resilience' but they did talk about how important it was to be given second chances, to have opportunities to learn from their mistakes and to try things out for themselves. Many children, particularly older ones, identified that they wanted to be given a chance to become more responsible (Selwyn and Briheim-Crookall, 2017).

Overall, young people were keen that their 'care system' gave them '*equality of opportunity*' (Action for Children, 2017). They were not necessarily asking for different things to their peers but parity; having fun, enjoying hobbies and school, having a chance to learn skills and gradually being given more responsibilities as they grew in age and confidence.

Taking part in activities such as going to clubs, volunteering or doing sports was a way to gain new skills and grow self-confidence. Having fun and doing things they enjoyed made them feel like other children. It gave a sense of normality (Coram Voice, 2015).

> *'With my drama, music, sport, I needed to have the encouragement and resources. So, if someone was in that position, I would make sure they had the resources and didn't feel out of it in terms of their clothing and their mixing with friends' (Coram Voice, 2015).*

Environment for professionals to flourish in

Maintaining a stable, high quality and committed workforce is central to the delivery of effective support services for children and families. Central to this was valuing and supporting the workforce. Research indicated that children's social workers can find their role '*simultaneously emotionally exhausting and intrinsically rewarding'* (Kinman and Grant, 2016). For example, nearly three-quarters (73%) reported high emotional exhaustion but in tandem, a majority (91%), reported strong feelings of personal accomplishment from their work. Furthermore, the majority (78%) of respondents in one social services survey said they were happy in relation to their work (IRISS, 2015).

Workers reported it was important for organisations to combat low morale and the high risk of work-related stress they faced. To support them professionals emphasised that they needed positive and supportive organisational cultures. Research findings indicated that a combination of organisational factors (such as workload, support and supervision) and individual factors (such as personal history, training and coping style) were key factors related to experiences of work (Kinman and Grant). Access to training, learning and professional development opportunities and being empowered to take decisions and exercise professional discretion were also important to staff well-being.

> *'I would love someone to come in and talk about love and attachment and trauma' (Residential care worker, McGhee, 2017).*

One study asked staff from social services to record their experiences in diary form over a one-week period. Analysis of themes showed that, from workers' point of view, good relationships with the young people they

supported, with their managers and peers were one of the most crucial aspects to feeling valued at work.

> *'I feel valued at work when I get positive feedback from my colleagues and supervisors. After every shift my team leader makes a point – thanking each member of staff for their hard work. All of the co-ordinators also make a point of thanking staff and highlighting good practice' (Worker, Cunningham, 2015).*

> *'Where attachment-focused learning and development opportunities were making significant impact on practice and outcomes, this was as a result of careful embedding of knowledge and skills within organisations through reflective supervision, external consultancy and the creation of policies and structures that were congruent with an attachment-based approach` (Scottish Attachment In Action and CELCIS, 2012).*

Making sure workers and managers were not isolated in their work and got the chance to learn from others was a common thread in some of the accounts from social care workers. Peer challenge was valued as these professionals explained:

> *'There were real strengths in having the opportunity to work within our cluster group, which consisted of neighbouring authorities. While organisational structures were different and care leaver services were delivered through different models, the issues and challenges which impacted upon our care leavers were very similar. There were a range of strengths in the different areas and we were able to learn from each other's examples of good practice and provide a peer challenge role' (Leaving care manager, Dixon and Baker, 2016).*

> *'We share expertise and strategies, because I think sometimes you get lost in your way of working and you don't tend to think outside*

> *the box, but seeing how other people do things and sharing that expertise is really useful for us' (Social care manager, Toombs, 2008).*

Feeling safe

The crucial issue may not be so much where the child lived, or under which legal order, rather what happened where they lived and making sure it was the right place from the child's point of view. Top of children's agenda was having a home where they felt safe (Action for Children, 2017).

> *'You should be safe and live with people who care about you' (Young person, Voypic, 2013).*

Care leavers articulated what constituted a good place to live; of upmost priority was that it was somewhere they felt safe, both within their home, and in their local neighbourhood.

> *'This is the only flat which has been decorated to look homely and I have no infestations in this flat, no holes in walls etc. which I have previously experienced in old flats and nothing was done' (Young person, Baker, 2017a).*

One study asked children in care whether they felt safe where they lived. The majority of the 611 children and young people who took part reported that they '*always felt safe*' where they lived; this was true for 98% of four-seven year olds, 83% of eight-ten year olds and 82% of those aged 11-18 (Selwyn and Briheim-Crookall, 2017).

However, for some children care did not provide a safe environment both physically and emotionally. Some of the young people interviewed in research studies described experiences of emotional neglect and rejection while they were in care. At worst, a small minority of young people had experienced abuse from carers or other young people in their placement (Rahilly and Hendry, 2014; Care Inquiry, 2013; Biehal, 2013).

Love and being cared for

Lots of children described how they wanted to feel welcome where they lived. They wanted to be accepted.

> *'To feel safe, to get on with the family you are living with, to feel cared for and loved, to feel part of a family and being included, to live a life like a child that is not in care' (Young person, Voypic, 2013).*

Achieving a sense of belonging could prove complicated and difficult. Children wanted support in navigating their feelings and experiences to help them settle where they were whilst retaining the links that were important to them. They described how they could feel a conflict from being part of two families simultaneously (Dickson, 2009). Many of those who did not live with their birth family still retained strong connections and allegiance to them. At times this could lead to a sense of '*divided loyalty*' when they lived with different families or when building relationships with others (Sinclair, 2005a).

> *'Foster carers act like they are your family at New Year and stuff like that and you feel, I don't know how to describe it, you feel, well obviously a stranger because its somebody else's family – I don't know it just felt weird. At the children's home at the New Year and everything we were all just like a big family and it was good' (Young person, Social Work Agency, 2006).*

> *'I felt sad when I left my family. The feeling was like having a solid block of ice inside me…when all the ice has melted, I will be ready for a new family' (Young person, Oliver, 2010).*

Some young people also talked about the importance of being treated as part of the family and where they lived being comfortable. They did not want to be treated differently to others where they lived. For example, some said they thought it was unfair if they were left behind when carers went on holiday.

> *'Over the last few years it has become virtually impossible to treat foster children as we would our birth children. If we can't treat them equally this creates issues within the house in a huge variety of day to day situations (e.g. birth son and foster child at same college. I had to ring the college and social worker to get permission for birth son to bring foster child home when there was extreme weather. If he'd been a birth child I'd have just rung them both)' (Carer, Lawson, 2017).*

> *'We have been fostering for 16 years. Our own children have known no other life and consider themselves to be part of the team. The fostered children are an integral part of our close and extended family, because that's what fostering is about: an ordinary life in an ordinary family setting' (Carer, Lawson, 2017).*

Linked to 'everyday ordinary' lots of children wanted a loving adult to look after them, they didn't like it when they perceived their carer or worker were only caring for them for money and were doing things just because it was their job.

> *'I feel like the majority of people I lived with were doing it for a pay check, I remember I had a family that had two different living rooms one for us and one for their own children so for me you need to want to help people, treat them like your own children, the whole thing about being loved and feeling loved is a high thing for a child, it's been proven through research lacking that can have serious problems in the future' (Young person, Rohan, 2016).*

Love, care and affection are important for all children, looked after children's views reiterated the importance of these for them too (NICE, 2013). They needed to know that people cared for them. They needed someone who would give them the support, love and encouragement other people experienced.

Looking at children's experiences showed a mixed picture in terms of how far this was achieved for everyone (Dickson, 2009). Many thought there were too many rules and regulations relating to carer and workers, such as not being able to give hugs or advice based on their own lives (Action for Children, 2017).

> *'It was good to have a hug, and good for them to say, 'I love you, we're proud of you' … It was good to be told that you were loved, cause obviously being in foster care, at times, it's quite lonely … It was good to feel the love in different ways' (Young person, Dickson, 2009; Young person, Coram Voice, 2015).*

> *'If I was angry or upset they know…like [name of worker] talks to me about her problems when she…and then it makes me think, I can talk to her, talk to another worker because they went through the same, they went through a problem that I used to go through. What I go through they went through, it's like depression. That's what I go through and I get upset and then I try and hurt, harm myself and then I go and talk to them because they stop me. So, it's better, they're nicer. And the other two would be third and fourth because they are the only two that helped me. It's…helped me with college…' (Young person, Berridge, 2012).*

Some young people recorded that they had not always had love and care in their lives. This had impacted on them in different ways; affecting their self-confidence and was a source of sadness. Lack of love and affection had a significant impact on children's emotional wellbeing, in particular their self-esteem (Dickson, 2009). As these young people shared:

> *'Physical contact and emotional warmth was definitely lacking in my placement […] we never ever ever hugged, never ever… but obviously deep down that's what any child in care would want really, they want to feel accepted' (Young person, Rahilly and Hendry, 2014).*

> *'I also feel that staff in residential don't show young people enough love and affection like we would get at home' (Young person, Action for Children, 2017).*

> *'Way too institutionalized children's homes. Do you know how much we needed a hug?' (Young person, Coram Voice, 2015).*

Some young people felt their carers or workers did not use language or actions to show them that they mattered to them. There was a tension apparent in some of the comments from workers and carers between 'professional' and 'personal' spheres. It was not always clear to people how to manage these areas and the degree they could show affection and talk affectionately about children. It appeared that some carers and workers were more comfortable talking about 'love' than others and how they perceived it fitted with their own identity and conception of their role in relation to looked after children. Resolving such issues were of central importance to children and fundamental to the quality of their care experiences and childhood.

> *'It's a basic human need to feel loved, wanted, accepted, warmth . . . And if those are missing there are going to be problems' (Young person, Dickson, 2009).*

> *'I reckon you need love and support, that'd be the main thing, but there's a million ways that you can show it . . . I think that's probably about the only thing you actually need. It's the only thing that a real family can possibly give you'. (Young person, Dickson, 2009).*

9. Conclusions

Often, it was adults who shaped the 'care system' and decided what it should look like. Here we have aimed to redress this imbalance by looking at cross-cutting themes based on a wide set of views from children, care leavers, carers, parents and professionals. Ultimately these views pointed to the need for a 'care system' that was 'with us not against us'. Collectively they communicated a vision that the best 'care system' in Scotland was one that created opportunities.

- Opportunities to listen to views.
- Opportunities to develop quality relationships.
- Opportunities for parity.
- Opportunities to connect across children's lives.
- Opportunities to be supported.
- Opportunities to be loved and cared for.

The ask based on these views was for the people who mattered to looked after children to have the opportunities they needed to build relationships, access resources, support and training but ultimately the opportunity for their views to be heard, valued and included. As Holmes (2017) recently reminded in her citation of Tillich, '*the first act of love is to listen',* but sometimes we need to tune in differently.

The review of care in Scotland is an opportunity to do this and tune in together, to build in partnership the best 'care system' for Scotland. This rapid research contributes to this work by looking at some of the evidence on what the people who know they system best believed was needed.

10. Appendices

Appendix 1

Review approach

Around 80 UK research reviews and studies were included in this rapid review (see References for a full list of evidence sources). This report is a summary of the key themes and issues that emerged from the review. The quotes used in this review are from the young people or adults interviewed or consulted in the various studies. The review is selective (not systematic); it included only research and reports based in the UK.

The sources of evidence varied in the number of participants involved in the research; the smallest number was six and largest over 2000. Research studies used a range of methods to gather participants' views; these were mainly interviews (face to face), surveys (online and paper) and focus group discussions.

Limitations of the review

Given the short timescale for the work, the research comprised a focused, and not a systematic, review of the evidence. The review focused on evidence sources that speak from the perspectives of children, young people, parents, carers and professionals.

Given the large volume of research on looked after children it is very likely some important research studies are not included here. There are notable gaps in the review. For example, fewer studies were included that directly asked the parents of looked after children for their views. Much of the research included in the review looked at foster carers' views, there was less focus on the views of residential staff and adoptive families.

The research in the review included data collection from across the UK but at times there was limited information specific to the Scottish context.

Inevitably, research will only capture a proportion of the many young people who are looked after. There are some groups whose views may be

less likely to be included in studies, for example, very young children, disabled children and those less likely to engage with services are likely to find their perspectives absent. There was also an absence of research on the views of older adults who had been in care. The focus of the research reviewed tended to look at those currently engaged or who had recently left the 'care system'. Furthermore, hardly any longitudinal studies which tracked young people over time were identified.

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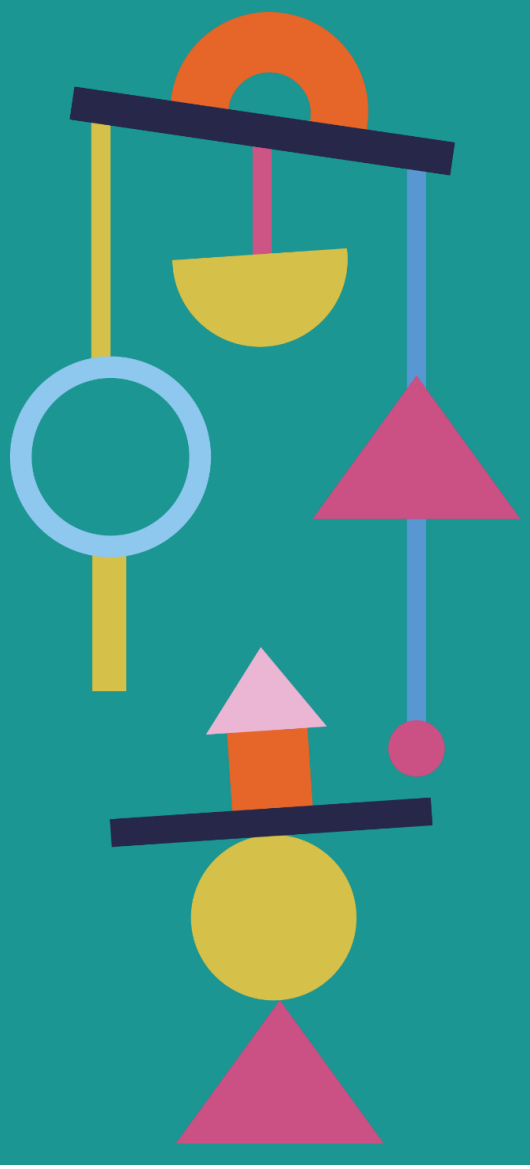
Overview of Advisory Groups, Reviews and Boards



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Overview of Advisory Groups, Reviews and Boards currently in place in Scotland advising the Scottish Government on matters relating to looked after children.

1. Scottish Child Abuse Inquiry
2. Secure Care Strategic Board
3. National Review of Care Allowances
4. National Child Protection Leadership Group
5. Disabled Children and Young People Advisory Group
6. Partnership for Action on Drugs in Scotland
7. Scottish Adverse Childhood Experiences (ACE) Hub
8. Children's Hearings Improvement Partnership
9. Strategic Commissioning Project Board (Doran Review)
10. Homelessness Prevention and Strategy
11. Youth Justice Improvement Board
12. Poverty and Inequality Commission (child poverty)
13. The Advisory Group for Additional Support for Learning (AGASL)
14. GIRFEC National Improvement Support Group
15. Community Jobs Scotland Advisory Board
16. The Care Review – currently running
17. Youth Commission on Mental Health – announced December 2017

1. Scottish Child Abuse Inquiry

Purpose

[October 2019 deadline]

The overall aim and purpose of the Inquiry is to raise public awareness of the abuse of children in care, particularly during the period covered by the Inquiry. It will provide an opportunity for public acknowledgement of the suffering of those children and a forum for validation of their experience and testimony

1. The Inquiry will do this by fulfilling its Terms of Reference which are set out below. To investigate the nature and extent of abuse of children whilst in care in Scotland, during the relevant time frame.
2. To consider the extent to which institutions and bodies with legal responsibility for the care of children failed in their duty to protect children in care in Scotland (or children whose care was arranged in Scotland) from abuse (regardless of where that abuse occurred), and in particular to identify any systemic failures in fulfilling that duty.
3. To create a national public record and commentary on abuse of children in care in Scotland during the relevant time frame.
4. To examine how abuse affected and still affects these victims in the long term, and how in turn it affects their families.
5. The Inquiry is to cover that period which is within living memory of any person who suffered such abuse, up until such date as the Chair may determine, and in any event not beyond 17 December 2014.
6. To consider the extent to which failures by state or non-state institutions (including the courts) to protect children in care in Scotland from abuse have been addressed by changes to practice, policy or legislation, up until such date as the Chair may determine.

7. To consider whether further changes in practice, policy or legislation are necessary in order to protect children in care in Scotland from such abuse in future.
8. Within 4 years (or such other period as Ministers may provide) of the date of its establishment, to report to the Scottish Ministers on the above matters, and to make recommendations

Definitions:

1. 'Child' means a person under the age of 18.
2. For the purpose of this Inquiry, "Children in Care" includes children in institutional residential care such as children's homes (including residential care provided by faith based groups); secure care units including List D schools; Borstals; Young Offenders' Institutions; places provided for Boarded Out children in the Highlands and Islands; state, private and independent Boarding Schools, including state funded school hostels; healthcare establishments providing long term care; and any similar establishments intended to provide children with long term residential care. The term also includes children in foster care. The term does not include: children living with their natural families; children living with members of their natural families, children living with adoptive families, children using sports and leisure clubs or attending faith based organisations on a day to day basis; hospitals and similar treatment centres attended on a short term basis; nursery and day-care; short term respite care for vulnerable children; schools, whether public or private, which did not have boarding facilities; police cells and similar holding centres which were intended to provide care temporarily or for the short term; or 16 and 17 year old children in the armed forces and accommodated by the relevant service.
3. "Abuse" for the purpose of this Inquiry is to be taken to mean primarily physical abuse and sexual abuse, with associated psychological and emotional abuse. The Inquiry will be entitled to

consider other forms of abuse at its discretion, including medical experimentation, spiritual abuse, unacceptable practices (such as deprivation of contact with siblings) and neglect, but these matters do not require to be examined individually or in isolation.

2. Secure Care Strategic Board

[December 2018 deadline for making decisions on procurement of secure estate]

The Secure Care Strategic Board (SCSB) is being established to lead the development of a strategic approach to responses to children and young people in and on the edges of secure care in Scotland, providing a clear set of strategic proposals and a recommended approach to commissioning which fulfils medium and longer term expectations and projections in relation to use of secure care.

The Board will agree priorities informed by the findings and recommendations of the secure care national project, specifically:

- Secure Care in Scotland: Looking Ahead (CYCJ: October 2016)
- Secure Care in Scotland: Young People's Voices (July 2017)
- Chief Social Work Officers and Secure Care in Scotland (CYCJ, May 2017)

and the reports arising from the Securing Our Future Initiative (2009); along with more current and emerging sources of evidence and analysis.

The Board will consider:

- The pathways for children and young people whose behaviours present a high risk of significant harm to themselves and/or others, including the interface with the broader looked after, GIRFEC, CAMHS and mental health systems, education, and the CHS and Criminal and Community Justice systems.
- A transformative, preventative approach which takes account of best evidence, the direction of the Care Review and emerging and established approaches to close support and so called alternatives to secure care should be explored.
- Particular consideration should be given to the mix of children on care and protection grounds through the Children's Hearings

System and sentenced children and their rights in line with the UNCRC.

- The Board should also consider the implications of changes in how 16 and 17 year olds are treated taking account of the role of HM YOI Polmont and the legislation which offers additional protection for 16 and 17 year olds subject to compulsory supervision.
- The anticipated level of demand for secure care in Scotland in the period 2020 to 2030 and engage with providers around plans to meet the anticipated needs of children for whom secure care is the most appropriate intervention.
- The Board should seek to take an independent and evidence informed approach to recommendations on future commissioning; taking account of national, regional and local dimensions, including the role of integrated joint boards.

The Board may consider that it needs to establish work streams that will support its work.

The secure care national project and the current Secure Care National Steering Group have suggested a need for two work streams initially:

- The development of the Getting it Right for Children and Young People in Secure Care in Scotland Strategy and Standards Framework; and
- Building a strategic partnership to develop the Commissioning cycle, engaging all responsible corporate parents in a review of commissioning and resourcing arrangements for secure care

The Board will keep both the Children's Hearings Improvement Partnership and the Youth Justice Improvement Board updated on progress and join up through established work streams under CHIP and YJIB where appropriate to support the development and implementation of areas of work.

At a national level, the Secure Care Strategic Board will consider the recommendations made in the Secure Care in Scotland: Looking Ahead report. The Board should give specific consideration to:

- Strategic vision and direction for secure care in Scotland;
- Statement on the place of secure care in the continuum of responses;
- National Standards Framework for Secure Care; and
- Commissioning arrangements to consider short and long term funding.

The Board will have a key role in developing and agreeing a plan to be taken forward and will guide and oversee work.

Specifically the Board will:

- Take collective responsibility for delivery of the strategy and achieving effective outcomes.
- Identify and advise on managing risks and issues associated with delivery.
- Commit resources to support delivery.
- Make appropriate links to other national policies and agendas in particular the Care Review.
- Demonstrate accountability.

3. National Review of Care Allowances for Foster and Kinship carers

Aim

The National Review of Care Allowances (the Review) will consider firstly a national approach to care allowances for children living in foster care, and then the implications of this for other equitable groups of children living in kinship care and adoptive placements in Scotland. A national approach should be able to be implemented within the current level of overall funding.

Tasks

Explore the feasibility of introducing a new national scheme of foster care allowances that delivers parity, equity and sustainability and improves on the current 'system'.

Agree a realistic methodology for calculating national care allowances based on the needs of children living in foster care and equitable, kinship and adoptive care placements.

Consider some broader options for financially remunerating foster carers that might be achieved should funding become available or that could be achieved through new welfare powers being devolved to the Scottish Parliament and the roll out of Universal Credit.

Output

The Review Group will produce a report of its findings, outlining the options explored and making recommendations that can be presented to Scottish Ministers and CoSLA leaders for consideration.

Consultation

The Scottish Government will be responsible for conducting any sector wide consultation that may be required either during and/or following the findings of the Review.

Timescale

The Review will begin in Autumn 2017 with an expected completion date of Autumn 2018.

Meetings

The Review Group will have flexibility to agree a schedule of meetings and organise other activities that will help them to complete the tasks of the Review.

Due to the complexities surrounding the individual elements of this Review, chairs have expressed an interest in taking a phased approach which they will present to group members at an introductory meeting. A reference group will support and help to gather views/information from represented bodies to feedback to the core group.

Secretariat and analytical support for meetings will be provided by the Scottish Government.

Note: Scottish Government policy officials will not be required to attend every meeting of the Review core group but proper representation will be ensured depending on agenda items.

4. National Child Protection Leadership Group

Remit

To support, strengthen and improve, from a national perspective, activity on child protection across Scotland. The Leadership Group will identify where there is potential for collaborative solutions to be developed and promoted nationally in order to deliver more effective, consistent protection and support for children and families and to reduce duplication of effort. The Leadership Group will also provide scrutiny and advice to Scottish Government on proposed policy changes.

In particular, the Group will:

- Have oversight of implementation of the recommendations in the Care Review Report.
- Make appropriate links to emerging child protection issues and other relevant pieces of work.
- Support Chief Officers to strengthen delivery of their responsibilities, as set out in the National Guidance for Child Protection in Scotland (2014), and to identify areas where further work may be required.
- Develop a number of regional leadership events for all Chief Officers' Groups and Chairpersons of Child Protection Committees to network, share good practice and collectively horizon scan for new risks facing children and young people.
- Work with Child Protection Committees in Scotland to support local areas to deliver robust continuous improvement programmes.

Membership

The Group is Chaired by Mark McDonald, Minister for Childcare and Early Years along with COSLA's Children and Young People Spokesperson, once appointed, as Vice Chair. Membership is drawn from organisations which advise, deliver or support improvement in child protection practices and services in Scotland.

Membership responsibilities

All members will have the following responsibilities:

- To demonstrate personal and collaborative leadership for the sector, taking shared responsibility for tackling challenging issues and implementing change.
- To bring their knowledge and expertise to inform work on child protection.
- To consult with colleagues in their organisations, and where relevant, other organisations, before and after meetings of the Group.
- To act as advocates for improvements promoted by the Group and influence change in their own organisations and beyond.
- To identify any risks and issues which impact on the delivery of actions and to propose actions for mitigating and resolving these.
- To provide constructive challenge, and advice to the Scottish Government.

5. Disabled Children and Young People Advisory Group

Terms of Reference – December 2016

1. To advise Scottish Government on issues relevant to the development and implementation of policy having an impact on disabled children and young people and their families.
2. To provide advice and oversight on the development and implementation of the Scottish Government's commitment to develop a framework to support disabled children, young people and their families.
3. To promote and facilitate on-going engagement and participation of disabled children and young people in the development and implementation of relevant legislation and polices.
4. To actively promote links and shared working with other relevant advisory groups and organisations and develop networks to ensure that the needs of disabled children and young people and their families are taken into account when developing policy and services.

Structure

The group will meet quarterly. Dates for meetings will be published well in advance, and members must make every effort to attend and contribute.

It is anticipated that short-life sub-groups will be formed to look in detail at specific issues reflected in the work plan. The sub-groups will be self-running and can invite people with expertise from outwith group membership to contribute.

Stakeholder events can be held from time to time to gather views from a wider range of organisations.

The purpose and need for the group will be reviewed annually along with the membership.

Membership

1. Membership of the group aims to be representative of the children's disability sector as well as organisations representing young disabled people and families of disabled children. Membership is drawn from a range of public and third sector organisations and individuals.
2. A proportion of members will be disabled young people – although their membership may be through a separate reference group to ensure appropriate inclusion.
3. A proportion of the members should be representative of the voice of parents of disabled children or young people.
4. Organisations or individuals may approach the Chair to be considered for membership; any decision on membership will be made by the Chair and the group in conjunction with Scottish Government secretariat. The Chair and the other members of the group may also propose new members.
5. Members may nominate a named alternate of a similar standing in their organisation.
6. Members not attending 3 or more consecutive meetings will be asked to step down from the group.

6. Partnership for Action on Drugs in Scotland

Background

The Scottish Government worked closely with key stakeholders to develop the new Partnership for Action on Drugs in Scotland (PADS) group. PADS was officially launched on Tuesday the 19th January 2016 and is chaired by the Minister for Public Health and Sport, Ms Aileen Campbell MSP.

Purpose

The Partnership will coordinate, direct and oversee the implementation of a programme of work to deliver outcomes and benefits that minimise harm caused by problem drug use through:

- better prevention of drug problems, meaning people are less likely to develop a substance misuse problem;
- enabling sustained recovery, meaning people receive support which helps them recover from problem drug use;
- reducing harm to people taking drugs and others, including children and families.

PADS will complement the established Road to Recovery strategy. It brings together leaders from the fields of addiction, mental health, public health, inequality, social work and health and social care, and will help lead and focus the sector on three priorities;

- Building communities focused on recovery and tackling stigma.
- Quality and consistency of service planning and delivery.
- Harm reduction and reducing drug-related deaths.

These priorities are currently being developed through the formation of three themed groups. Each group is developing a work plan that will invite further partnership with a wider range of stakeholders in order to draw on collective strengths and assets. There is also specific consideration of Prevention, Education and Research Data and Evidence.

Workstreams:

1. Reducing Harm and Drug-related Deaths (Chair: Roy Robertson)
2. Improving the Quality of Services (Chair: Colin Sloey)
3. Building Recovery Centred Communities and Reducing Stigma (Chair: Celia Tennant)
4. Research, Data and Evidence (Chair: Brian Kidd)
5. Children Affected by Parental Substance Misuse (CAPSUM) (Chair: Neil Hunter)

7. Scottish Adverse Childhood Experiences (ACE) Hub

Purpose:

The purpose of the group is to develop and inform implementation of an action plan which will be led and co-ordinated by NHS Health Scotland to contribute to **preventing** and **responding** to adverse childhood experiences by:

- championing a Scotland wide movement to increase understanding and inform action to address the impact of ACEs on individuals, communities and services in order to support a more informed approach in policy and practice.
- identifying new opportunities to strengthen action on ACEs nationally and locally across health and partners as they emerge through policy, practice and research.
- considering the potential areas identified in the ScotPHN report 'Polishing the diamonds' to develop an action plan to support a broad public sector response to ACEs.

A draft action plan is in development with the following headings (from ScotPHN report) but this is to be shaped and informed by the Group:

- Awareness and Understanding
- Addressing ACEs in existing policies
- Data Collection
- Primary Prevention
- Secondary Prevention
- Tertiary Prevention
- Routine Enquiry

Terms of reference:

- The group will meet 4-5 times per year. Meetings will be approximately 2 hours.

- The group will be chaired by Linda de Caestecker, Director of Public Health, NHS Greater Glasgow and Clyde.
- Secretariat support will be through NHS Health Scotland.
- The group will be a subgroup of the Directors of Public Health and will report on action to Directors of Public Health through the Chair. Health Scotland will report through its own accountability mechanisms.
- Group members will contribute in an advisory capacity from their professions/disciplines.
- The group will support the promotion of the research base and implications for policy and practice through networks, events and other ways of engagement and communication (e.g. linking with the SG community of interest).

N.B. The Scottish Government is represented on the Scottish ACE Hub by Sara Dodds. Sara also co-ordinates the **SG ACEs Network**, chaired by John Froggatt. This internal network brings together SG officials from different policy areas to share ACEs evidence and policy and practice responses.

8. Children's Hearings Improvement Partnership (CHIP)

By its very nature the Hearing is built on partnership and co-operation – within a defined set of roles, duties and obligations. Bringing these key interests together – with a focus on delivering change and improvement is core to Children's Hearing Improvement Partnership (CHIP). The CHIP is made up of all relevant partners involved in the Hearings System.

A commitment to work together to further the best interests of children and young people, through sharing ideas and co-ordinating our efforts is what the CHIP is all about.

Key work streams

Generating evidence and promoting improvement

Objectives:

To identify if we generate the right evidence, share and utilise it effectively to support and promote improvement.

Getting it right in the hearings system

Objectives:

1. Developing Guidance on referral to the reporter.
2. Creating clear understanding of roles of named person and lead professional within the hearing system.
3. Clarifying how Child's Plan can be used beneficially by reporters and children's hearings.
4. In general, ensuring that GIRFEC and the children's hearing system belong to the same continuum of decision making to promote the wellbeing of the child.

5. Redeveloping Blueprint on Processing of Children's hearings to modernize and widen scope.

Learning and development in the hearing system

Objectives:

To positively impact on outcomes and experiences for children, young people and families within the Children's Hearings System through improving: awareness; knowledge and understanding of roles; quality of training, learning and development resources; and quality of working relationships across and between the professionals and agencies involved in their lives.

- To decide and agree on a common core approach to L&D.
- To develop a proposal that explores the development of a national model of L&D delivery.
- To identify the key subject areas and delivery model approach.
- To identify, agree and source the means needed for a sustainable and successful model of delivery that will make an impact.

Permanence

Objectives:

- To develop a CHIP response and action plan in relation to the publication of the permanence research carried out by the Scottish Children's Reporter Administration.
- To improve permanence practice and policy.
- To initiate a targeted review of the Adoption and Children (Scotland) Act 2007 in relation to the permanence process.

Also implementation work on 'Better Hearings' which Children's Hearings Scotland is doing.

9. Strategic Commissioning Project Board (Doran Review)

Remit

- Agree to the proposals set out in the Project Initiation Document. This was agreed at the first meeting of the Board on 24 June 2013.
- The Board will meet at the end of each stage of the project to review progress and approve the next stage of work.
- Recommends and agrees changes to the project as appropriate.
- Agrees the resources required by the next Stage Plan.
- Sets the overall strategy and looks at how the project links in with other initiatives.
- Approve completed products.
- Responsible for communications between the Project Management Team and external stakeholders.

10. Homelessness prevention and strategy

What we do

We provide strategic oversight and direction to the work of the Scottish Government and local authorities to tackle and prevent homelessness.

We are responsible for:

- Embedding the prevention of homelessness activity with the general principles of early intervention, through a continued focus on the development of the Housing Options Hubs.
- Strategically addressing the adverse impacts of welfare reform, specifically to promote understanding and develop and support good practice within the Scottish housing community.
- Continued leadership at both political and corporate level promoting and improving partnership working between departments and services in local government, RSL and voluntary sector to address homelessness with a specific focus on promoting partnership work with Social Work Services and Health Boards.
- Ensuring all housing providers (including Registered Social Landlords (RSLs) and the private rented sector (PRS) work together to maximise the access of homeless households to existing stock.

11. Youth Justice Improvement Board

Remit

At a national level, the Youth Justice Improvement Board will drive a culture of improvement in youth justice to make a sustained impact on priority areas, which will be kept under review. Its primary role is to support the delivery of the Youth Justice Strategy and, in particular, its priorities around:

- Advancing the whole 'system' approach.
- Improving life chances.
- Developing capacity and improvement.

The Board is supported by 3 implementation groups focusing on the above priority areas, supported by the Centre for Youth and Criminal Justice.

12. Poverty and Inequality Commission (Child Poverty)

As set out in the Fairer Scotland Action Plan, a major initial role for the Commission will be to provide advice to Ministers on the development of the first Delivery Plan, as set out in the Child Poverty (Scotland) Bill, due in April 2018. In order to provide its crucial input to the Delivery Plan, the Commission will be established and meet for the first time in summer 2017.

The process for involving the Commission, as set out below, has been agreed with the Chair. This is a three stage process to guarantee the independent advice and scrutiny roles of the Commission.

First, Ministers will make a formal request to the Commission for advice on, for example:

- What should be included within the first Delivery Plan (bearing in mind the Child Poverty (Scotland) Bill);
- What policies and actions would deliver effective results;
- Whether there are particular policies and programmes which could be more effective or are not working as they should;
- How Scottish Government portfolios can maximise their potential for reductions in child poverty.

Second, the Commission will consider the request and will produce a detailed response utilising their expertise, and in conjunction with other specialists as they see fit. This response will be subsequently published on Commission web pages.

Third, the Commission will then provide feedback to Ministers on the final Delivery Plan. Again, this feedback will subsequently be published online in a timely way to inform debate.

13. Advisory Group for Additional Support for Learning (AGASL)

Role

The Group will formally advise the Scottish Government and Scottish Ministers of issues relating to the implementation of the Additional Support for Learning legislation. This may relate to policy and practice development and may include issues which impact on the successful implementation of Additional Support for Learning.

The Group will be Chaired by a member of the group nominated by the Advisory Group Membership. The secretariat will be provided by the Scottish Government.

Remit

The group will make recommendations on key actions to support the continuing implementation of Additional Support for Learning.

14. GIRFEC National Improvement Support Group

Purpose

Reporting to the Minister for Children and Young People, the main purpose of the National Implementation Support Group (NISG) is: to act as a critical adviser to the Scottish Government in the development and implementation of GIRFEC across Scotland; and to drive forward preparations by local authorities and health boards to a state of readiness to meeting their statutory duties relating to the GIRFEC provisions in the Children and Young People (Scotland) Act 2014 (CYPA), to be commenced in August 2016.

15. Community Jobs Scotland Advisory Board

Role of Group

The Community Jobs Scotland (CJS) Advisory Group has been established to monitor implementation of the CJS programme, discuss developments and make recommendations for improvement. The Group will ensure the project is well integrated with wider national and local employability objectives, and contributes to the aspirations of 'Scotland's Youth Employment Strategy', and any subsequent refresh. The Group comprises of key stakeholders and its objectives are:

- Review CJS reports prepared quarterly by SCVO on performance and delivery of the programme and propose actions, assist in resolving or finding solutions to eliminate issues identified.
- Monitor progress towards performance targets.
- Promote and assist integration of CJS with Local Strategic Skills Pipelines.
- Contribute in developing and improving CJS.
- Facilitate good partnership working across the agencies involved with CJS.
- Assist in identifying policy areas where the CJS model could be appropriate.
- Provide advice on specialist areas including support for vulnerable groups.
- Provide feedback to SCVO and Scottish Government on CJS.
- Receive and comment on reports from the CJS Appeals panel.
- Identify and promote CJS links with other SG policies and programme development.
- Identify and promote CJS links with Local Authority activities to support longer term sustainability.
- Capture and share learning.
- Reporting to Ministers as and when required.

Overview of Legislation, Policy and Timeline

November 2017

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1. Overview of Legislation and Policy Relating to 'Looked After Children' and Care Leavers in Scotland

Introduction

This briefing outlines the current (November 2017) legislative and policy context for looked after children and care leavers in Scotland. It provides a summary of the legislative framework within which organisations provide care and support to children and young people, and describes key policy developments since 2000. Also included is a look ahead at policy proposals and commitments which may, if enacted, have an impact on looked after children and care leavers. Appendix A provides a list of relevant Scottish legislation, going back to 1967. Appendix B provides a timeline of key events, reports, policy and legislation from 1601 to date.

The primary aim of this briefing is to help identify areas for more detailed inquiry and analysis. By providing an overview of Acts, regulations, Ministerial Orders, guidance and strategy, the briefing attempts to illustrate the interconnecting components within which care, protection and support for children and young people is organised and delivered by public authorities and their partners. The briefing also aims to provide an accessible narrative on how the current (and prospective) legislative and policy framework has developed, highlighting the issues which have driven changes.

A Legislative Overview

Legislation is not the only source of law. As McRae noted in her comprehensive review of the 'legal' framework for children looked after by Scottish local authorities:

> *"The legal framework draws on the common law, institutional and academic texts and, increasingly, obligations under European and international law. How the courts interpret and apply legislation in legal disputes and criminal cases shapes how social work, education*

> *and health services translate their duties and powers into practice." (McRae, 2006)*

To understand a child or young person's journey through care it is necessary to consider this wider legal context, exploring how the different aspects of the 'legal' framework interact on the ground. That would require an extensive analysis, within closely defined parameters (e.g. a primary age child in kinship care). This overview does not provide that. However, in profiling the key components of legislation and policy, this briefing provides an introduction to the complexity of the framework within which care is provided.

Like many other legislative frameworks, the statutory underpinning of Scotland's looked after child 'system' allow for interpretation, and flexibility in their implementation. Relevant legislation (much like the policy which precedes or encompasses it) is often clear on the general objectives it is trying to realise, but purposefully light on detail about the form an action or service should take on the ground. For example, two local authorities may take different approaches to the assessment of kinship carers, while both remaining compliant with the law. This is a practical response to the significant structural and resources variations which exists between notionally identical organisations (such as 'local authorities'). Prescribing duties in a general way allows implementation to be shaped by local context, with the affected public authorities taking into account their unique demography, histories, geographies, resources, etc.

This arrangement, with national legislation and policy setting out goals and minimum expectations, and individual organisations determining 'how' to meet those goals or expectations, has led to a significant degree of differentiation in local systems and practice. It also means that it is not possible to describe Scotland's looked after child 'system'. There is an identifiable Scottish framework, but due to the flexibility afforded organisations in implementation, and wider legal factors (such as court

rulings), there are in fact at least thirty two looked after child 'systems' in Scotland. And it is in the context of local systems that the day to day experiences of children, young people and families are shaped. This briefing presents a high-level picture of the overarching Scottish framework, detailing what specific organisations are expected to do. Children, young people and families' personal experiences should help to clarify the extent to which local systems have realised the goals and expectations set out by this national framework.

Legislative Framework

This section summarises the main legislative framework for children and young people who are, or have been, 'looked after' by a Scottish local authority. 'Core' refers to those pieces of legislation explicitly relating to looked after children and care leavers. Where extant legislation in this scope has not been included it is because its function is largely technical (i.e. modifying or giving effect to another piece of legislation). A list of relevant legislation, responsible for shaping Scotland's 'looked after child' 'systems', and a child or young person's journey through them, is included at Appendix A.

To aid accessibility, this section presents the core legislative framework in a simplified, sequential format, with new legislative provisions 'replacing' older ones. In reality, new legislative provisions are often just patches to older laws, modifications (in the form of amendments) applied to update primary legislation so that it can meet the aims of current policy. However, representing the framework in its 'amended' form would provide a distorted picture of how the framework developed over time. Therefore, unless otherwise noted, this section presents legislation as it was originally enacted, identifying significant modifications, amendments and reforms with the legislation which introduced them (rather than the legislation they change).

Primary legislation (Acts of Parliament)

The Social Work (Scotland) Act 1968 provides foundations on which much of the current looked after children's 'system' has been built. The Act established Scotland's children's hearing system (for cases of children requiring compulsory measures of care), and set out local authority duties toward promoting the welfare of their populations (including children). The legislation also gave the 'central authority' (now Scottish Ministers) powers to issue guidance in relation to the provision of the 'care system', and required local authorities to establish residential establishments. Subsequent amendments to this legislation, introduced over the past fifty years, have introduced duties on local authorities to provide, among other things, direct payments to disabled people, and self-directed support options for a range of groups, including children in need.

The Children (Scotland) Act 1995 constitutes the primary piece of legislation in respect of the care and welfare of children and young people in Scotland. Part 1 defines parental responsibilities and parental rights, and sets out provisions for the rights of children in a range of circumstances (such as in parental divorce, or where a guardian is appointed). Part 2 is focused on the promotion of children's welfare and wellbeing by local authorities and Children's Hearings. Local authorities' duties towards looked after children are set out in section 17. These include:

- to safeguard and promote the child's welfare, taking the welfare of the child as its paramount concern (this may be restated as a duty to always put the child's welfare first, in any situation);
- to make use of services, as appropriate, which would be available for the child if he or she were cared for by his or her parents;
- to take steps to promote regular and direct contact between the child who is looked after and any person with parental responsibilities, so far as is practicable, appropriate and consistent with the duty to safeguard the child's welfare;

- to provide advice and assistance with a view to preparing the child for when he or she is no longer looked after;
- so far as is practicable when making decisions about the child, to ascertain and have regard to the views of the child, his parents and any other person whom the local authority think is relevant; and
- to take account, so far as is practicable, of the child's religious persuasion, racial origin and cultural and linguistic background.

Local authorities may deviate from these duties only when it is necessary to protect members of the public from serious harm, and then only to the extent required to achieve protection for the public (section 17(5)).

Section 22 of the 1995 Act places local authorities under a duty to safeguard and promote the welfare of children in their area who are in need ('children in need'), through the provision of a range of services appropriate to meet the needs of those children. And, "so far as is consistent with that duty" to safeguard and promote the welfare of children, the local authority must seek to secure the upbringing of such children by their families.

Section 25 sets out the conditions under which a local authority must provide accommodation for a child residing, or found, within their area. These conditions include the child being lost or abandoned, or where the person caring for a child is being prevented from doing so (e.g. due to sickness or incarceration). This section also gives local authorities the power to provide accommodation to any child in their area if they consider that to do so would safeguard or promote the child's welfare.

Section 29 describes the duties of local authorities towards young people who cease to be looked after and are eligible for aftercare services (i.e. 'care leavers'). These duties consist of providing advice, guidance and assistance, which may include, in some specific circumstances, financial assistance where UK welfare benefits are not available, or to cover expenses related to education or training.

The Regulation of Care (Scotland) Act 2001 focuses primarily on the registration and regulation of care services (including fostering, adoption and residential services), and the regulation, registration and training of social service workers. To this end the Act established the Scottish Commission for the Regulation of Care (now part of the Care Inspectorate) and the Scottish Social Services Council.

The Education (Additional Support for Learning) (Scotland) Act 2004 sets out the duties of local authorities and other agencies to assess, monitor and support any child who requires additional support in order to engage in education. Amendments made in the Education (Additional Support for Learning) (Scotland) Act 2009 clarified that all looked after children are automatically considered to have additional support for learning needs, and that they must be assessed to determine whether or not they require a Coordinated Support Plan. The amendments also improved access to tribunals (for the appeal of local authority decisions) and provided for a national advocacy service for children with additional support for learning needs.

The Adoption and Children (Scotland) Act 2007 provides the legislative foundation for contemporary permanence planning and adoption practice. The Act comprehensively updated the adoption process in Scotland, and the rules under which adoption agencies operate. The Act also introduced 'Permanence Orders', a new legal route designed to secure greater stability for a child within a care placement.

The Children's Hearings (Scotland) Act 2011 sets out structural changes to the Children's Hearings system, updates the grounds on which a child can be referred to a children's panel (see Appendix A) and replaced "Compulsory Supervision Requirements" with "Compulsory Supervision Orders" (CSO). Principally, the Act brings together local children's panels under the direction of a new public body, Children's Hearings Scotland. This new body oversees and manages the Children's Hearing system

across the country, ensuring greater consistency, and accelerating the transfer of learning and best practice between local areas.

The Children and Young People (Scotland) Act 2014 (the 2014 Act) is, like the Children (Scotland) Act 1995 and Social Work (Scotland) Act 1968, a landmark piece of legislation, introducing a range of significant reforms across many aspects of children's services. Taken together, the Act's parts are focused on facilitating a shift in public services resources towards the early years of a child's life, and towards early intervention whenever a family or young person needs help. The legislation places new duties on public authorities to report on the steps they have taken to secure the United Nations Convention on the Rights of the Child 1989 (UNCRC), and provides new powers to Scotland's Commissioner for Children and Young People, enabling she/he to investigate the extent to which a service provider has had regard to the rights, views and interests of an individual child or young person. (Previously the Commissioner could only investigate matters affecting a group of children or young people.) The 2014 Act also establishes a statutory planning process for children's services, with an emphasis on prevention, early intervention and cooperation between public services. Alongside other parts relating to the Named Person and Child's Plan, this statutory planning process essentially places Scotland's overarching children's policy framework, Getting it Right for Every Child (GIRFEC), onto a statutory footing.

The 2014 Act introduces a number of important changes for looked after children and care leavers in Scotland. In summary, these are:

- Every child and young person (up to their 18th birthday) will have a Named Person (Part four);
- Every looked after child and care leaver (up to their 18th birthday) will have a Child's Plan (Part five);
- 600 hours (a total soon to be raised further) of free early learning and child care for all two year olds who are 'looked after' or secured with

friends or relatives through a Kinship Care Order (Part six, sections 47 and 48);

- Introduces 'corporate parenting' duties on certain publicly funded individuals and organisations (Part nine);
- Extends eligibility for aftercare assistance up to an individual's 26th birthday (from a previous statutory upper limit of 21st birthday); new duty on local authorities to report on the death of a young person in receipt of aftercare services (Part ten);
- Introduces 'Continuing Care', providing certain care leavers with the opportunity to continue with the accommodation and assistance they were provided with immediately before they ceased to be looked after (Part 11);
- Places requirements on local authorities to provide support for children considered to be 'at risk of becoming looked after' (Part 12);
- Duties local authorities to provide assistance for applicants and holders of a Kinship Care Order (Part 13);
- Establishes Scotland's national Adoption Register on a legal footing, and provides Ministers with powers to mandate its use by all adoption agencies (Part 14).

Regulations, Ministerial Orders and Statutory Guidance

In addition to primary legislation (Acts of parliament), Scotland's 'care system' is built on a matrix of secondary legislation and statutory guidance, each of which provides more detailed direction, to relevant organisations and individuals, about how to implement the main Acts. Secondary legislation (e.g. regulations and Ministerial Orders) is set out in 'statutory instruments' and carries the full weight of law (i.e. they are enforceable in the courts). It is issued by Ministers of the Scottish Government, under powers delegated to them by a specific Act. Secondary legislation is therefore not subject to the same parliamentary approval process as primary legislation. Statutory Guidance is also issued under powers delegated to Ministers (sometimes referred to as 'executive

authority'), but it does not carry the same legal weight as secondary legislation. Relevant organisations must follow the instructions set out in statutory guidance, unless they have a good reason not to (e.g. if to do so would prevent them from fulfilling a statutory duty).

The Residential Establishments – Child Care (Scotland) Regulations 1996 (founded on the Social Work (Scotland) Act 1968, in reference to the Children (Scotland) Act 1995, and subsequently amended), address the provision of residential care provided by local authorities and other agencies. They reinforce the responsibilities of managers to ensure that the welfare of the child is safeguarded and promoted, and set out the steps which must be taken in respect of, among others, the vetting of staff, safety, and the provision of education.

The Support and Assistance of Young People Leaving Care (Scotland) Regulations 2003 (founded on the Children (Scotland) Act 1995 and the Regulation of Care (Scotland) Act 2001, and subsequently amended) provide the main legislative structure for 'through-care' and 'after-care' services in Scotland. Their aim is to reinforce the parenting responsibilities of local authorities for young people who have been in their care, and to emphasise the importance and necessity of providing support through the transition to adulthood. The accompanying guidance highlights "local authorities' power and duty to continue to look after them [young people] until, normally, they are 18; [and] to ensure that they are prepared and ready for the time when they are no longer looked after". The regulations introduce new duties in respect of the assessment of young people's needs, and the planning which must follow (called 'Pathways'). The regulations also seek to strengthen planning, as well as the relationship between young person and the local authority, through the provision of a Pathways Coordinator for young people. Regulations also cover how financial assistance and accommodation for care leavers should be provided, and recording keeping and an appeals process managed.

The Looked After Children (Scotland) Regulations 2009 (founded on the Children (Scotland) Act 1995 and Adoption and Children (Scotland) Act 2007, and subsequently amended) are perhaps, on the basis of their relevance to care planning, the most important operational piece of legislation in the Scottish looked after system. Through the revocation and amendment of much previous legislation, and the introduction of new provisions related to assessment and planning (Part II), looked after at home (Part IV), kinship care (Part V), foster care (Parts VI and VIII) and residential care (Part IX), the regulations underpin many of the 'looked after child' processes in operation today.

The accompanying guidance to the regulations draws attention to the three principles which underpin the primary legislation and the regulations:

- To give paramount consideration to the welfare of the child;
- To consider the views of the child;
- To avoid delay and to make the minimum intervention necessary to a child's life.

In brief summary, regulations three, four and five describe the assessment and planning process which every local authority must undertake in respect of a child in, or coming into, care. This includes the information which must be collected, the purpose of assessment, questions which must be considered (e.g. permanence), and the individuals and organisations who should be consulted in the preparation of a plan. These provisions situated the care planning process for looked after children much more clearly within the Getting it Right for Every Child framework. Regulations four and five also refine the rules governing contact between a looked after child and their parents, family members, individuals with parental responsibilities or rights, and other specified persons. Regulations 44, 45 and 46 specify how children's cases must be reviewed, in terms of approach and frequency.

Regulation eight focuses on looked after children 'cared for by their parents', clarifying local authorities' responsibilities. Accompanying guidance states that "children who remain at home [...] are subject to the same care planning regulations [four and five] as children placed away from home".

Regulations ten through 16 have the effect of establishing 'kinship care' as a placement of parity with fostering, residential and at home. Regulation ten provides the legal description for what a 'kinship carer' is, and Regulation 11 sets out the aspects a local authority must consider before placing a child in kinship care.

Regulations 17 through 20 revise and update the requirements in respect of fostering panels: the means by which prospective foster carers are assessed as suitable, and whether a specific carer is suitable to care for a particular child. The regulations specify the qualifications and experience of panel members, their terms of reference and operating procedure. Regulations 21 through 32 provide the operating framework for the delivery of foster care itself, including the approval and continued review of foster carers, rules governing placements, etc. (Following amendment in 2014, the regulations also set a 'placement limit', of no more than three unrelated children being placed with a foster carer at one time.)

Regulation 33 allows for the payment, by local authorities, of financial allowances to kinship carers and foster carers. Regulations 36 through 41 provide the rules governing placements of children made in an emergency.

The Adoption Agency (Scotland) Regulations 2009 (made on the Adoption and Children (Scotland) Act 2007) set out the steps Adoption Agencies are required to take before making decisions about individual adoption cases. The Regulations also cover the provision of Permanence Orders with the authority to adopt, and how the views of the child, dependent on age and maturity, must be taken into account, as well as those of other relatives.

The Secure Accommodation (Scotland) Regulations 2013 make provision for the use and management of secure care accommodation for children. These include the conditions under which a looked after child may be placed in secure care, and the duties and actions of local authorities and others when such an action is taken.

NB There is a significant number of other regulations and guidance documents. Highlighted here are the ones which we think are the most important.

Other relevant legislation and conventions

While only the core legislative framework has been summarised above, it is important to note that a much broader and diverse range of legislation does impact directly on looked after children and young people. In part, this is because children are rarely 'looked after' for the entire duration of their childhood. The support which they and their families receive, either before or after a period in care, is organised and regulated under other, related-but-distinct, legislative provisions (although these may be contained in the same Act of Parliament). To properly understand a child's journey 'into' and 'out of' care, particularly in terms of assessing the support a child and family received before a decision was taken for the child to become 'looked after', it is necessary to look beyond the looked after child 'systems'.

Moreover, Scotland's local looked after 'systems' do not exist in isolation from other public policy developments. Changes in local government or NHS structures, or reforms to educational governance, can significantly affect the way services and support for looked after children are organised and delivered. For example, the integration of health and social care, through the Public Bodies (Joint Working) (Scotland) Act 2014 has led to the extensive restructure of many local authorities and health boards, with associated changes to the management, funding and governance of services for children and families. Additionally, the Social Care (Self-

Directed Support) (Scotland) Act 2013, established a framework within which certain groups of social care users, including families with children deemed 'in need' or with a disability, could direct what and how support is provided to them. Elsewhere, changes to UK welfare rules, while not specifically targeted at looked after children or their carers, have had an extensive impact on how kinship care in particular is financed and supported by Scottish local authorities.

A full list of relevant Scottish and UK legislation is included at Appendix A. Within this list is also reference to relevant international conventions, including the United Nations Convention on the Rights of the Child (UNCRC) 1989, whose principles and provisions have steadily been incorporated into Scottish primary legislation (most notably through the Children (Scotland) Act 1995 and the Children (Scotland) Act 2014). The UNCRC requires states to protect children from all forms of violence, abuse, neglect and mistreatment (Article 19) and protect children from sexual abuse and exploitation (Article 34). The UNCRC also sets out rights for children (i.e. individuals under the age of 18) directly relevant to the 'care system', including:

- a right to live with parents unless it is harmful for the child (Article 9);
- a right to be reunited with parents, if a child and family are living in different countries (Article 10);
- a right to special protection and help if a child cannot live with their parents (Article 20);
- a right to have the best care if a child is adopted or living in foster care;
- a right to have your living arrangements checked regularly if a child is living away from home.

The UNCRC also provides for more general rights, such the right to an opinion, and for it be listened to and taken into account (Article 12), and the

right to best possible health, and access to medical care and information (Article 24).

Policy development: A brief, recent history

Legislation is the legal embodiment of Government policy. But legislation is not the only vehicle for policy. Guidance, strategies, ministerial announcements and, critically, finance, all play a significant role in defining objectives and directing activity on the ground. Furthermore, the Scottish Government (or UK Government) are not the only source of policy. Many publicly funded organisations are authorised to issue guidance and standards, and a wide range of other bodies provide advice on 'good practice', which is often incorporated into local policies. Indeed, most 'national' policy is interpreted and adapted by local or regional authorities, and then repackaged for specific local audiences. Scottish Government guidance on school exclusion, for example, is often translated by local authorities into local guidance and procedure, before being circulated to schools. Furthermore, local implementation can be shaped by cycles of self-evaluation and inspection (e.g. by the Care Inspectorate), with findings and recommendations encouraging a local focus on particular issues.

Over the past two decades policy activity relating to looked after children has increased steadily, and from 2006 there has a been a steady stream of reviews, policy updates and guidance, with at least one significant publication or announcement a year (and often more). All of these have had some influence in shaping the policy framework. This section provides an introduction to key national policy developments, related specifically to looked after children and care leavers in Scotland, since 2006. It concentrates on national policy documents (e.g. strategies, guidance, etc.) and major initiatives. (For more detail, Appendix B provides a list of major policy developments from 1601 to date.)

Getting it Right for Looked After Child and Young People

In 2006, the Social Work Inspection Agency (SWIA) published 'Extraordinary Lives: Creating a positive future for looked after children and young people in Scotland'. Involving almost 200 young people and adults, this comprehensive review sought to demonstrate what good care for children and young people looks like, to identify good practice and to recommend in what ways care can be further improved. The review reported six key messages:

1. Looked after children can overcome adversity in childhood and lead successful adult lives.
2. Too many adults have low expectations of what looked after children can achieve. Children and young people can do well when they are cared for.
3. Relationships with skilled adults can help looked after children and young people develop successfully.
4. Children and young people looked after away from home need stability and the chance to put down roots. Being moved frequently from one care setting to another is damaging and often restricts their access to education and health care.
5. Tackling the disadvantage and discrimination still experienced by many looked after children requires planning at every level in a local authority and between them and their partners in delivering children's services. Champions are needed to make sure that local authorities and their partners provide the best possible care.
6. Developing an understanding of what children and young people think about services intended to help them supports effective engagement and long-term service planning.

Furthermore, as a component of the above review, 'Celebrating Success: what helps looked after children and young people achieve?' (2006) identified five critical factors for the success of children and young people:

- Having people in their lives who cared about them.
- Experiencing stability.
- Being given high expectations.
- Receiving encouragement and support.
- Being able to participate and achieve.

'Getting it right for children in foster care and kinship – A National Strategy' (2007) provided part of the Scottish Government response to the SWIA reports, set out principles to underpin Scotland's approach to foster care and kinship care. (These were then reflected in the Adoption & Children (Scotland) Act 2007 and Looked After Children Regulations 2009). Those principles were:

- The needs of the child must be paramount and the child's preferences should be taken into account;
- Unless there are clear reasons why placement within the family would not be in the child's interests, care within the wider family and community circle will be the first option for the child;
- If that is not possible, the child should be placed with foster carers with a specific purpose and plan, designed as (a) as part of a planned short-term arrangement, or (b) a planned process that will result in a return home or to a more suitable temporary care arrangement, or (c) in care with a permanent substitute family arrangement underpinned by a permanence order or an adoption order or other relevant court order.

In 2007, a Ministerial short-life working group was convened to better understand the educational barriers and issues looked after children and young people experience. The final report of this initiative, 'We Can and Must Do Better' (WCMDB) was intended to act as a catalyst for change. The group identified 19 specific actions, relating to, among others, how partners (e.g. local authorities and NHS Health Boards) worked together, and what skills, knowledge and competencies professionals and carers

needed in order to ensure looked after children and young people were emotionally, mentally and physically healthy. (A programme of training materials for all staff working with looked after children was developed to facilitate this.)

In 2008, the Scottish Government published, 'These are our Bairns: A guide for community planning partnerships on being a good corporate parent', which highlighted the key role of local authorities and their partners as corporate parents. This policy and practice document was particularly valuable in demonstrating the responsibility of all partners across local authorities and associated agencies to work together to meet the needs of looked after children and young people, as well as care leavers.

Also in 2008, Scotland's Commissioner for Children and Young People laid before Parliament 'Sweet 16: The Age of Leaving Care in Scotland'. The report showed that many young people leave care aged 16 or 17, when they are not ready to face the challenges this presents. The report made 23 recommendations, prompting a range of initiatives and activities (including development of Staying Put Scotland).

Responding to 'We Can and Must Do Better', in 2009 the Scottish Government issued CEL 16 (2009), formal notification to all NHS Board Chief Executives that the recommendations of WCMDB were to be implemented within the indicated timescales. The actions to be taken forward by NHS Health Boards related primarily to the provision of health assessments, skills and competencies of health staff, the nomination (in each territorial health board) of a Director to hold corporate responsibility for looked after children and care leavers (including ensuring statutory duties on the Health Board were being met).

In 2009, the Scottish Government initiated the National Residential Child Care Initiative (NRCCI), a strategic review of residential child care services. Its purpose was to develop an agreement of expectations between local authorities and their providers to ensure effective commissioning of

services, which lead to better outcomes for children and young people. The review was tasked with providing sector driven recommendations to the Scottish Government, local government and providers of residential child care. These were published in 'Higher Aspirations, Brighter Futures' (2009), and included a recommendation for a new Residential Child Care Level nine qualification to be developed, and rolled out across the residential care workforce. (The Scottish Government agreed with this recommendation, and implementation is now pending.)

Also in 2009, concurrent to the NRCCI, a review of Scotland's secure care provision was carried out. The Securing Our Futures Initiative (SOFI) made a range of far reaching recommendations, relating to the structure, management and focus of secure care. These recommendations were accepted in full by the Scottish Government, precipitating significant reform of secure care in Scotland.

In the Scottish Government's response to the NRCCI and SOFI reports, they recognised that there was both a need and opportunity to bring connected work on looked after children together. This is because, they reasoned, many of the challenges facing residential childcare – around culture, leadership, planning and joined up working – apply to other parts of the looked after children sector. Consequently, in 2010, the Scottish Government established the Looked After Children Strategic Implementation Group (LACSIG). Chaired by the Minister for Children and Young People, and consisting of a main group and eight sub-groups, this was to be the mechanism for coordinating and driving forward an implementation programme for all looked after children and young people in Scotland. The LACSIG structure aimed to bring strategic leaders from across children's services alongside the Scottish Government and local authorities, enhancing policy development discussion, and emphasising the critical leadership role of a number of individuals and organisations.

LACSIG ran for four years (2010 – 14). As a result of the recommendations and actions of its various groups, a number of important policy initiatives emerged (many of which are still in the process of implementation). Key among these were:

- Establishing a Permanence and Care Team (PaCT), in 2012, to drive and facilitate whole system improvement in care and permanence planning for looked after children. The PaCT provides dedicated, expert support to organisations throughout the system (e.g. local authorities, Children's Hearing, etc.). The PaCT is based at CELCIS (more on which below). In 2014, the Scottish Government and PaCT formed a partnership to deliver the Permanence and Care Excellence Programme (PACE). This programme utilises specific improvement methods to identify, test and scale up changes to the permanence planning process, securing measurable benefits in both the quality and speed of decision making;
- Delivery of the Foster Care Review (2014) to formalise and conclude a series of longstanding discussions about potential changes to Scotland's foster care system. (More detail about the Foster Care Review is in a dedicated section below.);
- Development of national guidance on young people's transition out of care, Staying Put Scotland (2013). This articulated an explicit philosophy of care, with relationship based practice, and extended, graduated transitions, as central elements. (This guidance laid policy foundations for Part 11 (Continuing Care) of the Children and Young People Scotland Act 2014.);
- 'Housing Options Protocol for Care Leavers: Guidance for Corporate Parents' (2013), encouraging housing authorities to make specific provision for care leavers, improving access to housing and preventing homelessness;
- Scoping and policy development work to inform a National Mentoring Scheme for Looked After Children (2013) which would

harness the capacity and skills of volunteers to improve outcomes for children through relationships; (This scheme, Intandem, is now underway, financed by Scottish Government and delivered by a range of mentoring providers.);

- Development and publication of national 'Guidance on the Health Assessment of Looked After Children in Scotland' (2014), setting out, for the first time, minimum standards for the conduct and content of health assessments, and expectations about the healthcare pathway which follows from that.

In 2011, to help speed up improvement in the looked after children's sector, the Centre for Excellence for Looked After Children in Scotland (CELCIS) was established. Building on the successes (in supporting the modernisation of Scotland's residential care sector) of the Scottish Institute for Residential Child Care, CELCIS acts as an intermediary organisation, working alongside partners delivering care and support, to identify and secure meaningful improvements in processes and practice. By enhancing the sectors' capacity to affect meaningful systems change, CELCIS facilitates the implementation and realisation of Scottish Government and priorities policy objectives (many of which flow out of prior reviews and inquiries, or the work of groups such as LACSIG).

In 2011-12, following the passing of the Children's Hearings (Scotland) Act 2011, the Children's Hearings Improvement Partnership (CHIP) was established, to help coordinate and support implementation of the reforms. In 2016, the CHIP published 'The Next Steps Towards Better Hearings', research into the views of practitioners and children and young people involved with the hearings system. 'Better Hearings' forms the basis of on-going work to develop service standards for the Children's Hearings System.

In June 2012, the Scottish Parliament's Education and Culture Committee launched an inquiry to look at the decision-making processes involved in determining whether a child should be removed from the family home

and taken into care. The Committee published an interim report in March 2013, exploring a number of issues, including the complexity of decision-making processes, the cost of childcare and the balance between parents' and children's rights. Continuing its inquiry the following year, the Committee took further evidence focusing on improving the process of decision-making and its outcomes. In September 2013, the Committee published its final report, concluding that "current decision-making processes are not always delivering the best outcomes for children and their families". The Committee made a number of recommendations, including:

- The complementary skills of staff in universal services and in social work must be used more effectively;
- The Scottish Government and local government must take all necessary measures to improve staff retention in children's social work;
- Further research is needed on claims that parents with learning disabilities are discriminated against;
- Work on establishing a "better, more rounded picture of a looked-after child's wellbeing" should be progressed as a matter of priority.

The Scottish Government responded to the Committee's final report in December 2013 and has since provided an update on action taken to implement the Committee's recommendations. Acting Children's Minister Fiona McLeod confirmed plans for a Looked After Children Strategy and an announcement on extending financial support to kinship carers.

In December 2012, the Scottish Government commissioned the National Foster Care Review, to be carried out by the Looked After Children Strategic Implementation Group (LACSIG) Foster Care Hub. The review was designed to assess the viability and effectiveness of certain reform options, and to provide Scottish Government and local authorities with a

set of clear recommendations for change. A final report was published in December 2013. Recommendations in the review included:

- The establishment of a set of clear descriptors for the different types of foster care placements available, to be "set out in national guidance, and embedded into practice via the Care Inspectorate's Annual Return for Fostering Agencies and appropriate national statistics";
- The introduction of a maximum placement limit through a new National Care Standard for Foster Care and Family Placement Services;
- The development of a National Learning and Development Framework for Foster Care, underwritten by new National Care Standards.

The Scottish Government responded to the findings of the Review, indicating its agreement with the review's recommendation to limit the number of children in a fostering household to three, with some exceptions. The response also agreed with the recommendation for better descriptions of foster care placements, with a working group set up on how to build the new descriptors into national statistics. It was announced that a national foster care database will not be taken forward, but the response stated that commissioning data may be collected via annual returns by the Care Inspectorate. Work to establish a Scottish national minimum fostering allowance began in 2015, and a final decision is pending. In 2016 the Scottish Government committed to parity, at a local authority level, in the allowances provided to foster carers and kinship carers.

Current national policy objectives for looked after children and care leavers were set out most recently in the Scottish Government's 2015 strategy 'Getting it Right for Looked After Children and Young People'. This strategy is focused on tackling inequality, and realising the Scottish Government's

aim of removing the significant barriers which prevent children and young people from achieving their potential. As the document's introduction notes:

> *"This strategy is built on the principles of GIRFEC, reaffirms our commitment to improve outcomes for looked after children and lays out our vision for the future. It is not about a change of direction, but consolidates the aims that have become well understood within the sector over recent years, reaffirms ambitions and builds on work underway."*

The strategy sets out the Scottish Government's vision of a 'care system' where fewer children need to become looked after, where quicker decisions are made about permanence, where there is a substantial reduction in the number of children and young people on long-term supervision, and where outcomes are improved. The strategy is underpinned by a clear focus on relationships for looked after children and young people, and this theme links together the strategy's three parts: 'Early Engagement', 'Early Permanence', and 'Improving the quality of care'.

In respect of Early Engagement, the aims are to:

Reduce the number of children who need to become looked after by -

- Embedding the use of the GIRFEC approach to ensure that children and their families are at the centre of planning and services, alongside the existing provisions of the Social Care (Self-directed Support) (Scotland) Act 2013;
- Increasing the use of strategic commissioning to ensure that the needs of families are understood and the right services are in place to meet families' needs at an early stage;
- Providing additional support to families at the edge of care, e.g. through Third Sector Fund and bespoke improvement programmes;

- Ensure that children are only looked after at home where this is the best option for them, and there is a clear plan and services in place to meet their needs;
- Ensure that those children who do require statutory intervention are identified at an early stage and that a plan for permanence (either with the birth family or an alternative permanent home) is in place.

To achieve this, the strategy commits to rolling out the Realigning Children's Services programme to at least six Community Planning Partnerships (CPPs) by 2017, and to share the learning. It also states an expectation that CPPs consider joint-commissioning approaches; an expectation underlined by the Children's Services Planning requirements set out in the Children and Young People Act 2014 (Part 2). Similarly, the strategy notes the introduction of new duties, under Part 12 of the 2014 Act, on local authorities to ensure that families receive the help they need before compulsory measures of care are deemed necessary. The strategy also articulates a policy link between Part 12 and Self-Directed Support, noting that these options (which are available to children considered 'in need') should give supported persons control and responsibility over their own support arrangements. Finally, the Scottish Government states its expectations that local authorities should "presume against" looked after at home status, except where it is part of a clear plan to remedy short term issues or a step towards permanence.

In respect of Early Permanence, the strategy describes this as a "secure, stable, nurturing home" which supports the child's wellbeing, allowing them to be happy, thrive and achieve the best outcomes possible. Every child, the strategy notes, should have this. To that end, the strategy outlines the Scottish Government's aims as:

Reduce the number of children and young people on long-term compulsory supervision (over two years) by -

- Increasing the number of children and young people achieving and sustaining permanence through returning home, kinship care orders, permanence orders or adoption;
- Increasing the number of older children, children with disabilities and sibling groups achieving permanence;
- Reducing the length of time it takes for children and young people to achieve permanence;
- Ensure that where children are looked after away from home they have the minimum number of placements possible before achieving permanence;
- Build the capacity of carers to take on harder to place children.

To achieve this, the Scottish Government commits to the extension of the Permanence and Care Excellence Programme, and sharing the learning among local authorities. It will also publish practice notes for frontline workers, guidance on contact, and work through the Children's Hearing Improvement Partnership (CHIP) to push forward improvements in the permanence planning process. Linked to the Children and Young People (Scotland) Act 2014, the strategy also notes the introduction regulations for the governance of the adoption register, and commencing the support available to individuals under Part 13 (Kinship Care Assistance). Implementing a recommendation of the National Fostering Review (2013), a new typology of foster care placements will be introduced.

In respect of improving the quality of care, the strategy stresses that, for those children who need to be 'looked after' over a long term, they must receive the highest quality of care and support in order to meet their wellbeing needs. To that end, the strategy commits to:

- Requiring corporate parents to work collaboratively to provide the support and services needed to improve outcomes for looked after children and young people;

- Requiring corporate parents to prepare, keep under review and publish a corporate parenting plan setting out how responsibilities will be met;
- Enabling looked after young people to leave care at a time and pace that is appropriate for their needs, supporting them through their transition to interdependency reflecting the policy aims set out in Staying Put Scotland and reflecting the ambition that young people are more fully integrated into their community;
- Supporting all looked after children and young people to have a trusting, consistent relationship in their lives and ensuring these key people are involved in supporting our young people to make key decisions;
- Ensuring carers have the necessary skills, experience and support to meet the increasingly complex needs of the children and young people they care for.

To achieve this, the strategy points directly to the corporate parenting duties introduced by the Children and Young People (Scotland) Act 2014 (Part 9), and the steps around monitoring and reporting corporate parents which Scottish Government will take to drive improvement. It also committed to publishing guidance on how the new 2014 Act's provisions around aftercare (Part 10) and continuing care (Part 11), [both of which have now been done]. The Scottish Government also convened a working group to explore a 'right to return' policy, which would allow care leavers to return back to care placements after a period of independence (an arrangement not currently permitted under continuing care legislation, although local authorities have powers to provide it should they decide to). Finally, the Scottish Government committed to a National Mentoring Scheme for looked after children at home (a programme now being managed by Inspiring Scotland), and introducing a degree-level qualification for residential workers (also known as the 'level nine' – a commitment originally made in response to the NRCCI, in 2009).

In 2016, Scotland's Secure Care National Advisor conducted a review of the recent changes introduced to secure care, its current operations, and future development. In response to 'Secure Care in Scotland: Looking Ahead', the Scottish Government established the Secure Care Strategic Board, tasked with leading and coordinating the national response to children and young people in and on the edges of secure care in Scotland.

Also in 2016, the Scottish Government announced a National Child Protection Improvement Programme for Scotland (CPIP). This programme includes existing commitments on child sexual exploitation; child trafficking; and internet safety, along with a number of new areas of work. These include: a review of practice in the Children's Hearings System; agreeing steps to promote and support leadership; refreshing the role of inspection agencies; improving data and evidence; agreeing further action to address the impact of neglect on children and young people; and a review looking at how the child protection system currently works and what could be improved across Scotland. The child protection system review concluded in early 2017, with the report 'Protecting Scotland's Children and Young People: It's still Everyone's Job'.

2. Horizon Scanning

The Care Review is operating against a backdrop of continued, varied policy and legislative developments.

To enable the Care Review to establish the necessary links with, and have the opportunity to potentially influence, relevant areas, this section outlines some upcoming or proposed developments; as set in 'A Nation With Ambition: The Government's Programme for Scotland 2017-18' , which was published on 5 September 2017. The Care Review may wish to consider whether there are any gaps in the programme, making recommendations about what additional steps need to be taken in order to improve a child or young person's experience of care.

The Programme for Government includes a number of relevant priorities within the portfolio of the Deputy First Minister and Cabinet Secretary for Education and Skills. These include:

- the development of a strategic approach to responses to children and young people in and on the edges of care;
- the roll out of the Permanence and Care Excellence (PACE) programme throughout all local authorities in Scotland;
- a National Kinship Care Advice Service for kinship care families and professionals in autumn 2017;
- a review of Foster, Kinship and Adoption allowances and to bring forward proposals for national kinship care and foster care allowances in summer 2018;
- a drive to ensure all local authorities refer children and prospective adopters to Scotland's Adoption Register by March 2018;
- a requirement for corporate parents to publish their plans by the end of March 2018 to allow Scottish Ministers to report to Parliament by July 2018;

- to commission a progress review on the use of family support services to prevent children going into care;
- the development of Secure Care National Standards and the establishment of a transformative model for secure care in Scotland through a new Secure Care Strategic Board, which will report by end 2018;
- embedding Adverse Childhood Experiences (ACEs) to prevent them occurring but also to support resilience and the overcoming of past experiences;
- bringing forward a bill to raise the minimum age of criminal responsibility;
- the Children and Young People (Information sharing) Bill;
- Support legislation to prohibit the physical punishment of children;
- the doubling of funded early learning and childcare provision;
- the continuation of the Children and Young People Improvement Collaborative and Realigning Children's Services programme (mapping to ensure the right services are in place including for those children who are looked after at home);
- the delivery of child protection commitments such as: National Child Abuse Prevention Plan; linking with National Police Vulnerable Persons Database to identify all children and young people on local child protection registers; revised outcomes focused framework of inspections; consultation on revising abuse and neglect of children criminal offences; programme to tackle neglect, and; implementing actions around child sexual exploitation by end of 2018;
- a review of the Children (Scotland) Act 1995 in so far as Parental Rights and Responsibilities, contact and residence cases are dealt with in family cases in Courts;

Specific priorities in relation to education include:

- planned "Radical reform" of the education system, including:

- more control of resources for head teachers, through the Pupil Equity Fund;
- expert help for teachers from Regional Improvement Collaborative;
- a new Education Bill to give head teachers new powers and responsibilities; a Head teachers Charter; a revised funding approach for schools; strengthening the role of parents in schools; establishing home-link workers for every school;
- the provision of full, non-repayable bursaries for care experienced young people who obtain university places (for those under 26);
- a review of Personal Social Education and services for counselling for children and young people;
- progressing the Commission on Widening Access's Report 'Blueprint for Fairness', recommendations. This includes targets for every university to ensure that, by 2021, 10% of entrants to each university are from Scotland's 20% most deprived backgrounds;
- the publication of Learner Journey recommendations by end 2017 – to deliver improvements in the join up between schools, colleges and universities;
- embedding best practice from the successful Improving Gender Balance project to improve participation by under-represented groups in STEM learning, courses and training, particularly for women and girls;
- ensuring there is a teacher or professional in every school with responsibility for promoting parental, family and community engagement.

Additionally, the Scottish Child Abuse Inquiry has now commenced, and is scheduled to conclude in October 2019. A variety of activities also continue to ensure that 'Getting It Right For Every Child' underpins all practice and policy for children and young people. A number of Children's Hearings initiatives are also being progressed, aimed primarily at improving children and young people's experience of the Hearings system. Better Hearings is

looking at, among others, (i) consistent practice in the delivery of Hearings, (ii) considering the views of children and young people on attendance in Hearings and (iii) ensuring children and young people's effective participation. This is being supported by the implementation of a digital strategy.

The Children's Hearings Improvement Partnership (CHIP) is also tasked with embedding continuous improvement within the Hearings system. Additionally, the newly created young people's board, Our Hearings, Our Voice, gives young people with experience of the Hearings System the opportunity to have a decision making role in the continuous improvement and development of the system, using their direct experience, knowledge and perspective.

Further embedding the United Nations Convention on the Rights of the Child into policy development is a specific priority in the Programme for Government, as is increasing the participation of children and young people in matters relating to them, at both national and local levels. This includes the establishment of a Young Disabled People's Forum to enable thirty disabled people aged 14-25, with a variety of disabilities, to come together and share their experiences while expressing opinions and having their voices heard and respected.

Policy developments for unaccompanied minors arriving in Scotland, and how they are subsequently cared for and supported, will feature in the coming year, as will steps to facilitate the continued implementation of the Getting It Right for Looked After Children and Young People strategy . This will further require embedding continuing care and aftercare policy, and undertaking a review of adoption legislation. There are also extensive plans to continue workforce development, across the children's sector (with reference made to health and social care integration).

Finally, in October 2017 the First Minister announced that all care leavers will be exempt from paying Council Tax up until their 26th birthday. Action to realise this objective will progress over the coming year.

Programme for Government commitments in relation to Communities, Social Security and Equalities – including local Government and Housing, include:

- the establishment of a homelessness and rough sleeping action group to end rough sleeping and transform the use of temporary accommodation, utilising a £50m fund with the objective of "Ending Homelessness Together";
- creation of a new £50m fund to tackle the causes of, and rise in, child poverty, building on the Child Poverty Bill;
- additionally, the implementation of recommendations of the independent advisor on poverty and inequality in "The life chances of young people in Scotland " report – priorities of which are mental health, employment and housing;
- exploration of a citizen's basic income scheme, with plans including:
    - a fund to help local authorities develop their proposals further, and establish suitable testing
    - asking the Poverty and Inequality Commission to feed into the Government's thinking
- the introduction of Best Start Grant for low income families by summer 2019 – also work to provide a financial health check to families on low incomes;
- the introduction of a three-year rolling funding for third sector organisations;
- an additional £20m for alcohol and drug services;
- new target of 50,000 affordable homes by the end of the Parliament;
- free sanitary products for students in schools, colleges and universities;

- new package of support for young carers through the Carers (Scotland) Act 2016.

Other relevant activity within this portfolio includes work to ensure support is in place for those leaving care and accessing housing, and the continued implementation of the national strategy to tackle social isolation.

While there was no direct Programme for Government commitments related to looked after children within the Economy portfolio, a key piece of work being taken forward relates to supporting young people into sustainable employment, with a particular focus on young care leavers and young people with disabilities. This work draws upon a range of charities, service providers, private employers and philanthropic organisations. It also has links to Learner Journey work and activities of Skills Development Scotland.

Some relevant targets, in relation to economy and employment, include:

- aspirations to reduce youth unemployment by 40% by 2021;
- a "more inclusive" approach to helping unemployed people find work;
- continuing to implement the Developing the Young Workforce strategy;
- continued investment of £100 million per year in apprenticeships, flexible workforce development and individual training accounts.

The Justice portfolio includes three priorities with clear links to looked after children and the 'care system':

- to review the legislative framework (Part 1 of the Children (Scotland) Act 1995) around children and young people's contact with parents and families;
- establish a specific offence of domestic abuse covering both physical and psychological abuse;

- new justice programmes aiming to reduce reoffending and divert people from crime.

Other work underway, and led by the Justice team, includes supporting voluntary services with links to continuing/after care, such as the "Moving On" project in conjunction with HMP Polmont, Action for Children and Barnardo's. Also, a continued look at community safety policy, and keeping under review the provision of legal support in Children's Hearings and Court proceedings.

The Programme for Government commitments within the Health and Sport portfolio include:

- an audit of CAMHS rejected referrals and a commitment to act upon the audit's findings;
- continued implementation of the Mental health strategy – and of key importance, improving transitions for young people moving from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services, including potential future flexibility for those aged 18-25 to continue their care and treatment with CAMHS if they so choose;
- Continuing Partnership Drug Initiative and Scottish Families Affected by Alcohol and Drugs
- the provision for all (eligible) first-time mums to receive Family Nurse Partnership support;
- Early intervention work around increasing activity levels, tackling poor diet and obesity;
- A new Mental Health Strategy, increasing the level of investment in mental health services and improving support from birth to young adulthood.

Other relevant work being led by the Health and Sport portfolio covers a range of topics. This includes a refresh of the 2016 Pregnancy and Parenthood in Young People Strategy. It also includes progression of the

Childsmile programme, of which one key aim is to reduce oral health inequalities among children in Scotland. The Health and Sport team is also leading on reducing violence against women and girls through strategies such as "Equally Safe."

Legislation for 2017-18, planned or underway

- Budget Bill (annual budget bill in relation to spending, devolved taxes etc.)
- Education Bill (a new Education Bill to give more power to head teachers, more support to teachers and strengthening the role of parents)
- Management of Offenders Bill (reducing length of time many people will be required to self-disclose offending behaviour)
- Minimum Age of Criminal Responsibility Bill (moving age of criminal responsibility from eight to 12 years old)
- Vulnerable Witnesses and Pre-recorded Evidence Bill (includes an aim that children, wherever possible, should not have to give evidence in court during a criminal trial)
- Children and Young People (information sharing) Bill
- Child Poverty Bill
- Domestic Abuse Bill
- Housing (amendment) Bill
- Social Security Bill

3. Appendices

Appendix A: Relevant Legislation

Primary Legislation

Police (Scotland) Act 1967

Social Work (Scotland) Act 1968

Local Government (Scotland) Act 1973

Adoption (Scotland) Act 1978 [Part IV]

Foster Care (Scotland) Act 1984

Access to Health Records Act 1990

Age of Majority (Scotland) Act 1969

Children (Scotland) Act 1995

Disability Discrimination Act 1995

Criminal Procedures (Scotland) Act 1995

Community Care (Direct Payments) Act 1996

Human Rights Act 1998 (incorporating the European Convention on Human Rights)

Data Protection Act 1998

Children Act 1989

Children (Leaving Care) Act 2000

Regulation of Care (Scotland) Act 2001

Community Care and Health (Scotland) Act 2002

Education (Disability Strategies and Pupils' Educational Records) (Scotland) Act 2002

Mental Health (Care and Treatment) Scotland Act 2003

Homelessness etc. (Scotland) Act 2003

Criminal Justice (Scotland) Act 2003

Local Government (Scotland) Act 2003

Protection of Children (Scotland) Act 2003

Commissioner for Children and Young People (Scotland) Act 2003

Further and Higher Education (Scotland) Act 2003

Anti-social Behaviour etc. (Scotland) Act 2004

Family Law (Scotland) Act 2006

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

Joint Inspections of Children's Services and Inspection of Social Work Services (Scotland) Act 2006

Scottish Schools (Parental Involvement) Act 2006

Protection of Vulnerable Groups (Scotland) Act 2007

Adoption and Children (Scotland) Act 2007

Public Health etc. (Scotland) Act 2008

Education (Additional Support for Learning) (Scotland) Act 2009

Equality Act 2010

Public Services Reform (Scotland) Act 2010

Post-16 Education (Scotland) Act 2013

Social Care (Self-Directed Support) (Scotland) Act 2013

Public Bodies (Joint Working) (Scotland) Act 2014

Children and Young People (Scotland) Act 2014

Community Empowerment (Scotland) Act 2015

Community Justice (Scotland) Act 2016

Education (Scotland) Act 2016

Carers (Scotland) Act 2016

Secondary Legislation

Support and Assistance for Young People Leaving Care (Scotland) Regulations 2003

Residential Establishment – Child Care (Scotland) Regulations 2006

Adoption (Disclosure of Information and Medical Information about Natural Parents) (Scotland) Regulations 2009

Adoption Agencies (Scotland) Regulations 2009

Looked After Children (Scotland) Regulations 2009

Looked After Children (Scotland) Amendment Regulations 2009

Adoption Agencies (Scotland) Amendment Regulations 2010

Children's Hearings (Scotland) Act 2011 (Transfer of Children to Scotland) Regulations 2013

Secure Accommodation (Scotland) Regulations 2013

Looked After Children (Scotland) Amendment Regulations 2013

Looked After Children (Scotland) Amendment Regulations 2014

Aftercare (Eligible Needs) (Scotland) Order 2015

Provision of Early Learning and Childcare (Specified Children) (Scotland) Amendment Order 2015

Support and Assistance for Young People Leaving Care (Scotland) Amendment Regulations 2015

Scotland's Adoption Register Regulations 2016

Children and Young People (Scotland) Act 2014 (Consequential Modifications) 2016

Kinship Care Assistance (Scotland) Order 2016

Relevant Services in Relation to Children at Risk of Becoming Looked After (Scotland) Order 2016

Child's Plan (Scotland) Order 2016

International Conventions

UN Convention on the Rights of the Child 1989 (Ratified by the UK Government in 1991) & Optional Protocols (various dates)

Hague Convention 1993

UN Convention on the Rights of Persons with Disabilities (Ratified in 2009)

Appendix B: Timeline of Key Policy, Legislation and Reports which have impacted on the development of the current Scottish 'care system'

(NB where reports and law from the rest of the United Kingdom have had an influence these have been included)

1601 The Poor Law

Established a basic social security system to the United Kingdom.

1872 Education (Scotland) Act

Made school attendance compulsory for children aged 5-13 in Scotland. Placed control of education with new, democratically elected schools boards rather than the church.

1889 Prevention Of Cruelty To, And Protection Of, Children Act ('The Children's Charter')

Made child abuse and neglect a criminal offence. The legislation came about as a result of five years of persistent lobbying.

The Scottish National Society for Prevention of Cruelty to Children (NSPCC) is established

1904 The NSPCC is given authority to remove children from abusive or neglecting homes.

1908 Children Act

This is the first legislation in the UK to recognise the need for children who offend to be dealt with separately from adult offenders by establishing a juvenile justice system. The minimum age of criminal responsibility is created and set at seven years old.

1924 The Assembly of the League of Nations passes The Declaration of the Rights of the Child. This is the first international instrument to recognise children's rights.

1930 Adoption of Children (Scotland) Act

Adoption becomes legal in Scotland (Four years after England and Wales).

1932 Children and Young Persons (Scotland) Act

The age of minimum criminal responsibility is raised to eight years.

1945 Education (Scotland) Act

The school leaving age is raised from 13 to 15. This signifies a change in attitudes towards children and their duty towards the family business.

1946 The Clyde Committee publishes its report

A Scottish inquiry into the situation of homeless children and children 'boarding out', as a response to the death of a child, Dennis O'Neill, in foster care in 1944. The Clyde Committee took place at the same time as the Curtis Committee in England. Both made strong recommendations regarding the quality of care in residential homes and that residential care was made more 'family-like'.

1947 National Health Service (Scotland) Act

Came into effect 5 July 1948 and created NHS Scotland

1948 Children Act

Came about in response to the 1946 Clyde and Curtis reports. Required local authorities with more than 400 children to establish unitary children's committees and children's officers. Only four local authorities and two counties in Scotland and England were big enough to be caught by the legislation.

1950 The European Convention on Human Rights is passed (UK ratified in 1951)

1959 The UN Declaration on the Rights of the Child is passed.

1963 Children and Young People Act

This Act placed an obligation on local authorities to provide support to families in order to avoid children going into care. This is part of a steady societal reorientation towards thinking of the family unit more holistically.

1964 The Kilbrandon Report

Marked a decisive change in Scottish children's policy, recommending the setting up of the Children's Hearings System and that children who offend are treated according to the same welfare-based approach as children who have experienced neglect and abuse. Included the core concept that a lay panel should in most cases replace the role of juvenile courts.

1965 Teaching Council (Scotland) Act

Established the General Teaching Council in law, giving teachers similar control of their profession as lawyers and accountants and to ensure teachers were qualified and certified to teach.

1967 Police (Scotland) Act

Established a duty on police officers to investigate and report child care issues, creating a duty towards children.

1968 Social Work (Scotland) Act

Forms the foundation of today's children's services and social work system. It introduced social work departments in all local authorities and made social workers the key professional for children's care and protection.

1971 The Children's Hearings System came into being.

1973 'Born To Fail' child development study was published by the National Children's Bureau which, for the first time, highlighted the

adversities of 'disadvantaged' children in almost every aspect of life, including health and education.

1978 Adoption (Scotland) Act

Introduced a number of significant changes including: outlawing private adoption based on financial transaction; establishing official adoption agencies and made non-agency adoption other than for birth relatives illegal; introducing adoption allowances and recognised the need for support services for children, parents and adoptive parents; placed a duty on adoption agencies to consider alternatives to adoption and placed emphasis on the importance of preventative measures; introduced grounds by which parents' consent to initial placement for adoption could be dispensed with ('freeing for adoption').

1983 Health and Social Services and Social Security Adjudications Act

Created legal safeguards and far more rigorous procedures for placing young people in secure care, establishing an assumption of parental rights and requiring Secretary of State approval for such placements.

1984 Foster Children (Scotland) Act

First dedicated piece of legislation for fostering in Scotland. Set out the duties of local authorities towards children in foster care, including inspections and whistleblowing. Secondary legislation was passed under this Act, namely the Boarding-Out and Fostering of Children (Scotland) Regulations and, later, the Fostering of Children (Scotland) Regulations 1996.

1986 The UK Parliament votes to abolish corporal punishment in UK state schools. The abolition is extended to fee-paying schools in Scotland in 2000.

1988 The Cleveland Inquiry publishes its findings

Inquiry into a number child sexual abuse cases in Cleveland in England, finding that the children concerned had not been listened to by professionals.

1989 UN Convention on the Rights of the Child

Ratified by the UK in 1991, committing the UK to taking steps (including legal, administrative and budgetary steps) that would ensure all children in the UK enjoy their human rights, irrespective of gender, nationality, ethnicity, religion, language, place of residence and any other status.

1990 NHS and Community Care Act

Saw the UK move towards part privatisation care in certain areas, further complicating the professional landscape and leading to an increase in non-qualified, non-trained staff. It also resulted in specialisation of social workers.

Review of Child Care Law in Scotland report published

Established in 1988 by the Secretary of State for Scotland to review the law governing child care in Scotland. Published 95 recommendations with emphasis on the role of universal services in child care provision.

1991 Age of Legal Capacity (Scotland) Act

Sets out the types of contracts that may be made by young persons. Defines the age of legal capacity and particular exceptions. Provides young people with the power of consent.

Staffordshire 'Pindown' Inquiry

'Pindown' was a method of behaviour management used in children's homes in Staffordshire, England in the 1980s involving the isolating of children. The inquiry report condemned the practice and the report had a major impact on children's law in the UK.

1992 Orkney Child Abuse Inquiry

An inquiry into the circumstances surrounding the removal of children from their families due to concern about satanic ritual sexual abuse. National guidance issued as a consequence to improve practice, support and training across Scotland.

Skinner Review report published 'Another Kind of Home'

A review of residential child care provision. Emphasised the need for children's rights to be central to care delivery and for an overhaul of the 'system'. Emphasised that a more positive approach to residential care should be taken.

The Fife Inquiry published its findings

A review into the way in which Fife Council ran its children's services, finding that a number of local reforms to social work aimed at keeping families together were too 'hands-off' and put children at risk.

1994 Local Government (Scotland) Act

Reorganisation of local authorities which led to a major reduction in the number of social work departments. The Act established the role of the Chief Social Work Officer and led to fragmentation between how local authorities delivered children's services.

Following publication of the Finlayson Report 1992 and the Local Government (Scotland) Act 1992, reporters were placed within a national organisation, the Scottish Children's Reporter Administration.

The Scottish Children's Reporter Administration (SCRA) was established.

1995 Children (Scotland) Act

This Act defined the range and scope of Local Authority intervention in family life in order to safeguard children. It placed an explicit obligation on local authorities to facilitate and promote the involvement of birth families in the lives and upbringing of children taken into care and was the first piece of legislation in Scotland embedding children's rights into law, making the consideration of a child's lifelong interest a paramount concern in adoption decisions.

1996 Secure Accommodation (Scotland) Act

Concerned with the use of secure accommodation for any child who is being looked after by a local authority or for whom the local authority is responsible under Criminal Procedure legislation.

The Social Work Services Inspectorate published 'A Secure Remedy: Review of Secure Care in Scotland' which reviewed whether the provision of secure care in Scotland was compliant with the Convention on the Rights of the Child.

1997 Kent Review of Children's Safeguards publishes its findings

The review was concerned with the dangers faced by young people living away from home. Recommended standardisation of child protection statistics and an enhanced role for child protection committees.

Sex Offenders Act

Made sex offenders subject to notification requirements and introduced a sex offenders register.

1998 Human Rights Act

Transposes the European Convention on Human Rights into UK law.

Data Protection Act

Established basic principles which remain relevant today, setting out conditions under which data can be 'processed'.

1999 The Edinburgh Inquiry publishes its findings

Looked into the circumstances of abuse in residential care in Edinburgh. The inquiry investigated whether complaints were properly handled and to determine whether further safeguards were needed to protect children from abuse. 135 recommendations were made including how to improve the investigation and review of historical procedures and allegations; review of current procedures, practice and guidelines in operation in the City of Edinburgh; and recommendations to ensure that every measure is in place to minimise child abuse.

The Scottish Office published 'Aiming for Excellence: Modernising Social Work in Scotland'

In the immediate aftermath of Scottish devolution, this white paper explored the need for reforming social work services in Scotland and made several proposals, including a stronger role for social work in contributing to social inclusion and the up-skilling of the workforce, including through registration and regulation of the profession.

2000 The Waterhouse Inquire publishes its report 'Lost In Care -- inquiry into abuse in Welsh Children's Homes and Foster Care'

Resulted in changes in policy in England and Wales as to how authorities deal with children in care. Recommendations included the appointment of an independent children's commissioner for Wales, whistleblowing procedures to allow staff to raise concerns, and a children's complaints officer to be appointed in every local authority to deal with allegations of abuse.

2001 The Scottish Executive publishes 'For Scotland's Children'

Introduced the concept of the 'Named Person' – a lead professional assigned as contact person for every child. The Named Person role

was to be held by education and health professionals, rather than social work.

Protection from Abuse (Scotland) Act

Legislation concerning domestic abuse extending protection for victims and police power to arrest and charge individuals who commit domestic abuse.

Regulation of Care (Scotland) Act

Established the Scottish Social Services Council (SSSC) and legislates for care standards and a social work code of practice to be put in place.

2002 Fife Inquiry publishes its findings

Followed the conviction of an employee in Elie and Leven on 30 charges of sexual abuse of children from 1959 to 1989. Recommendations included: more rigorous staff recruitment and selection processes; improve and maintain staff awareness of abuse issues and safeguarding children; provide children and young people with ways to express their views about their care; better inspection and monitoring processes.

The Scottish Executive publishes a child protection audit and review report 'It's everyone's job to make sure I'm alright'.

The report made 17 recommendations aimed at reducing child abuse and neglect in Scotland and improving the services for the children who experience abuse and neglect.

The Care Commission publishes National Care Standards in line with the Regulation of Care (Scotland) Act 2001.

2003 Report in to the circumstances of the death of Caleb Ness published, leading to the reorganisation of the Edinburgh Social Work

department and reviews of child protection practices by other agencies.

Support and Assistance of Young People Leaving Care (Scotland) Regulations

Set out the duties owed by local authorities towards young people leaving care or ceasing to be looked after.

Protection of Children (Scotland) Act

Gives Scottish Ministers the authority to establish a list of those disqualified from working with children. It also placed a duty on organisations to report individuals with access to children in a paid or voluntary capacity who has harmed or put a child at risk of serious harm, even where such act did not constitute a criminal offence.

Mental Health (Care and Treatment) (Scotland) Act

The Act introduced specific provisions in relation to children and has clear links to the Children (Scotland) Act 1995, introducing a range of powers and duties put in place for both health boards and local authorities to address the needs of children and parents with mental health problems.

Criminal Justice (Scotland) Act

Places certain limits on physical punishment of children by their parents (although it doesn't outlaw it all together).

SSSC introduces requirement for social workers to register by 2005.

The Office of the Commissioner for Children and Young People in Scotland is established. Kathleen Marshall is the first to be appointed to the role in 2004.

2004 Education (Additional Support for Learning) (Scotland) Act

Created a duty on Local Authorities to provide learning support to children with additional needs.

Bichard Inquiry report is published.

Inquiry into the murder of two schoolgirls in Soham in 2002 recommended that those working with children and other vulnerable groups should be registered. Led to the Protection of Vulnerable Groups Act 2007.

The Scottish Executive issues a full apology to victims of abuse in children's homes in Scotland.

The Scottish Executive publishes 'Getting It Right For Every Child' reviewing the Children's Hearings System.

2005 Protection of Children and Prevention of Sexual Offences (Scotland) Act

The purpose of this Act was to improve the protection given to children and young people from those who would wish to cause them sexual harm or exploit them for sexual purposes (grooming).

The Scottish Executive publishes 'Holding Safely: A guide for residential care practitioners and managers about physically restraining children and young people'.

Introduction of requirement on managers of residential childcare services to register with SSSC before 2009.

The Adoption Policy Review Group (APRG) publishes its final findings. The Group was tasked with addressing barriers to adoption. The APRG findings led to the Adoption (Scotland) Act 2007 and the introduction of permanence orders.

2006 The 21st Century Social Work Review group publishes its findings in the report 'Changing Lives', looking at how social services could better meet needs, recommending a stronger role of universal

services in early intervention and a more targeted role of social work in cases concerning complex, unpredictable, longer term needs and risk.

The Social Work Inspection Agency publishes 'Extraordinary Lives: Creating a positive future for looked after children and young people in Scotland'. The purpose of this review was to demonstrate what good care for children and young people who are looked after by local authorities looks like, to identify good practice and to recommend in what ways care can be further improved.

2007 The Scottish Government publishes the resource and learning materials 'We Can And Must Do Better', targeted at everyone concerned with outcomes for children and young people, last updated in 2013.

Adoption and Children (Scotland) Act

Introduced new permanence orders and allowed for both partners in an unmarried couple to adopt jointly, including same-sex partners. It also extended the right to counselling to siblings affected by adoption. The Act did not follow through initial proposals to transfer cases from the hearings system to the courts if an adoption plan was put forward, nor did the Act establish a right for parents to put their views directly to the local authority Adoption Panel which considers the plan.

Protection of Vulnerable Groups (Scotland) Act

Introduced the PVG Scheme, designed to create a fair and consistent system that would help to ensure that those who have regular contact with children and protected adults through paid and unpaid work do not have a known history of harmful behaviour.

2008 The Scottish Government publishes 'These Are Our Bairns: A guide for community planning partnerships on being a good corporate

parent', introducing the concept of corporate parenting in Scotland and establishing a broad reference point.

2009 Early Years Framework

Key policy of the Scottish Government, aimed at ensuring all children in Scotland get the best start in life and emphasising early intervention.

Looked After Children (Scotland) Regulations

Sets out the definition of a kinship carer for the first time and extends the obligations on local authorities to also take into account contact with the family more widely when determining where to place a child in care. Statutory Guidance was published in 2011, setting out further details.

Education (Additional Support for Learning) (Scotland) Act

Amends the 2004 Act and makes Looked After Children a priority group for educational support by establishing a presumption that children with experience of care have additional support needs, unless an assessment finds otherwise.

The National Residential Child Care Initiative (NRCCI) publishes its reports, making a number of recommendations relating to how residential care is provided in Scotland.

2010 The Scottish Government publishes 'National Guidance for Child Protection in Scotland', most recently updated in 2014.

The Looked After Children Strategic Implementation Group (LACSIG) is set up to take forward the recommendations and implementation programme recommended by the NRCCI.

The Scottish Government publishes guidance on the role of the Chief Social Work Officer.

2011 Children's Hearings (Scotland) Act

Set out significant reforms to the hearings system designed to modernise and streamline the hearings system through a number of structural reforms. This was in part to reflect the changing nature of referrals during the 1990s which saw a significant increase in referrals on 'care and protection' grounds and a drop in referrals due to juvenile offences.

Introduction of requirement on managers in housing support services and managers in care-at-home services to register with SSSC before 2014.

The Scottish Government adopts the Whole Systems Approach programme for addressing the needs of young people involved in offending. Underpinned by 'Getting it Right for Every Child', this ensures that anyone providing support puts the child or young person – and their family – at the centre.

The Education and Culture Committee commenced an inquiry into the educational attainment of 'Looked After Children' to examine the reasons why more significant progress had not been made since devolution in improving the educational attainment of 'looked after children' and what can be done to address this.

2012 The Doran Review publishes its recommendations aimed at providing better outcomes and experiences for children and young people with complex additional support needs.

The Jimmy Savile sexual abuse police investigation commences.

2013 Foster Care Review report is published, making six recommendations for improvement.

Secure Accommodation (Scotland) Regulations

Modernises the legislation and sets out the definitions and parameters of secure care.

Social Care (Self-Directed Support) (Scotland) Act

Allows those eligible for social care to choose how support is provided to them. In the context of 'looked after' policy, this has had the largest impact on children with disabilities.

The Scottish Government publishes Scotland's first National Action Plan for Human rights (SNAP) 2013-2017

2014 Children and Young People (Scotland) Act

Landmark piece of legislation in many areas of 'Looked After' policy and children's services more widely. The Act covers: The rights of children (and Scottish Ministers' obligations in that regard); the Commissioner for Children and Young People in Scotland; Children's Services Planning; Named Person; Child's Plan; Early Learning and Childcare; Corporate Parenting; Aftercare; Continuing Care; services relating to children at risk of becoming looked after; kinship care; the Adoption Register; school closures; and children's hearings.

Public Bodies (Joint Working) (Scotland) Act 2014

Sets out the framework for health and social care integration.

The Independent Inquiry into Child Sexual Abuse in England and Wales was announced. The first interim report is expected in 2018.

The Scottish Government publishes 'Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls'.

2015 The Scottish Child Abuse Inquiry commences, looking at the historic abuse of children in care. The Inquiry aims to raise public awareness of the abuse of children in care. It will provide an opportunity for public acknowledgement of the suffering of the children and it will be a forum for validation of their experience and testimony. Expected to report autumn 2019.

'Evaluation of Whole System approach to Young People Who Offend in Scotland' report was published in 2015 by The Scottish Centre for Crime and Justice Research, funded by the Scottish Government.

2016 The Child Protection Systems Review commences. The final report, 'Protecting Scotland's Children and Young People: It's still everyone's job' was published in 2017.

Statutory guidance on the Role of the Chief Social Work Officer published by the Scottish Government, amending 2009 guidance.

CELCIS report published: "The Role of the Solicitor in the Children's Hearings System" as part of the Children's Hearings Improvement Programme.

The Children's Hearings Improvement Partnership (CHIP) publishes 'Next Steps Towards Better Hearings' comprising research into the views of practitioners and children and young people involved with the hearings system. 'Better Hearings' forms the basis of on-going work to develop service standards for the Children's Hearings System.

Education (Additional Support for Learning) (Scotland) Act

Modifies the 2004 Act, including by extending the right of children to request additional support for learning, rather than only parents and carers being able to do so. This provision will commence in early 2018.

The Child Protection Improvement Programme (CPIP) is launched, identifying nine areas for work, currently on-going.

2017 Independent Review of Learning Disability and Autism is announced.

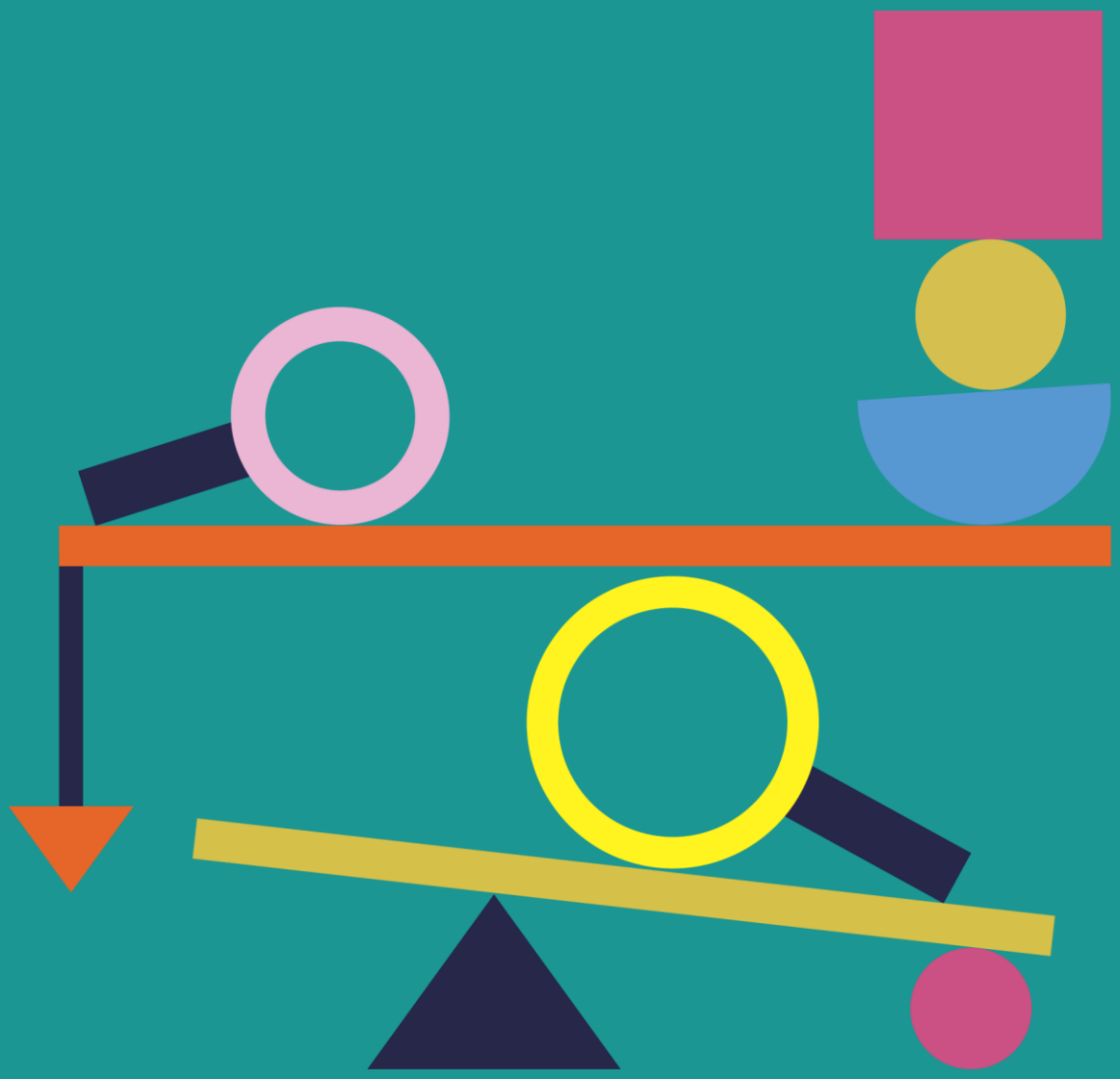
Limitation (Childhood Abuse) (Scotland) Bill

Allows victims of abuse dating back as far as 1964 to seek compensation for their injuries though the civil courts. Victims

currently have just three years from the date of their injury - or from their 16th birthday - to bring a court action.

The Secure Care Strategic Board commenced in October.

Overview of Reviews



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1. Overview of Reviews Relevant to the 'Care System' in Scotland

Introduction

As part of building a solid foundation for the Care Review, we looked at the work of other reviews of child care practice undertaken in recent years. Our purpose in doing this was to learn from what has already been achieved; ensure we learn from the ways in which these reviews were conducted, especially learning from the ways in which their recommendations were actioned; to ensure that we avoid duplicating work which is already being taken forward elsewhere; and assist early identification of areas where it may be helpful to connect our work with what other people are doing.

While there has been much activity in this area, we selected practice initiatives particularly relevant to care experienced children and young people, and looked in more detail at:

- The National Residential Child Care Initiative (2009)
- The Doran Review of Learning Provision for Children and Young People with Complex Additional Support Needs (2010-12)
- The Foster Care Review (2012-13)
- Secure Care in Scotland: Looking Ahead (2016 –present)
- Child Protection Improvement Programme (2016 – present)
- Child Protection Systems Review (2016-17)

2. The Reviews

The National Residential Child Care Initiative

The National Residential Child Care Initiative published its reports in December 2009 and proposed five main areas of action:

- Culture change (now called care planning)
- Workforce
- Commissioning
- Improving learning outcomes
- Improving health outcomes

The supporting 28 recommendations were grouped under three headings:

- Matching resources and needs (eight recommendations): These covered residential care within a broad continuum of service; information, research and planning; active participation of young people; assessment and care planning; the nature and role of residential care; Education; Health; and the transition out of care
- Commissioning (five recommendations): Covering national strategic commissioning; local strategic commissioning; improving outcomes; scrutiny ; and additional services
- Workforce (15 recommendations) which focussed on: recruitment, induction and retention; and rigorous and safe recruitment.

All of the recommendations were supported by Scottish Government (SG) while a short-life working group was established to take forward two recommendations relating to staff training and qualifications. In general, the plan at the time of publication was to progress recommendations directly with relevant organisations or through existing groups and committees. The work of this review led to the development of the Level nine Qualification, the future of which is of particular relevance to the Care Review.

The Doran Review of Learning Provision for Children and Young People with Complex Additional Support Needs.

This Review was commissioned in 2010 and finding variations in all aspects of services nationwide, noted a need for better joined-up working across agencies. It advocated that the team around a child or young person needs to be highly trained and experienced, and raised concerns regarding the availability of professional training in both breadth and depth. Parents and professionals reported difficulties in obtaining information about resources available.

The Doran Review's final report made 21 recommendations directed at a range of organisations and service providers including SG, Education Scotland, local authorities, health boards, General Teaching Council for Scotland (GTCS), training providers, independent and Grant-Aided Special Schools (GASS), and the three National Centres (CALL Scotland, Enquire and the Scottish Sensory Centre) funded by Scottish Government to support children and young people with complex additional support needs.

The overall aim was that:

- Children and young people, supported by their parents and/or carers, have an easily accessible route to early integrated assessment of, and provision for their complex additional support needs from the earliest stage of development.
- Services offered are responsive to changing needs, lead to the best possible outcomes and are delivered where possible within the home community.
- There is a presumption of entitlement to the highest quality of services which should be inclusive, efficient, equitable and effective in meeting the assessed needs and promote optimum inclusion in society.
- Local and national provision are complementary and operate with coherence.

Of the **21** recommendations made by the Doran Review:

- Two were not accepted as it was felt they directly relate to local authorities responsibilities and autonomy in terms of making decisions, with regard to both staffing levels and allocation of resources.
- 19 recommendations were accepted with 13 being actioned promptly. Four of these are being addressed through a Code of Practice due to be published in January 2018. These relate to authorities being held to account in terms of implementing national policies; being explicit about the values which underpin their local policies; specific supports required by those working with children and young people with complex additional needs; and workforce development plans taking account of the specialist communication skills required to support children and young people.

Education Scotland is taking forward two recommendations which relate to the development of learning communities; and also how best to provide training leading to appropriate qualifications. A further recommendation about curriculum development is being progressed via both the Code of Practice and the work of Education Scotland as mentioned above.

The General Teaching Council is taking forward workforce planning. Providing a comprehensive map of provision has been addressed by launching the "Find a Service" resource on Enquire's website in September 2014.

A recommendation requesting that the Scottish Government review the adequacy of existing legislation was delegated to The Advisory Group for Additional Support for Learning (AGASL) who support SG and Scottish Ministers in developing policy and implementing Additional Support for Learning legislation. They found this to be sufficient and are reviewing an additional recommendation involving reviewing data collection to help improve performance standards.

Two recommendations relate to the child's single plan and guidance on ensuring GIRFEC approaches take account of the changing needs of children and young people in this group. These are addressed in on-going implementation of GIRFEC and by the Children and Young People (Scotland) Act 2014.

A Strategic Commissioning Project, supported by five work streams and overseen by a Project Board, was established in June 2013 to take forward the remaining six recommendations. These include recommendations which relate to funding research and development; strategic planning and commissioning of national services and provision; national data collection to inform planning and commissioning of services; and to levels and distribution of funding.

The Foster Care Review

The Foster Care Review was established in December 2012 and published its final report a year later, making six recommendations regarding the issuing of placement descriptors; a national foster carer database; placement limits for fostering households; learning and development for foster carers; allowances and fees.

Recommendation One was to establish a set of clear descriptors for the different types of foster care placements available to children and young people in Scotland. These descriptors would be for use in a child's care plan, where clarity over the purpose of every placement is critical (even if that purpose changes over time). The descriptors are set out in national guidance, embedded into practice and were incorporated in the Care Inspectorate's Annual Return for Fostering Agencies from 2016/17.

Recommendation Two relates to exploring strategies to develop a national database of foster carers both to help with matching children and carers; and to ensure children's safety by maintaining a national record of carers whose registration had been revoked. This task was undertaken by a short-life working group who met between October 2014 and January 2015, and

discussed the key themes of: *Safety of Children* and *Finding Places for Children*. The group's final report was endorsed by the Reference Group in March 2015.

Recommendation Three about placement limits was addressed by an amendment to The Looked After Children (Scotland) Regulations and came into force in December 2014; while SG has commissioned research to help inform a review of allowances (Recommendation Five) due to commence this autumn. SG are establishing a short life working group to take this forward.

While all of the recommendations were, in general, accepted Recommendation Six in relation to fees was felt to be a matter for local authorities to action. SG report this has yet to be actioned.

Recommendation Four regarding Learning and Development is of particular relevance to the Care Review. In July 2014, the Scottish Government commissioned the Scottish Social Services Council (SSSC) to develop a learning and development framework for foster carers. Following the publication of findings of a consultation held during the summer of 2016, it was agreed that Scottish Ministers will consider options for implementation of the new standard in the context of the Care Review. The Scottish Government has said that it will then establish an expert group to consider a cost analysis and agree a realistic plan and timeframe for implementation.

Secure Care in Scotland: Looking Ahead

The Report "Secure Care in Scotland: Looking Ahead" was published in October 2016 and calls for action in relation to:

- Strategic vision, direction and leadership from all stakeholders responsible for making decisions about young people who are in, and on the edges of, secure care, particularly the Scottish Government, local authorities and their representative bodies COSLA and the Scottish Local Government Partnership (SLGP).

- An explicit statement on the place of secure care in the continuum of responses to very high vulnerability and risk.
- Further exploration of the complex interface between secure care and the Children's Hearings System; adult justice and custody; looked after children's services and; the Scottish Government's Getting It Right for Every Child (GIRFEC) strategic approach.
- A National Standards Framework which includes a care pathway for young people on the edges of, and in, secure care that clearly articulates: the preparation, information and support young people should be offered before and during admission, and with day to day living in a restrictive care setting; advocacy and participation arrangements and expectations and resourcing of this; a health care pathway, including mental and emotional health and wellbeing; and revisiting and strengthening guidance in relation to transition support and aftercare.
- A Secure Care National Strategic Board to provide leadership and direction, giving voice to care experienced young people and involving them in driving a long term programme of transformation for secure care and approaches to young people on the edges of secure care in Scotland.

The Secure Care National Strategic Board has been established to lead and coordinate the work required to develop and realise the national strategy and standards framework; and a strategic partnership approach to engage all responsible corporate parents in the review of commissioning and resourcing arrangements for secure care. It will agree priorities informed by the findings and recommendations of the secure care national project, specifically:

- Secure Care in Scotland: Looking Ahead (CYCJ: October 2016)
- Secure Care in Scotland: Young People's Voices (July 2017)
- Chief Social Work Officers and Secure Care in Scotland(CYCJ, May 2017)

It will also consider the reports arising from the Securing Our Future Initiative (2009); along with more current and emerging sources of evidence and analysis and will report to Ministers by December 2018.

Child Protection Improvement Programme (CPIP)

A National Child Protection Improvement Programme (CPIP) was announced in February 2016. It included existing commitments on child sexual exploitation; child trafficking; and internet safety, along with a number of new areas of work, specifically: a review of practice in the Children's Hearings System; agreeing steps to promote and support leadership; refreshing the role of inspection agencies; improving data and evidence; agreeing further action to address the impact of neglect on children and young people; and a review looking at how the child protection system currently works and what could be improved across Scotland.

A Child Protection Systems Review Group, independently led by Catherine Dyer (Former Crown Agent and Chief Executive of the Crown Office and Procurator Fiscal Service), was established to look at the operation of the formal child protection system - including Child Protection Committees, Child Protection Registers and case conferences, and Initial and Significant Case Reviews - and to recommend what changes or improvements might be needed to these underpinning processes and structures in order to protect children and young people more effectively.

Reports of the Review Group and the wider CPIP were published together in March 2017. The final report of this group reflected a shared commitment to continue what is already working well and made 12 recommendations, all of which were accepted by the Scottish Government.

The focus of the recommendations was on:

- Leadership, governance and accountability (recommendations one-six)

- Developing a learning culture (recommendations seven-ten); and
- Having shared values (recommendations 11 &12)

And they include:

- the Care Inspectorate becoming the central repository for all Initial and Significant Case Reviews
- Establishing a National Child Protection Leadership course
- Forming a National Child Protection Register

The Vision of the wider CPIP is rooted in GIRFEC and in:

- Engaging early and supporting families
- Empowering practitioners to intervene to protect children when support is not working
- Having a transparent and learning culture which values and supports its workforce

Its work is organised around nine strands:

- Systems review: All the recommendations were accepted and the Review Group is being reconvened in April 2018.
- Neglect: The improvement programme designed to tackle neglect is being piloted in Dundee, Inverclyde and Perth & Kinross. The "installation" stage which requires localised responses to be developed in response to service improvement prioritised is being monitored. The pilot will run to the end of the current financial year. Interim recommendations, based on the evaluation of local needs and context, will be provided to Ministers in December 2017. Findings from the pilot will be used to inform further neglect improvement activity.
- Child Sexual Exploitation (CSE): The National CSE Working Group is taking forward an action plan which includes raising awareness with night–time economy workers; developing a guide for health practitioners and a self-evaluation toolkit for Child Protection

Committees; and organising regional workshops where best practice can be shared.

- Child Trafficking: A working group has been established to take forward revisions to the existing age assessment guidance; Feedback from UK National Referral Mechanism pilots is expected; The terms and scope of research into child trafficking routes in Scotland is being drafted; and consultation regarding the new statutory role child trafficking guardianship role is being developed. This work is due to be completed in November 2017.
- Child Internet Safety: The National Action Plan on Internet Safety for Children and Young People was published in April 2017. It includes delivering briefing sessions on online safety across the country and exploring with social media providers how child internet safety can be improved.
- Children's Hearings: Engagement has taken place to ensure Community Justice Plans take account of vulnerable 16 and 17 year olds, while the use of diversionary services is being maximised and the opportunity to increase the number of cases remitted from Court to the Children's Hearing System is being explored.
- Inspections: A high level Advisory Group has been established to develop a revised inspection framework which focusses on the experiences and outcomes of the most vulnerable children. It will consider how scrutiny and improvement can best be provided for all services and will collaborate with partners to develop and improve self-evaluation tools. The group was due to report to Ministers in May 2017 but this date was postponed to allow sufficient time for consultation.
- Leadership: A National Child Protection Leadership Group held their first meeting in June 2017 and will work across the leadership and workforce development landscape to take forward relevant actions from CPIP work streams. They will organise regional events for Chief Officers' Groups and CPC Chairs to promote networking, sharing of

good practice and to collectively horizon scan for new risks affecting children and young people: and support practitioner engagement to strengthen child protection practice.

- Data and evidence: Work is underway with CELCIS to develop a joint data and evidence hub to support the improvement programme and develop a strategic approach to improving the use of evidenced based practice and the sharing of learning.

The CPIP is also committed to developing a National Child Protection policy and National Child Abuse Prevention Plan which will create strong and dynamic cross- government policy connections to keep children and young people safe. The CPIP is working with Children in Scotland to develop a process for providing confidential expert advice from across the children's sector to support officers from across Scottish Government in consulting on new policy, strategy or legislation. The Directorate for Children and Families is taking the lead in promoting and embedding this approach across Scottish Government.

3. Going Forward

Getting It Right For Every Child (GIRFEC)

All current approaches to promoting children and young people's wellbeing are based on further embedding our national GIRFEC approach. At a national level, this policy has been tested and developed across Scotland over a period of more than ten years steady following a successful pathfinder launched in Highland Council in 2006, however implementation across the country is at different stages. Although during this time, children's services have become more integrated and child-centred.

Its main components are each child having a Named Person; a shared approach to assessment; a Lead Professional being appointed where children have more complex needs; and all agencies involved in the child's life's working to a shared, single plan. The approach is enshrined in The Children and Young People (Scotland) Act 2014 and recent challenges in respect of when information can be shared by and with the Named Person have now been addressed. The approach has been endorsed by successive governments and its principles and practices are increasingly being embraced by organisations in the wider children's services landscapes.

All of the Reviews described above have framed their recommendations within the GIRFEC context which ensures compatibility and ultimately makes sense for those responsible for implementing new approaches.

The Challenge of Post-Review Implementation

Understandably, all of the recommendations made by reviews cannot be actioned during the life of the review itself. Different approaches have been adopted to achieve this – in some instances the recommendation is remitted to an existing body or national group to action, in others the recommendation includes a dedicated group being established to take it forward while at other times the approach has been to establish an overarching strategic group to progress all of the remaining actions.

There may also be an opportunity to adopt a more innovative approach- for example, establishing a national group with regional hubs, ensuring there is continuing opportunity to work with community planning partnerships to develop solutions responsive to local needs.

Policy Mapping: Programme for Government Links

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1. Introduction

As part of the Care Review's work to date, it has considered the current and future national policy landscapes, in so far as that is possible, in order to understand the policy and legislative context within which the Care Review is operating.

This will enable the Care Review to establish the necessary links with, and have the opportunity to potentially influence, relevant areas of national policy or legislative development. This work will also help the Care Review to consider whether there are any gaps in the work being taken forward in order to make recommendations on what more is needed to improve a child or young person's experience of care in Scotland. This work also complements other parts of this report around current reviews that are underway and how policy and legislation has evolved in Scotland over relatively recent times.

The Scottish Government published *A Nation With Ambition: The Government's Programme for Scotland 2017-18*[110] on 5 September 2017 which set out its priorities, through a series of commitments, for the 2017-18 parliamentary year. A number of those commitments have a link, in one way or another, to looked after children and, thereby, the Care Review. Additionally, at the October 2017 SNP conference, the First Minister announced that all young care leavers will be exempt from paying Council Tax.

There is a huge amount of other work underway across the Scottish Government, in addition to these commitments and announcements, which have links to the potential scope of the Care Review.

[110] http://www.gov.scot/Publications/2017/09/8468

What has been highlighted through this mapping work is that care for children and young people in Scotland cuts across a huge swathe of the Scottish Government's current and planned work. Of the nine Cabinet portfolios, seven (including First Minister's portfolio) have an interest in the work of the Care Review. That is huge. And it's a huge opportunity for the Care Review to be in the position to shape how future should be taken forward through the recommendations it makes.

In addition to the First Minister's commitment to the Care Review, the following work with links to children and young people's experience of care is underway at a national level across the seven portfolios and with the involvement of key partners within the care sector.

2. Education and Skills Portfolio – including Childcare and Early Years, and Further Education, Higher Education and Science

The Programme for Government included a large number of priorities which fall within the Deputy First Minister and Cabinet Secretary for Education and Skills' portfolio.

These include, first and foremost, the commitment to the Care Review itself. Additional commitments of importance and interest include:

- the development of a strategic approach to responses to children and young people in and on the edges of care;
- the roll out of the PACE programme throughout all local authorities in Scotland;
- a National Kinship Care Advice Service for kinship care families and professionals in autumn 2017;
- a review of Foster, Kinship and Adoption allowances and to bring forward proposals for national kinship care and foster care allowances in summer 2018;
- a drive to ensure all local authorities refer children and prospective adopters to Scotland's Adoption Register by March 2018;
- a requirement for corporate parents to publish their plans by the end of March 2018 to allow Scottish Ministers to report to Parliament by July 2018
- to commission a progress review on the use of family support services to prevent children going into care;
- the development of Secure Care National Standards and the establishment of a transformative model for secure care in Scotland through a new Secure Care Strategic Board, which will report by end 2018;

- embedding Adverse Childhood Experiences (ACEs) to prevent them occurring but also to support resilience and the overcoming of past experiences;
- the provision of full, non-repayable bursaries to care experienced young people who obtain university places (for those under 26, and to a maximum of £7,625);
- bringing forward the Minimum Age of Criminal Responsibility and the Children and Young People (Information sharing) Bills;
- the provision for all (eligible) first-time mums to receive Family Nurse Partnership support;
- a legislative ban on the physical punishment of children;
- the doubling of funded early learning and childcare provision;
- the continuation of the Children and Young People Improvement Collaborative and Realigning Children's Services programme (mapping to ensure the right services are in place including for those children who are looked after at home);
- the delivery of child protection commitments such as: National Child Abuse Prevention Plan; linking with National Police Vulnerable Persons Database to identify all children and young people on local child protection registers; revised outcomes focused framework of inspections; consultation on revising abuse and neglect of children criminal offences; programme to tackle neglect, and; implementing actions around child sexual exploitation by end of 2018;
- an increased number of health visitors (through reform and improvement of health visiting services)
- a review of Personal Social Education and services for counselling for children and young people;
- bringing forward an Education Bill to reform school governance and place more power with headteachers;

- progression of the work of the Commission on Widening Access (equal access to university by 2030) and the establishment of an Access Delivery Group;
- the publication of Learner Journey recommendations by end 2017 – to deliver improvements in the join up between schools, colleges and universities, and;
- a review of the Children (Scotland) Act 1995 in so far as Parental Rights and Responsibilities, contact and residence cases are dealt with in family cases in Courts.

Other priority activity underway across Government spans a number of different policy areas. For example, the Scottish Child Abuse Inquiry has been underway for some time now and will continue until October 2019. Work also continues to ensure that *Getting It Right For Every Child* underpins all that practitioners and policy makers do across Scotland for our children and young people.

A number of Children's Hearings initiatives are being progressed which are, primarily, aimed at improving children and young people's experience of the Hearings system. Better Hearings is looking at things like consistent practice in the delivery of Hearings, considering the views of children and young people on attendance in Hearings and ensuring their effective participation. This is being supported by the implementation of a digital strategy. The Children's Hearings Improvement Partnership is also tasked with embedding continuous improvement within the Hearings system and comprises a wide range of partners to do so. Additionally, the newly created young people's board, Our Hearings, Our Voice gives young people with experience of the Hearings System the opportunity to have a decision making role in the continuous improvement and development of the system, using their direct experience, knowledge and perspective.

Further embedding the *United Nations Convention on the Rights of the Child* into policy development is another priority as is increasing the

participation of children and young people in matters relating to them, at both national and local levels, ensuring that they are at the heart of decisions that affect them. This includes the establishment of a Young Disabled People's Forum to enable thirty disabled people aged 14-25, with a variety of disabilities, to come together and share their experiences while expressing opinions and having their voices heard and respected.

A number of complex areas of policy development relating to looked after children are also being progressed and cover matters such as: unaccompanied minors arriving in Scotland and how they are subsequently cared for and supported; the continued implementation of the *Getting It Right for Looked After Children and Young People Strategy*[111]; further embedding national continuing care and aftercare policy[112], and; undertaking a review of adoption legislation.

Furthermore, consideration continues to be given to workforce training and development, learning and standards particularly in light of health and social care integration.

From an education perspective, work continues to provide additional support to those in education who need it as well as to increase the number of looked after young people securing a positive destination after they leave school, including the opportunity to fulfil their potential with regard to qualifications.

This portfolio also has within its remit Audit Scotland's current work on children and young people's mental health services.

[111] http://www.gov.scot/Publications/2015/11/2344/0
[112] http://www.gov.scot/Publications/2004/03/19113/34719

3. Communities, Social Security and Equalities – including local Government and Housing

Programme for Government commitments falling within this portfolio include:

- the establishment of a homelessness and rough sleeping action group to end rough sleeping and transform the use of temporary accommodation utilising a £50m fund with the objective of "Ending Homelessness Together";
- the creation of a new £50m fund to tackle the causes of, and rise in, child poverty, building on the child poverty Bill. Additionally, the implementation of recommendations of the independent advisor on poverty and inequality in "*The life chances of young people in Scotland*[113]" report – focuses of which are mental health, employment and housing;
- the introduction of Best Start Grant for low income families by summer 2019 – also work to provide a financial health check to families on low incomes;
- the introduction of a social security Bill, and;
- the introduction of three-year rolling funding for third sector organisations.

Other activity underway across Government, and linking to looked after children, includes ensuring support is in place for those leaving care and accessing housing as well the continued implementation of the national strategy to tackle social isolation.

[113] http://www.gov.scot/Publications/2017/07/3569

4. Economy, Jobs and Fair Work – including Employability and Training

While there were no direct Programme for Government commitments related to looked after children within the Economy portfolio, a key piece of work being taken forward is around supporting young people into sustainable employment, with a particular focus on young care leavers and young people with disabilities.

This work draws upon a range of charities, service providers, private employers and philanthropic organisations. It also has links to Learner Journey work (see Education portfolio PfG commitments) and Skills Development Scotland.

5. Justice – including Community Safety

Two Programme for Government commitments within the Justice portfolio, and with links to looked after children, are:

- to review the legislative framework (Part 1 of the Children (Scotland) Act 1995) around children and young people's contact with parents and families, and;
- the continuing passage of the Domestic Abuse Bill.

Other work underway, and led by the Justice portfolio, includes supporting voluntary services with links to continuing/after care, such as the "Moving On" project in conjunction with HMP Polmont, Action for Children and Barnardos. Other significant pieces of policy work in this portfolio, linked to looked after children, relate to the work of Police Scotland, community safety, and the provision of legal support in Children's Hearings and Court proceedings.

6. Health and Sport – including Mental Health and Public Health

The Programme for Government commitments arising from the Health and Sport portfolio include:

- an audit of CAMHS rejected referrals and a commitment to act upon the audit's findings;
- continued implementation of the Mental health strategy – and of key importance, improving transitions for young people moving from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services, including potential future flexibility for those aged 18-25 to continue their care and treatment with CAMHS if they so choose, and;
- Continuing Partnership Drug Initiative and Scottish Families Affected by Alcohol and Drugs work.

Other work being led by the Health and Sport portfolio covers a range of topics. This includes a refresh of the 2016 *Pregnancy and Parenthood in Young People Strategy*[114]. It also includes progression of the Childsmile programme of which one key aim is to reduce oral health inequalities among children in Scotland. Another important aspect of the portfolio's work, which links to looked after children, is reducing violence against women and girls through strategies such as "Equally Safe[115]".

[114] http://www.gov.scot/Publications/2016/03/5858
[115] https://beta.gov.scot/publications/equally-safe/

7. Rural Economy and Connectivity – including The Islands

No specific Programme for Government commitment has been made under this portfolio which relates to looked after children.

However, the provision of, and access, to services for looked after children in rural locations and the Islands underpins much of the work across Government.

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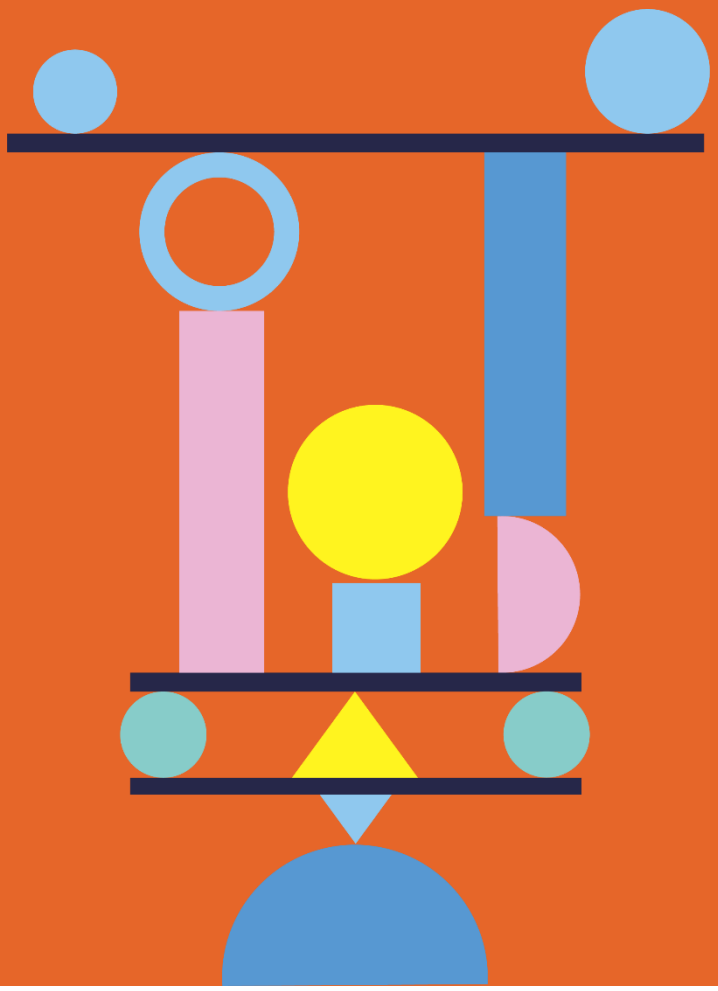
Statistical Baseline Paper



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1. Preface

This paper has been prepared to facilitate and inform the Care Review, summarising relevant statistics and other quantitative information.

It provides a comprehensive introduction to the population-level and systems data currently collated and published on Scotland's looked after children and care leavers, incorporating comparative UK and international data where applicable. It is designed to prompt discussion and debate, and to identify questions for further, more in-depth investigation and consideration.

Context and analysis has been provided throughout, to help explain the strengths, limitations and possibilities of certain data sources and extrapolations. The report also highlights areas where little or no data on the population or system is currently available.

The statistics replicated below are subject to revision by the data owners (i.e. Scottish Government). Links to the original sources are available throughout. A glossary of frequently used terms used is provided at Appendix A, and a discussion on what lies behind these key terms (such as 'looked after') is set out in the relevant chapter below. Please note that percentages stated may not total 100 due to rounding.

2. Data sources and analysis

'Statistics' relating to looked after children and young people have roots in a number of different sources, including official publications, Freedom of Information requests, formal research studies and, on occasion, individual testimonies.

Unfortunately, many of the best known and widely cited 'statistics' are unreliable, due either to weaknesses in the original data they are based on (e.g. high error rate, collection methods, small sample sizes), poor analysis (e.g. unsubstantiated extrapolations, presentation of data correlation as causation,) or misreporting (e.g. coverage of percentage increases/decreases without reference to the actual numbers, or statements which do not provide wider context and caveats).

This briefing concentrates on data from quality-assured statistical sources, such as the Scottish Government's Children's Social Work Statistics report. These national publications, usually based on secure annual returns from public bodies, and prepared to UK Office of National Statistics standards, can be considered of good quality. However, even in these publications, in bringing together as they do a variety of material from different sources, there are areas of less reliability. This briefing flags these areas, explaining the reasons for caution.

The Scottish Government's annual Children's Social Work Statistics, the main source of national statistics for looked after children and young people, is published each year in spring, presenting data collected over the twelve months up to and including the previous July; i.e. the 2018 publication shows data from beginning-August 2016 to end-July 2017.

Furthermore, to ensure a breadth of commentary across areas the Care Review may be interested in, relevant survey and research data has been included throughout the briefing. Accompanying commentary will assess

the strength of the specific sources, and the reliability of conclusions drawn from the specific data, as well as drawing out key trends which the Care Review may wish to consider.

The majority of longitudinal analysis in this briefing will cover the last 10 years for which data is available (2007-2017), in order to illustrate trends and changes; however this has been lengthened and shortened, where appropriate, to accentuate any key messages.

3. Definition of a looked after child in Scotland

To properly understand the statistics relating to looked after children and care leavers, and in particular the strengths and limitations of the data set, it is necessary to have a detailed understanding of precisely who is reflected in the numbers. This comes down to the specific legal definitions of certain groups, such as 'looked after children', or 'kinship care'.

Firstly, who can become a 'looked after child'? Under Part 2 of the Children (Scotland) Act 1995 ("the 1995 Act"), which provides the main legal framework for supporting looked after children in Scotland, a 'child' is defined as a person under the age of 18 (i.e. aged 0-17 years inclusive)[116]. All Parts of the Children and Young People (Scotland) Act 2014 ("the 2014 Act") define a child in this way too. Therefore, while it is the case that different definitions of a child exist in other legal contexts, in respect of the 'looked after' system a person can be considered a 'looked after child' at any time from birth up to their 18th birthday. (It is possible for a child to remain 'looked after' by a local authority beyond their 18th birthday, as part of private arrangement between the family and the local authority. Where this does happen, it is usually due to the child's significant physical and/or mental disabilities, which require the local authority to provide ongoing care).

Of the population of children, who is considered a 'looked after child' is set out in section 17(6) of the 1995 Act, as amended by the Adoption and Children (Scotland) Act 2007 ("the 2007 Act") and Children's Hearings (Scotland) Act 2011 ("the 2011 Act").

[116] Children (Scotland) Act 1995, Section 93, Article (2)(a)

A child is 'looked after' by a local authority when he or she is:

a) provided with accommodation by a local authority under section 25 of 1995 Act; or

b) subject to a compulsory supervision order or an interim compulsory supervision order made by a children's hearing in respect of whom the local authority are the implementation authority (within the meaning of the 2011 Act); or

c) living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities, as a result of a transfer of an order under regulations made under section 33 of the 1995 Act or section 190 of the 2011 Act; or.

d) subject to a Permanence Order made after an application by the local authority under section 80 of the 2007 Act.

Please note that the law does not recognise any hierarchy of 'status' within the looked after child system (i.e. a child subject to a Permanence Order is not 'more' looked after than a child provided with accommodation under section 25 of the 1995 Act). The different legal routes do lead to differences in the way a child's care is managed, reflecting the extent to which parental rights and responsibilities are transferred to the local authority and, relatedly, the social work processes (such as reviews) which are mandated. However, in general terms, the duties of a local authority, or any other corporate parent, apply equally to all looked after children in Scotland.

The sections below provide some further detail about what these different legal routes mean in practice, particularly in terms of the child's experience.

a) Provided with accommodation by a local authority under section 25

Where a child is provided with accommodation by a local authority under section 25 of the 1995 Act, it is done so in agreement with the child's

parent(s), carer, or child themselves. The local authority is not compelled by a court or Children's Hearing to provide the accommodation, nor the child to accept it. This legal route is often referred to as 'voluntary measures' or a 'voluntary arrangement'.

Section 25 of the 1995 Act enables local authorities to offer accommodation to a child if it is in the child's best interest. Local authorities are under a duty to provide accommodation to a child when no one has parental responsibility for him or her, he or she is lost or abandoned or the person who has been caring for him or her is prevented, whether or not permanently and for whatever reason, from providing him or her with suitable accommodation or care. The local authority can also use section 25 to provide respite services for children; if the child is accommodated for more than 24-hours (in a continuous period) then they are considered to be 'looked after' for as long as they remain in that local authority-provided accommodation.

A Scottish local authority has the power to provide accommodation to a person, under section 25, up to their 21st birthday, if the provision of accommodation would safeguard or protect their welfare.[117]

b) Subject to a compulsory supervision order (or interim compulsory supervision order)

Where a child is considered to be 'at risk'[118], and it is not possible for public services to address that risk in cooperation with the child and/or their parents/carers, a Children's Hearing can make a 'compulsory supervision order' (or an 'interim compulsory supervision order')[119]. This means the child becomes a 'looked after child', with their local authority responsible for ensuring the conditions of the order are implemented, and for providing (and coordinating) the services and support necessary to address the

[117] Children (Scotland) Act 1995, section 25(3)
[118]For a list of reasons (in law referred to as 'grounds') why a child may be considered 'at risk', and therefore referred to a Children's Hearing, please see Appendix B
[119]The legislation under which the Children's Hearings System operates is the Children's Hearings (Scotland) Act 2011. This Act entered into force on 24 June 2013.

child's needs. A compulsory supervision order (CSO) is sometimes referred to as 'compulsion' or 'compulsory measures'.

A CSO may contain conditions about who the child should have contact with, and where they must live. Where a CSO requires a child to live away from their usual place of residence (e.g. with their parents), the local authority must provide appropriate accommodation to meet the needs of the child, such as with foster carers, kinship carers, or in a group setting (e.g. residential home or school).

Where no condition of residence is attached to a CSO, children become 'looked after' by their local authority but remain living with their parents/carers. This group are often referred to as 'looked after at home'.

A Children's Hearing determines how long a CSO will last, for up to a maximum of one year, or to the child's 18th birthday, whichever comes first. The CSO can be renewed, amended, or ended by a Children's Hearing.

c) Living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities

The four countries of the United Kingdom maintain a reciprocal agreement, set out in law, to recognise the legal orders by which children become 'looked after' in each of the different UK legal jurisdictions. Therefore, a child living in Scotland may be considered to be 'looked after' if they are subject to an English, Welsh or Northern Irish order which, under regulations made under section 33 of the 1995 Act[120] or section 190 of the 2011 Act[121], a Scottish local authority has recognised as equivalent to a compulsory supervision order (as made by a Children's Hearing), accepting the legal responsibilities (duties) which come with it.

When a 'looked after child' moves to Scotland, the relevant English, Welsh or Northern Irish authorities must inform the Principal Reporter and the

[120] The Children (Reciprocal Enforcement of Prescribed Order s etc. (England and Wales and Northern Ireland)) (Scotland) Regulations 1996
[121] The Children's Hearings (Scotland) Act 2011 (Transfer of Children to Scotland – Effect of Orders made in England and Wales or Northern Ireland) Regulations 2013

Scottish local authority to which the child is moving. Where appropriate, agreement is then reached to 'transfer' responsibility for the child's supervision, care and education to the Scottish local authority. The child then becomes a Scottish 'looked after' child, with their supervision reviewed and, if necessary, renewed through the Children's Hearing system. This process also works in the other direction too. If a looked after child (subject to a compulsory supervision order) moves from Scotland to England, Wales or Northern Ireland, the relevant authorities in those jurisdictions recognise the child's legal status as 'looked after' and, where appropriate, will take on responsibility for the child's care and protection.

However, it is possible for looked after children from England, Wales and Northern Ireland to live in Scotland without any transfer of 'looked after child' duties to a Scottish local authority. For instance, a child may be living inScotland in a residential unit or with foster carers provided by the private or third sector, and continue to be under the supervision of the relevant English, Welsh or Northern Irish authority. This is also true in the reverse, with Scottish looked after children living with carers elsewhere in the UK. In these circumstances specific arrangements (concerning the child's education, care and health) are made between the placing authority (from England, Wales, Northern Ireland or Scotland) and the relevant local authority and health board/trust in the part of the UK where the child is placed.

d) Subject to a 'Permanence Order'

A Permanence Order transfers certain parental rights to a child's local authority, including the right to regulate the child's residence (up until the child's 18th birthday). It is a long-term measure of care, used to secure permanence (i.e. physical and emotional stability with one set of carers) for a child who has no reasonable prospect of returning to live with their biological family, but for whom adoption is not appropriate or desirable at this particular time. Once a Permanence Order is in place, a compulsory

supervision order, which must be reviewed at least every year, can be removed.

A child provided with long-term accommodation under a Permanence Order is considered a 'looked after child', and all the specific and general duties of corporate parents apply.

e) Children in other alternative care arrangements

It is important to note that many children in Scotland live in alternative care arrangements (i.e. not with their biological parents) but are not considered to be 'looked after'. This group includes children who have been adopted (under an Adoption Order), those who are living with friends and relatives (either in a private family arrangement or under a Kinship Care Order (Section 11 of the 1995 Act)) and those whose placement is secured by a Residence Order (Section 11 of the 1995 Act). The group also includes children who have been removed to a place of safety under a Child Protection Order.

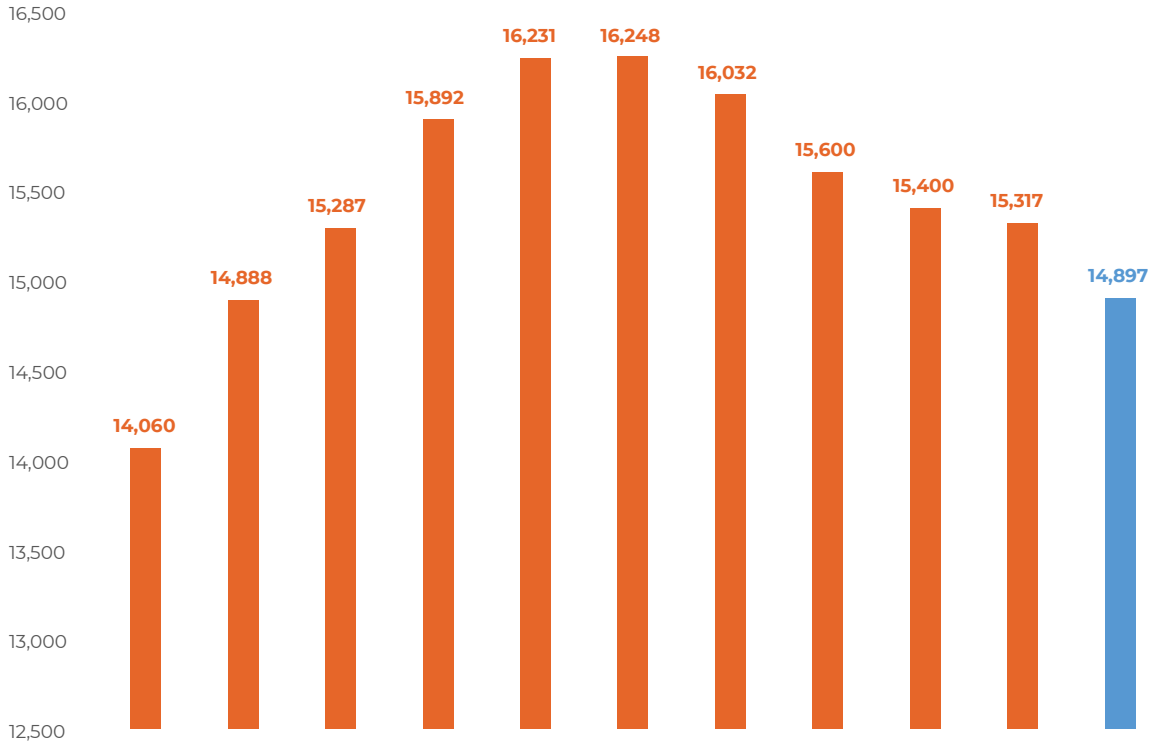
Public authorities are under a number of specific duties in respect of each of these groups. For instance, a child living with family under a Kinship Care Order may be eligible for regular financial support from their local authority. Similarly, a child removed to a place of safety under a Child Protection Order must be provided with accommodation and support by their local authority. However, while the law requires certain public authorities to treat these groups of children as if they were 'looked after' in some circumstances, they are not, under the parameters set out by section 17(6) of the 1995 Act, 'looked after children'. This means they are not covered by the complete range of statutory duties which apply to any looked after child (such as the duties for corporate parenting or Additional Support for Learning), and, critically for the purposes of this paper, will not necessarily be included in the statistics for 'looked after children' or 'care leavers'.

4. Children and young people who are 'looked after': population characteristics

Size of population

On 31 July 2017, the most recent date for which we have national data, the total number of children 'looked after' by a Scottish local authority was 14,897. This total includes children in all types of care setting, such as residential care (including residential schools and secure care), foster care, formal kinship care, and looked after at home. Chart 1 below shows how this total population has changed from 2007 to 2017.

Chart 1: Total number of looked after children in Scotland, 2007 - 2017[122]

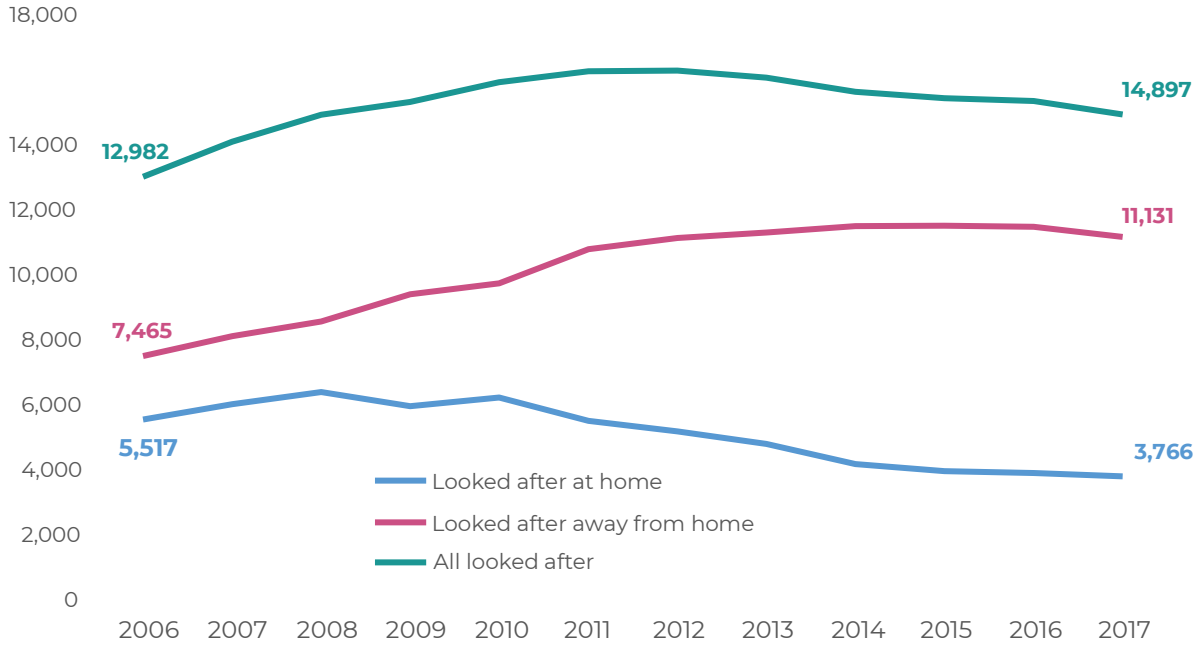


The total number of children 'looked after' by Scottish local authorities has fallen steadily over the last four years (by 5.7% since 2012); see Chart 2 below. A number of factors will have contributed to this, but the fall does correlate closely with a sharp drop in the number of children 'looked after

[122] Scottish Government (2018) ;Children's Social Work Statistics Additional Tables - amended June 2018;, Table 2.1: Number of children looked after, by age and gender, 2002-2017

at home' (i.e. with parents). The reasons for this drop, is in part due to local authorities tidying up their databases and removing cases where the child ceased to be looked after but otherwise, are unclear, but in the four years since 2012 this specific 'lookedafter' population decreased by nearly 25% (from 5,153 to 3,870 in 2016). Indeed, if children 'looked after at home' are excluded from the total, the number of children 'looked after and accommodated' (i.e. provided with accommodation away from their parents) actually continued to increase up until 2015. (For further detail please see Table 1, and the section below 'Placement Types'.)

Chart 2: Total number of looked after children in Scotland by placement type, 2007 - 2017[123]



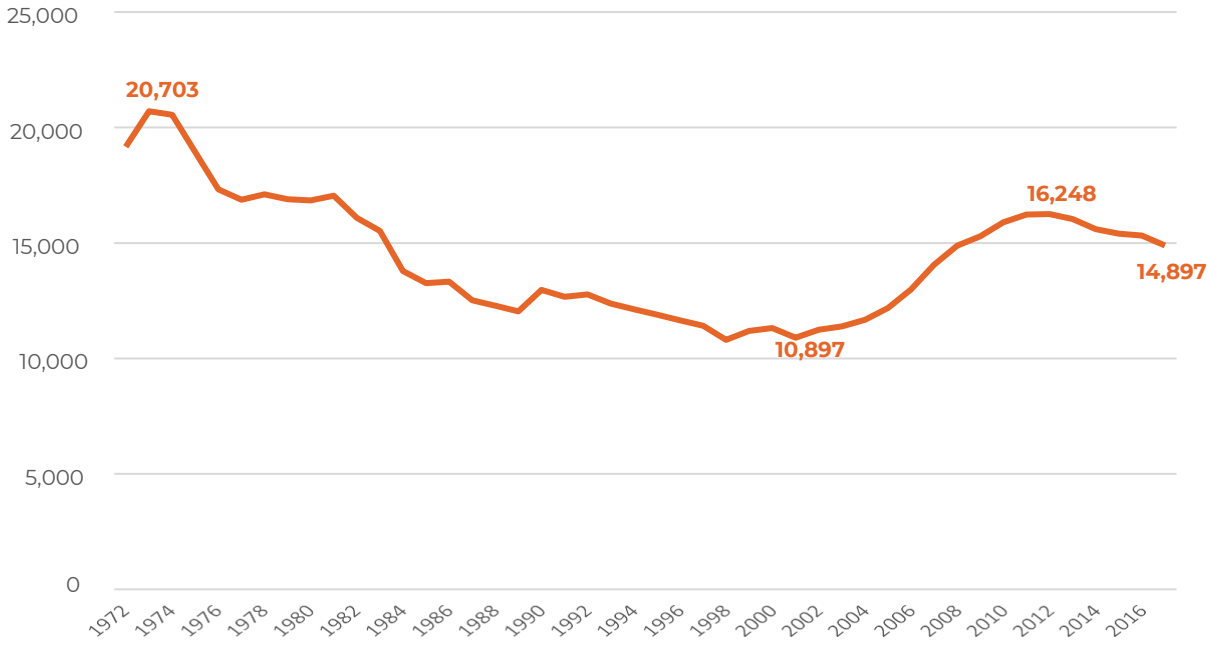
[123] Scottish Government (2017) Children's Social Work Statistics Additional Tables - amended June 2018;, Table 2.2: Number of children looked after by type of accommodation, 2002-2017(1),(2)

Table 1: Number and proportion of children who are 'accommodated'[124]

	2013	2014	2015	2016	2017
Total Looked After Children	16,032	15,600	15,404	15,317	14,897
Total excluding 'at home'	11,270	11,458	11,477	11,447	11,131
% 'accommodated'	70.3	73.4	74.5	74.7	74.7

Viewed over decades, the size of Scotland's 'looked after child' population has fluctuated considerably. As Chart 3 below illustrates, from a peak in the mid-1970s the total number of children 'looked after' by Scottish local authorities fell intermittently until the late 1990's, from which it started to increase steadily again. Between 2001 and 2012 the number of 'looked after children' grew from 10,897 to 16,248; an increase of 49% over twelve years.

Chart 3: Total number of looked after children, 1972 - 2017[125]



Increases and decreases in the size of the 'looked after' population will be linked to multiple, interrelated factors, including changes in policy or

[124] CELCIS calculations, based on data from Scottish Government (2017) Children's Social Work Statistics Additional Tables - amended June 2018;
[125] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018; Table 1.1a: Number of children looked after by type of accommodation, 1971-2017(1),(2)

legislation, local government reorganisation, shifting social and political expectations (often in response to high-profile child protection cases) and technical changes in statistical questions or collection methods. Changes in the size of the overall child population may also be factor, but probably only a very limited one. Between 2001 and 2012, when the 'looked after child' population grew by 49%, Scotland's under 18 year old population (0-17 years inclusive) actually fell by 5.4% (from 1,097,605 to 1,038,464).[126]

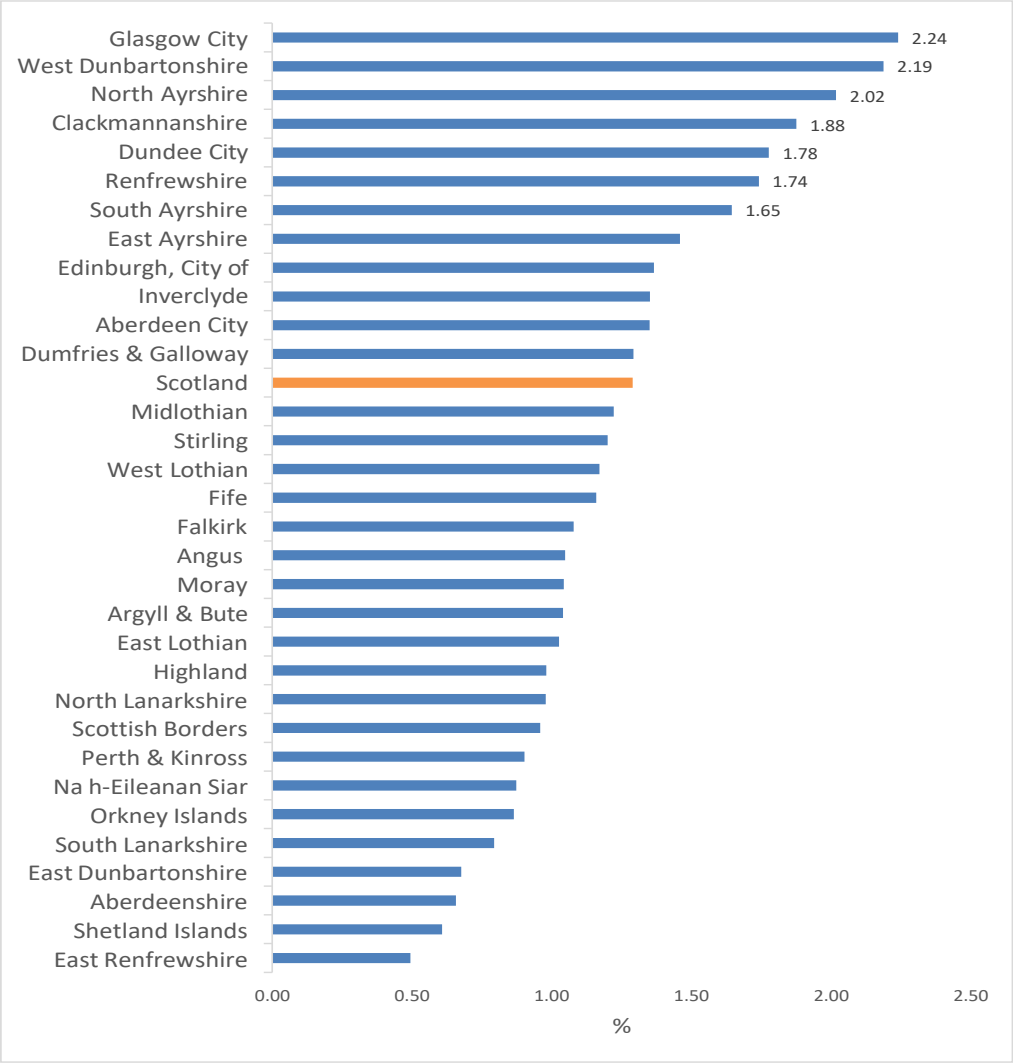
[126] General Records of Scotland (2014) Mid-year population estimates: Scotland and its Council areas by single year of age and sex: 1981 to 2013

Chart 4: Total 'Looked after Children' by Local Authority, 31st July 2017[127]

[127] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018;, Table 3.3: Children looked after by type of accommodation and local authority; National Records of Scotland (2017)

Chart 4 above provides a picture of Scotland's total looked after child population (at 31 July 2017), broken down by the local authority which is legally responsible for them. Unsurprisingly, the City of Glasgow, being the local authority area with the largest population (615,170), also had the highest number of looked after children (2,827). At the other end of the scale, Orkney, Scotland's smallest local authority population, also has the smallest number of looked after children (32).

Chart 5: Looked after Children by Local Authority, as proportion of Local Authority Child (0-19 years) Population, July 2017[128]



[128] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018;, Table 3.3: Children looked after by type of accommodation and local authority; National Records of Scotland (2018) Mid-2017 population Estimates Scotland;, Table 3: Estimated population by sex, five year age group and administrative area, mid-2017

However, as Chart 5 above illustrates, a large population does not necessarily equate to high numbers of looked after children. North Ayrshire, for example, is home to 28,982 people aged between 0-19, placing the area near the population median among Scottish local authorities (i.e. in a biggest to smallest population ranking, it is 15th). But it has the seventh largest population of looked after children, at 585. Similarly, while Clackmannanshire has the smallest general population among mainland local authorities, at 51,450, and 11,349 0-19 year olds, its 213 looked after children means it has the highest proportion, per head of total population, of all local authorities. (The reasons for these variances are explored in sections further below.)

In addition to local variance, it is also important to note that: (a) the total number of children 'looked after' by a Scottish local authority is not an accurate measure of how many looked after children actually reside in a local authority area, as children are frequently placed outwith their home local authority (i.e. with foster carers or in a residential school); and (b) the total number of Scottish looked after children is not necessarily equal to the number of looked after children living in Scotland. At any time a number of Scottish looked after children will be placed in other parts of the UK, and similarly English, Welsh and Northern Irish children will be placed in Scotland. No published data is available on the number of looked after children currently residing in geographical or administrative (e.g. local authority, NHS Health Board, etc.) areas.

Gender

On 31 July 2017, 55% (8,121) of all looked after children were male, and 45% (6,776) female. As Table 2 below shows, these proportions hold fairly consistent across all age brackets. Within the total Scottish population of

0-21 year olds, 51% (660,983) are male, suggesting that males are slightly more common in the 'care system' than females.[129]

Table 2: Children looked after on 31 July 2017, by age group and gender[130]

	Under 1	1-4	5-11	12-15	16-17	18+	Total
Male	211	1,367	3,002	2,554	922	65	**8,121**
% Male	*52*	*53*	*54*	*55*	*53*	*54*	***55***
Female	198	1,136	2,549	2,108	726	59	**6,776**
% Female	*48*	*47*	*46*	*45*	*47*	*46*	***45***
Total	**409**	**2,503**	**5,551**	**4,662**	**1,648**	**124**	**14,897**

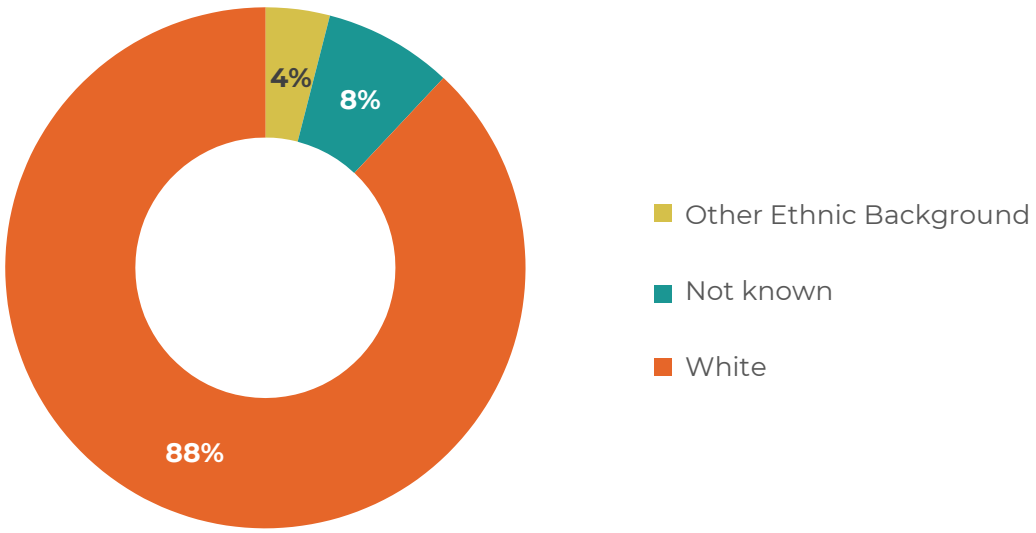
Ethnicity

In respect of their ethnicity, on 31 July 2017, 87.5% of looked after children were recorded as 'white'. A further 4% (613) were recorded as having other ethnic backgrounds, including 'mixed ethnicity' (1.8% / 272), 'black, black Scottish or black British (0.6% / 94) and 'Asian, Asian Scottish or Asian British' (0.8% / 126). For 8.3% (1,243) their ethnicity was recorded as 'not known'.

[129] National Records Scotland (2017) Estimated population by age and sex, Scotland, mid-2017

[130] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018; Table 1.1

Chart 6: Children looked after on 31 July 2017, by ethnic group[131]



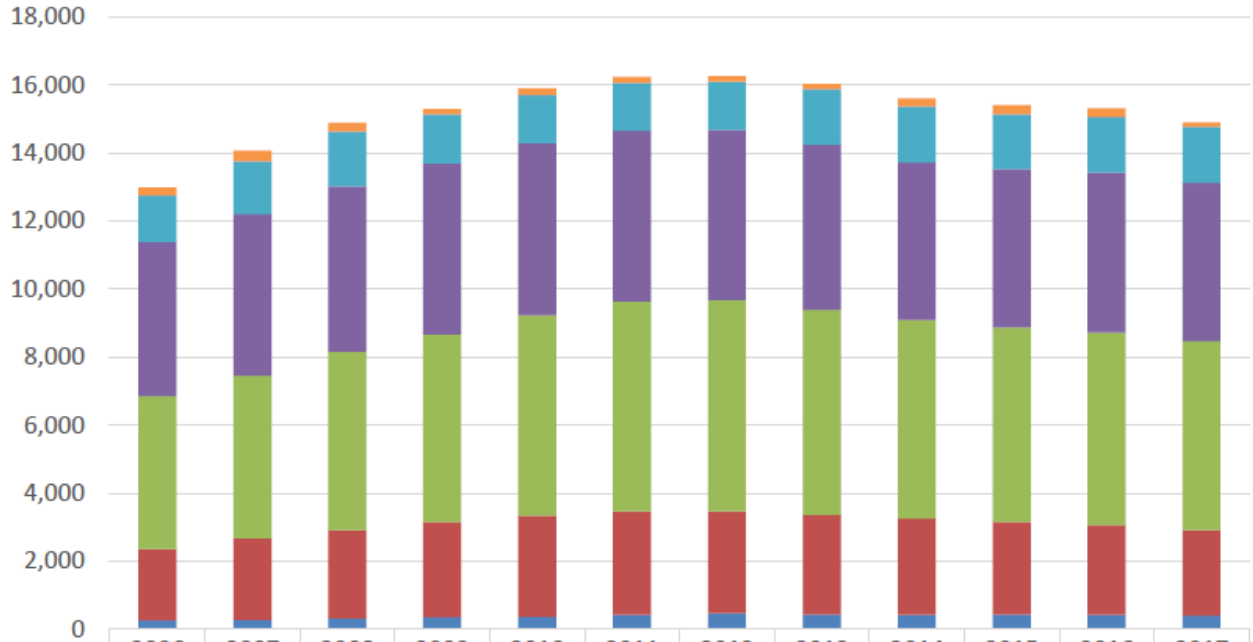
Across Scotland as a whole, 96.3% of the population (all ages) were recorded as being of a 'white' ethnic background (including all white ethnic categories).[132] When contrasted with the data for looked after children, this may suggest that children and young people from 'non-white' ethnic backgrounds are disproportionally represented in the 'care system', but this cannot be said for sure due to the high proportion of unknown ethnicities recorded.

Age

On 31 July 2017, 19.5% of the looked after population was aged 0 – 4 years old (pre-school); 37.3% was aged 5 – 11 (primary-school age); 31.3% was aged 12 – 15 years old; and 11.9% were aged 16 – 21. Children of compulsory school age (5 – 15 years old) comprised 68.5% (10,213) of the total.

[131] Ibid; Table 1.2
[132] Scottish Government (2017) Ethnic Breakdown of Scotland

Chart 7: No. of children looked after by age, 2006-2017[133]



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18+	220	296	258	146	184	167	155	161	226	260	263	124
16-17	1,379	1,558	1,605	1,457	1,423	1,407	1,413	1,626	1,644	1,617	1,632	1,648
12-15	4,524	4,746	4,858	5,017	5,047	5,021	5,007	4,851	4,639	4,648	4,698	4,662
5-11	4,495	4,794	5,255	5,510	5,897	6,167	6,204	6,031	5,834	5,722	5,659	5,551
1-4	2,098	2,382	2,586	2,800	2,968	3,036	3,001	2,919	2,823	2,712	2,636	2,503
Under 1	266	284	326	357	373	433	468	444	434	441	429	409

Chart 7 above shows the total number of looked after children, by age, at the statistical 'year-end' (i.e. 31 July)[134] of 2006 to 2017. Although proportions in the various age brackets have remained broadly consistent over this time, it is interesting to note that the number of infants (under the age of 1), although a small group in terms of numbers, has gradually increased since 2006, rising from 2% (266) in 2006, to 2.7% (409) in 2017.

[133] Scottish Government (2017) Children's Social Work Statistics Additional Tables - amended June 2018;, Table 2.1: Number of children looked after by age and gender, 2002-2016

[134] Up until 2008-09

More children are starting to be looked after at younger ages. The percentage of children becoming looked after under the age of 1 has grown from 8% in 2007 to 15 % in 2017.[135]

	2007	2016	2017	2007 %	2016 %	2017 %	10-year profile
Under 1	412	658	647	*8*	*16*	*15*	
1-4	1,157	916	972	*22*	*22*	*23*	
5-11	1,513	1,321	1,287	*29*	*31*	*31*	
12-15	1,878	1,175	1,191	*36*	*29*	*28*	
16-17	274	41	85	*5*	*1*	*2*	
18-21 (2)	11	5	4	*0*	*0*	*0*	
Total	**5,245**	**4,116**	**4,186**	***100***	***100***	***100***	

The number of young people aged 18 and above who remain 'looked after' beyond their 18th birthday has consistently been a relatively small proportion of the total, sitting at just 0.8% (124) in 2017.

Disability

On 31 July 2017, 1,636 (11%) of looked after children were recorded as having a disability, 10,433 (70%) had no disability recorded, and for 2,828(19%) the disability status was not known.

Unfortunately it is not possible to provide a more detailed picture of looked after children's disability. Due to recent changes in the statistical return provided by local authorities to Scottish Government, the data for 2015-17 is not comparable to that collected in previous years. Furthermore, current disability data is not broken down (in a published form) by age, gender or placement type (apart for secure care, where 39% were recorded as having at least one disability).

The changes aim to bring Scottish statistical reporting into line with the rest of the UK, using the definition of 'disability' set out in the Equality Act 2010. From 2015- 16, local authorities report on the question: "does the young

[135] Scottish Government (2017) Children's Social Work Statistics 2016/17; Table 1.3 Number of children starting to be looked after by age and gender, 2003-2017(1)

person have a mental or physical impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-today activities?" In previous years the statistical return asked local authorities to report on the additional support needs of those looked after children with a recorded disability; a confusing approach, which led to wide variance in the numbers reported between local authorities (due to differences in how 'additional support need' and 'disability' are understood, assessed and recorded). In 2014-15 data indicated a total of 13% of looked after children with a disability had an 'additional support need', with one local authority reporting 3% and another 44%. Such significant discrepancies between one local authority and another, in a context when every looked after child in Scotland is considered to have additional support for learning needs unless assessed otherwise[136], places a question mark over the reliability of such findings. Particularly, when the figures for Scotland are contrasted with data for English looked after children, which identifies 57% (20,220) of looked after children as having 'special educational needs'[137]. According to UNICEF data, of the 604,847 children in residential care in Eastern Europe and Central Asia, almost half (291,493) were recorded as having a disability[138].

Care Plans

Every looked after children or young person must be provided with a care plan by the local authority. This care plan should include important information for the child or young person's care, including areas such as care, education and health needs, as well as family links like sibling contact[139].

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[136] Under the Education (Additional Support for Learning) (Scotland) Act 2004, as amended by the Education (Additional Support for Learning) (Scotland) Act 2009.
[137] UK Government (2017) Outcomes for children looked after by LAs: 31 March 2016; Table 4a: Number of children who have been looked after continuously looked after for at least twelve months, children in need and all children with special educational needs
[138] UNICEF (2010) A Home or in a Home?; Table 8.1 Children with disabilities in residential care in 2000, 2005 and 2007
[139] Scottish Government (2015) Getting It Right For Looked After Children And Young People Strategy;, Better outcomes for looked after children and young people

Table 3 below shows the number and percentage of looked after children and young people with and without a care plan, on 31 July 2017, broken down by type of care. Those children looked after at home or in kinship care tended to be without a care plan compared to those in foster care (93% and 90% for looked after at home and kinship care respectively, compared to 99% and 98% for foster care and residential care respectively). Overall, 95% of looked after children had a care plan in place. One reason why a child may not have had a care plan in place is timing; if they became looked after in the fortnight preceding the collection of statistics, their status as a looked after child would be recorded, but a care plan not yet prepared.

Table 3: Children looked after with and without a current care plan, at 31 July 2017[140]

Accommodation Type	With a current care plan	Without a current care plan	Total	With a care plan (%)	Without a care plan (%)
Looked After at Home	3,509	257	3,766	93	7
Kinship Care	3,711	427	4,138	90	10
Foster Care	5,178	74	5,252	99	1
Residential Care	1,477	32	1,509	98	2
Total	**14,104**	**793**	**14,897**	**95**	**5**

Placement type

As suggested in sections above, there are a variety of distinct 'types' of care placement. The statistics divides these into two broad groups: 'in the community' (looked after at home; kinship care; foster care; prospective adopters; and, other community) and 'residential accommodation' (all forms of residential care and education). Within these broad groups the

[140] Scottish Government (2018) Children's Social Work Statistics Scotland 2016/17:, Table 1.2: Children looked after with and without a current care plan, at 31 July 2017

numbers are then sub-divided further, between specific types of care, such as foster care, kinship care, residential schools and secure.

In 2017, children in 'foster care' represented the largest placement type, comprising 35% (5,252) of all looked after children (14,897). 'Kinship care' and 'looked after at home' were the next largest placement types, at 28% (4,138) and 25% (3,766) respectively. Within residential care (constituting 10% of the total, or 1,509 children), 5% (746) were in some form of residential home, 2.5%(375) in a residential school, and 0.4% (56) in secure care.

Table 4 below also shows that the proportions of children in various placement types varies considerably when further subdivided by children's age. In 2017, over 60% (8,274) of children under the age of 12 were in 'community' placements (e.g. foster care, looked after at home, kinship care). Of the 56 looked after children in secure care, all were between the age of 12 and 17.

Over the past 15 years, the proportions of the population in the two broad groups ('community' and 'residential') has remained broadly consistent, with approximately 90% considered 'in the community' and 10% in 'residential accommodation' in any given year. But beneath those heading, the proportions of looked after children in the various, distinct placement types has changed considerably. For example, between 2012 and 2017 the proportion of children looked after at home fell by 26%, from 5,123 to 3,766. At the same time, increasing numbers of children were looked after in kinship care, which grew from 4,076 to 4,138. The 2015-16 year actually saw a small decline in the number being fostered, but looked at over a longer period, foster care has expanded dramatically in Scotland; between 2002 and 2017 the number of children in foster care increased by 66%, from 3,170 to 5,252. As a proportion of the total 'incare' population, foster care grew from 28% to 35% over this period[141].

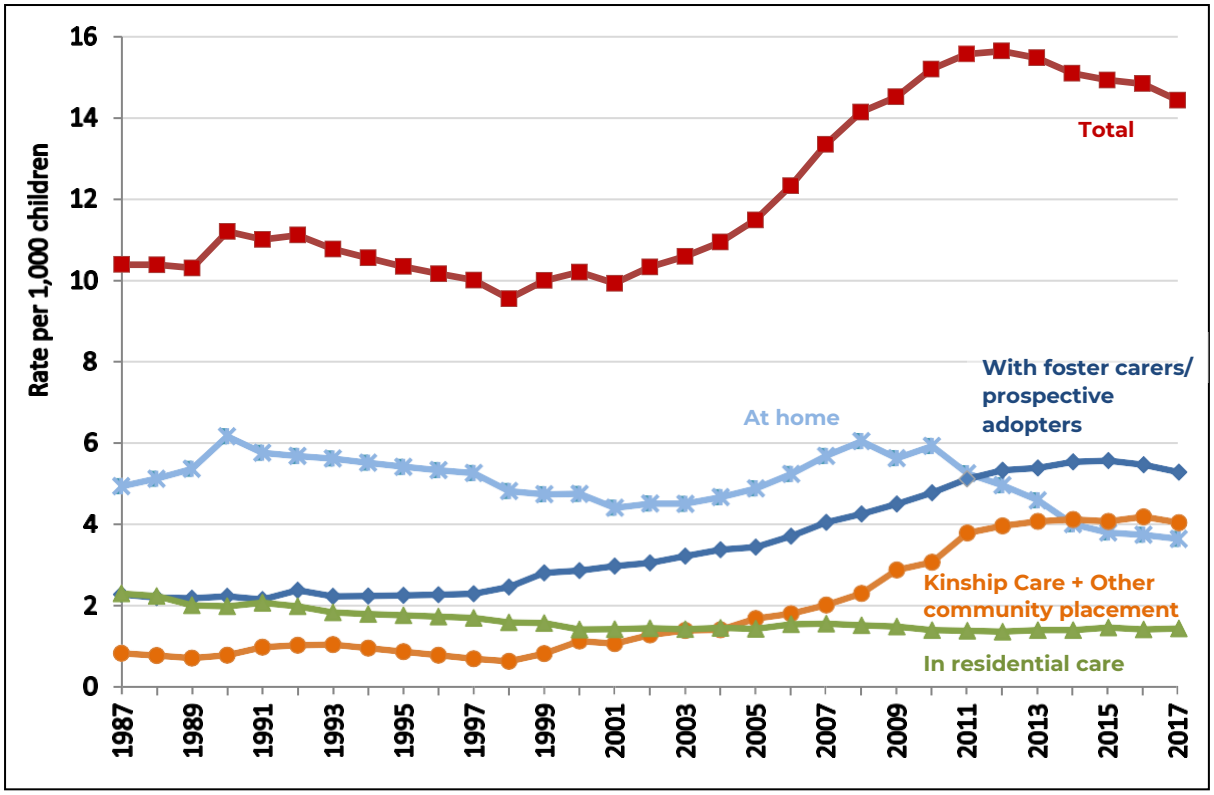
[141] Scottish Government (2018) Children's Social Work Statistics Scotland, 2016-17; Placement Type

Table 4: Children looked after on 31 July 2017, by placement and age[142]

Type of accommodation	Age Group					
	<5	5-11	12-15	16-17	18+	Total
In the community:	**2,905**	**5,369**	**3,825**	**1,190**	**99**	**13,388**
Looked after at Home	768	1,484	1,242	260	12	**3,766**
Kinship Care (with friends / relatives)	848	1,843	1,127	304	16	**4,138**
Foster Care provided by Local Authority	915	1,260	901	388	45	**3,509**
Foster Care purchased by Local Authority	242	720	550	212	19	**1,743**
With prospective adopters	132	62	0	0	0	**197**
In other community	0	0	0	26	0	**35**
Residential Accommodation:	**7**	**182**	**837**	**458**	**25**	**1,509**
In local authority home	0	54	336	216	35	**619**
In voluntary home	0	0	72	32	*	**127**
In residential school	0	58	223	86	8	**375**
In secure accommodation	0	0	36	19	0	**56**
In other residential	0	50	170	105	0	**332**
Total	**2,912**	**5,551**	**4,662**	**1,648**	**124**	**14,897**

[142] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018; Table 1.4: Children looked after at 31 July 2017(1),(2) by type of accommodation

Chart 8: Children looked after per 1,000 children under 18 by type of accommodation, 1987-2017[143]



Within foster care and residential care specifically, there is a further subdivision:

a) children accommodated with carers provided by the local authority, or (b) children accommodated with carers purchased through an independent agency (such as Kibble, Care Visions, Barnardos, Aberlour, Harmeny School, etc.).

As the data in Table 4 below shows, in 2017 the proportion of foster carer placements provided directly by Scottish local authorities was 71%, and those purchased from independent agencies 29%. In residential care (excluding residential schools, secure, other etc.) the proportions were 81% in local authority provided homes, and 19% in homes purchased from

[143] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17;, Chart 1: Children looked after per 1,000 children under 18 by type of accommodation, 1987-2017

independent agencies.[144] Foster care purchased by the local authority has grown significantly over recent years, from 20% to 29% of all foster care between 2009 and 2016.

Table 5: Proportions of children in local authority or purchased placements, foster care and residential care, 2010 – 2017[145]

	2010	2011	2012	2013	2014	2015	2016	2017
Foster care total	**4,697**	**5,068**	**5,279**	**5,333**	**5,522**	**5,478**	**5,392**	**5,252**
With Foster Carers provided by LA	3,651	3,871	3,946	3906	4002	3891	3826	3509
% of total	78	76	75	73	72	71	71	67
With Foster Carers purchased by LA	1,046	1,197	1,333	1427	1520	1587	1566	1743
% of total	22	24	25	27	28	29	29	33
Residential Home total	**702**	**703**	**654**	**687**	**696**	**697**	**717**	**746**
In Residential Home provided by LA	620	615	564	575	579	564	581	619
% of total	88	87	86	84	83	81	81	83
In Residential Home purchased by LA	82	88	90	112	117	133	136	127
% of total	12	13	14	16	17	19	19	17

[144] At the time of writing (October 2017) 5 secure units provide care and protection in Scotland, of which only one (Edinburgh Secure Services) is operated by a local authority.
[145] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17;, Table 2.2: Number of children looked after by type of accommodation, 2002-2017

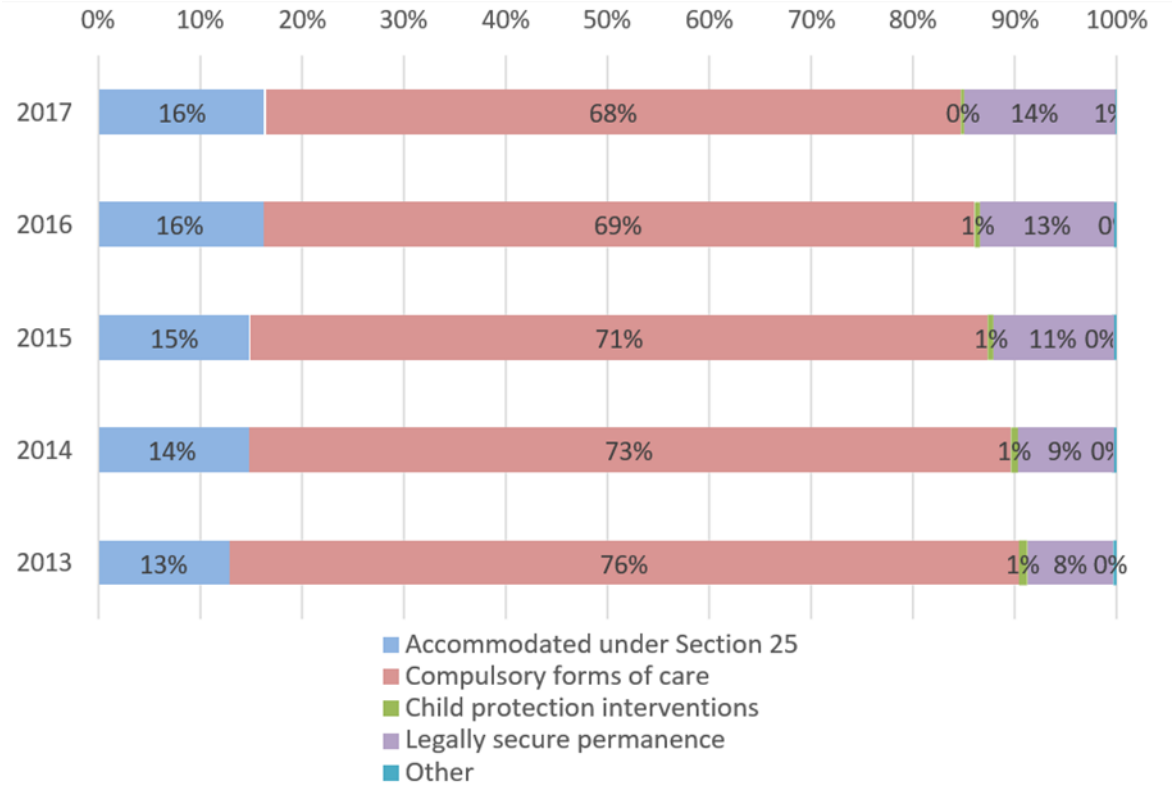
Unfortunately there is no data currently published on the number of placement moves that a child or young person experiences over their full time in care (although it would be possible to generate such figures for a significant proportion of looked after children). From the available data, which relates only to placement moves within a year, 79% of looked after children remained in the one care placement in 2017, 16% had two, and 5.5% with three or more placements.[146] English data for 2017 shows that, within their population of looked after children, 65% remained in one placement, and 35% had two or more placements in 2017.[147]

Legal basis on which a child is looked after

As outlined in the 'Definition of a Looked After Child' section above, children and young people enter (and remain in) the 'care system' through a variety of legal mechanisms. On 31 July 2017, of all the children who were 'looked after', 68% (10,545) were subject of a Compulsory Supervision Order issued by a Children's Hearing. Less than 1% (61) were looked after by means of a Child Protection measure. Over 16% (2,394) were looked after under Section 25 of the 1995 Act (i.e. on a voluntary arrangement between family and local authority), 13% (1,931) were on Permanence Orders, and another 3% (408) were looked after under 'another legal reason'.

[146] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17;,Table 2.6: Number of looked after children by number of placements during the past year(1), 2012-17(2)
[147] UK Government (2017) Children Looked after in England including adoption: 2016 to 2017; Table A2: Children looked after at 31 March by placement

Chart 9: Children looked after by legal reason, 2013-2017[148]



As Chart 9 above illustrates, 'compulsory measures' (such as compulsory supervision orders or child protection) are the most common legal basis for a child or young person being 'looked after'. However, it is of note that the proportion of children subject to compulsory measures has dropped by nearly 9% since 2012, offset by increases in the number of children secured in care placements by means of a Permanence Order, and by children being provided with accommodation under Section 25 of the 1995 Act.

In addition, please note that in a small number of cases children may have more than one 'legal status'. Such situations are rare, but an example would be a young person with a Permanence Order, who is later subject to a Compulsory Supervision Order because of other concerns. This may explain why the total 'legal reasons' on 31 July 2017 (14,942) is higher than the total number of looked after children (14,897).

[148] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17;, Table 2.5b: Number of children looked after by legal reason group, 2002-2017

Data published by Scottish Government shows the legal status of looked after children on 31 July of each year, therefore showing us only their legal status on that day, and not, for example, the legal reason by which they became looked after, or the various legal reasons they have been subject to while in care. Although this data is not published, the Children's Looked After Statistical return from local authorities is provided at an individual child level, and it should be possible to provide such figures on request.

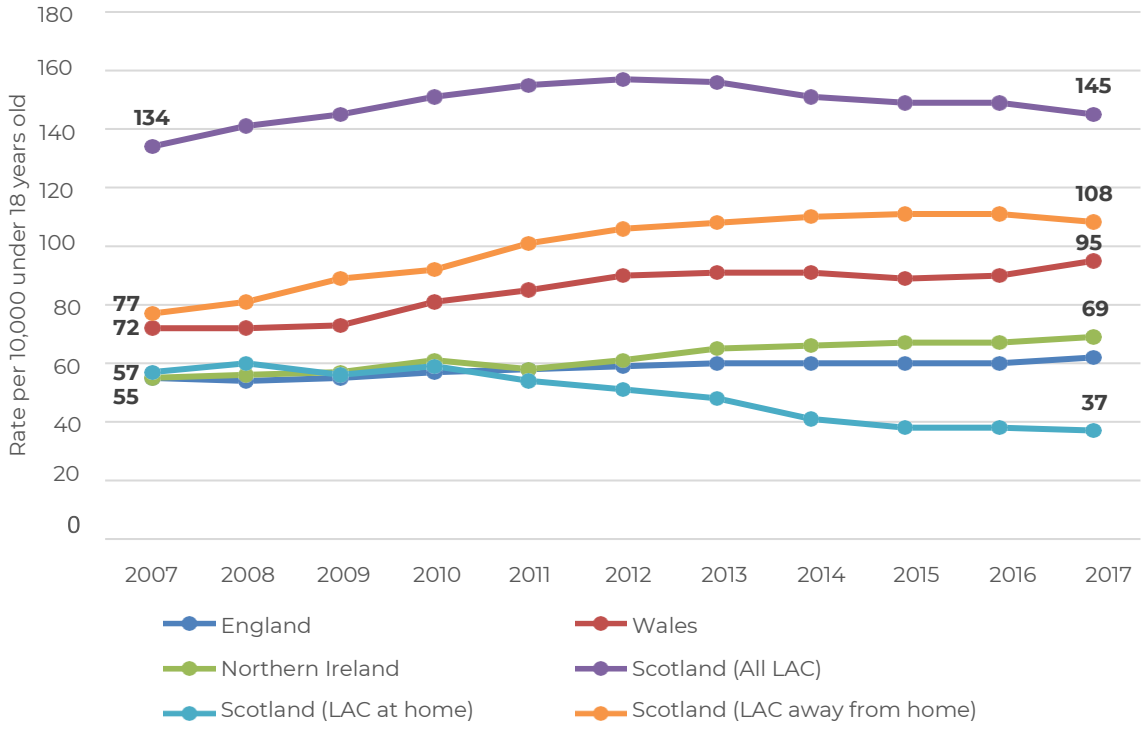
Unaccompanied Children

Current statistical data does not distinguish those children who are looked after due to their status as 'unaccompanied children' (e.g. refugees, or abandoned by parents who were illegal economic migrants). The Scottish Government estimate that approximately five unaccompanied children arrive in Scotland each month[149]. By comparison, Kent local authority (which incorporates Dover, is the nearest English local authority to the Calais refugee camp) received over 1,000 unaccompanied children in 2015[150]. However, whilst the numbers in Scotland are relatively small, the specific needs of such children are complex, in terms of care placements and integration, ensuring their culture and beliefs are respected and catered for.

[149] Scottish Government (2017) Refugees and Asylum Seekers; Unaccompanied Children
[150] The Home Office (2015) Letter to Council Leaders Areas on Dispersal of Unaccompanied Asylum Seeking Children;

UK Comparison of number of looked after children

Chart 10: Cross-UK comparison of rate of looked after children per 10,000 of the population of 0-18 year olds, 2007-2017[151]



How does Scotland's population compare, in terms of size, to other parts of the UK? Chart 10, above, shows the rate of looked after children per 10,000 under 18 year olds (in the general population). Like Scotland, the rate of looked after children in England, Northern Ireland and Wales increased over the past decade, but has remained relatively static over recent years. In Scotland the rate decreased slightly from 157 per 10,000 in 2012, to 149 in 2016, while Northern Ireland and Wales saw small increases (see Table 6 below).

Even when children 'looked after at home' are excluded from the Scottish total (as it is a placement much less common in the rest of the UK), the rate per head is still significantly higher than other countries in the UK: 111 out of every 10,000 Scottish under 18's were looked after (and

[151] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17;, Table 2.9: Cross UK comparison of the number looked after children and rate per 10,000 children under 18, 2005-2017

accommodated) in 2016, compared with rates of 90 for Wales, 67 for Northern Ireland and 59 for England.

Table 6: Number of looked after children, 2013 – 2017, UK comparison[152]

	2013	2014	2015	2016	2017
England	68,060	68,810	69,480	70,440	72,670
Wales	5,770	5,745	5,615	5,660	5,955
Northern Ireland	2,810	2,860	2,875	2,890	2,983
Scotland (All LAC)	16,170	15,625	15,360	15,330	14,982
Scotland (LAC at home)	**4,950**	**4,255**	**3,935**	**3,880**	**3,815**
Scotland (LAC away from home)	**11,220**	**11,370**	**11,425**	**11,450**	**11,167**

Table 7: Rate of children looked after per 10,000 children under 18, 2013-2017

	2013	2014	2015	2016	2017
England	60	60	60	60	62
Wales	91	91	89	90	95
Northern Ireland	65	66	67	67	69
Scotland (All looked after)	156	151	149	149	145
Scotland (looked after at home)	***48***	***41***	***38***	***38***	***37***
Scotland (looked after away from home)	***108***	***110***	***111***	***111***	***108***

However, any such cross-border or international comparison of statistics must be treated with caution. Within the UK alone there are key

[152] ibid

differences in looked after children's legislation, decision making structures, and other critical process. Whilst the available statistics do show higher numbers of looked after children in Scotland than the rest of the UK, what they do not show is the differences in how kinship placements are managed and recorded between different UK countries, or the varied approaches to securing permanence for children. But even within this mix, Scotland's system is particularly distinct.

The Children's Hearings System[153] has access to legal orders with no ready equivalent anywhere else in the UK (such as Permanence Orders), and the significant majority of care placements are provided directly by public authorities (rather than purchased from the third or private sector). In England, 'friends and relatives' who are potential carers are (in theory) assessed as foster carers, or for residence / special guardianship orders; in Scotland it is rare for 'friends and relatives' to be assessed and approved as foster carers, remaining instead in their own category (found only in Scotland) of 'kinship care'. (Kinship care exists extensively across the UK, but only in Scotland is it a formal placement type for looked after children, distinct from foster care.)[154]

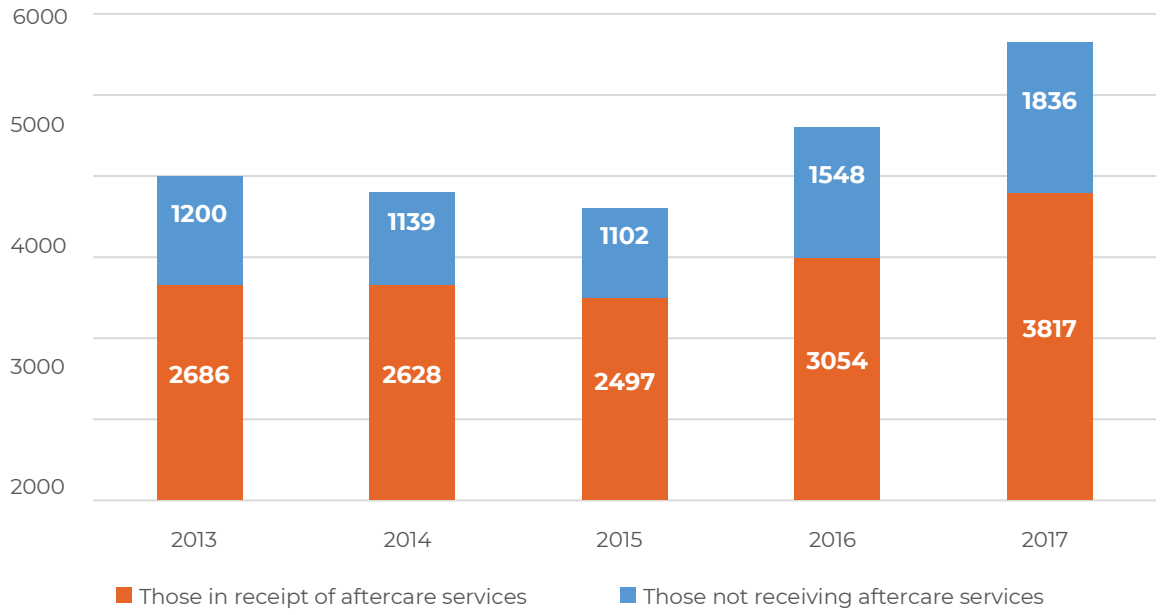
[153] Children's Hearings Scotland The Children's Hearings System
[154] Scottish Government (2017) Looked After Children

5. Young people who are 'care leavers': Population characteristics

Numbers

On 31 July 2017, there were 5,653 young people (aged 16 – 25 inclusive) who were 'care leavers'. These are young people who, under the current provisions of Section 29 of the Children (Scotland) Act 1995, are entitled to advice, guidance and assistance (i.e. 'aftercare') from a local authority.

Chart 11: Number of young people eligible for aftercare services, by receiving / not receiving, 2012 - 2017



After a period of a gradual fall in the number of care leavers, 2015-16 saw a significant increase on the previous year (up 28%). This is likely to be due to the expansion of aftercare eligibility in the Children and Young People (Scotland) Act 2014, which raised the age to which young people were entitled to assistance from their local authority, from their 21st birthday to their 26th birthday.

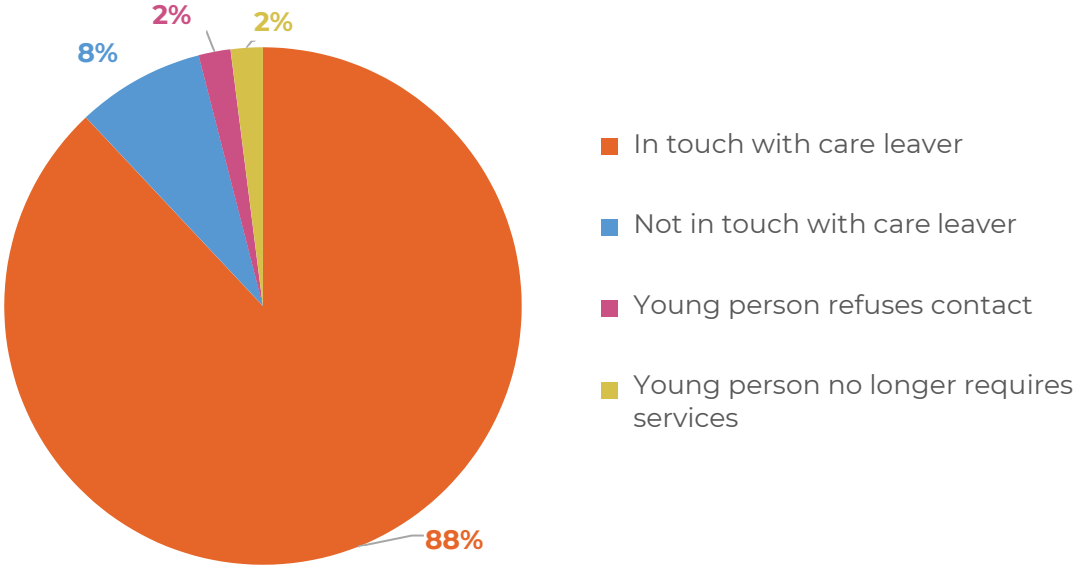
Chart 11 above also provides an insight into the numbers of eligible young people who are in receipt of aftercare services. In 2017, 67.5% (3817) were in

receipt of some form of aftercare support from their local authority. The remaining 32.5% (1836) were not receiving services, but this does not necessarily mean they are out of contact with the local authority, or that support is not available to them.

However, it is interesting to contrast the Scottish picture with that in the other parts of the UK. Their statistics focus on whether the local authority is still in contact with the care leaver, providing more detail on the relationship. In 2016, 88% of English care leavers were reported to be in contact with their local authority, a further 10% had either rejected contact or were out of touch, and 2% were no longer in need of support (see Chart 12 below). In Wales, 93% (465) of their 495 care leavers were reported as still being in touch with statutory services[155].

[155] Welsh Government (2017) Care leavers on their 19th birthday during year ending 31 March by local authority and number or per cent in touch

Chart 12: Proportions of English Care Leavers 'in contact' with their local authority, 2016,[156]



Gender

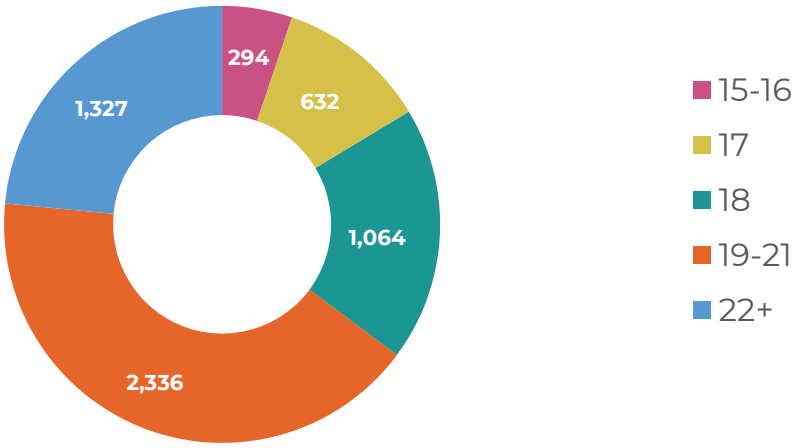
The gender split of young people eligible for aftercare mirrors the gender proportions of the looked after children population. On 31 July 2017, 53% (2,995) were male, and 47% (2,658) were female.

Age

Young people become eligible for aftercare if they "cease to be looked after" (i.e. leave care) on or after their 16th birthday. In a small number of cases, a young person may cease to be looked after just before their 16th birthday (by virtue of their Compulsory Supervision Order's end-date); local authorities will usually treat these young people as if they left care after their 16th birthday.

[156] UK Government (2017) Children Looked after in England including adoption: 2016 to 2017: Table F1: Care leavers now aged 19, 20 and 21 years old by gender, contact with the local authority and activity

Chart 13: Young people eligible for aftercare, by age, on 31 July 2017[157]



Accommodation

On 31 July 2017, of the young people eligible for aftercare for whom their current accommodation was known, 45% (984) were living at home with parents, or with friends and relatives. Another 61% (1,115) were living either with their own tenancy or some form of semi-independent living. A further 10% (166) were living with former foster carers or in residential care (a number which should increase in future years, following the introduction of 'Continuing Care'). 6% (124) were officially homeless, and 4% (92) were in custody.

[157] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018;, Social Work Stats Additional Tables - Table 1.15

Table 8: Young people eligible for aftercare, by age and current accommodation, on 31 July 2017[158]

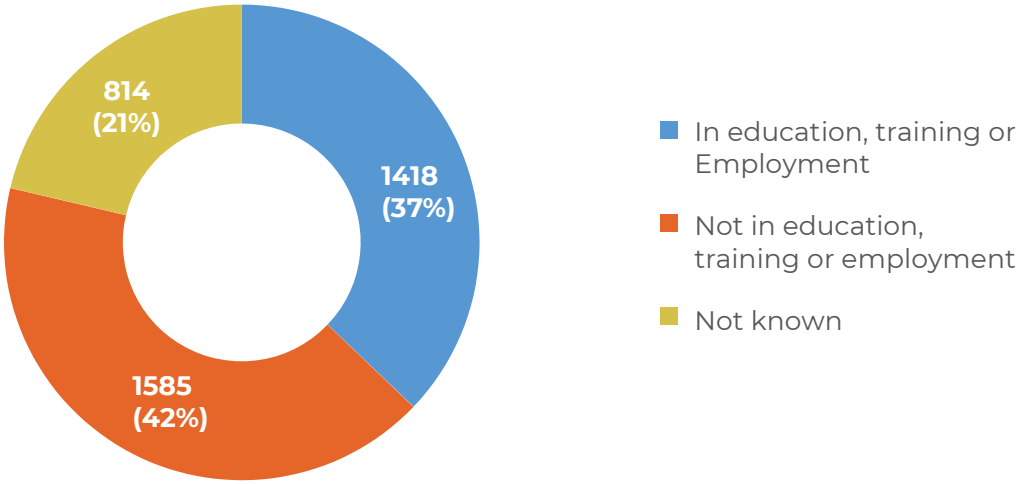
	15-16	17	18	19-21	22+	All ages
Home with biological parents	66	119	98	210	62	555
With friends / relatives	29	78	105	159	58	429
Own tenancy / independent living	7	82	174	560	292	1,115
Supported accommodation	40	62	132	292	86	612
Former foster carers	6	15	55	78	12	166
In residential care	*	11	32	38	*	99
Homeless	12	19	19	54	20	124
In custody	*	11	14	39	*	92
Other destination	10	8	35	42	11	106
Not known	12	62	112	265	68	519
Not receiving aftercare	132	208	370	452	386	1548
Total	**353**	**667**	**1066**	**1876**	**640**	**4602**

Employment, Education and Training

On 31 July 2017, of those young people who were in receipt of aftercare services from a local authority (total = 3,817), nearly 37% (1,418) were in education, training or employment. Of these, 301 were in higher education (HE), 313 were in education other than HE (including school and college), and 804 were in training or employment.

[158] Ibid.

Chart 14: Employment, Education and Training status of Scottish young people in receipt of aftercare services, on 31 July 2017[159]



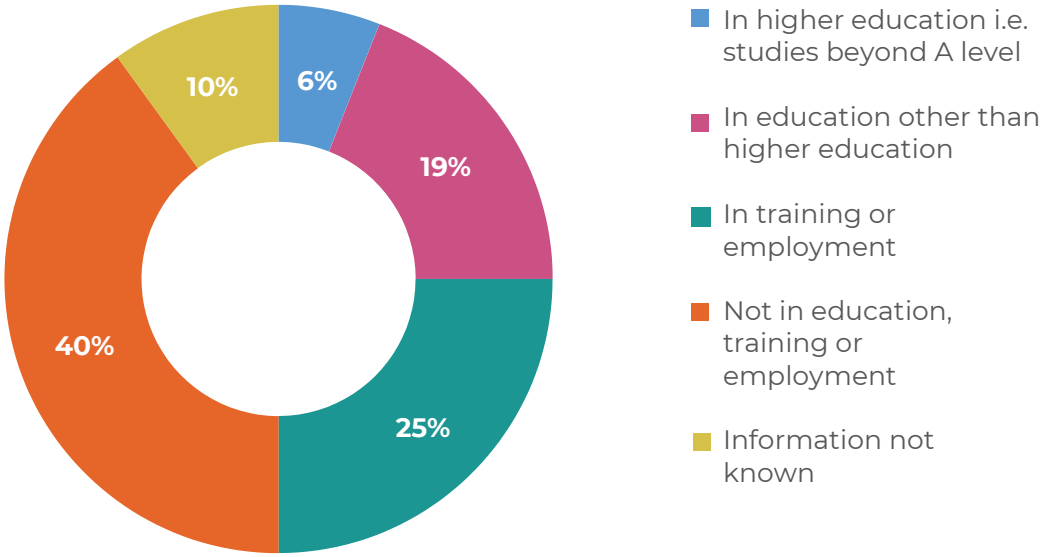
Of the 42% (1,585) recorded as not being in education, training or employment, a significant number (159) were not able to be due to illness or disability, and a further 126 were looking after family members.

For 21% (814) of young people in receipt of aftercare services, their activity/status was "unknown". This number can be added to the 1,836 young people who were not receiving aftercare on 31 July 2017, and for whom, therefore, we have no indication of their education, employment and training status. This means we do not have data for over 46% of care leavers.

Scotland's numbers are similar to those from England (see Chart 15 below), which show for all care leavers aged 18-21 years old in 2015, 40% were not in any form of education, training or employment.

[159] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17;, Social Work Stats Additional Tables – amended June 2018 - Table 1.16-1.17

Chart 15: Education, Employment or Training status of care leavers in England, 2015[160]



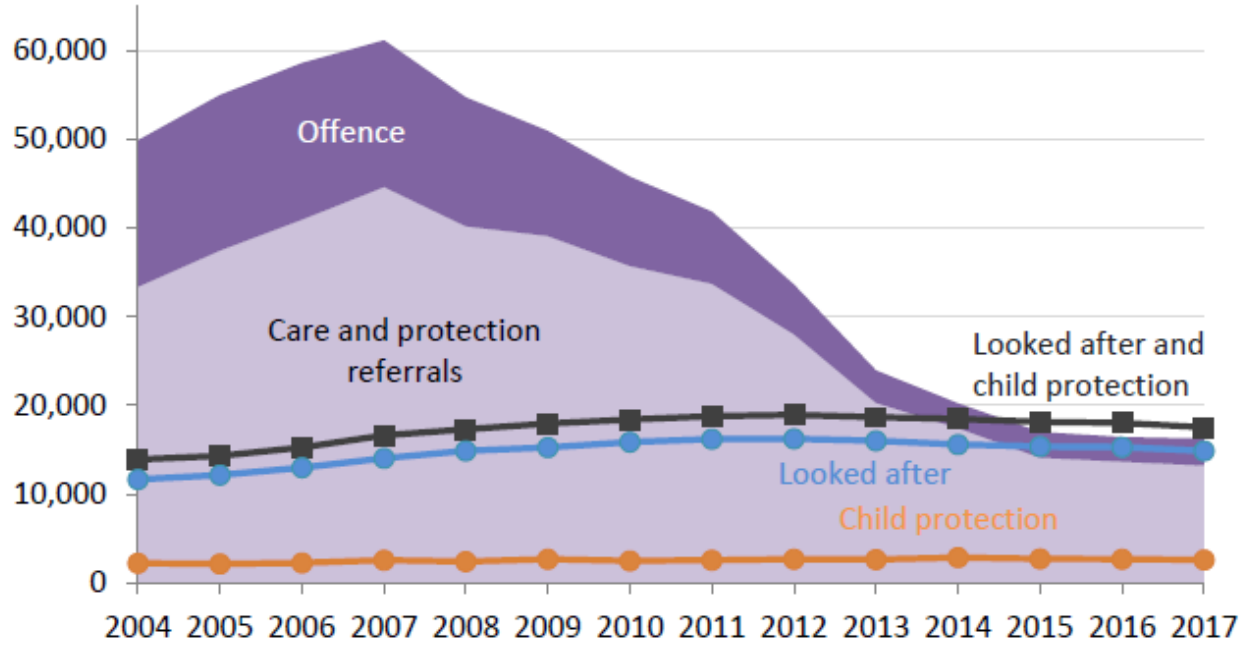
[160] UK Government (2017) Children looked after in England Including Adoption: 2016 to 2017:, Table F1: Care leavers now aged 19, 20 and 21 years old by gender, contact with the local authority and activity1,2

6. Care pathways

Coming into Care

Children and young people are in care for a number of different reasons. A child's complex additional support needs (e.g. disability), or issues relating to care and neglect are reasons why a child can become 'looked after'. But, in the majority of cases, it is the need to secure 'care and protection' for a child which constitutes the principle (if not exclusive) reason for bringing a child into care.

Chart 16: Children Referred to the Children's Reporter and numbers looked after/on child protection register, 2004-2017[161]



Interestingly, as the graphic above illustrates, the number of children and young people referred to the Children's Reporter has decreased dramatically over the past decade, by almost 73% (from 49,850 to 13,240).[162] The decrease is reflected in both offence and non-offence referrals. (An offence referral would constitute the children or young person committing

[161]Scottish Government (2018) Children's Social Work Statistics Scotland, 2016-17;, What are the trends in other children's social work data
[162] Scottish Government (2018) Children's Social Work Statistics Scotland, 2016-17;, What are the trends in other children's social work data

an offence, whereas a non-offence referral would specifically be focussed on concerns around the welfare of the child.) The reasons for this fall are various, but the outcome is that, of the children being referred, a much higher proportion now progress onto a Children's Hearing, and potentially some form of legal order which brings the child into care. The number of offence referrals has risen slightly as of the last (2017/18) report from SCRA[163] but still makes up only a small proportion of the total.

Child Protection

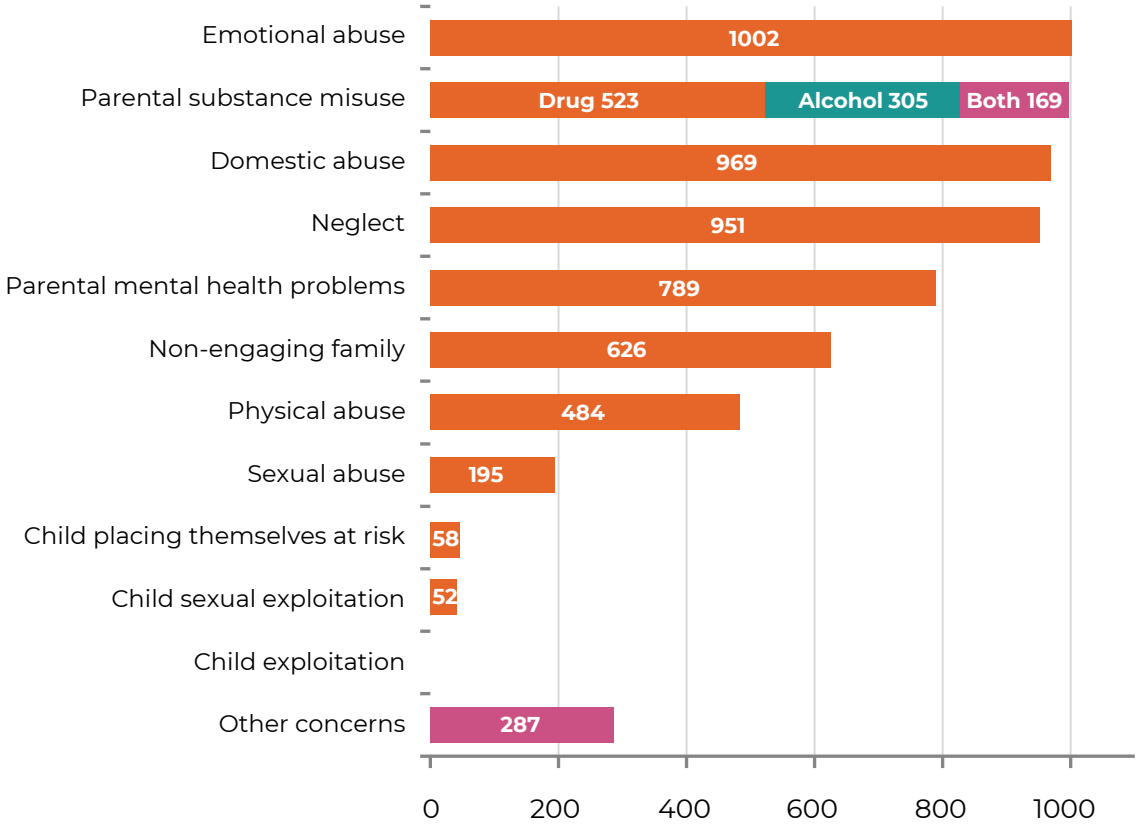
Child protection data provides a useful lens concerning the reasons children may require to become looked after (although it is important to note that not all children who are subject to child protection concerns are or become looked after). Chart 17 below provides an overview of some of the main concerns identified at the case conferences of children who were on the child protection register. Parental substance misuse, domestic abuse, emotional abuse, neglect and parental mental health problems comprise 73% (4,708) of concerns raised in child protection cases, whereas other serious concerns such as child exploitation and sexual abuse are cited in 4% (247) of cases. Emotional abuse is shown as the issue most likely to be raised in many child protection cases, being referenced in 16% (1002) of cases. (Please note also that any one single referral can have multiple reasons attached to it (e.g. a child could be experiencing both physical and emotional abuse). The 'other concerns' noted at the bottom of the table, is a new category from 2016; this includes children at risk of being trafficked.

Chart 17 below illustrates the breadth and complexity of the issues leading to child protection concerns. Particularly when it is considered that child protection concerns are likely to be interconnected; for example, the likelihood of neglect, (defined as "the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious

[163] Scottish Children's Reporter Association, Statistical Analysis 2017-18

impairment of the child's health or development") could be seen to increase as a result of serious parental substance abuse.

Chart 17: Concerns identified at the case conferences of children who were on the child protection register, 2017[164]



Children's Hearings

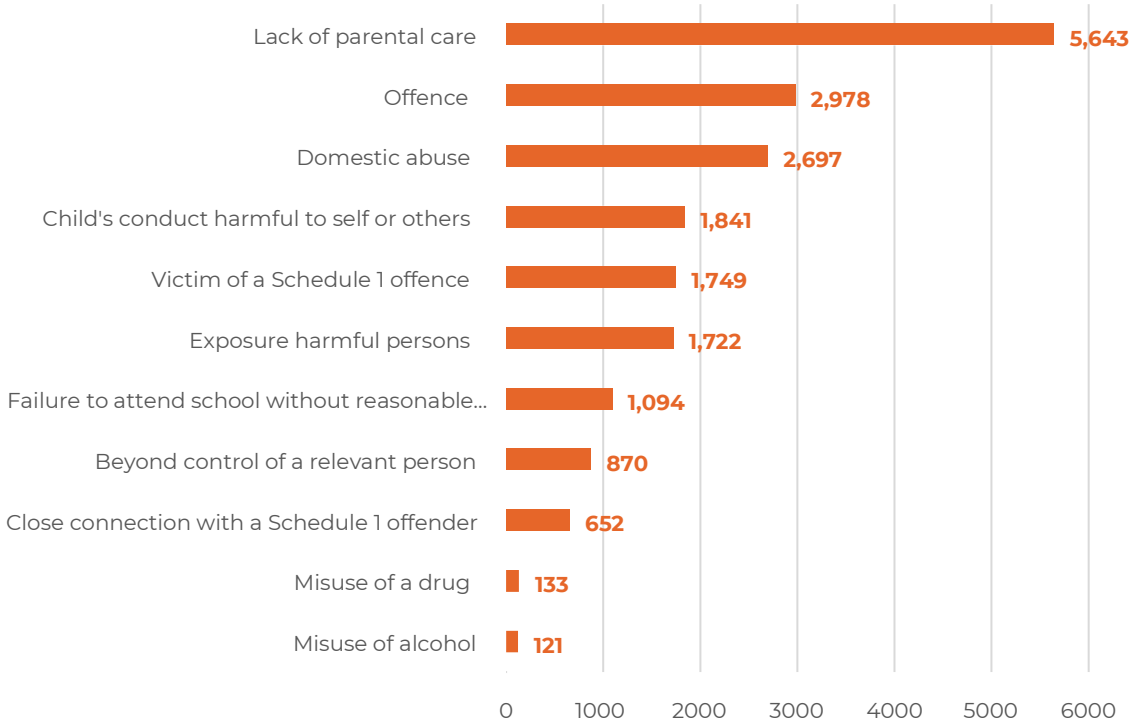
For those children who either progress onto, or are referred directly to, a Children's Hearing, another data set becomes available which can shed light on why some children become 'looked after'.

Chart 18 below details the 'grounds' on which children and young people are referred to the Children's Reporter in 2016-17. Lack of parental care was the most frequently cited ground for referral, used 5,643 (29%) times. Being a victim of, or exposed to, a Schedule 1 offender (anyone convicted of an

[164] Scottish Government (2018) Children's Social Work Statistics Scotland 2016/17;, Chart 4: Concerns identified at the case conferences of children who were on the child protection register (2017)

offence against a child listed in Part I of the Criminal Law Scotland Act 1995[165]) is also referencedin 15% (2,870) of cases, whilst committing an offence accounts appeared in 15% (2,978) of cases. (The proportion of referrals citing offence grounds has dropped significantly in recent years, from a high of 33% (16,741) in 2003-04). Misuse of drugs or alcohol accounts for only 1.3% (254) of cases.

Chart 18: Children & Young People Referred to the Children's Reporter, 2016-17, by grounds for referral[166]

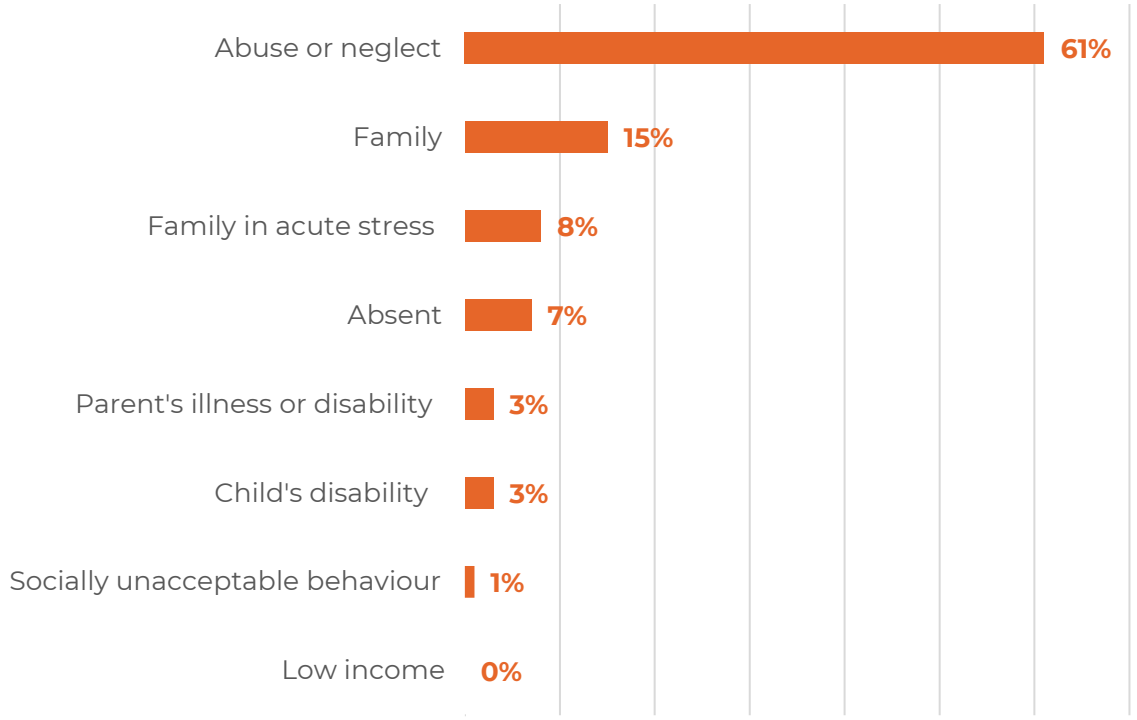


While grounds for referral to the Reporter are a useful guide to why children become looked after, they are a limited one. In particular, they exclude all those children who become looked after by a means other than a Children's Hearing. Unfortunately, the available statistics in Scotland do not provide details of the reasons children become actually looked after. The English looked after child data set does, and it is reasonable to assume

[165] National Objectives for Social Work Services in the Criminal Justice System: Standards Throughcare;
[166] Scottish Children's Reporter Association (2016); Statistical Analysis 2016/17;, Table 1.4 Number of children and young people referred in 2016/17, by section 67 ground and Compulsory Supervision Order status at the point of referral

that the reasons leading English children to be taken into care are broadly similar to those in Scotland.

Chart 19: Children looked after in England on 31 March 2017, by category of need[167]



Why children become looked after: An international perspective

The process by which children and young people become 'looked after' varies between individuals, and between different jurisdictions (as noted above). However, the reasons why children become looked after also varies considerably between countries. Recent international research by CELCIS[168] highlighted that,in Europe, protecting children from abuse, neglect and exploitation are now the principal reasons for children being

[167] UK Government (2017) Children looked after in England including adoption: 2016 to 2017; All children looked after at 31 March by gender, age at 31 March, category of need, ethnic origin, legal status and motherhood status, 2013 to 2017
[168] CELCIS (2017) Towards the Right Care for Children: Orientations for Reforming Alternative Care Systems; Africa, Asia, Latin America (Part 2: Why Are Children in Formal Alternative Care Settings?

brought into care. The same can be said for South American countries. In African and Asian countries, removing children from situations of material destitution (i.e. extreme poverty) remains a significant driver, and across a range of societies cultural factors can also play a part (for example babies born to the very young and/or unwedded mothers). In some cases external factors, such as conflict or natural disasters (including disease epidemics) can lead to many children being brought into care.

Stein (2014) finds that in African, Asian and South American countries and in some post-communist European, an estimated 2 million children and young people are living in large institutional care - this is mainly a result of poverty, disasters, war, famine and disease on families and communities[169].

Any international comparison must be heavily caveated, the challenges of differing definitions, cultural norms and socio-economic systems making robust analysis difficult. However, the data and available research is strong enough to conclude that different countries' 'care systems' are, in some cases, orientated towards different social needs and objectives, even if, ultimately, they are all focused on addressing issues related to 'poverty', and the risks it presents to children.

Links between deprivation and coming into care

The relationship between poverty and children and young people becoming looked after has been well documented elsewhere. Within Scotland, Chart 20 below illustrates the correlation between child poverty levels in a local authority area and the percentage of looked after children and young people (as a percentage of the 0-17 year old population). If we accept a hypothesis that reducing poverty levels can have an influence on the rates of children and young people coming into care, reducing pressure in families and thereby reducing incidents which lead to intervention by social work services, recent political developments in Scotland (including

[169] Stein (2014) How does care leaver support in the UK compare with the rest of the world?

Child Poverty legislation and the Scottish Poverty and Inequality Commission) hold promise.[170]

Naomi Eisenstadt, the Scottish Government's Independent Advisor on Poverty and Inequality, and author of "The Life Chances of Young People in Scotland: A Report to the First Minister"[171], recognised how young people's life chances are shaped by deprivation, other forms of disadvantage, and protected characteristics. The six characteristics are defined as: Living in a deprived area; Ethnicity; Disability; Caring responsibilities; Being 'looked after' and leaving care.

Children and young people who are looked after could be affected by a number of these issues - or all of them - at any one time. Eisenstadt's report confirms, for example, that a poorer state of mental health is associated with greater socioeconomic disadvantage for the majority of indicators. Children and young people living in more deprived areas are also more likely to be affected by poor mental health than those living in less deprived areas.

Eisenstadt finds:

> *"Young people from the most deprived areas are also more likely to experience fragmented post-school transitions than those from the least deprived areas: they are less likely to stay on at school, and more likely to experience multiple post-school transitions, to be unemployed when they leave school, or to move into a short-term training programme."*

Young people from the most deprived areas, as with those from a looked after background, are more likely to go on to study at college and less likely to go on to university than those from the least deprived areas.

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[170] Scottish Government (2017) The Poverty and Inequality Commission
[171] Scottish Government (2017) Independent Advisor on Poverty and Inequality, The Life Chances of Young People in Scotland, A Report to the First Minister

Physical health is affected as well, with rates of regular smoking significantly higher amongst young adults living in the most deprived areas compared to the least deprived areas, with 10% of 15 years olds in the most deprived SIMD quintile smoking regularly, compared to 5% in the least deprived quintile in 2015.

In a Joseph Rowntree Foundation study[172], Paul Bywaters (et al) finds a similar link between being looked after and poor socioeconomic outcomes:

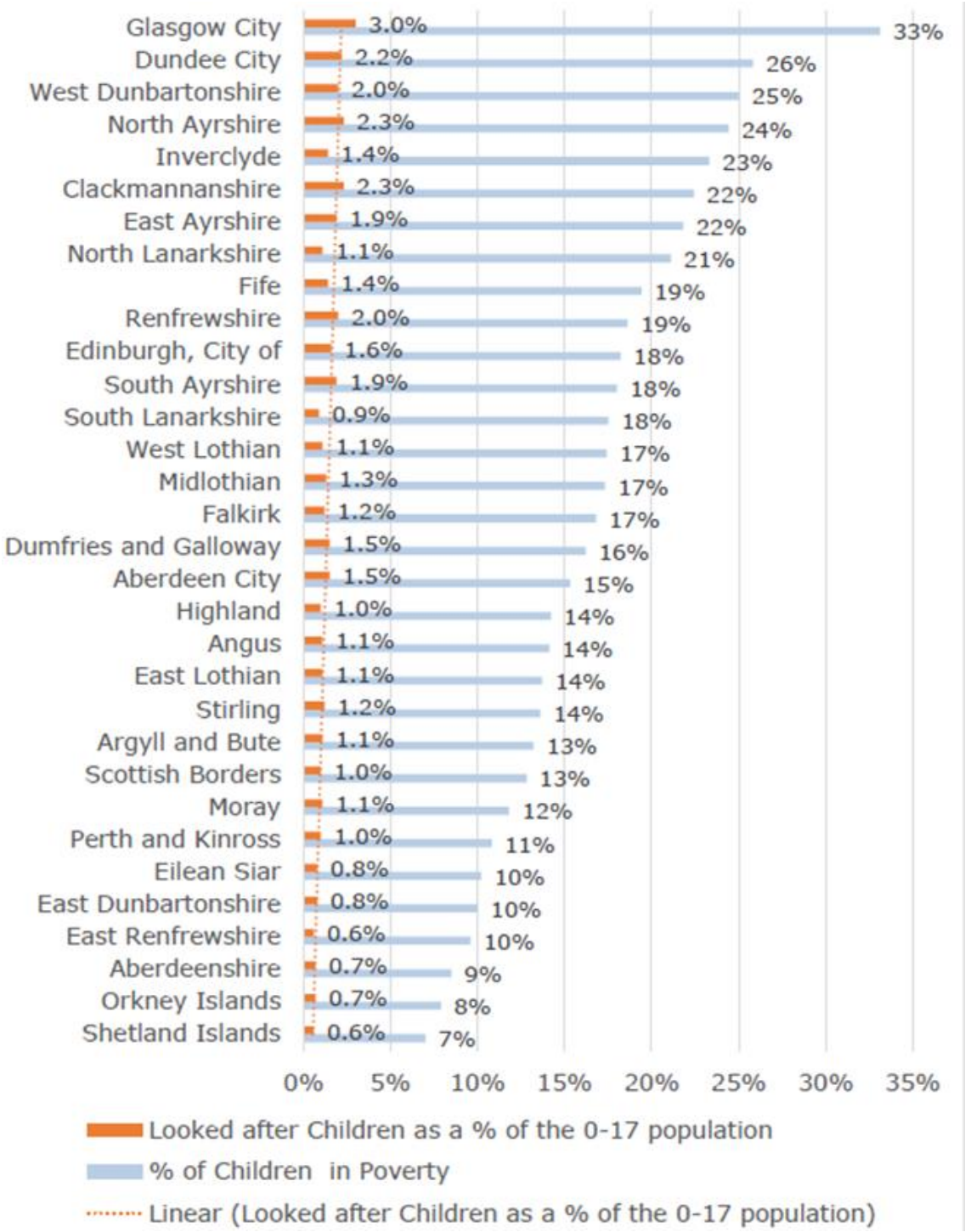
> *"Studies provide evidence that being looked after as a child has a sustained impact on a number of socio-economic outcomes including: reduced income, lower socio-economic status, reduced educational attainment, increased homelessness and unemployment. However, it is not possible from these studies to disentangle the effects of maltreatment from the effects of being looked after."*

Chart 20 below shows a potential link between the percentage of children in poverty and the percentage of the population of 0-17 year olds who are looked after. More research at the level of postcode SIMD status within local authorities could potentially be stronger, but within local authorities the range of SIMD profiles makes it difficult to establish a link to the number of looked after children at this level of resolution.

These findings will be expanded on, with direct reference to the outcomes for looked after children and young people, in the "Outcomes" section of this paper.

[172] Joseph Rowntree Foundation (2016) The Relationship Between Poverty, Child Abuse and Neglect: An Evidence Review; The impact of child abuse and neglect on adult poverty

Chart 20: % of Children in Poverty compared to % of LAC, by Local Authority Area 2016-17 as of31st July 2017[173][174]



[173] Scottish Government (2012) Local authority Level Child Poverty data from HMRC
[174] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018; Table 3.1: Children starting and ceasing to be looked after, by local authority, 2016-17

Age of Children and Young People Becoming 'Looked After'

Children and young people enter the Scottish 'care system' at all ages. In 2017, 39% (1619) were under aged 0 – 4; 31% (1287) were aged 5 – 11; 28% (1,191) were aged 12 -15. Only a very small number became looked after aged 16 or over. (Please note that these numbers may count the same child twice, as they may have more than one 'care episode' in a year.)

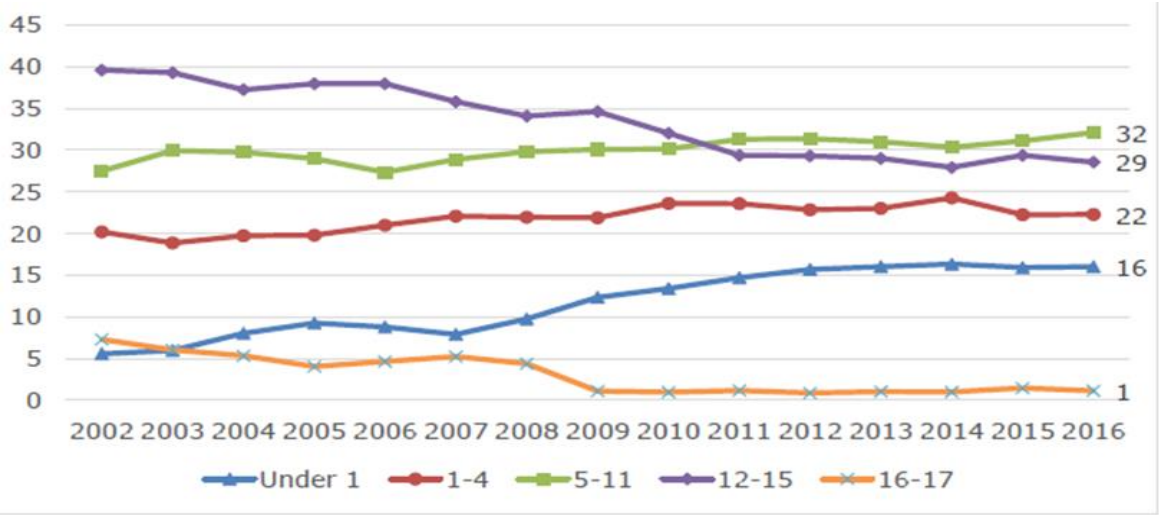
Table 9: Children starting to be looked after, by age proportion, 2013-2017[175]

	2013	2014	2015	2016	2017
Under 1	16	16	16	16	15.5
1-4	23	24	22	22	23
5-11	31	30	31	32	31
12-15	29	28	29	29	28.5
16-17	1	1	1	1	2
18-21	0	0	0	0	0
Not known	0	0	0	0	0
Total	**100**	**100**	**100**	**100**	**100**

As table 9 above shows, over recent years the ages at which children 'start' tobe looked after has changed relatively little. But if the timeline is extended further, there have been some interesting shifts.

[175] Scottish Government (2018) Children's Social Work Statistics Additional Tables 2016-17; Table 2.1: Number of children looked after by age and gender, 2002-2017(1),(2)

Chart 21: Percentage of Children starting to be looked after in different age groups, 2002 - 2017[176]



The main point of interest is the rise in infants (under 1) becoming looked after, showing an increase of 57% over this timeframe (from 183 in 2002, to 409 in 2017). Children between the age of 1-4 and 5-11 both show an increase of 33%; from 1,768 and 3,781, and 2,503 and 5,551, respectively.

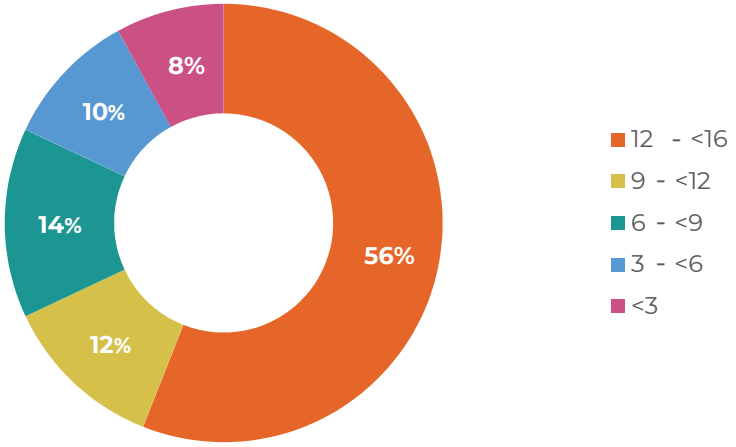
Certain factors are worth bearing in mind when considering children's care pathways, and the age (and reason) at which they come into care. For example, with no child beneath the age of 12 able to be prosecuted for an offence (due to legal convention, the minimum age of criminal responsibility being 8)[177], it follows that the 12 – 15 year old age bracket should see an increase in the proportion of the general population coming into care, as some children may be coming into care on offence grounds.

Chart 22 below describes at what point children and young people became involved in the Children's Hearings System. It shows that over half of children and young people (63, 56%) were aged between 12 and 15 when they were first subject to a compulsory supervision order (CSO). Of the 105

[176] Ibid.
[177] Scottish Government (2017) A Nation With Ambition: The Government's Programme for Scotland 2017-18

young people who took part in the study reflected in the Chart 22, 20 (18%) of them had been on CSOs for at least 10 years at the time of their Hearing.

Chart 22: 16-17 year olds, and age comparison when Compulsory Supervision Order first made[178]



Length of Time Children and Young People are 'Looked After'

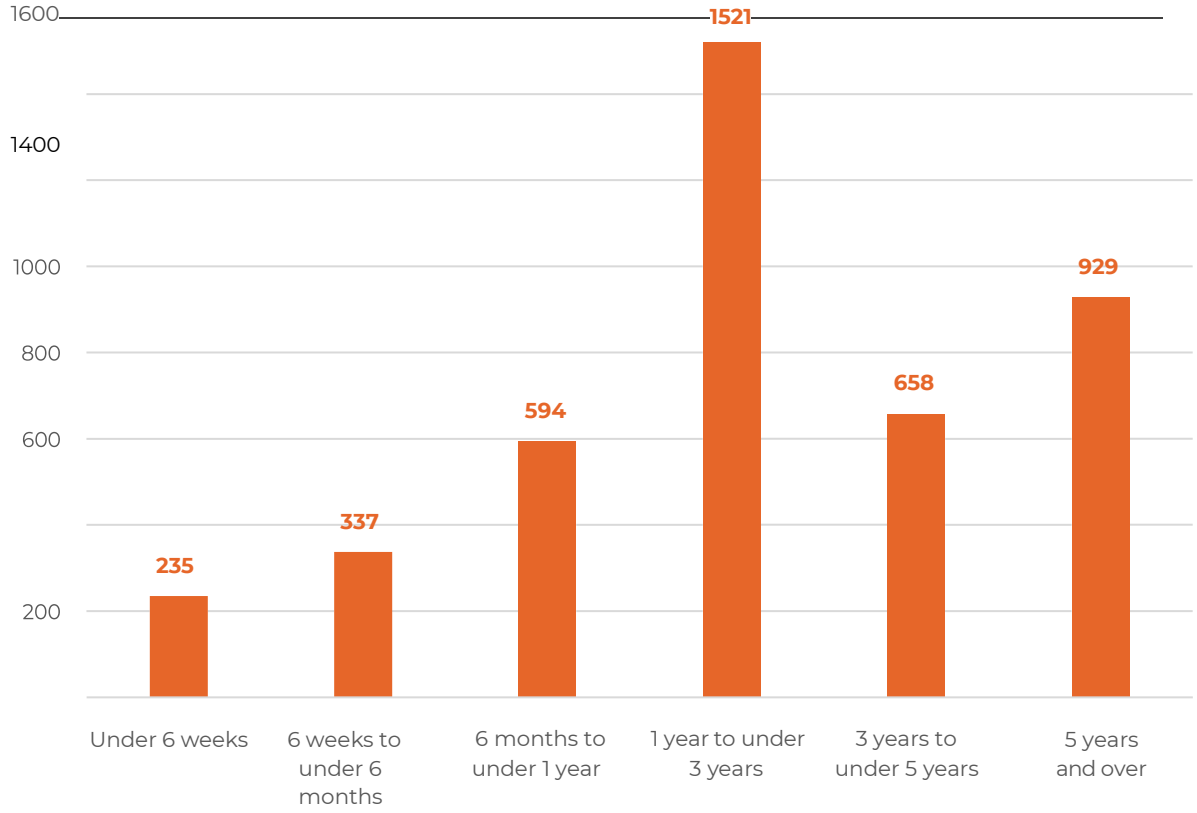
Charts 23 and 24 below provide an illustration of the length of time a child or young person remains 'looked after'. The data shows that, in general, the time a child or young person is 'looked after' has remained fairly consistent over recent years, with a significant majority in care for 0 – 3 years. Over a third were in care for between 1 – 2 years. This suggest that, for most children, care is a relatively medium-term intervention (i.e. a period of their life lasting under 3 years); albeit some may cease to be looked after due to adoption or residence orders. However, it is also true the number of children and young people being looked after for five years or more has been increasing steadily, rising from 674 in 2012, to 752 in 2016. One reason for this may be the introduction of Permanence Orders, which secure a child in their placement until adulthood, but which do not remove a child's looked after status. It is also likely to be an effect of children becoming

[178] Scottish Children's Reporters Administration (2016) 16 and 17 year olds in the Children's Hearings System; Figure 1. Age when CSO first made

looked after at younger ages, as if a child becomes looked over after the age of 11 they cannot be statutorily looked after for 5 years – most ceasing to be looked after at 16.

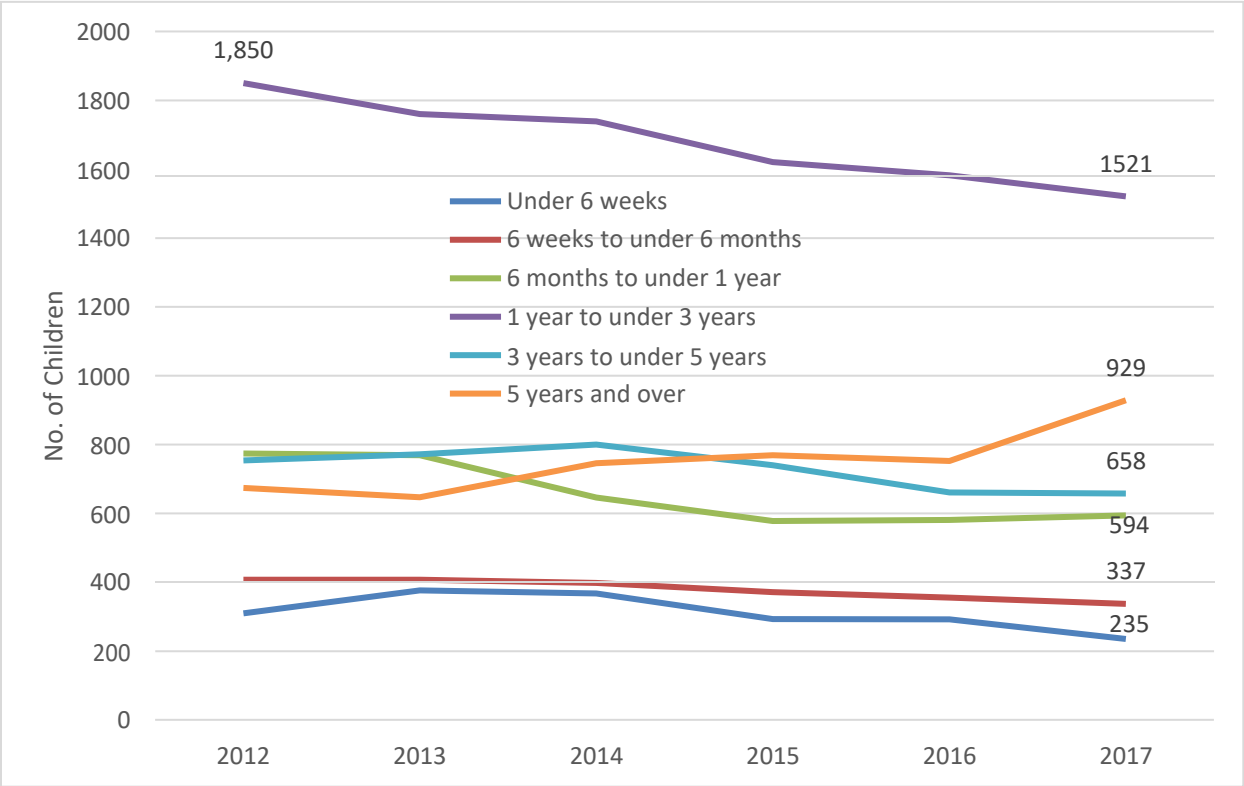
(Please note that this data does only relate to children and young people who ceased to be looked after in 2016-17; children who remained in care throughout the year are not counted.

Chart 23: No. of children ceasing to be looked after by length of time looked after, 2017[179]



[179] Scottish Government (2018) Children's Social Work Statistics Scotland 2016/17, Table 1.4: Number of children ceasing to be looked after by length of time looked after and age, 2003-2017

Chart 24: No. of children ceasing to be looked after by length of time looked after (2012-2017)[180]



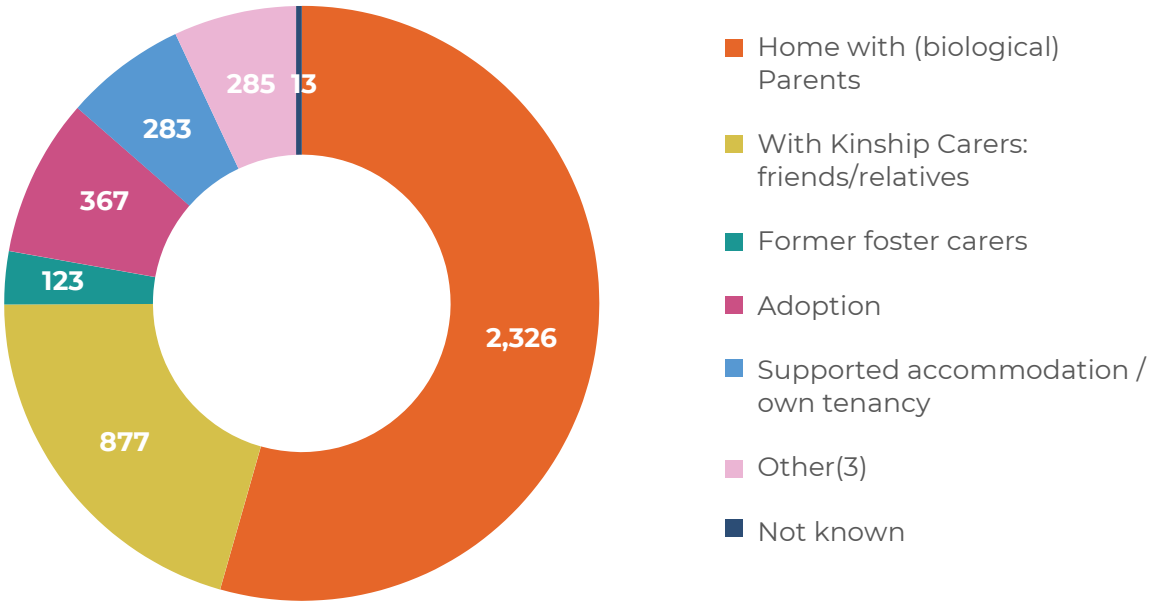
The length of time children remain in care is important because it provides an indicator of how 'care' is used, and should therefore inform how services are designed and delivered. For example, in 2016-17 only a small proportion (572) of children ceased to be looked after less than six months after their care episode began, in contrast to the 1,521 children who had remained in care for a year or two. Combining this with knowledge that the majority of looked after children leave care to return to their parents, this may suggest that attention should be focused on ensuring parents receive the support they need in order safeguard and promote the wellbeing of the child when they cease to be looked after.

[180] Scottish Government (2018) Children's Social Work Statistics Scotland 2015/16;, Table 1.4: Number of children ceasing to be looked after by length of time looked after and age, 2003-2016

Destinations on Leaving Care

In 2016-17, of those children and young people who ceased to be looked after, 54% (2,326) returned home to live with biological parents. This is across all age ranges, and includes young children who are being rehabilitated with their families (and may be subject to alternative care and protection arrangements in the future), and older children who may be leaving care permanently, as 'care leavers'.

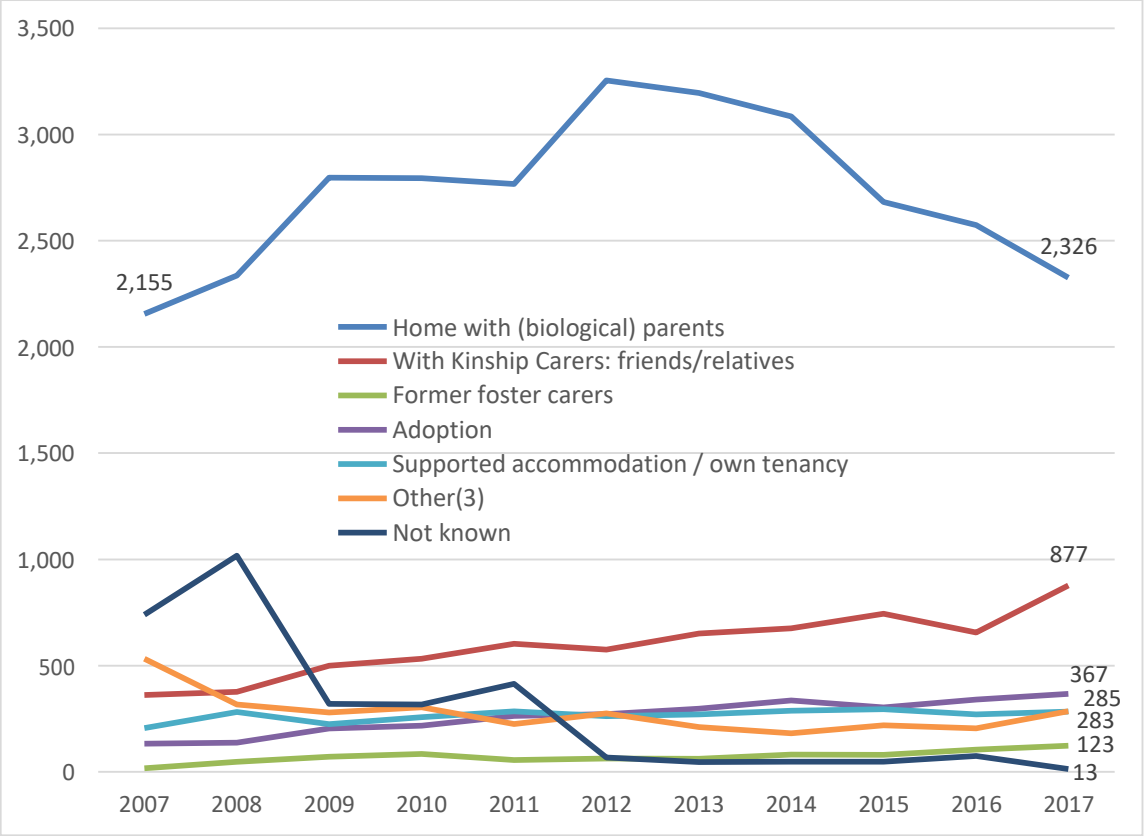
Chart 25: Number of children ceasing to be looked after, by destination, 2017[181]



As chart 26 below shows, while there has been some variance in the total numbers over recent years, overall the proportions have remained relatively constant, and 'returning home to parents' is consistently the most common destination over the last 10 year period.

[181] Scottish Government (2018) Children's Social Work Statistics Scotland 2016/17;, Table 1.5: Number of children ceasing to be looked after, by destination, 2002-2017

Chart 26: Number of children ceasing to be looked after, by destination, 2007-2017[182]



Brothers and sisters (Sibling) Contact

Sourcing accurate information in relation to sibling contact can be difficult; however, there are some academic studies and international research which can be referred to as an introduction to the issue.

A study between the SCRA and the University of Strathclyde[183] found that:

> *"Sibling networks of looked-after and accommodated children can be large, diverse in age and spread over multiple households and care types (kinship, foster, residential care and adoption). This creates challenges in terms of supporting sibling relationships."*

[182] Scottish Government (2018) Children's Social Work Statistics Scotland 2016/17;, Table 1.5: Number of children ceasing to be looked after, by destination, 2002-2017
[183] University of Strathclyde, School of Social Work (2017) Supporting Sibling Relationships of Children in Permanent Fostering and Adoptive Families;

> *"Children who were accommodated and subsequently placed permanently away from their birth parents experienced a high degree of estrangement from siblings. 58% of these children had biological siblings who were 'stranger' siblings and 68% of children were living apart from at least one of their 'familiar' biological siblings."*

Attachment, defined as a "deep and enduring emotional bond that connects one person to another across time and space"[184] is said to be critical to a child's personal development, and, if a sibling – or any other care-giver – has been removed from that child's life, then it can have a damaging impact on their personal development. Children in care generally want to be placed together with their siblings, and when this is not possible, they want frequent contact and information about their siblings[185].

The Government of South Australia held an inquiry in order to find out more about sibling contact for looked after children. Their "Report on the inquiry into what children say about contact with their siblings and the impact sibling contact has on wellbeing" (2011)[186] delved into the issue in some depth, finding that:

- In 48 cases (of the 66 they investigated) there was no documented information that sibling separation was in the best interests of the child or young person.
- In 16 cases there was no explanation for the separation of siblings.

In 45% of the cases, the child or young person's views about residing with their siblings was documented in the preceding 12 months. The child or young person's views would not have been available in 15% of cases due

[184] John Bowlby (1969) From Psychoanalysis to Ethology: Unraveling the Roots of Attachment Theory
[185] Herrick, M. A., & Piccus, W. (2005). Sibling connections: The importance of nurturing sibling bonds in the foster care system. Children and Youth Services Review, 27(7), 845-861
[186] Australian Government (2011) Report on the Inquiry into what Children say about Contact with their Siblings and the Impact Sibling Contact has on Wellbeing;

to the child's age and/or capacity to contribute their views. Therefore, 40 per cent of files did not document the child or young person's views in the preceding 12 months where the child or young person was capable of doing so.

This mirrors the findings of the SCRA and University of Strathclyde study[187] which found that "Children's contact arrangements and wishes in this regard were frequently not recorded as part of the hearing process or recorded in piecemeal fashion throughout a child's file".

Often, the reasons for separation of siblings are justified as in the 'best interests' of the child. For example, a child or young person may express a strong view during a Children's Hearing that they do not want to live with their sibling orthey may be at risk of abuse from the sibling (however it is important to note thatthis equates to a small number of child protection cases).

It may also be the case that carers and resources do not have the capacity to accommodate large sibling groups.

[187] University of Strathclyde, School of Social Work (2017) Supporting Sibling Relationships of Children in Permanent Fostering and Adoptive Families;

7. Outcomes for looked after children

Education & Post-School Destinations

Outcomes data for care leavers in Scotland is limited, with the Education Outcomes for Looked After Children report, published annually by the Scottish Government[188], providing the majority of data.

Chart 28 below shows that, in the year 2016-17, 72% (362) of looked after children left school aged 16 or under, compared to 28% (14,526) of their non- looked after peers. Only 5% (25) of looked after children left school at age 18 or over, compared to 26% (13,395) of all school leavers.

Chart 28: School Leavers' ages - 2016/17[189]

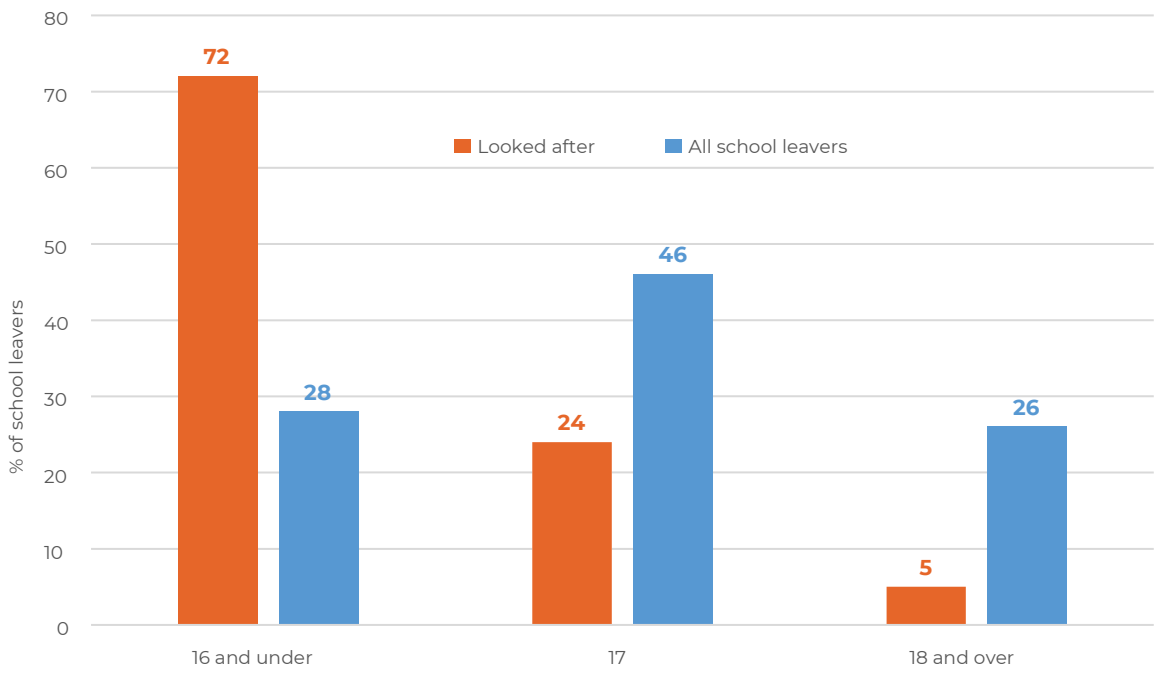
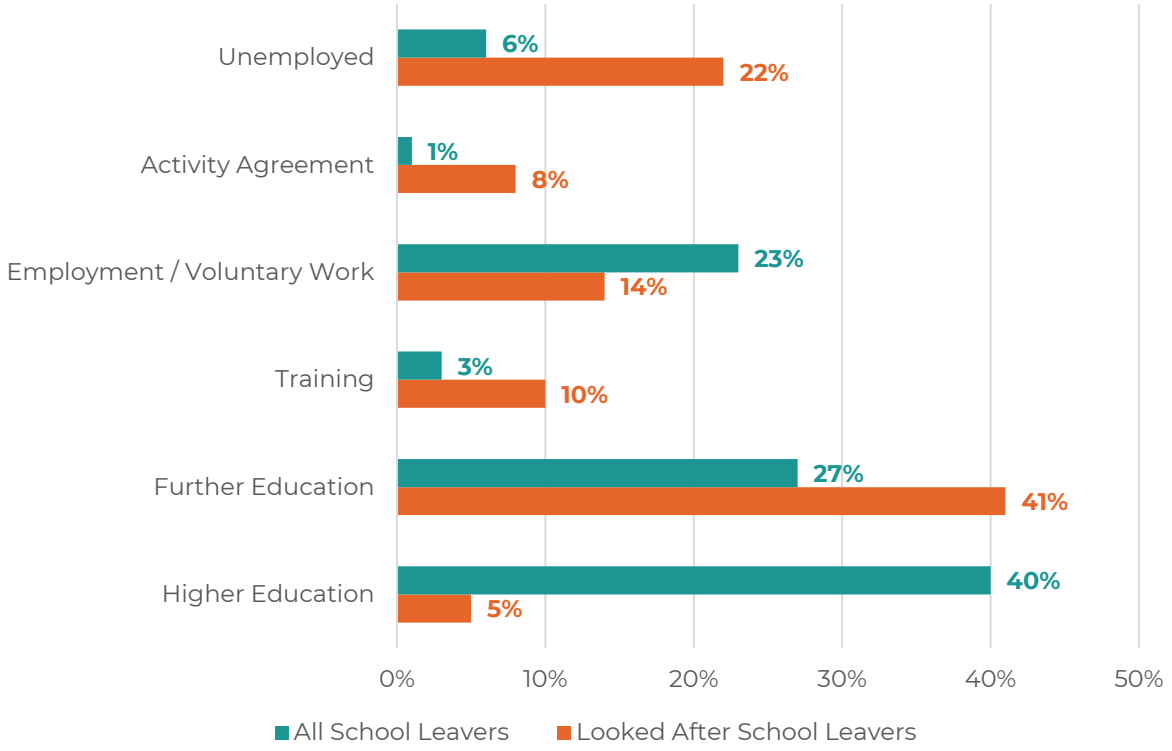


Chart 29 and 30 show that attainment levels remain lower than the national average; contributed to by the fact that looked after children tend to leave school earlier than their peers (thereby restricting the level of qualifications they can attain). This may also explain why, of those looked after children who left school in 2016-17, only 6% went directly into higher

[188] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;
[189] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;_Chart 1: Age of all school leavers and those who were looked after 2009/10-2016/17(1)

education, compared to the national average of 41% of school leavers. 23% of all school leavers are recorded as entering employment or voluntary work upon leaving school, compared to just 19% of looked after school leavers.

Chart 29: % of school leavers by initial destination, comparing all school leavers with those who were looked after, 2016/17[190]



It is likely that these educational outcomes are affected by the higher rates of school exclusions experienced by looked after children (shown in Chart 32 below), as compared to the average pupil: 169 cases per 1,000 looked after pupils, compared to 27 per 1,000 in the general school population. The relevant Scottish Government statistical publication explicitly highlights a link between exclusion and lack of educational attainment, showing that only 5.7% of pupils who had been excluded in 2015/16 went

[190] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;, Table 2.1: Percentage of school leavers by initial destination, for all school leavers and those who were looked after children, 2009/10 - 2016/17

on to achieve Level 6 or above in terms of qualifications, whereas 57.7% of pupils who had no exclusions, achieved Level 6 or above[191].

The data available also suggests a correlation between care placement type and educational attainment, shown in Chart 30. For example, foster care is associated with higher educational attainment levels, with 94% of looked after children in foster care going on to achieve SCQF level 4 or better, compared to 51% of children looked after at home. Indeed, 33% of children looked after at home go on to leave school with no qualifications at Level 3 or higher.

[191] Scottish Government (2017) Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions;, Section 5 - The Impact of Exclusion on Children and Young People- Included, Engaged and Involved

Chart 30: Highest level of attainment of looked after school leavers, by placement type, 2016-17[192]

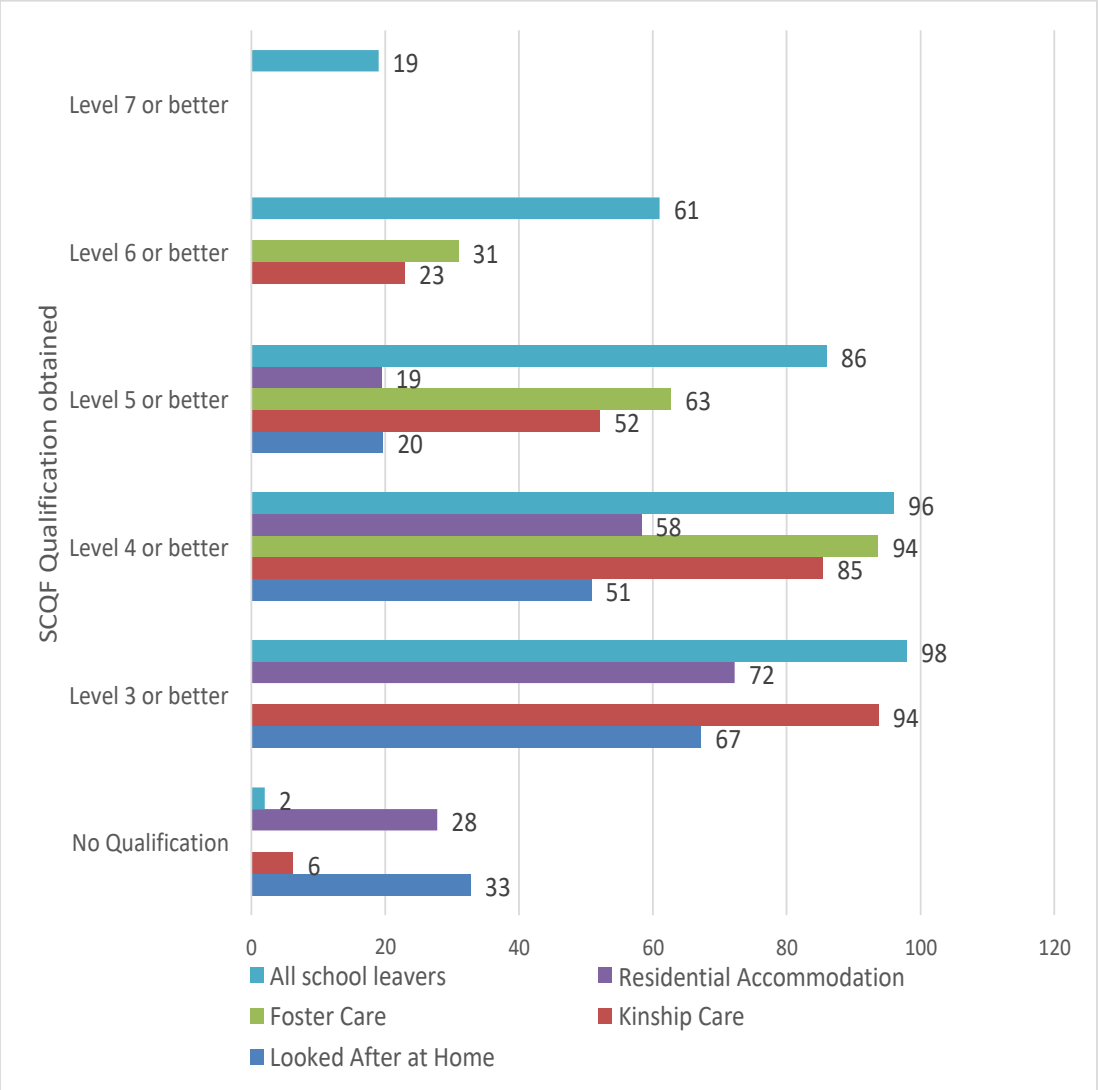


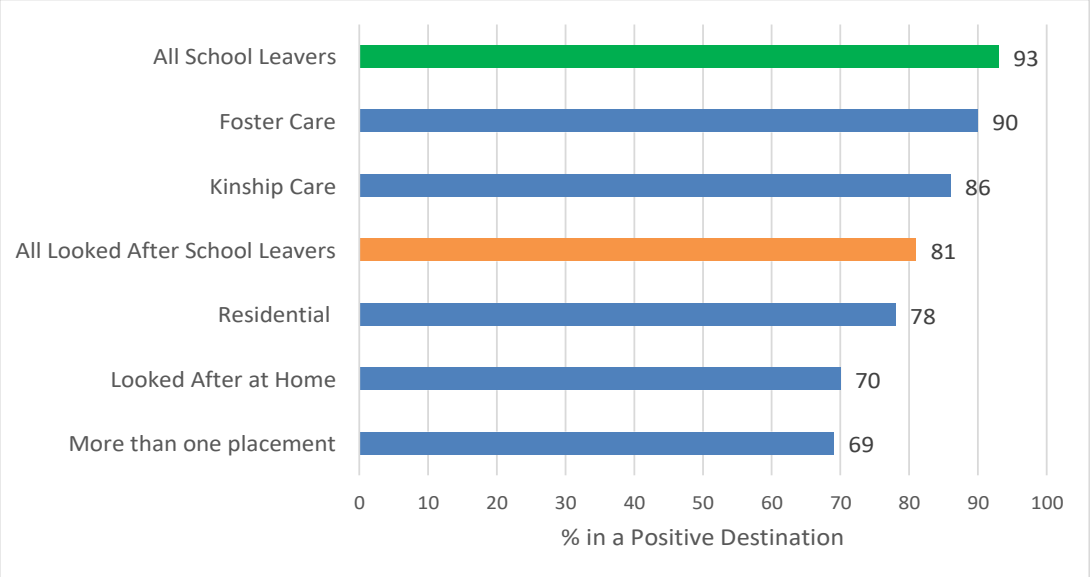
Chart 31 below shows that 70% (61) of looked after at home school leavers went onto a 'positive destination', compared to 90% (126) of school leavers from a foster care placement. A positive destination is defined as education, training or employment. (Please treat such conclusions with caution though, as the numbers on which they are based are small, and subject to revision in future years.)

[192] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;, Table 1.2: Highest level of attainment of school leavers looked after for the full year, by placement type, 2016/17l

Table 10: Percentage of Primary 1, Primary 4, Primary 7 and Secondary 3 children looked after for the full year, achieving the Curriculum for Excellence (CfE) level relevant to their stage, by number of looked after placements they experienced in 2016-17[193]

	Reading	Writing	Listening & Talking	Numeracy
1 placement	56.3	50.1	63.7	52.8
2 placements	50.0	48.1	59.4	46.5
3 placements	48.1	48.7	62.0	40.5
4 or more placements	48.0	48.0	60.0	53.9
All looked after for entire school year	**55.0**	**49.7**	**63**	**51.4**

Chart 31: Positive initial destinations among looked after school leavers with one placement, by placement type, 2016-17[194][195]



[193] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;, Percentage of Primary 1, Primary 4, Primary 7 and Secondary 3 children achieving the CfE level relevant to their stage(1), by accommodation type, 2016/17; Table 5.3 Looked after for the full year
[194] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;, Table 2.3: Positive initial and follow-up destinations among looked after school leavers with one placement, by placement type, 2016/17
[195] Scottish Government (2017) leavers

Chart 32: Exclusion rate per 1,000 pupils by all pupils, looked after children, 2009-10 to 2016-17[196]

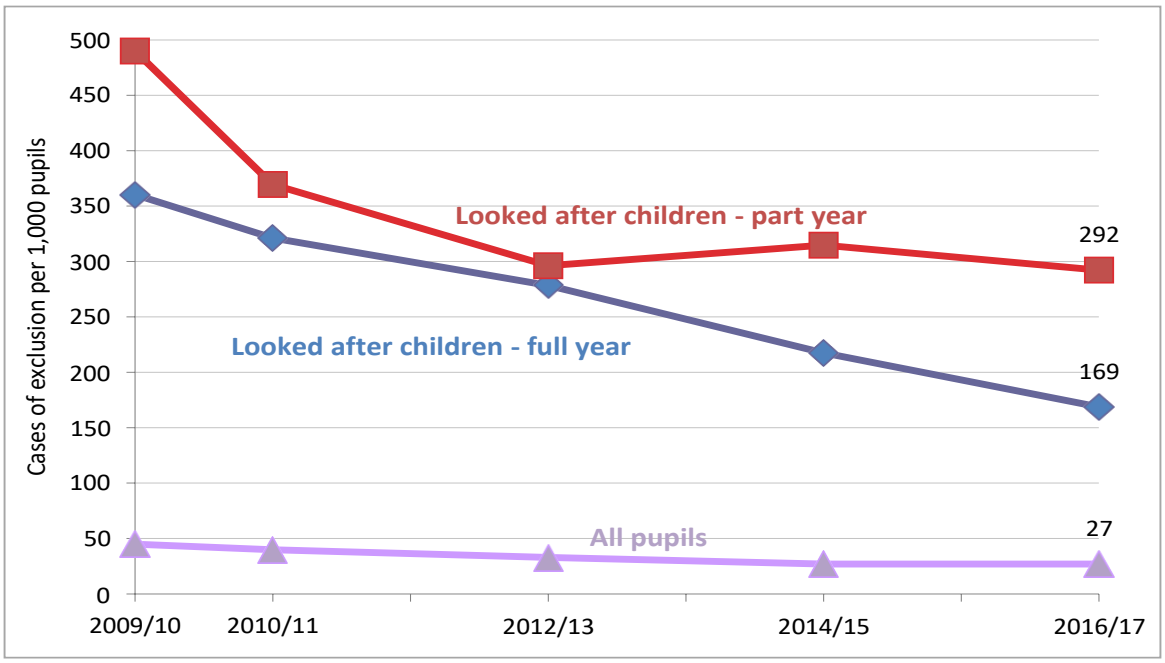
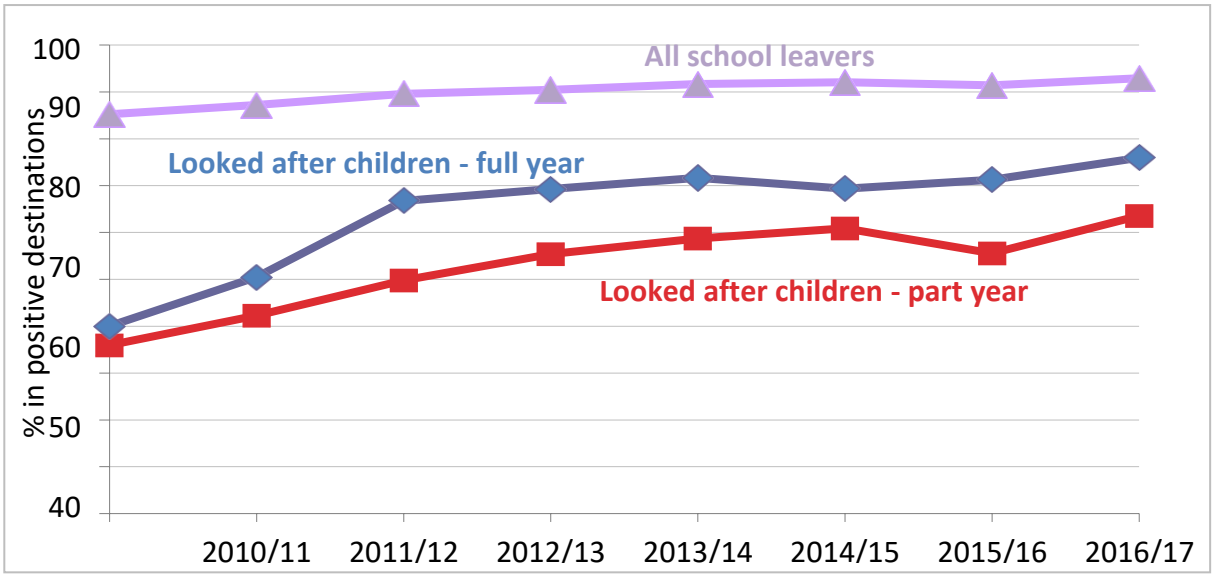


Chart 33: Looked after children in positive follow up destinations, 2009-10 to 2016-17[197]



[196] Scottish Government (2018) Education Outcomes for Looked After Children 2016/17;, Chart 5: Exclusion rate per 1,000 pupils by all pupils, looked after children, 2009/10 to 2016/17

[197] Scottish Government (2018) Education Outcomes for Looked After Children 2015/16; Chart 3: Looked after children in positive follow up destinations nine months after leaving school, 2009/10 to 2016/17

English data shows that over 10% (30,720) of looked after pupils (in England) had at least one school exclusion, compared to less than 2% of all children. The number of looked after children excluded goes up at secondary school stage, with 16% of English looked after children being excluded at least once[198].

Premature Death

Table 11: Causes of death of looked after children 2009 - 2011[199]

Cause of death	Numbers of children
Life limiting conditions	8
Other health (includes sudden death, complex health conditions, illness)	7
Suicide	5
Accidental death	5
Murder	1
Drug/alcohol related	3
Unknown/unascertained	1

Table 11 details the causes of death of the 30 looked after children in Scotland who died between 2009 and 2011. The data, published by the Care Inspectorate, identified health conditions as the main causes of death. (Some children become looked after due to health conditions.)

Completed suicides and accidents each accounted for five deaths of children and young people and three children and young people died from substance misuse.

[198] UK Government (2017) Statistics on schools, post compulsory education, training, qualifications and spending; Table 6: Exclusions by type of school for children who have been looked after continuously for at least twelve months1,2, children in need and all children

[199] Care Inspectorate (2013) A report into the Deaths of Looked after Children in Scotland 2009-2011 Table from Care Inspectorate report: Causes of death of looked after children 2009 - 2011

Homelessness

Chart 34: No. of homeless applicants formerly looked after by the LA in Scotland, 2007-08 to 2016-17

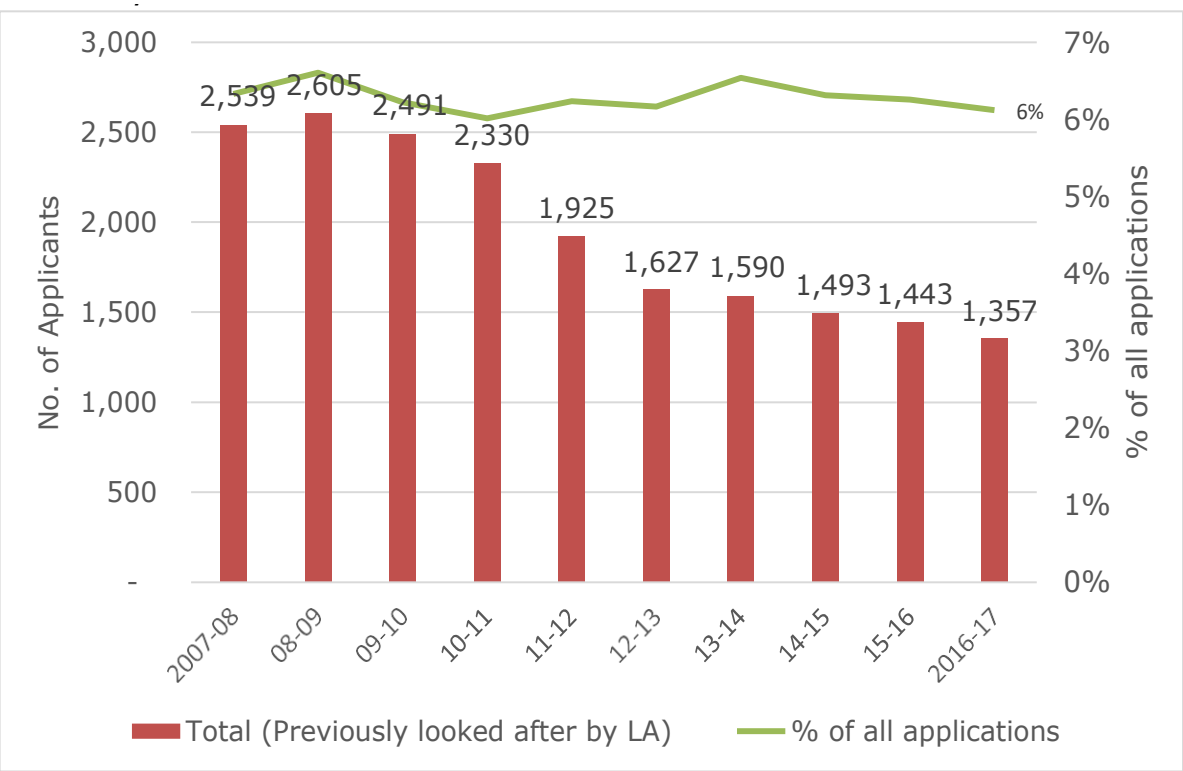
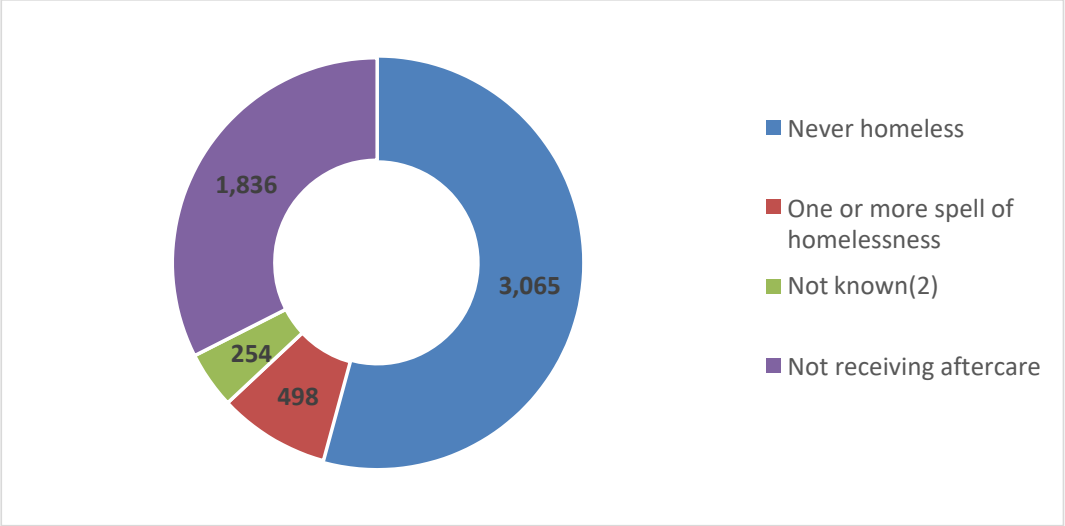


Chart 35: Young people eligible for aftercare services - episodes of homelessness since becoming eligible for aftercare services, 31st July 2017[200]



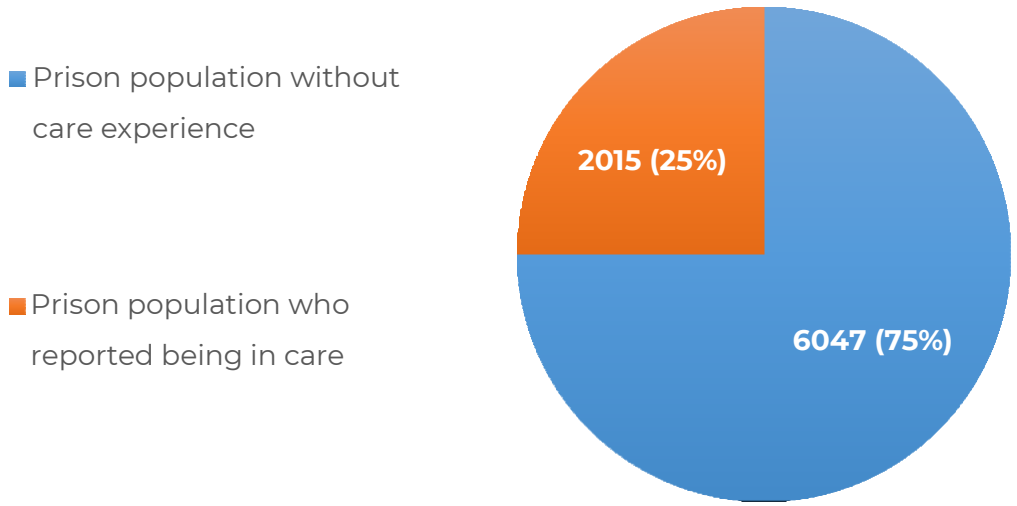
Link between Care Experience and Prison

The link between care and prison is often cited in the media, but robust data on the relationship is limited. The proportional figure, shown in Chart 36 below, refers to a joint analysis of data by the Scottish Centre for Crime and Justice Research and the University of Glasgow. The study cites figures from the Prison Reform Trust, showing that 25% (2015) of prisoners reported that they had been in care at one point. This differs slightly from reports by the Scottish Prisons Trust in 2015[201], who recorded 31% of adult prisoners as having been in care. In addition, of the 327 young men under 21 in HMYOI Polmont who responded to the Scottish Prison Service's Prisoner Survey, a third (33%) reported being in care at some point in their childhood, and a quarter reported being in care at the age of 16.[202]

[200] Scottish Government (2018) Children's Social Work Statistics Additional Tables - amended June 2018;, Table 1.19: Young people eligible for aftercare services on 31 July 2017(1) - episodes of homelessness since becoming eligible for aftercare services
[201] Scottish Prison Service (2015): Prisoners Survey 2015 - Young People in Custody
[202] Centre for Youth and Criminal Justice (2017) Children and Young People in Scotland: Looking Behind the Data;

While such statistics are demanding attention, it is important to bear in mind how such information is collected. Data in relation to prisoner's care experience is often collected via a survey, where each individual is asked whether they have been 'looked after' or not. There is not always explanation or background given alongside this question, leaving latitude for error.

Chart 36: Proportion of Prison Population with care experience, 2015 (from total of 8,062)[203]



However, research studies provide a check on national survey figures, and broadly the numbers found are consistent. In a recent study of 103 young offenders at HMYOI Polmont (Cesaroni, 2017), three out of every five young people who were interviewed indicated that their family had been involved with the Children's Hearings system and one third (33%) reported being removed from their family and placed in supported accommodation.

Measuring Happiness

Measuring the 'happiness' (general wellbeing) of any group is a complex task, requiring consideration of a number of subjective factors. But, in the

[203] University of Glasgow and Scottish Centre for Crime & Justice Research (2015) Who's in Prison: a Snapshot of Scotland's Prison Population 1.2.1 Care experience and contact with Children's Hearings System

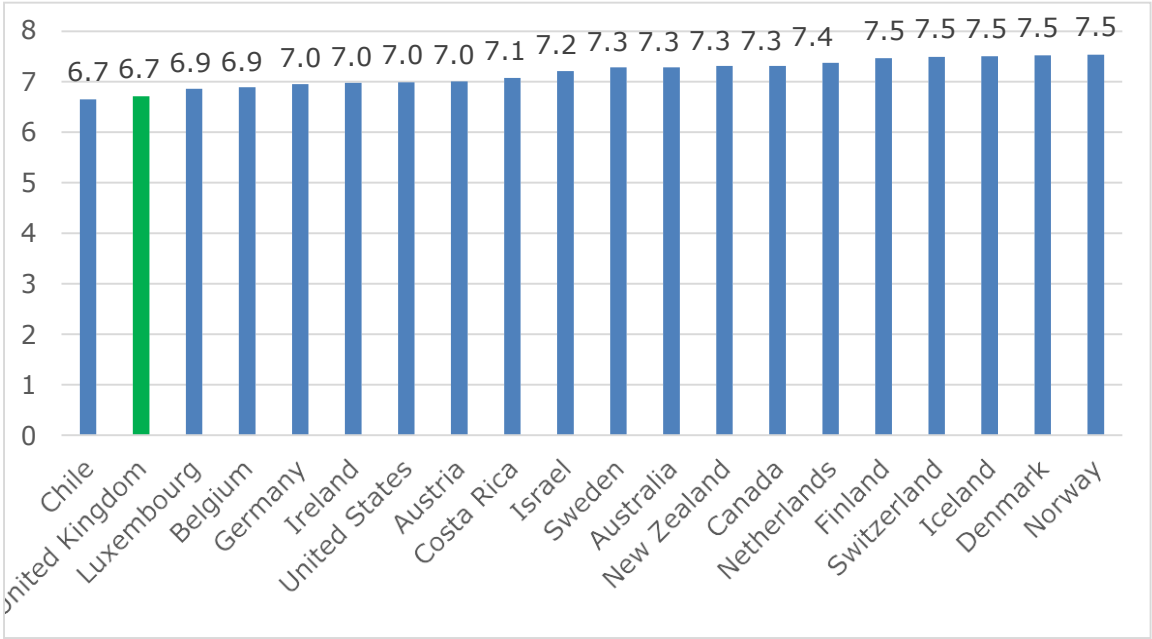
wake of growing inequality[204] in many countries, and in trying to gain more nuanced understanding of systems such as children's 'care', organisations have been exploring new measures, which can provide a picture of how individuals and groups are feeling about their lives. The head of the UN Development Program, amongst others, has spoken up against what she called the "tyranny of GDP"[205], (alongside which could be sat a range of other 'output' measures), arguing that "paying more attention to happiness should be part of our efforts [...]."

The World Happiness Report is a measure of happiness, published annually by the United Nations Sustainable Development Solutions Network. The World Happiness Report asks people to evaluate the quality of their current lives on a scale of 0 to 10 for each country, averaged over the years 2014-2016. Key factors include economic variables (such as income and employment), social factors (such as education and family life), and health (mental and physical). These countries are surveyed on GDP per capita, social support, healthy life expectancy, social freedom, generosity, and absence of corruption.

Within this report, in the three Western societies (United States, Britain and Australia), mental illness was identified as more important than income, employment or physical illness in determining 'happiness'. In every country, physical health was found to be important, yet in no country is it more important than mental health. The study also finds that key factors for the future adult are the mental health of the mother and the social ambiance of primary and secondary school[206].

[204] Oxfam An Economy For the 1%: How privilege and Power in the Economy Drive Extreme Inequality and How This can be Stopped
[205] World Happiness Report (2017) World Happiness Report (2017), Chapter 1: Overview (John F. Helliwell, Richard Layard, and Jeffrey D. Sachs)
[206] World Happiness Report (2017) World Happiness Report (2017), Chapter 5: The Key Determinants of Happiness and Misery (Andrew Clark, Sarah Flèche, Richard Layard, Nattavudh Powdthavee, and George Ward)

Chart 37: Top 20 'Happy' Countries, compared with happiness explanation variance[207]



The Happiness Report's calculations are illustrative rather than conclusive. But even within their significant limitations, their strength is to shift the debate from measuring the performance of a system to its impact on the people the system exists for. To give a very simplistic example, if most people in a country are rich but also unhappy, should it be considered that the system(s) are working well? Looked after children data is not only limited, what we do have is focused overwhelmingly on measuring inputs and outputs, not experience or wellbeing.

The Scottish Government aims to capture data on health and wellbeing indicators as part of their realigning children's services programme. The Government has developed entirely new surveys to capture this data, which includes surveying children and young people directly using questions such as "How often do you feel you have a good life?" and "How

[207] World Happiness Report (2017) World Happiness Report (2017), Figure 2.2: Ranking of Happiness 2014-2016

often do you feel happy?"[208]. This development may lead to a broader, more holistic data set for children in the future.

[208]Scottish Government (2017) Children's Wellbeing Surveys;

8. Data gaps

This paper has presented some of the existing data that exists for looked after children, young people and care leavers in Scotland. However, it is not an exhaustive and completely comprehensive review; instead it focuses on areas which the Care Review has expressed an interest in, and for which there is reliable data.

Moreover, very significant gaps in the data remain. We cannot say, for example, how many care experienced people there are in Scotland, or how many care experienced young people are currently at university.

The current data sets, and the lack of linkage between them, also make it very difficult to map children's 'care journeys'. Information is available on how many children's panel hearings there were in a year; how many children and young people have had two placements or more; and, how long children had been in care at the time of leaving. But, at present, it is not possible to draw out the care journeys of individual children. The information exists within systems, but without effort (involving much technical work), it remains fragmented. For example, the information from SCRA and local authorities is not currently linked, precluding a wide range of analyses around the operation of the Children's Hearings system and the implementation of Compulsory Supervision Orders. Nor is looked after child information linked to UK or Scotland-wide administrative data sets, which would allow journeys to be mapped pre and post care. No such linkage is simple, and many practical and ethical considerations would need to beworked through, but if the resources and willing are available, Scotland would be able to say much more about the drivers into, experiences within, and outcomes of, its 'care system' for infants, children and young people and their families .

There also continue to be issues with data quality in some areas, with discrepancies between data providers over definitions and local practice. Opportunities exist to build capacity in local authorities and other potential data providers, improving the quality and consistency of the available information.

It should be recognised too that most of the available data only shows a 'snapshot' of the 'care system', a picture taken on a specific date (in most instances, 31 July). Indeed, the Scottish Government itself has identified a large number of gaps in the data which are either outwith their ability to collect or are more appropriately measured by in-depth qualitative studies[209]. They have presented these gaps as questions, which include:

- What are children's situations prior to becoming looked after?
- How suitable are placement types for children?
- Are placement endings planned?
- Why do children choose to stay in their care settings?
- What impact does the extension of aftercare have on young people?

Additional gaps/areas in need of further development of data collection and reporting include:

- Domestic violence
- Intergenerational and recurrent cycles of care
- Homelessness and direct links to leaving care
- Involvement in youth justice
- LGBT and other protected characteristics
- Care placement moves
- Effective understanding of outcomes
- Poverty

[209] Scottish Government (2015) Looked After Children Data Strategy

9. Appendices

Appendix A: Glossary of terms

Term or Phrase	Explanation
Adoption / adopted	Process by which all parental responsibilities for a child are transferred to an individual(s), by means of an Adoption Order.
Asylum Seeker	An asylum seeker is a person who says that he or she is a refugee but whose claim for refugee status under the UN Refugee Convention to a state that has signed that Convention has not yet been definitively settled.
Care experienced	This term has no basis in legislation or statutory guidance. Therefore no fixed, universal definition is available. In general, the term is used to describe persons who are, or have been at any time, 'looked after' by a local authority. To manage eligibility for support, individual organisations have chosen to develop their own definitions. For example, the University of Strathclyde, uses the following definition of 'care experienced': • Currently a 'looked after' child or young person; • Currently or were a UK 'care leaver', (i.e. eligible for aftercare support from a UK local authority); • Were looked after by a UK local authority for three months or more during the years of compulsory school education (5-15 years old).
Care leaver	A person who 'ceased to be looked after' on or after their 16th birthday, but who has not yet reached their 26th birthday. (This includes persons who were 'looked after at home' and 'looked after away from home'. All 'care leavers' are, subject to anassessment, eligible to 'aftercare' support from their local authority. Corporate Parenting duties (Part 9 of Children and Young People (Scot.) Act 2014) apply toall care leavers.
"in care"	Where the child is currently 'looked after' by a local authority. (For further information, please refer to main text of briefing above.)

Term or Phrase	Explanation
Corporate Parent	An organisation or individual listed, or within a description listed, of schedule 4 of the Children and Young People (Scotland) Act 2014. These organisations and individuals are subject to all the duties set out in Part 9 of the 2014 Act.
Kinship Care	Term used to describe a child who lives with, and is cared for by, a relative or friend of the family. However, the term is frequently used to describe three similar but legally distinct groups: a) *Formal kinship care*, where the child is 'looked after', and so living with relatives or friends under the supervision of a local authority. b) *Informal kinship care*, where the child is living with relatives or friends on the basis of a private agreement with the child's parents, and is not 'looked after' by a local authority. c) *Subject to a section 11 order* (referred to as a 'residence' or 'Kinship Care Order'), where the child lives with relatives or friends to whom certain parental responsibilities have been transferred by a Court. These children are not 'looked after' by a local authority, but may be eligible for a range of support from publicly funded organisations.
Kinship Care Order	A legal order, made by a Court under section 11 of the of the Children (Scotland) Act 1995; this transfers certain parental responsibilities to a named individual(s). If the child's situation meets certain criteria (e.g. they were, or were at risk of, being 'looked after'), the section 11 order may be referred to as a Kinship Care Order. This entitles the child and carer, under Part 13 of the Children and Young People (Scotland) Act 2014) to support from their local authority. A child subject to a 'Kinship Care Order' (aka a 'section 11 order') is not 'looked after' by a local authority.

Term or Phrase	Explanation
Looked after child	A child to whom a local authority is providing a level of care and protection, as an outcome of either an agreement with the child's family, or a legal process (which transferred certain responsibilities for the child's welfare to the local authority). A child for whom a local authority has a duty to safeguard and promote their welfare and wellbeing (and which shall, in the exercise of their duties to him/her, be the local authorities' paramount concern); A child eligible to the support and assistance of all 'corporate parents', as appropriate to their function.
Looked after at home	The child is subject to a Compulsory Supervision Order (CSO) with "no condition of residence". The child lives with their parent(s), or other family member, under the supervision of the local authority. The child is 'looked after' by the local authority for the duration of the CSO.
Looked after away from home	The child is either: a) subject to a Compulsory Supervision Order with a condition of residence; b) provided with accommodation under section 25 of the 1995 Act; c) subject to a Permanence Order; or d) living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities. The child lives with carers 'away from' their parents or regular carers, under the supervision of the local authority, in kinship care, foster care or some form of residential care (including secure care).
Formerly/previously looked after	The child or young person who was, but is no longer, 'looked after' by a local authority. This could apply to a person of any age, including children who went on to be adopted, thosewho returned to the care of their parents after being accommodated elsewhere, care leavers, etc.

Term or Phrase	Explanation
Refugee	A refugee is someone whose individual application for asylum has been granted. They have been recognised as needing protection under the 1951 UN Refugee Convention
'Section 11 order' (also known as a 'Residence Order' or 'Kinship Care Order')	A legal order, made by a Court, under section 11 of the Children (Scotland) Act 1995. The order transfers parental responsibilities (including decisions over residence) to a named individual(s), such as a grandparent, aunt, etc. A child subject to a section 11 order is not 'looked after' by a local authority.

Appendix B: Grounds for referral to a Children's Hearing

Section 67 of the Children's Hearing (Scotland) Act 2011[210] sets out the grounds on which a Reporter may refer a child to a Children's Hearing. These are:

a) the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care,

b) a schedule 1 offence has been committed in respect of the child,

c) the child has, or is likely to have, a close connection with a person who has committed a schedule 1 offence,

d) the child is, or is likely to become, a member of the same household as a child in respect of whom a schedule 1 offence has been committed,

e) the child is being, or is likely to be, exposed to persons whose conduct is (or has been) such that it is likely that—

   i. the child will be abused or harmed, or

   ii. the child's health, safety or development will be seriously adversely affected,

f) the child has, or is likely to have, a close connection with a person who has carried out domestic abuse,

g) the child has, or is likely to have, a close connection with a person who has committed an offence under Part 1, 4 or 5 of the Sexual Offences (Scotland) Act 2009 (asp 9),

[210] Children's Hearing (Scotland) Act 2011 [http://www.legislation.gov.uk/asp/2011/1/contents]

h) the child is being provided with accommodation by a local authority under section 25 of the 1995 Act and special measures are needed to support the child,

i) a permanence order is in force in respect of the child and special measures are needed to support the child,

j) the child has committed an offence,

k) the child has misused alcohol,

l) the child has misused a drug (whether or not a controlled drug),

m) the child's conduct has had, or is likely to have, a serious adverse effect on the health, safety or development of the child or another person,

n) the child is beyond the control of a relevant person,

o) the child has failed without reasonable excuse to attend regularly at school,

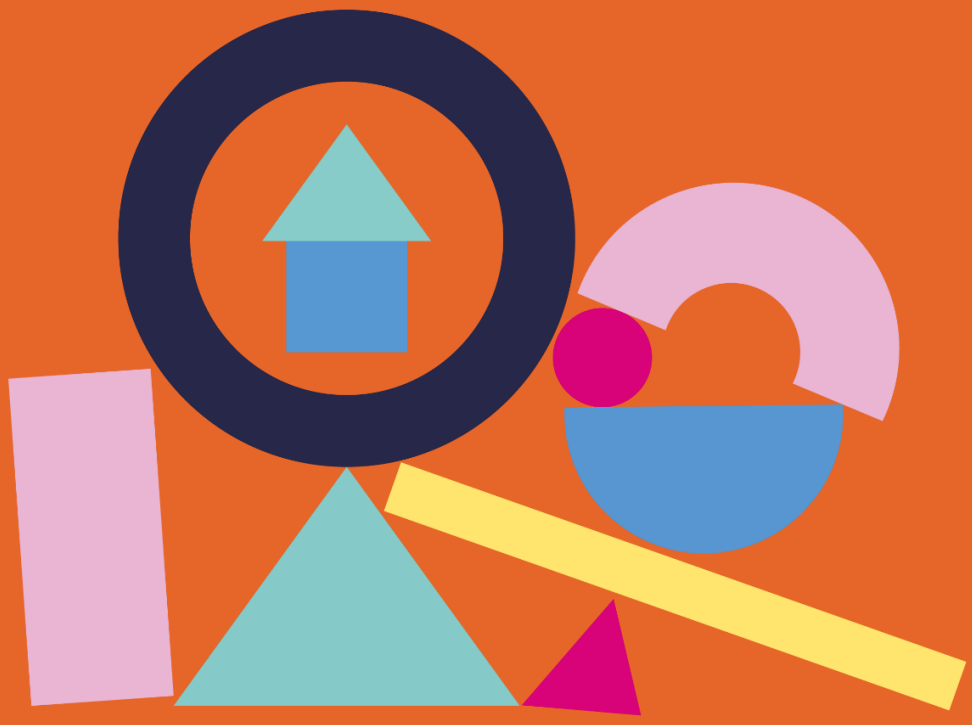
p) the child—

   i. is being, or is likely to be, subjected to physical, emotional or other pressure to enter into a marriage or civil partnership, or

   ii. is, or is likely to become, a member of the same household as such a child.

Best Place in the World

What helps to make a good childhood?



An international comparison and case studies from three European countries

Dawn Griesbach, Jennifer Waterton and Claire Baker

July 2019

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1. Introduction

Background

In May 2019, as part of the Journey Stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a rapid review approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[211]

[211] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

Aim of this review

This review was carried out on behalf of the Care Review's Best Place work group. Its aim was to provide a contribution in answering the following questions:

- What evidence is available about how Scotland compares with other countries on a range of indicators of 'a good childhood'?
- What do we know about:
    - Whether Scotland is improving, getting worse or staying the same in relation to indicators of a happy childhood?
    - The factors which explain Scotland's position in relation to other countries?
    - How children in care are currently doing in relation to the indicators of a 'good childhood'?

The Care Review Best Place work group made it clear that their primary interest for this review was in relation to 'what makes a good childhood' – and that the primary focus of the review should **not** be on children in care, but on **ALL** children in Scotland. The group wanted to know how Scotland can become the best place in the world to grow up, and they suggested that there may be opportunities to learn from other countries where childhood is a more positive experience than it is in Scotland.

Structure of the report

The report is structured as follows:

- Section two provides a summary of findings from the Care Review to-date which are relevant to the questions in this review – in particular, what is needed to make Scotland the best place in the world to grow up.
- Section three discusses the process used in this review to identify countries where children appear to be flourishing.
- Section four shows how Scotland compares to 41 other countries in relation to five indicators of child subjective well-being. Countries

whose children report positive well-being on all five indicators are identified, and three of these are selected as case studies.

- Section five presents case studies in relation to Finland, the Netherlands and Sweden.
- Section six considers the question of whether childhood in Scotland is getting better or worse.
- Section seven looks at how children in care are faring in relation to indicators of a 'good childhood'.
- Section eight provides some concluding remarks.

2. What the Care Review has learned so far

This section summarises the main findings from the Discovery stage of the Care Review in relation to the issue of Scotland being the best place in the world to grow up.

The views of children and young people presented in the 1000 Voices report focused on the question of what the best 'care system' in Scotland would look like to them. This found that the best 'care system' in Scotland would be one where care experienced children, young people and adults:

- Feel more in control
- Are accepted, understood and treated as equals, with respect
- Receive help as early as possible, and so do their families
- Stay for longer in places they view as home
- Have people they trust and who are always there
- Can realise their dreams and be successful
- Know what is happening, why it is happening and can access more information and help where needed
- Feel happy more than they feel sad
- Can fully be who they are
- Can have love and give love.

The 1000 Voices report summarised the aspirations of care experienced children, young people and adults in relation to the 'care system' – that it should (i) be child-centred; (ii) take the whole care journey into account; (iii) prioritise relationships; (iv) be fair and inclusive; and (v) be based on the best standards of care.

There was a recognition that the 'care journey' began long before any formal processes were implemented. As such, those who took part in the 1000 Voices study wanted to see early intervention and preventative

services in place to support children and families before problems required admissions to care.

The evidence review carried out by Baker (2017) specifically addressed the question of 'what would the best 'care system' in the world look like'. This review found evidence of six cross-cutting elements which emerged as important in building a better 'care system':

- Vision and influence: the best 'care system' listens and empowers participation and decision-making.
- Trusting relationships: the best 'care system' identifies and nurtures the bounds that are important.
- Everyday ordinary: the best 'care system' challenges discrimination and promotes positive identity.
- Right support, right time: the best 'care system' is flexible and responsive to individual needs.
- Coherence: the best 'care system' connects to what comes before, during and after.
- Aspiration, love and feeling safe: the best 'care system' provides opportunities to grow and flourish.

The Care Review statistical baseline overview provided information about the 2017 World Happiness Report, which is an annual publication produced by the United Nations Sustainable Development Solutions Network. The World Happiness survey asks representative samples of people aged 15 and over, from countries around the world, to evaluate the quality of their current lives on a scale of zero to ten. The survey measures economic variables (such as income and employment), social factors (such as education and family life) and health (mental and physical). Among the findings of this study, as reported in the Care Review statistical baseline overview, were that:

- Mental health was identified as more important than income, employment or physical health in determining 'happiness'.

- In every country, physical health was found to be important, yet in no country is it more important than mental health.
- Key factors for the future adult are the mental health of the mother and the social ambiance of primary and secondary school.

In 2019, the United Kingdom was ranked 15th out of 156 countries in happiness.[212] No separate information was available for Scotland.

[212] The Care Review statistical baseline overview presented findings from the 2017 World Happiness Report. This information has been updated here to refer to the most recent (2019) report: https://worldhappiness.report/ed/2019/

3. The process of identifying countries where children flourish

This section briefly discusses some of the practical difficulties of undertaking research to determine how Scotland compares with other countries in terms of providing a good place for children to grow up.

This section goes on to explain that, for pragmatic reasons, this review will focus on only a **very limited** set of international indicators. These will be used, first, to provide a comparison between Scotland and other countries in relation to those indicators; and second they will be used as the basis for selecting three case study countries for which the concept of childhood can be explored in more detail.

The indicators chosen for this purpose will relate to five different aspects of child self-reported well-being. It is important to emphasise that the indicators selected for this review are **not** intended to provide a comprehensive picture of the well-being of children in Scotland as compared with children in other countries.

The challenges of international comparison

There are a number of challenges in carrying out international comparisons of children's experiences of childhood.

A 'good childhood' means different things in different countries

What counts as a good childhood in Scotland may be similar in many ways to what constitutes a good childhood in England; however, it may be entirely different to what is considered to be a good childhood in Italy, Russia, Sweden, China, the United States, or India.

Developing a suite of indicators which measure the underlying concept ('a good childhood') is therefore very challenging. It requires an approach which

can identify core features which 'translate' effectively across multiple cultural domains and for which a suitable indicator can be developed.

'Childhood' is a complex concept

A 'good childhood', in particular, is an extremely complex concept to measure. One study in the UK uses a set of 16 indicators (the Good Childhood Index) which, taken together, provide a measurement of what children and young people themselves have said are the key elements of a good childhood.[213] The index uses one question to measure children's happiness with their life as a whole, five questions to measure children's overall satisfaction with their lives, and then a further ten questions to measure children's feelings about their family, friends, home, health, the way they use their time, their feelings about their future, the things they own, the choices they have, their appearance, and their school. Each year, this index is used as part of a survey of a representative sample of children and young people in the UK, to provide a snapshot of children and young people's perceptions and experiences of childhood. Repeated studies allow changes in these perceptions and experiences to be tracked over time. However, because the findings from the Good Childhood Index alone do not provide a comprehensive picture of the experience of childhood in the UK, data from two other large (English) surveys are also analysed as part of this study.[214]

Most studies, when attempting to measure children's experiences of childhood use either subjective or objective measures of child well-being, or a combination of both. (See the Health & Well-being evidence review for an explanation of the difference between subjective and objective measures of well-being.) Such measures may comprise a very wide range of indicators. For example, a recent evidence review by the Scottish Government (September 2018), which summarised the available evidence

[213] Further information about Good Childhood Index is available from the Children's Society website: https://www.childrenssociety.org.uk/what-we-do/research/well-being/background-programme/good-childhood-index
[214] Children's Society, *Good Childhood Report*. See https://www.childrenssociety.org.uk/good-childhood-report - accessed July 2019.

on child and adolescent health and well-being in Scotland in relation to the SHANARRI domains, reviewed progress in relation to 143 indicators.[215]

International comparisons are often out-of-date by the time they are published

There are some datasets – including datasets relating to the well-being of children and young people – which have been developed specifically to enable international comparisons to be made. Data collection, analysis and reporting processes are all particularly complex and time consuming in international studies. For this reason, most published large-scale international comparison studies refer to data that is between four and five years old. This is significant because, by the time the data is published, the things that the study was measuring may have changed, and indeed government policies may have moved on to address the very problems that the findings of these studies had identified.

Scotland vs UK

Another common issue – which affects Scotland, in particular – is that international comparison studies often include the United Kingdom – but do not usually present findings for each of the countries of the United Kingdom separately. (This is generally because the sample size for the study is too small to allow for separate analysis on a regional basis.) In addition, in some cases the United Kingdom findings may not include data

[215] Scottish Government (2018) *Child and adolescent health and wellbeing in Scotland – evidence review*. See https://www.gov.scot/publications/child-adolescent-health-wellbeing-scotland-evidence-review/ - accessed July 2019.

from Scotland. Indeed, in some international studies, the 'UK' data comes from England only.[216, 217, 218]

As will be shown in Section 4, the experience of childhood is, at least in some ways, quite different in Scotland than it is in England.

[216] UNICEF (2007) *Child poverty in perspective: An overview of child well-being in rich countries. Innocenti report card 7.* See the note 15 on page 46, which explains that data only on England was used for the study. https://www.unicef-irc.org/publications/pdf/rc7_eng.pdf - accessed July 2019.
[217] Jacobs Foundation (2015) *Children's views on their lives and well-being in 15 countries: A report on the Children's Worlds survey, 2013-14.* See http://www.isciweb.org/_Uploads/dbsAttachedFiles/10and12FullReport.pdf - accessed July 2019.
[218] A recent report by UNICEF provides international comparisons with England and Northern Ireland, but not Scotland and Wales: UNICEF (2018) *An unfair start. Inequality in children's education in rich countries. Innocenti report card 15.* See https://www.unicef-irc.org/publications/995-an-unfair-start-education-inequality-children.html - accessed July 2019.

4. The international health behaviour of school-aged children study

Bearing in mind the issues described above, the study which will be used in this review to compare children in Scotland to children in other countries will be the international Health Behaviour of School-aged Children (HBSC) study.

HBSC is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study is carried out through a survey of a representative sample of school children aged 11, 13 and 15. The survey takes place every four years in 49 countries / regions around the world, using a common research protocol. Scotland joined the study in 1986, and the first Scottish survey took place in 1990. The research team in Scotland has provided the international co-ordination of the study since the mid-1990s.

Children and young people take part in the survey by filling out a questionnaire which is administered in the classroom. All participating countries use a standard questionnaire which contains a core set of questions asking about:

- Children's backgrounds: demographics, social background (family structure, socio-economic status, etc.)
- Individual and social resources: family support, relationships with peers, school environment, experiences of bullying and being bullied
- Health behaviours: physical activity, eating and dieting, smoking, alcohol use, cannabis use, sexual behaviour, experiences of violence and injuries
- Health outcomes: physical symptoms, life satisfaction, self-reported health, body image, and body mass index.

Many countries also include additional items in their national questionnaires that are of particular interest to that country.

A strength of the HBSC study is that, it not only provides international comparisons between **Scotland** (**not the UK**) and many countries in the rest of the world on indicators of self-reported well-being for children and young people, but it also allows comparisons between younger (i.e. 11-year-old) and older young people (13- and 15-year-olds). The survey also allows changes in self-reported well-being to be tracked over time.

The HBSC questionnaire is long and takes around 40 minutes to complete. The published international reports of the study (which will be used in this review) only present a fraction of the findings from the survey.

The most recent HBSC survey was carried out in 2017/18. However, findings from this survey are not yet available. The most recent international report of the survey was published in 2016,[219] which relates to the 2013/14 survey.[220]

For the purposes of this review, findings in relation to five indicators are presented in Section four. The indicators are:

- Perceived family support;
- Life satisfaction;
- Self-rated health;
- Perceived classmate support at school;
- Experience of being bullied at school.

On the basis of this information, three countries have been selected as case studies to explore, in more detail, aspects of childhood in those countries.

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[219] Inchley J *et al* (eds) (2016) *Growing up unequal. HBSC 2016 study (2013/2014 survey).* See http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/health-behaviour-in-school-aged-children-hbsc/hbsc-international-reports/growing-up-unequal.-hbsc-2016-study-20132014-survey - accessed July 2019.

[220] A copy of the English-language version of the 2013/14 HBSC questionnaire is available from: http://www.cahru.org/content/05-research/hbsc-scotland/hbsc_nr14_interactive_final.pdf - accessed July 2019.

Perceived family support

In the HBSC survey, children and young people's perceptions of the support they get from their families was measured using the Multidimensional Scale of Perceived Social Support (MSPSS).[221] The MSPSS uses a combined score based on the responses to four questions which measure the extent that children feel supported by family, peer group, etc. In relation to family support, children and young people were asked if:

- They feel that their family really tries to help them
- They can get emotional support from them when they need it
- They can talk to their family about problems
- The family is prepared to help them make decisions.

Response options for each question ranged from very strongly disagree = one to very strongly agree = seven. Anyone scoring an average of 5.5 or more on the MSPSS was categorised as having high perceived family support.

Findings

The proportion of children who perceived they have good family support decreased as the age of the child increased. Overall, for 11-year olds, 80% of girls and 79% of boys said they had good family support. This decreased to 69% (girls) and 72% (boys) for 13-year olds, and further decreased to 64% (girls) and 67% (boys) for 15-year olds.

The figures for Scotland were below the average for all three age groups, but the deficit was most pronounced for 15-year olds. For this group, both the girls and the boys reported perceived family support levels which were ten percentage points or more below the average (for girls the figures were 54% compared to overall levels of 64%, and for boys 55% compared to 67% overall).

[221] Zimet GD, Dahlem NW, Zimet SG, Farley GK (1988) The Multidimensional Scale of Perceived Social Support. *J Pers Assess. 52(1)*:30–41.

The highest ranked country for all three age groups was Albania. Here, the proportions who perceived good family support ranged between 82% and 93% across ages and genders. By contrast, Greenland was the country with the lowest scores on perceived family support. In Greenland, the proportion ranged between 34% and 51% across ages and genders.

Overall, 39 countries were measured on this indicator. Scotland was ranked 27th for 11-year olds, 25th for 13-year olds and 32nd for 15-year olds.

Life satisfaction

In the HBSC survey, children and young people aged 11, 13 and 15, were asked to rate their life satisfaction using a visual analogue scale: the Cantril ladder. The Cantril ladder has 11 steps: the top indicates the best possible life and the bottom indicates the worst. Respondents were asked to indicate the ladder step at which they would place their lives at present (from zero to ten). A score of six or more was defined as high life satisfaction.

Findings

For life satisfaction, the main points to note are as follows:

The proportion of children who reported high life satisfaction generally decreased as the age of the child increased – although this is mainly due to a decrease in reported life satisfaction among older girls. Overall, for 11-year olds, 89% of both girls and boys reported high life satisfaction. This decreased to 82% (girls) and 89% (boys) for 13-year olds and further decreased to 79% (girls) and 87% (boys) for 15-year olds.

The figures for Scotland were above average for 11-year olds and 13-year olds (both for girls and boys), and above average (by one percentage point) for 15-year-old boys. However, 15-year old girls reported life satisfaction levels which were three percentage points below the average (76% in Scotland compared to 79% among 15-year old girls overall).

The highest ranked country for 11- and 13-year olds was Albania, and for 15-year-olds, it was Armenia. In these two countries, the proportions of children and young people reporting high life satisfaction ranged between 89% and 96% across ages and genders. By contrast, the countries with the lowest scores on life satisfaction were Flemish-speaking Belgium (for 11-year olds), Greenland (for 13-year olds) and the former Yugoslav Republic of Macedonia (for 15-year olds). In these countries, the proportion reporting high life satisfaction ranged between 72% and 81% across ages and genders.

Overall, 42 countries were measured on this indicator. Scotland was ranked eighth for 11-year olds, 17th for 13-year olds and 25th for 15-year olds.

Self-rated health

In the HBSC survey, children and young people aged 11, 13 and 15, were asked to describe their health (Would you say your health is ...?). Response options were excellent, good, fair and poor.

Findings

The proportion of children who rated their own health as fair or poor generally increased as the age of the child increased. Overall, for 11-year olds, 10% of girls and 9% of boys described their health as fair or poor. This increased to 16% (girls) and 11% (boys) for 13-year olds, and further increased to 21% (girls) and 13% (boys) for 15-year-olds. Girls were more likely than boys to report fair or poor health across all age groups.

The figures for Scotland were below the average for all three age groups, but the deficit was most pronounced for 15-year olds. For this group, the proportion of girls and boys rating their health as fair or poor was five percentage points or more below the average (for girls the figures are 26% compared to 21% overall, and for boys 21% compared to 13% overall).

The highest ranked country for all three age groups was the former Yugoslav Republic of Macedonia. Here, the proportions who rated their health as fair or poor ranged between 2% and 7% across all ages and

genders. By contrast, the two countries with the lowest scores on self-rated health were the Republic of Moldova (for 11-year olds) and Latvia (for 13- and 15-year olds). In these countries, the proportion reporting fair or poor health ranged between 13% and 38% across all ages and genders.

Overall, 42 countries were measured on this indicator. Scotland was ranked 32nd for 11-year olds, 34th for 13-year olds and 36th for 15-year olds.

Perceived classmate support at school

In the HBSC survey, children and young people aged 11, 13 and 15, were asked to indicate their agreement or disagreement with the statement that: 'Most of the students in their class(es) are kind and helpful.' Response options ranged from strongly disagree to strongly agree.

Findings

In relation to perceived classmate support, the main points to note are as follows:

- The proportion of children who agree that their classmates are kind and helpful generally decreases between the ages of 11 and 13, but less so between the ages 13 and 15. Overall, for 11-year olds, 74% of girls and 73% of boys agree that their classmates were kind and helpful. This drops to 65% (girls) and 66% (boys) for 13-year olds, and is one percentage point lower for 15-year old girls, with no change reported for 15-year olds boys. Very large cross-national differences were observed, with high prevalence in some countries and low prevalence in others in all age groups.
- The figures for Scotland are below average for all three age groups (except in the case of 11-year old boys, who are slightly above the average for boys in this age group). Among 15-year olds, the proportion of both girls and boys in Scotland who report having kind and helpful classmates is at least nine percentage points below the average (for girls the figures are 55% in Scotland compared to 64% overall, and for boys, 52% compared to 66% overall).

- The two countries whose children are most likely to report having kind and helpful classmates are the former Yugoslav Republic of Macedonia (for 11-year olds) and the Netherlands (for 13- and 15-year olds). In these countries, the proportions reporting good classmate support ranged between 84% and 90% across ages and genders. By contrast, Bulgaria was the country where children and young people were least likely to agree that their classmates were kind and helpful. Here, the figures ranged between 31% and 51% across ages and genders.
- Overall, 42 countries were measured on this indicator. Scotland was ranked 24th for 11-year olds, 33rd for 13-year olds and 34th for 15-year olds.

Experience of being bullied

In the HBSC study, children and young people aged 11, 13 and 15 were asked how often they had been bullied at school in the past couple of months. The question was preceded by the following definition of bullying:

> *'We say a student is being bullied when another student, or a group of students, say or do nasty and unpleasant things to him or her. It is also bullying when a student is teased repeatedly in a way he or she does not like or when he or she is deliberately left out of things. But it is not bullying when two students of about the same strength or power argue or fight. It is also not bullying when a student is teased in a friendly and playful way.'*

There were five response categories for this question as follows: (i) I haven't been bullied at school in the past couple of months, (ii) It has only happened once or twice, (iii) 2 or 3 times a month, (iv) About once a week, (v) Several times a week.

Findings

In relation to experiences of being bullied, the main points to note are as follows:

In general, the proportion of children who reported being bullied at school at least two or three times a month in the past couple of months **decreased** as the age of the child increased. Overall, for 11-year olds, 11% of girls and 14% of boys reported being bullied two or three times a month. The figure for girls remained the same at age 13 but dropped for boys to 12%. At age 15, 8% of girls and 9% of boys said they were bullied at school two or three times a month. Very large cross-national differences were observed, with high prevalence in some countries and low prevalence in others.

The figures in Scotland were higher than the average (i.e. worse) for all age groups, but particularly for 11- and 13-year old girls. For 11-year old girls, the proportion who said they were bullied at least two or three times a month was 16% in Scotland compared with 11% overall. Among 13-year-old girls, the figures were 18% in Scotland compared to 11% of girls overall. Among boys in Scotland, only 11-year olds reported levels of bullying that were higher than the average (16% in Scotland compared to 14% overall).

Overall, 42 countries were measured on this indicator. Scotland was ranked 32nd for 11-year olds, 35th for 13-year olds and 25th for 15-year olds.

Summary

Scotland was ranked relatively high compared to other countries in relation to only one of the five selected indicators from the HSBC study: life satisfaction. However, compared to other countries' 15-year old girls, Scotland's girls were less likely to report high life satisfaction.

There are several countries whose children **consistently** (across all age groups) reported more positive experiences than (i) children in Scotland and (ii) children in many of the other participating countries – in terms of good family support, good classmate support and high levels of life satisfaction. The children in these same countries were also less likely than children in Scotland (and children in other participating countries) to rate

their own health as 'fair' or 'poor' or report being frequently bullied at school. These countries were:

- Albania
- Croatia (but not on life satisfaction)
- Denmark (but not on family support)
- Finland
- Netherlands (but not on self-rated health)
- Norway (but not on self-rated health)
- Slovenia
- Spain (but not on perceived classmate support)
- Sweden (but not on life satisfaction)
- Switzerland (but not on experiences of being bullied).

From this list, this review has selected Finland, the Netherlands and Sweden for its illustrative case studies. These three countries have been chosen because (i) the Best Place work group specifically expressed an interest in knowing more about these countries and (ii), information is readily accessible, in English, on children and family policies and educational policies in these countries.

5. The case studies

This section presents further details about legislation and policies affecting children and families in Finland, the Netherlands and Sweden.

Each case study contains the following sections: (i) Basic facts; (ii) Child and family policies; (iii) Education policies; (iv) Child welfare policies; (v) Children's rights.

Information for the case studies has been gathered from four main sources:

The PERFAR website (Population Europe Resource Finder and Archive): [222] PERFAR contains, among other things, information about a broad collection of policies related to population developments throughout Europe. This information is intended to support comparative analyses of policies between countries.

The United National Human Development Programme website:[223] The UNHDP's approach to advancing human well-being emphasises the importance of expanding the richness of human life, rather than simply the richness of the economy in which human beings live. It is an approach that focuses on people and their opportunities and choices. The organisation produces country profiles, data and statistical reports.

Official government websites of Finland, the Netherlands and Sweden, where relevant information has been made available in English.

The concluding observations from the Committee on the Rights of the Child:[224] Reference is made to the 2015 concluding observations for Sweden and the Netherlands. The most recent set of concluding

[222] https://www.perfar.eu/about-us
[223] http://hdr.undp.org/en
[224] https://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx

observations available for Finland were published in 2011 and are not referred to here since it is likely that significant policy changes have taken place in Finland since 2011.

Information from these sources has been supplemented with other published information, where possible.

NOTE: In the timescales available, it has not been possible to quality check the information taken from public websites.

Finland

According to the World Happiness Report, Finland has been the happiest country in the world (out of 156 countries included in the study) for the past two years.[225] The World Happiness Report takes numerous factors into consideration when measuring happiness, including GDP per capita, social support, healthy life expectancy, freedom to make life choices, generosity and perception of corruption.

Children and family policies[226]

Childcare provision

The underlying principle of the development of the childcare system in Finland has been freedom of choice. In the 1960s, a variety of interest groups started to demand that women have equal opportunities to participate in the labour market. As a result, the Child Day Care Act was passed in 1973. But rather than settling competing demands for different kinds of support, the law provided an internationally unique synthesis of these preferences. Since 1990, families have been able to choose between enrolling their children in public day care or caring for their children at home until each child is three years old. As the cost of private day care is

[225] https://worldhappiness.report/ - see reports for 2018 and 2019.
[226] The information in this section has been taken from Korhonen K (2014) *Family policies: Finland*. PERFAR. See https://www.perfar.eu/policy/family-children/finland - accessed July 2019.

also reimbursed, there is public support for nearly all childcare arrangements.

After the parental leave period (when the child is nine-ten months old), parents are entitled to enrol the child in public day care until the child starts school (the year the child turns seven). The care may be provided in a public day care centre, a family day care setting, or a group family day care setting. The fees are based on the size of the family and their income, as well as on the number of hours of day care needed. The maximum monthly fee is 238 euros for the youngest child in day care and 215 euros for the second-youngest child. The fee for a subsequent sibling is 20% of the first child's fee.

In 2014, the government decided to restrict the universal right to day care as follows: if a parent is at home on parental leave, on a child home care leave, or on a leave of absence, the child will be entitled to day care on a part-time basis only.

Under the Child Home Care and Private Day Care Act, parents are entitled to take home care leave until the child turns three years old. The only precondition for receiving home care allowance payments is that the child must not be enrolled in a public day care centre. The allowance consists of two parts: a fixed care allowance amount and a means-tested care supplement. The monthly care allowance is 341 euros for one child under age three, 102 euros for each additional child under age three, and 66 euros for an older sibling who is still under school age.

Many municipalities also pay a so-called municipal supplement to parents who do not use their right to enrol their child in public day care. The amount of the supplement depends on the municipality. In 2013, the average monthly supplement was 178 euros. Of the parents of nine- to 24-month-old children, 49% were receiving home care allowance payments, and 35% of them were receiving a municipal supplement. The uptake of

the child home care allowance is highly gendered, as only 6% of those receiving the allowance are men.

A private care allowance may be claimed if the childcare is arranged by a private service producer, parish, or NGO. Charges in private day care are set by the service provider. The private care allowance (174 euros) and a means-tested supplement are paid separately for each child eligible for the benefit. A municipality may also pay families with children in private care a municipal supplement, which was 392 euros on average in 2013.

Maternity protection, paternity leave, parental leave

Parental leave entitlements in Finland are divided into three different periods: maternity leave, paternity leave, and parental leave.

The length of maternity leave is 105 working days (approximately five weeks before and 13 weeks after childbirth), during which the mother is entitled to maternity allowance payments. In addition, a special maternity allowance is paid to expectant mothers who, for health reasons, have to stop working before the actual maternity allowance period is scheduled to begin.

Paternity leave lasts a maximum of nine weeks, and may be taken in shorter periods until the child turns two years old. However, the father can take only up to three weeks of paternity leave while the mother is receiving maternity or parental allowance payments.

Parental leave is 158 working days (approximately 26 weeks), and may be divided between the parents. Both parents are simultaneously entitled to partial parental allowance if they work part-time and share the parental leave.

In 2012, the average level of parental allowance payments was 75% of previous income. If the parent was not employed before the birth, a minimum allowance of 24 euros per day is paid. Some 96% of employees covered by collective agreements in the private sector are entitled to a

paid maternity leave. Paid paternity leave entitlement is less common, but is becoming more frequent. In the case of paid parental leave, the allowance is paid to the employer.

Parental allowances are taxable income, and are financed from health insurance, which consists of the employer's sickness insurance contribution and the employee's health insurance payment. The minimum allowance (for persons who were not in employment before the birth), and 0.1% of the earnings-related parental allowance are financed by the state.

In most families, the bulk of the parental leave is taken by the mother. In 2013, only 9% of parental allowance payments were to fathers; however, the share of parental allowance paid to fathers has been growing.

Family allowances

The family allowance system has four main components: tax deductions, maternity benefits, child allowance, and housing allowance.

Since 1948, all families with children have been entitled to maternity benefits, which may be claimed as a "maternity package" (childcare items) or as a non-recurring cash grant. The Child Allowance Act went into effect in 1949. The allowance was universal from the beginning, but in 1962 the amount of the allowance was scaled so that subsequent children received a higher allowance. This can be seen as a pro-natal initiative, as a higher child allowance is a concrete incentive to have multiple children. In 1994, the level of child allowance was raised significantly and the family policy tax deduction system was practically abolished.

In 2009, most families expecting their first child claimed the maternity benefit as a 'maternity package'. This contains children's clothes and other necessary items, such as bedding, cloth nappies, and childcare products. Fewer families chose the alternative of a tax-free lump sum payment of 140 euros. In the case of a multiple birth, the maternity benefit is multiplied accordingly. Adoptive parents are also eligible for the maternity benefit.

In 2014, the monthly child allowance was 104 euros for the first child, 115 euros for the second child, 147 euros for the third child, 168 euros for the fourth child, and 190 euros for subsequent children. Single parents are entitled to a supplement of 49 euros per child. The allowance is tax-free and is paid until the child turns age 17. A single parent may also receive a child maintenance allowance (in addition) if the parent liable to pay maintenance does not do so.

Low-income households are eligible to receive a general housing allowance. The eligibility for and the amount of this allowance depends on the number of persons in the household, and the household's income and assets. The maximum allowance is 80% of reasonable housing costs (as defined by law).

In an effort to lower national debt levels, the government decided in 2014 to cut child allowance expenditures by 110 million euros (8%). There was strong opposition to this decision, and in response to the outcry, the government introduced a tax deduction for low-income and middle-income families with children for the years 2015-2017.

The main aims of children and family policies in Finland have been to give each family the flexibility to arrange childcare to suit their individual needs, to promote the sharing of childcare responsibilities within the family, to support fatherhood, and to minimise the damage that long periods of absence from the workforce may do to a woman's career. However, mothers are still far more likely than fathers to care for children under age three at home during the parental leave period. As the current parental leave system appears to place higher cost burdens on female-dominated sectors, there have recently been calls for a more equal distribution of family leave costs, and in 2013, the government decided to divide the child home care allowance period between parents so that each parent could use no more than half of the total allowance of 832 days.

Education policies[227]

One of the basic principles of Finnish education is that everyone must have equal access to high-quality education and training. The same educational opportunities should be available to all citizens, irrespective of their ethnic origin, age, wealth, or place of residence. The country's educational policies are based on the lifelong learning principle: i.e., that individuals can always advance to a higher level of education, regardless of the choices they make in between.

Organisation of the educational system

For each child, compulsory education starts in the year when he or she turns seven years old and ends after he or she has completed the basic education syllabus, or after ten years. During the year before compulsory education begins, the child can participate in pre-primary education. About 96% of six-year-olds go to pre-primary school. Compulsory basic schooling is provided for all children in this age group and lasts nine years. An additional tenth form of basic schooling is voluntary and gives pupils an opportunity to improve their grades and clarify their career plans. Education after completing the comprehensive school is not mandatory, but most Finnish children continue their education by enrolling in either an upper secondary general school or an upper secondary vocational school. The type of school they choose typically depends on their performance in the comprehensive school.

Both the general and vocational tracks last three years. It is possible for students to simultaneously attend a vocational and a general upper secondary school.

The Finnish higher education system consists of two sectors: polytechnics and universities. The mission of universities is to conduct scientific research, and to provide undergraduate and postgraduate education

[227] The information in this section has been taken from Mikkonen J (2014) *Educational Policies: Finland.* PERFAR. See https://www.perfar.eu/policy/education/finland - accessed July 2019.

based on this research. The mission of polytechnics is to provide professional training in response to labour market needs and to conduct R&D which supports instruction and promotes regional development.

Upper secondary and higher education in Finland are generally free of charge for students, but students typically have to pay for the cost of materials.

Compulsory education

The Finnish basic (comprehensive) school consists of nine grades and is compulsory for all children who reside permanently in Finland. Currently, the statutory school ages are seven to 16. Exemption from compulsory education is not legally possible. Municipalities are obliged to assign pupils to a school near their home, though parents are free within certain limits to choose a different comprehensive school. Textbooks and other materials and tools used during basic education are free of charge, and pupils are offered a free daily meal, even at private schools. In addition, health care and other welfare services are offered to pupils in school and free of charge. All pupils of compulsory school age have the right to guidance and support in learning and other schoolwork whenever the need arises.

Private education providers are licensed by the government. Private schools are often run by associations or societies affiliated with a church, a language (e.g., English, Russian, or German), or a pedagogy (e.g., Steiner). The private schools must follow the same laws and national core curricula as public schools.

Child welfare policy in Finland[228]

In Finland, parents or guardians are primarily responsible for a child's care and upbringing, but they are entitled to receive help from society. This help should be available at an early stage to ensure that parents can cope

[228] The information in this section has been taken from https://www.lastensuojelu.info/en/ - a website produced by the Central Union for Child Welfare. This provides an overview of child welfare policy in Finland in multiple languages.

with their parenting duties. If parents or guardians for some reason are unable to take care of their children's wellbeing, Finnish society is obliged to intervene. In this case, the task of child welfare services is to guarantee the child's wellbeing. So, help is not always voluntary, but the Child Welfare Act prescribes that child welfare authorities must act in certain situations to protect the child. The Child Welfare Act applies to all children in Finland regardless of their background.

Anyone who is concerned about a child's well-being can file a child welfare notification, and it may be submitted anonymously. Notifications may be submitted by day care or nursery workers, or teachers who have regular contact with the child. The police are also obliged to submit a notification if a child has committed a crime, drunk alcohol, used drugs or witnessed domestic violence. When a child welfare notification is submitted in relation to a child, the authorities usually discuss the matter with the family first.

Some of the reasons that child welfare notifications may be submitted include:

- A major change occurs in the family, affecting everyone.
- Parents cannot cope or suffer from psychological problems, depression or illnesses.
- Parents often drink a lot or use other intoxicants.
- There is domestic violence in the family.
- A child or young person does things that are dangerous or detrimental; for example, uses a lot of alcohol or drugs, commits crimes or is absent from school.
- A child has psychological problems.
- A child bears too great a responsibility for their age in the family's everyday life owing to the parent being sick, for example.

When a child welfare notification has been submitted, it will be assessed by a social worker. Depending on the situation, the assessment may involve an investigation into the need for services, made according to the Social Welfare Act, or an investigation into the need for child welfare services, made according to the Child Welfare Act.

In most cases a social worker contacts the family and invites the parents and child to discuss their circumstances. When assessing the situation, there may be several meetings with the family, and they may take place in the social welfare office, day-care centre, school or the family home. An interpreter can be present if necessary. The meetings are held to discuss why the notification was submitted and what could be done to help the child and the entire family. The social worker will often meet the child without the parents during the assessment process.

The circumstances of the child and family are investigated as thoroughly as necessary. If the family wishes, members of the extended family and other people close to the family can be involved in the process.

If it is deemed that the child and family would benefit from the support offered by social services but that they do not need services provided for in the Child Welfare Act, they will have a designated social worker for the time that they receive help from the services. It is optional for families to receive support from social services.

If it is deemed that the child and family require support from child welfare services, the child becomes a client and a social worker is appointed to handle his or her case. If the investigation into the need for services or child welfare services raises concerns about the child's situation, the child may become a child welfare client even if the child or the parents do not think it necessary.

If the investigation does not bring up any concerns nor is it deemed that the child and family need support, the child will not become a customer of social or child welfare services.

If, after investigating the need for child welfare services, the decision is made that a family needs child welfare services, the issues for which the child and family need help will be identified, and a written plan will be drawn up, together with the child and family. The plan is revised when necessary, or at least once a year. During the revision, the issues agreed on are discussed and it is evaluated whether or not the work has been helpful.

Support measures in open care

The basic principle is that if an intervention in the family's affairs is necessary, the least invasive route to help the family is preferred. Such primary services are called support measures in open care. Support measures in open care are always voluntary and based on co-operation with the family. Most child welfare work is implemented as support measures in open care.

There are various support measures in open care and they differ according to municipality. Examples include:

- Services at home: Services provided at home can be practical support, e.g. help with childcare, cooking, washing or cleaning. It aims to promote the family's well-being and prevent problems from arising.
- Family work provides help directly at home: Family work may include discussions, guidance and support for the parents in raising their children. It may also mean that a family receives support with various everyday activities, such as running errands or with domestic chores, or it may include organising activities that support a child's well-being.
- Support person or support family: A support person or support family can be assigned to a child or a family. A support person is an adult who helps with homework, for example, or is involved in a child or family's hobbies. A support family is an ordinary family, with

whom a child can meet as agreed, for example at weekends. Support families or support individuals are trained.

- Peer group activities: Peer group activities are for affected individuals to attend group sessions to meet other people in similar situations. Relatives and friends of immigrant parents often live far away; peer group activities allow them to meet people in different clubs and groups. Clubs and groups often provide activities; in other words, you can talk and get to know people while cooking, making crafts or during other events.
- Treatment and therapy services: Treatment and therapy services supporting a child's rehabilitation must be provided should a child need them. For example, if a child has learning difficulties, the school psychologist and school social worker can guide the child to the appropriate services.

Placing the child outside of their home

If the problems are so great that a child is not safe at home or from themselves, and there is no other way to change the situation, a child's care must be arranged away from home. This is called placement of a child. There are three kinds of placement:

- Short-term placements jointly agreed upon: In a difficult situation, a child or the family may be placed away from home for a short while as a support measure in open care. Open care placement is always voluntary. A child may also be placed for a short time, if it is predicted that the situation will improve quickly. For example, if the relationship between parents and a young person deteriorates to the extent that living together seems impossible, it may be suggested that the young person lives away from home for a while. The parents still decide on the child's care and affairs. The parents may also be participating in rehabilitation due to their own problems with alcohol or drugs or mental health, and then all the family will

live temporarily in an institution. If necessary, placement as a support measure in open care can be implemented immediately.

- Emergency placement if the child is in danger: If a child needs help immediately, and no one close to the child can take care of them, the child welfare services must take the child to a safe place. This is called emergency placement. Emergency placement is always temporary. It may be implemented, for example, if the parents are so intoxicated by alcohol or other drugs that they cannot take care of the child or if the child is left alone at home for a long time. The child may also cause danger to themselves by using alcohol or other drugs, for example. If it is evaluated that the child is in immediate danger, placement can be implemented even if the child or parents object to it. During placement, the child welfare services have extensive rights to decide on the child's affairs, though they work closely with parents and guardians. The family's situation and need for help is investigated during emergency placement. The aim is that the child can return to a safe home. The social worker evaluates whether placement can be ended, and issues a decision terminating placement. If it is evaluated that it is not safe for the child to return home, preparations for taking the child into care can be initiated.
- Taking into care is the final option: Taking into care means that a child is cared for away from home. It is the final option only to be used if the problems are very serious or if they have been ongoing for a long time. Usually before taking into care is implemented, many things have already occurred, and there have been significant efforts to help the child and family. When nothing else works, the law stipulates that a child must be taken into care. The authorities work closely with the child's parents and guardians, and the social workers cannot decide on certain matters such as the child's religion.

Taking into care

Taking into care is a long process, which is usually prepared in co-operation with the child and family. The grounds for the decision to take a child into care must: (i) demonstrate that the child's safety has been at risk, (ii) explain the manner in which the social services have tried to help the child and why these measures have proven inadequate, and (iii) justify how taking into care helps the child and why it is a better option for the child than staying at home. The parents and the child have a right of access to documents in which the grounds for taking into care are presented. A meeting must also be arranged to explain to them these grounds.

If a child who is 12 or older or the child's guardians oppose the act of taking into care, a court must rule on the case. The Administrative Court will be informed about the situation and rule in the best interests of the child. Decisions of taking into care issued by the Administrative Court can be appealed.

Usually a child taken into care lives either with a foster family or a child welfare institution. Prior to a child's placing away from home, the child welfare workers need to ascertain whether anyone close to the child can take care of him or her. When choosing an alternative care place, the child's linguistic, cultural and religious background should be taken into account as far as possible.

The reasons for taking into care must be explained to the child, including the objectives of alternative care. The child must be given sufficient opportunities to meet the social worker responsible for the child's affairs.

Taking into care does not mean that the child could not have contact with his or her parents. The child has a right to meet his or her parents and others close to him or her, as well as communicate with them. All these matters are also recorded in the child's client plan. The child's meetings and communication with the parents may be restricted only if they are harmful to the child on reasonable grounds. In this case, a decision on the

matter must be issued, which can be appealed against. A child aged 12 or older also has the right to refuse to meet the parents, if he or she so wishes.

Taking into care lasts as long as the child needs it

Taking into care is valid only as long as the child needs it. The duration depends, for example, on how well the parents are able to take care of their affairs and themselves during placement. The child welfare services aim to provide the child and family, during placement, with such support measures by which a child can return home. The social worker responsible for the child's affairs must evaluate at least once a year whether to continue keeping the child in care. Each case of a child being taken into care terminates at the latest when the child reaches the age of 18.

After-care

When taking into care ends, a child or young person may still need help and support. This is called after-care. The purpose of after-care is to facilitate the child or young person's return home or becoming independent. After-care may continue until the young person turns 21. The child welfare services together with the young person agree and plan which services and support measures after-care includes in practice. After-care may include support for housing, livelihood, work or study.

Children's rights

Provisions on the rights of children are laid down in the Constitution of Finland. Furthermore, the European Convention on Human Rights and the UN Convention on the Rights of the Child are also binding in Finland.[229]

According to the website, Humanium, Finland's children live in good conditions and the country belongs to one of the top ten child rights-respecting countries in the world.[230]

[229] https://stm.fi/en/social-services/child-welfare
[230] https://www.humanium.org/en/finland/

The Netherlands

According to the World Happiness Report 2019, the Netherlands is the fifth happiest country in the world (out of 156 countries included in the study).[231]

Children and family policies[232]

The Netherlands is usually classified as a corporatist (or conservative) welfare state: i.e., a state traditionally characterised by differences in social insurance entitlement and benefits across occupational groups. In addition, the country has a history of conservatism when it comes to families and gender roles, but also of relative liberalism regarding new forms of families (including same-sex couples). For the specific field of family policy, the Netherlands provides relatively high levels financial support for families with children, but much more limited support for working parents.

The plurality of family forms, together with individual responsibility and the privacy of family life, continue to be guiding principles of Dutch family policies.

Childcare provision

Preschool: The provision of publicly funded preschool (from the age of four) dates back to 1956 with the passage of the first Nursery Education Act. Under the current system, attendance at preschool is optional for four-year-olds, but is compulsory from the age of five onwards. In 2005/06, an estimated 74% of four-year-old children were enrolled in preschool programmes. Special preschool programmes are also offered to children ages two-four who are at risk of a language disadvantage (primarily migrant children).

Childcare and afterschool care: The financing structures and quality standards for childcare provision date back to the 1970s. The number of

[231] https://worldhappiness.report/ed/2019/.
[232] Selten W and Gauthier AH (2014) *Family policies: the Netherlands*. PERFAR. See https://www.perfar.eu/policy/family-children/netherlands - accessed July 2019.

children in care has increased rapidly in recent decades in response to the growing participation of mothers in the labour market, and to a series of stimulus measures by the government. The system currently encompasses a mix of public and private, and informal and formal care services. Many children attend childcare on a part-time basis, which reflects the high prevalence of part-time work among mothers (and to a lesser extent among fathers). The provision of childcare is regulated by the Childcare Act of 2005, which gave childcare its own statutory framework, including supervision and funding. This law was amended and renamed in 2010 as the "Childcare and Quality Standards for Playgroups Act". This act better regulated the alignment of playgroups and day nurseries in terms of the quality of their educational offerings and transferred to local municipalities the responsibility for providing early childhood education to all children.

The provision of after-school care is also made up of a mix of formal and informal care. Several laws passed in the late 1990s sought to extend the availability of after-school care. In 2007, schools became obliged to offer after-school care services to all children aged four to 12, wishing to participate.

The cost and funding of childcare varies considerably depending on the type of care. From 2007, there was a shift towards the "marketisation" of childcare, with childcare funding provided by a combination of parents, the state, and employers. Childcare subsidies to parents are administered through the tax system and are income-dependent, so that lower-income families receive a larger subsidy. In very recent years, this subsidy has been significantly reduced; a change which has been widely criticised. Compared to other countries in Europe, the actual cost of childcare is very high in the Netherlands, but so are also the benefits to families, resulting in a net cost to parents which is around the European average for average-income families.

Maternity protection, paternity / partner leave and parental leave[233]

The Netherlands was among the first countries to introduce a law on maternity protection (signed in 1930 but introduced in 1919). It provided 12 weeks of leave with full wage compensation (less for unmarried women). But while other countries significantly expanded their maternity leave entitlements during the following decades, the Netherlands did so only very slightly. As a result, the country's maternity scheme is currently among the shortest in Europe, with 16 weeks of leave with benefits equal to 100% of wages. This includes four (or six) weeks before the expected date of delivery, and 12 (or ten) weeks after the birth of the child. The law also stipulates that women may not be fired during their pregnancy.

As of January 1st, 2019, partners of mothers who have just given birth are legally entitled to one work week of paid leave. Partners who work full-time and part-time are eligible.[234]

In the Netherlands, both parents are entitled to unpaid parental leave of 26 weeks, which is designed to allow them to spend more time with their children. The number of hours of leave per week may not exceed half of the working hours per week, and arrangements for parental leave should be agreed with the employer. Unless the employer does so voluntarily, parental leave is not paid.

In 2013, 57% of the women entitled to parental leave took parental leave, and 28% of these women were paid while on leave. By contrast, only 23% of the men entitled to parental leave took the leave, and only 12% were paid.

Family allowances

Currently, all families living in the Netherlands are entitled to a family allowance if their child (biological, adopted, step or foster) is younger than

[233] Unless otherwise indicated, the information in this section is provided by Selten W and Gauthier AH (2014) *Family policies: the Netherlands.* PERFAR. See https://www.perfar.eu/policy/family-children/netherlands - accessed July 2019.
[234] https://www.iamexpat.nl/career/working-in-the-netherlands/sick-maternity-holiday-leave-time-off-work

18 years old. The amount of the family allowance depends on the age of the child (zero-six: €191.65, six-12: €232.71, 12-18: €273.78). Parents get family allowances for their 16 and 17 year-old children only if the children are enrolled in an education programme aimed at obtaining a basic qualification (see below). Furthermore, the parents of children who are earning more than €1,266 per quarter or who are entitled to study benefits are not entitled to a family allowance.

There are also various child and family tax benefits, including benefits for low-income families, lone-parent families, families with young children, and families using childcare facilities. There are also special allowances for families with children with disabilities.

Education policies[235]

The freedom of education is guaranteed under article 23 of the Dutch constitution, and includes the freedom to establish schools, organise teaching, and attend a school based on the student's own convictions. The education system is therefore diverse and reflects various religious, ideological, and educational beliefs. While education has a long history in the Netherlands, the present-day system is complex, as it includes various streams of education designed to position the Netherlands among the world's top five knowledge economies.

Organisation of the educational system

The present-day educational system is comprised of primary education for children ages four to 12 (approximately), secondary education for children ages 12 and over, and higher education. Since 1985, preschools (for four-year-olds) have been integrated into the overall primary school system.

Streaming between different types of education takes place in secondary school. As early as the end of primary school children take a test to assess their numeracy and language skills. The test results, together with

[235] Selten W and Gauthier AH (2014) *Educational policies: the Netherlands.* PERFAR. See https://www.perfar.eu/policy/education/Netherlands - accessed July 2019.

teachers' assessments, are then used to provide advice (which is not binding) to pupils and their parents about the most appropriate type of secondary school.

Students can choose between (i) a four-year pre-vocational education track (VMBO), which may or may not be followed by enrolment in a senior secondary vocational education track (MBO); (ii) a five-year general education track (HAVO); or (iii) a six-year pre-university education track (VWO). Currently, a very large number of schools offer these secondary education programmes. All of these schools are held to the same national standards. The government may intervene if a school does not meet these standards and in some cases has forced the closure of a school. Moreover, and despite the educational streaming, there is a certain degree of flexibility in that there are mechanisms in place to allow students to transfer under certain conditions from VMBO to HAVO, and from HAVO to VWO.

At the tertiary or higher education level, students can choose between pursuing a course within (i) a higher professional education institution (at an HBO, which is sometimes referred to as a high school (hogescholen)), (ii) a university (WO), or (iii) a higher distance learning programme (open university). In recent years, these tertiary institutions have been under increasing pressure by the government to specialise in order to better address the country's societal and economic challenges.

Compulsory education

The Compulsory Education Act of 1901 made primary education compulsory for all children between six and 12 years old. This compulsory education age was extended in 1969, when children became obliged to attend daytime classes starting on the first day of school of the month following their fifth birthday until the end of the school year in which they reach the age of 16. An amendment of the Compulsory Education Act in 2007 required students to attend school until they have obtained a basic qualification (HAVO, VWO, or MBO 2 level). This means that young people

between the ages of 16 and 18 who have finished the compulsory period of education, but who have not yet obtained a basic qualification, are now obliged to continue to attend school.

Child welfare policy[236]

In 2015, the Youth Act took effect, replacing the Youth Care Act 2005. The 2015 Act led to the decentralisation of the youth care system, resulting, since 2015, in local municipalities having responsibility for the organisation and functioning of youth care and associated services. This includes prevention, youth support, child protection measures, juvenile rehabilitation, child health and mental health services. The organisation of youth care at the level of the municipalities aims to improve the accessibility of children and family support services, and therefore to the prevention and early detection of problems. Within this new law, municipalities have an obligation to organise the care that children and young people need. Their local policy should focus on the following key themes, including: prevention and early detection of problems, strengthening the teaching and learning environment, strengthening opportunities and the problem solving abilities of young people and their social networks, improving the safety of children and young people, and taking an integrated approach to care and support for families / children.

The Youth Act also led to the combining of the Advice and Reporting Centres for Child Maltreatment with the Support Centre for Domestic

[236] Most of the information in this section has been taken from an English language summary provided on the website of the Government of the Netherland. See https://www.government.nl/topics/youth-policy/youth-care-and-child-protection - accessed July 2019. This information has been supplemented by further details provided on the Dutch child protection system in Bouma H, López ML, Knorth E & Brietens H (2016) *Briefing on the Dutch child protection system.* HESTIA (an international research project on child protection policy and practice). See http://www.projecthestia.com/wp-content/uploads/2015/03/POLICY-BRIEFING-NL.pdf - accessed July 2019

Violence into a single organisation, the AMHK (*Advies- en Meldpunt Huiselijk geweld en Kindermishandeling*).[237]

The AMHK provides advice on raising children and, when needed, guides parents and children into other areas of the youth care system. Anyone who suspects that a child is being abused or maltreated can also report this (anonymously) to the AMHK.

Care and advice teams

Schools are often the first place where children with problems are identified. When a teacher or other school staff member suspects a child may need professional help, he or she can contact a Care and Advice team. Care and Advice teams, consisting of teachers, youth care professionals, social workers, police and (depending on the situation) other professionals, try to address these problems at an early stage. Every school is obliged to have a Care and Advice team.

Council for Child Protection

If a child is being abused or neglected, legal steps can be taken to safeguard the interests of the child. The Council for Child Protection (or Child Protection Board) decides on which steps to take, based on information provided by the AMHK. Options include:

- Placing a child under the supervision of a family guardian;
- Removing a child from parental custody.

When the Council decides on an approach, a judge has to ratify the decision in court. During these proceedings, the child will also be allowed to speak, if he or she is 12 years or older. The parents will be heard too.

Children's rights

According to the website, Humanium, the Netherlands is one of the most child protective countries in the world. The country's government respects

[237] According to Bouma *et al* (2016), the term AMHK is the name used in legislation. However, in the practice field, the name *Veilig Thuis* (or safe home) is the term generally used.

the majority of principles outlined in the UN Convention on the Rights of the Child, and guarantees an optimal implementation.[238]

Nevertheless, various sources (including the Children's Ombudsman) have highlighted concerns about continuing high levels of child maltreatment (neglect and domestic abuse) in the Netherlands.[239, 240]

Sweden

According to the World Happiness Report 2019, Sweden is the seventh happiest country in the world (out of 156 countries included in the study).

Children and family policies[241]

Sweden is known for its generous family policies aimed at supporting a good balance between work and family life, and the well-being of children. Swedish family policy is organised around goals such as family economic security and physical well-being, children's rights and gender equality.

Sweden spends a bit more than three per cent of GDP on benefits related to children and families, which is one of the highest shares in the European Union. Beside these financial benefits, there is an extensive commitment to the provision of services to families such as highly subsidised childcare, free health and dental care, library services, etc. The guiding principles for family policy are in line with the ideology underpinning the Swedish welfare state, i.e. universal (rather than selective) welfare, general (rather than means-tested) rights, provided in cash or through services. Tax reductions have never been a feature of

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[238] https://www.humanium.org/en/netherlands/

[239] Dutch Ombudsman for Children (2014) *Ombudsperson report on children's rights in The Netherlands*. Report to the Committee on the Rights of the Child. See https://tbinternet.ohchr.org/Treaties/CRC/Shared%20Documents/NLD/INT_CRC_NGO_NLD_17975_E.pdf - accessed July 2019.

[240] Committee on the Rights of the Child (2015) *Concluding observations on the fourth periodic report of the Netherlands (CRC/C/NLD/CO/4)*. See section D: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G15/159/42/PDF/G1515942.pdf?OpenElement – accessed July 2019.

[241] Unless other indicated, information in this section has been taken from Stanfors M and Larsson C (2014) *Family policies: Sweden*. PERFAR. See https://www.perfar.eu/policy/family-children/sweden - accessed July 2019.

Swedish welfare provision. Given the progressive taxation rate, such a design would disproportionately benefit high income earners, which is not the aim in a redistributive social policy.

Family policy applies to all individuals permanently residing in Sweden. Family policy is also highly connected with labour market policy through the ambition that all individuals should be employed and be able to support themselves. The most important means by which family policy ambitions are achieved are through: childcare provision through day care centres and after-school services, parental insurance with job-protected leave rights, and child allowance and other family benefits.

Sweden is often seen as the archetype of the Nordic welfare state model. It has been in the forefront internationally when it comes to family policy and gender equality through a longstanding orientation towards work-family policies targeting men as well as women. Ambitious family policy is commonly seen as a main reason for the strong position of women in the labour market (Sweden has one of the highest female labour force participation rates in the EU) but also for the relatively high fertility rate (almost at replacement level) and low poverty among children (among the lowest in the EU). Generous spending on family benefits, flexible leave and working hours for parents with young children and affordable, high-quality childcare are seen as the main factors which underpin success.

Sweden was the first country in the world to introduce paid parental leave to fathers (not just mothers) in 1974. Since then the policy has been reformed continuously to support greater gender equality. Swedish family policy is based on the dual-earner model and asserts the same rights and obligations regarding family and labour market work for both women and men. Dual-earner support is income-related and individual, which together with individual taxation provides incentives for families to have two incomes instead of one.

Childcare provision

The Swedish government first introduced subsidised childcare in 1943, although publicly provided childcare was small-scale in the beginning and mainly a complement to the already existing crèches run by charity organizations, and Kindergarten, which mainly catered as play schools for upper class children. An expansion of publicly provided day nursery and family day-care capacity began in the 1960s and accelerated in the 1970s when it became a political issue of high priority and seen as an important prerequisite of increased employment of women with young children and the establishment of the two-earner family.

The preschool is a form of early childhood education and care for children aged between one-five years who have not yet entered into the mandatory preschool class.[242] Municipalities are required by the Education Act to provide preschool activities and childcare to all children that live in Sweden and are not enrolled in a preschool class or compulsory education. Generally children should be offered a spot in preschool from the age of one. Children have the right to attend preschool to the extent necessary for their parents to be able to work or study, or based on the child's own needs. This requirement includes preschool for children whose parents are unemployed or on parental leave with another sibling. These children should be offered a place in preschool for at least three hours per day or 15 hours per week. All children are entitled to free preschool for at least 525 hours per year from the autumn term when they turn three years old.

Sweden's maximum fee policy makes childcare affordable. Fees are calculated according to income with low-income families paying nothing while the cost is capped for all families. The remaining cost of childcare is subsidised by the municipalities. In 2017, 84% of children in Sweden aged one–five year's old attended preschool.

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[242] *Sweden: Early Childhood Education and Care*. 2018. See https://eacea.ec.europa.eu/national-policies/eurydice/content/early-childhood-education-and-care-80_en - accessed July 2019.

When a child turns six, he or she can participate in a non-compulsory pre-school year, which is free of charge and includes a hot lunch. It is designed to facilitate the transition from pre-school / day care to school and help children get accustomed to the school situation and prepare for primary school in a playful and non-demanding manner (without heavy studies or homework). School hours vary by municipality and after-school care is available.

Parental benefits

Parental leave allowances in Sweden are considered to be among the most generous in the world. Swedish law distinguishes between the right to 'parental leave' and the right to 'parental benefits'. Parents are entitled to be on full-time leave until the child turns 18 months, whereas parental benefits support opportunities for parents to combine work or studies with parenthood. Parental benefits apply to everyone living or working in Sweden and are covered by national health insurance.

Parental leave in Sweden is job-protected and granted by law to employed men and women. Employers may not discriminate against job applicants or employees for reasons related to his/her parental leave when it comes to employment, promotion, training, allocation of work, or dismissal, etc.

Parental benefits are paid out for 480 days (approximately 16 months) for one child. For 390 days, the compensation is linked to income (at the sickness benefit level, i.e. 80% of gross income in the previous 240 days, capped at a maximum €105 per day). For the other 90 days, the compensation is at a flat rate of €20 euros per day. The first 180 days must be days at the sickness benefit level. For children born before 1st January, 2014, each parent receives half of the 480 days but 60 days at the sickness benefit level are reserved for each parent while the rest of the days can be transferred between parents. For children born in 2014 or later, each parent receives 195 days each at the sickness benefit level and 45 days each at the minimum level, however, days can be transferred with the

exception of the aforementioned 60 days at the sickness benefit level that are reserved to each parent.

Single parents or parents with sole custody of the child are entitled to take all 480 days. Parents who have multiple births get extra: twins (90 days extra at the sickness benefit level and 90 days extra at the flat rate), triplets or more (180 days extra at the sickness benefit level for each child). Two parents can take out parental benefits for each child and thereby be home at the same time. Parents with a low income or no income receive approximately €25 euros per day at sickness benefit level. Parents who are registered job seekers receive parental benefits based on the income he/she had before when employed, i.e. at sickness benefit level. Students with no income from work get approximately €25, but if they worked before starting the education, they can receive parental benefits that are based on the latest salary.

Parents may use parental benefits until the child is eight or completes its first year at school. If the child is born on 1st January 2014 or later, the benefits may be taken out until the day the child turns 12 or completes its fifth year at elementary school.

There are also temporary parental benefits that are paid to parents who stay home from work to look after a sick child under the age of 12 (in some cases 16). Temporary parental benefit may also be paid in certain other cases, for example when the child's regular caregiver is ill. The father of a newborn baby is entitled to ten days of temporary parental benefit in connection with the child's birth. If the child is adopted, the parents are entitled to five days each. The pregnancy benefit is a kind of maternity protection which applies to women with physically demanding jobs who cannot work towards the end of pregnancy. Moreover, a woman who is not allowed to perform her ordinary work due to risks in the working environment may also receive pregnancy benefit.

Family allowances

The most important family allowances in Sweden are related to family policy and the social insurance system. They include different types of benefits that vary in importance for the family economy: parental benefits, child allowance, study assistance, maintenance support, housing allowance as well as family allowance during military service. The various forms of family allowance contribute to creating a good economic standard of living and increase freedom of choice for families with children and promote opportunities for parents to combine work and family life. All benefits, with the exception of study assistance, are administered by the Swedish Social Insurance Agency. The Swedish social insurance covers everyone that lives or works in Sweden and provides financial protection for families and children, for persons with a disability and in connection with work injury, illness and old age with the purpose to give financial security to families during periods with heavy burden of provision. The Swedish Social Insurance Agency ensures that different regulations are applied uniformly and fairly throughout the country. Decisions regarding benefits can be appealed in the manner that generally applies to administrative decisions. Study assistance (and other types of student financial aid) is administered by the National Board for Student Aid. It relates to a legal framework that is different from the social insurance. The board's decisions in study assistance matters may not be appealed, but cases may be re-examined to the advantage of the individual student.

All families with children living in Sweden receive financial support in the form of child allowance. A flat rate (tax-free, currently €115 per month) is automatically paid to the mother from the month following the birth of a child, or later, if, for example, the child moves into Sweden. The child allowance is paid up to and including the quarter of the year when the child turns 16. If the child is enrolled in full-time education (typically upper secondary school) the National Board of Student Aid will pay a study allowance. If this is the case, it is paid automatically without the need to

apply. A supplementary allowance for additional children is paid to families with two or more children. The state contributes a fixed sum to cover the costs of adoptions of foreign children if they are adopted through an authorized adoption organization.

Among the means-tested allowances, the housing allowance is for households with children living at home (either permanently or temporary). It may also be paid to young adults (younger than 29). The amount paid depends on housing costs, the size of the home, household income and number of children living at home. Parents are liable to contribute to their child's maintenance according to their ability. When a child lives with only one parent, the other parent should pay child support to support the child. There is maintenance support for single parents, which guarantees that children whose parents are living apart receive a certain allowance even when the parent liable to pay maintenance does not comply. It is paid to the parent with whom the child is living or it is paid directly to the child. Child support to children can be established by agreement between the parents or by a court. If the child is 18, child support is paid through an agreement between him / her and the parent who does not live with the child.

There is also a care allowance for parents of a child who has a disability or a severe illness (both temporary and long-term). The care allowance is intended to cover the extra costs entailed by the illness / disability or if the child needs extra supervision.

The municipal child-raising allowance is another form of family allowance. It is a voluntary form of financial support to families, which the municipalities can choose to introduce, finance and administer. The child-raising allowance provides greater opportunities for parents to stay at home and look after their child while the child is between one and three years of age. The benefit is paid on two conditions: (i) that the parents have already used 250 (or more) days of parental leave, and (ii) that they do not

enrol the child in full-time preschool. The maximum amount paid is low – €325 euros per month.

Family allowances are adjusted at regular intervals; some even change annually, taking into consideration changes in the price base amount (which reflects inflation). This is intended to adjust the value of the allowances to the cost of living. When it comes to housing allowances and child support, the benefits may be increased or decreased depending on the household's income.

Education policies[243]

In Sweden, all children aged seven-16 are required to attend school. There are ten years of compulsory schooling, divided into four stages: *förskoleklass* ('pre-school year', year zero), *lågstadiet* (years one–three), *mellanstadiet* (years four–six) and *högstadiet* (years seven–nine). Most children then go on to the optional *gymnasium* (upper secondary school, years ten–12) and graduate when they are 18–19. All children who are between six and 13 years old are offered out-of-school care before and after school hours.

Since 1977, all teachers are trained at teacher training colleges that are part of the higher education system. However, the number of academic courses each prospective teacher must take varies depending on the level at which he or she will be teaching. Both the quality and the quantity of the training teachers receive have been debated over the years. Most recently, the quality of the teacher training programmes has been the focus of discussions. At the same time, however, there is a shortage of trained teachers, and the number of non-trained personnel working in Swedish schools has increased.

[243] Stanfors M (2014) *Educational policies: Sweden*. PERFAR. See https://www.perfar.eu/policy/education/sweden.

Organisation of the educational system

Pre-primary education

While there is no compulsory pre-primary education in Sweden, more than 80% of all children ages one-six are in pre-school day care. Pre-school is an environment in which children are expected to learn in a playful manner. The year before compulsory school, all children are offered pre-primary school care, which combines the educational concepts of pre-school with those of primary school. The majority of six-year-olds participate in this school-based day care, which allows them to become accustomed to the school learning environment.

Primary education

Primary education lasts nine years and is compulsory for children ages seven-16. Comprehensive school is divided into three levels. The majority of schools are run by municipalities, but there are also independent schools which share objectives, but may differ in orientation. The comprehensive school is inclusive, and many children with special needs attend regular schools and receive assistance as needed. Relatively few children attend special schools, and home tuition is extremely rare. Primary education is free of charge.

Secondary education

Almost all (98%) students who finish comprehensive school go on to secondary school. All secondary programmes prepare students for higher education, although the extent to which they prepare students for academic programmes and provide them with a diversity of choices varies considerably. Compared to vocational programmes, general secondary programmes with a theoretical focus provide students with more choices when it comes to higher education. There is an even distribution of students in general (51%) and vocational (49%) programmes. Almost half of all students who graduate from secondary schools go on to higher education within three years. Secondary education is free of charge.

Tertiary education

Swedish universities date back to the founding of Uppsala University in 1477. Today higher education is provided by a wide range of institutions founded on teaching and research.

In Sweden, there are 14 public universities and 20 public colleges, as well as another 17 institutions that provide various kinds of higher education. Around 90% of higher education is provided by public institutions. Currently, higher education is the largest single area of public sector spending in Sweden, amounting to 60 billion SEK per year (or 2% of Sweden's GDP). There is an increasing tendency among universities and colleges to collaborate in order to make more efficient use of government resources.

Higher education is distinguishable from other types of post-secondary education in that it is based on the subjects taught in secondary education, and on advanced scientific (or artistic) methodologies and results. Although there are a number of professional and artistic programmes offered by institutions of higher education, they are much more academic than the primarily vocational post-secondary education programmes offered outside of the system of tertiary education.

Most higher education programmes follow the Bologna degree structure, and thus provide either undergraduate (bachelor's) or advanced (master's) degrees. The privilege of offering doctoral degrees was formerly reserved to universities but has recently been extended to a number of colleges. Like other kinds of education, higher education was free for all until autumn 2011, when fees were introduced for students from outside of Sweden, the EU/EEA, and Switzerland.

Child welfare policy in Sweden[244]

In Sweden, each of the country's 290 municipalities has a social services organisation managed by a local 'Social Welfare Board' of politically-appointed laypersons who are mandated to ensure that children in need or at risk of harm receive the support and protection they need.

Specifically, this board determines whether or not children can be placed in out-of-home care. On the frontlines, social workers offer both children and parents various kinds of support depending on whether a case has come to the attention of the social services through mandatory reporting (schools, health services, police) or whether parents have voluntarily applied for services. Sweden does not have specific child welfare legislation. It is instead integrated into the Social Services Act which is a framing law that covers support for children and families but also for persons in need of financial assistance or who have substance abuse problems. Sweden's child welfare system has thus been described as a combination of controlling and supportive.

In the broader area of child welfare and child protection policy, efforts have been made to categorise the Swedish 'system'. The 'system' is widely regarded as a child welfare 'system', as contrasted to a child protection 'system', and one which has a child focused orientation with aspects of family service as well. A family service orientation tends to view the child's problems as systemic and intervention therefore focuses on strengthening the family's capacities and family relations through parental support. A child focused orientation is framed around child development and outcomes where the child's present and future needs are emphasised along with valuing highly the child's perspective.

[244] The information in this section is taken from Gümüscü A, Nygren L and Khoo E (2018) Social work and the management of complexity in Swedish child welfare services. *Nordic Social Work Research*.

Children's rights

The website, Humanium, describes Sweden as a 'children's paradise', where children's rights are widely respected.[245] The main criticism against Sweden is that children's rights in the country are implemented inconsistently. In reality, there are disparities between municipalities and even between regions as these entities possess much autonomy on children's issues. This means that some young people are less protected than others because they live in places where their wellbeing and specific needs are not sufficiently taken into account.

In 1979, Sweden became the first country to ban corporal punishment of children. By introducing a ban in the Parent Code, which is a civil code, Swedish law explicitly states that parents cannot use any form of violence or other humiliating treatment as part of bringing up their children.[246] Sweden has decided to incorporate the UN Convention into Swedish law from 1st January 2020.[247]

[245] https://www.humanium.org/en/sweden/
[246] https://sweden.se/society/children-and-young-people-in-sweden/
[247] Ibid.

6. Scotland's performance on indicators of a happy childhood

As stated earlier in this report, the Scottish Government's ambition is to make Scotland the best place in the world to grow up. This section examines current evidence on whether Scotland is improving, getting worse, or staying the same in relation to indicators of a happy childhood.

Scottish Government official statistics on child well-being

The Scottish Government's National Performance Framework[248], (NPF) identifies a National Outcome for its children and young people that they should grow up 'loved, safe and respected so they realise their full potential'. Seven indicators have been developed to measure progress towards this National Outcome.[249] These are:

- **Child social and physical development**: The percentage of eligible children with no concerns at their 27- to 30-month child health review[250]
- **Child well-being and happiness**: The proportion of children aged 4-12 who had a borderline or abnormal total difficulties score (based on the Strength and Difficulties Questionnaire (SDQ))[251]
- **Children's voices**: Percentage of young people who feel adults take their views into account in decisions that affect their lives

[248] https://nationalperformance.gov.scot/
[249] Following the National Performance Framework review in 2018, some new child well-being indicators are in the process of development, and are therefore not referred to here.
[250] https://www2.gov.scot/Resource/0041/00410922.pdf
[251] The 'Strengths and Difficulties Questionnaire' (SDQ) is a standard measure of mental health and well-being which gives a measure of **overall** mental health and well-being, together with scores for five separate scales. The five scales cover emotional symptoms, conduct problems, hyperactivity / inattention, peer relationship problems, and pro-social behaviour.
See https://www.corc.uk.net/outcome-experience-measures/strengths-and-difficulties-questionnaire/

- **Healthy start**: Perinatal Mortality Rate per 1,000 births (stillbirths plus deaths in the first week of life)
- **Quality of children's services**: Percentage of settings providing funded Early Learning and Childcare (ELC) achieving 'good' or better across all four quality themes
- **Children have positive relationships**: Percentage of S2 and S4 pupils who report having three or more close friends
- **Child material deprivation**: Percentage of children in combined material deprivation and low income after housing costs (below 70% of UK median income).

Official Scottish Government statistics provide an incomplete and somewhat mixed picture of how Scotland is doing in relation to these seven indicators.[252] Trend data available for two of the indicators (quality of children's services and child material deprivation) suggests that there has been no change over the past few years.

In relation to the other five indicators, information on performance for the most recent year is still to be confirmed. For three of these five (child well-being and happiness, children's voices, and children have positive relationships), this means that there is currently no trend data available. For the other two indicators, there was an improving picture between 2013/14 and 2016/17 in relation to child physical and social development, and an overall improving picture between 2011 and 2016 on healthy start. However, with respect to the latter indicator, the general downward trend in perinatal mortality since 2011 changed direction (i.e. got worse) in 2016.

[252] https://nationalperformance.gov.scot/index.php/measuring-progress/national-indicator-performance

Other sources of information on child well-being and happiness

There is some information available from other sources on child well-being and happiness (one of the seven Scottish Government indicators for which there is currently no trend data available) – however it is not recent.

SALSUS – SDQ scores from 2006 - 2013

Research carried out by Black and Martin (2015)[253] reported that between 2006 and 2013, SDQ scores[254] for young people in Scotland remained fairly constant. This overall picture is the result of compensating and contrasting trends amongst the individual components of the SDQ score. In particular, fewer young people had conduct problems in 2013 compared to 2006 and, similarly, pro-social behaviour has been improving gradually since 2006. There has also been a small decrease in hyperactivity. In contrast, emotional problems and, to a lesser extent, peer problems, have worsened over time, with the main deterioration happening between 2010 and 2013.

Black and Martin also highlighted that, one of the most important findings of this study was the striking difference in results for 15-year old girls compared with the other groups (11- and 13-year old girls and boys). In terms of overall mental health and well-being, in 2013, 39% of 15-year old girls were abnormal / borderline on the SDQ scale. In 2010, the corresponding figure was 29%. This difference was statistically significant.

Health Behaviour of School-aged Children (Scottish survey)

Findings from the HBSC survey in Scotland also provide trend data and indicate a changing picture – not always in a positive direction – and

[253] Black, C and Martin, C. (2015) *Mental health and wellbeing among adolescents in Scotland: profile and trends. An Official Statistics Publication for Scotland.* See https://dera.ioe.ac.uk/24715/1/00488358.pdf

[254] Collected through the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS).

particularly for 15-year old girls. Some of the findings from this survey were that:[255]

- Between 2002 and 2014, an increased proportion of 11- and 13-year olds reported high life satisfaction. However, in the same period, there was a decrease in the proportion of 15-year olds reporting high life satisfaction.
- Between 2006 and 2014, health-related quality of life (measured using the KIDSCREEN-ten scale[256]) declined among 15-year old girls **and** boys.
- Between 1994 and 2014, there was an increase in the proportion of 13-year old and 15-year old girls reporting two or more psychological complaints. (The findings do not indicate the time period over which these complaints were experienced – i.e. in a week, in a month, or over a longer period.)

Summary

Official Scottish Government statistics and information from other surveys provide an incomplete picture about whether the experience of childhood in Scotland is improving. The available information indicates that certain aspects of childhood are stable and, in some cases (particularly for younger children), may be improving. However, there is evidence that well-being among 15-year olds, and particularly, 15-year old girls has been in decline from the 1990s onwards.

[255] Cosma A, Rhodes G, Currie C and Inchley J (2016) *Mental and emotional well-being in Scottish adolescents. HBSC briefing paper 24.* See http://www.cahru.org/content/03-publications/03-briefing-papers-and-factsheets/bp24.pdf
[256] https://www.kidscreen.org/english/

7. The experience of a 'good childhood' among children in care

This section briefly discusses what is known about the extent to which children and young people in care are experiencing a 'good childhood'. As there is no systematically collected data on the experiences of children in care in Scotland, this section will refer to data from an ongoing study in England and Wales collected by the Bright Spots programme.

The Bright Spots programme

The Bright Spots programme, developed by Coram Voice and the University of Bristol, has created a set of well-being indicators to allow services to design their work around what children and young people say is important to them.[257,] 258 Two online surveys – Your Life, Your Care (YLYC) and Your Life Beyond Care (YLBC) – have now been used widely by both English and Welsh local authorities, and national reports have been published on an annual basis since 2015.[259]

This programme of work identified four key domains that children in care said were important aspects of their well-being:

- Relationships (Indicators include: contact with birth parents, siblings and pets; trusting relationships with social workers, carers and friends; stability of placements; continuity with social workers)

[257] Selwyn J and Wood M (2015) Measuring wellbeing: a literature review. London: Coram Voice. University of Bristol, Hadley Centre for Adoption and Foster Care Studies and Coram Voice.
[258] Coram Voice and Hadley Centre for Adoption and Foster Care Studies (2015) Children and young people's views on being in care: A literature review. Bristol: University of Bristol.
[259] To date, the YLYC surveys have been used in 28 English and six Welsh local authorities. The most recent national report is based on the views of 2,684 children (aged four-18) from 17 local authorities in England. The YLBC survey covered 474 children and young people from six local authorities in 2018.

- Resilience (Indicators include: having a key trusted adult; opportunities to play, have hobbies and access to the natural world; getting second chances; enjoying school; support for learning; learning life skills)
- Rights (Indicators include: feeling free and safe from bullying; knowing and being able to contact your social worker; having the right to speak in private; feeling included in social work decision making; not being made to feel different because 'looked after')
- Recovery (Indicators include: feeling settled, liking bedroom and having sensitive carers; being trusted; parity with peers; access to computers / tablets; support services to help with difficulties; having an age appropriate account of personal history; happiness with appearance; feeling that life is getting better)

Questions were created from each of the indicators and to these were added four questions used in community surveys of children and adults. The four questions, using a scale of zero-ten, ask about overall life satisfaction, happiness, feeling that life is worthwhile and feeling positive about the future.

Measuring the well-being of children in care

The 2017/18 survey gathered views from a sample of 2,684 children in care from 17 English local authorities. This sample comprised four to seven year olds (total 397), eight to 11 year olds in primary school (total 656) and 11 to 18 year olds in secondary school (total 1631). Some of the key findings from this survey were that:

Children aged four-seven

- 97% of children in care aged four-seven reported moderate to high well-being.
- Among the 3% in this age group who reported low well-being were children who did not understand why they were in care and did not know who their social worker was. A few of these children were also

very unsettled in their placements, not trusting their carers and not believing their carers noticed how they were feeling.

- 92% of this group said that they mostly liked school.

Children aged eight-ten

- 96% of children in care aged eight-ten reported moderate to high well-being with most children saying they felt safe and settled.
- The vast majority (97%) trusted their carer, had a trusted adult in their lives (96%), and trusted their social worker (89%).
- Only one in ten of this group (13%) said they did not know who their social worker was.
- Generally, children in this age group were more satisfied with the contact they had with their parents than those in the 11-18 age group. However, around a third said they wanted more parental contact, and 5% wanted less parental contact. 13% of this group had no contact with either of their parents.
- The majority (52%) were satisfied with the amount of contact they had with siblings, but 16% wanted less.
- 88% liked school 'a lot' or 'a bit' and felt their carers were interested in what they were doing in school. However, 30% were afraid to go to school because of bullying.
- Children in this age group who reported low well-being (four %) appeared to be isolated and have unsatisfactory contact arrangements (reporting either too little or too much). They did not feel safe or settled in their placements, did not have a trusted adult in their lives, did not feel included in decision-making, did not trust their social worker or have a good friend.

Children aged 11-18

- 82% of children in care aged 11-18 reported moderate to high well-being. Well-being was higher for those who had been looked after for two years or more.

- 83% of this group thought life was getting better. Compared to young people in the general population, a larger proportion of looked after young people felt safe where they were living; more boys liked school; and both girls and boys felt that their carers were interested in what they were doing in school.
- 92% had a trusted adult in their lives. Most trusted their social workers and thought their carers were sensitive and noticed how they were feeling.
- However, one in ten of the children in this age group said that they did not have a good friend. Not having friends was associated with moves in care, and not having access to a computer / tablet outside school.
- Over a quarter (28%) of the young people in this group had no contact with either parent. The lack of contact was often the young person's choice, though many also wished that their parents could be more reliable and caring. In addition, more than a quarter also said that the contact they had with their parents was not often enough.
- A third of this group (33%) wanted more contact with their siblings.
- 60% of this group worried 'most' or 'some of the time' about their feelings or behaviour. More than a fifth though they were getting insufficient help with their worries.
- Around a third (31%) of this group said they had had three or more social workers in the previous year. Young people with frequent changes in social workers were less likely to trust their social workers.

The study concluded that the majority of children and young people in care had similar levels of subjective well-being as their peers in the general population. However, relationships with social workers and carers were important in improving well-being.

Low well-being was associated with (i) lack of positive relationships in their lives, and (ii) their rights not being met (i.e. feeling excluded from decision-

making, feeling unsafe or unsettled in placements, and feeling that they were not being taught life skills.

Measuring well-being among care leavers

The 2018 Bright Spots survey among care leavers found that the relatively positive picture in terms of looked after children's subjective well-being does not endure.[260] Care leavers reported much lower levels of subjective well-being both in comparison to their peers in the general population (aged 16 to 24) and compared to adolescents in care (aged 11-18).

For example, almost one in four care leavers (in England) (23%) have low life satisfaction, compared to just 3% of 16 to 24 year olds in the general population. In addition, compared to the general population of young people, a higher proportion of care leavers have low wellbeing across a number of measures. A fifth (20%) of care leavers said they did not feel that things they did in life were worthwhile, in contrast to just 4% of their peers, whilst one in five care leavers (19%) said they felt lonely always or most of the time, compared to one in ten young people in the general population.

Summary

Based on the findings of the Bright Spots study, children in care have similar levels of well-being to children in the general population. The importance of having trusted adults in their lives, and feeling safe and settled in placements are crucial for children in care.

Unfortunately, the relatively good levels of well-being reported by children in care appear not to be sustained upon leaving care.

[260] https://coramvoice.org.uk/sites/default/files/cv-olbc-snapshot-a2-poster_1.4.19.pdf

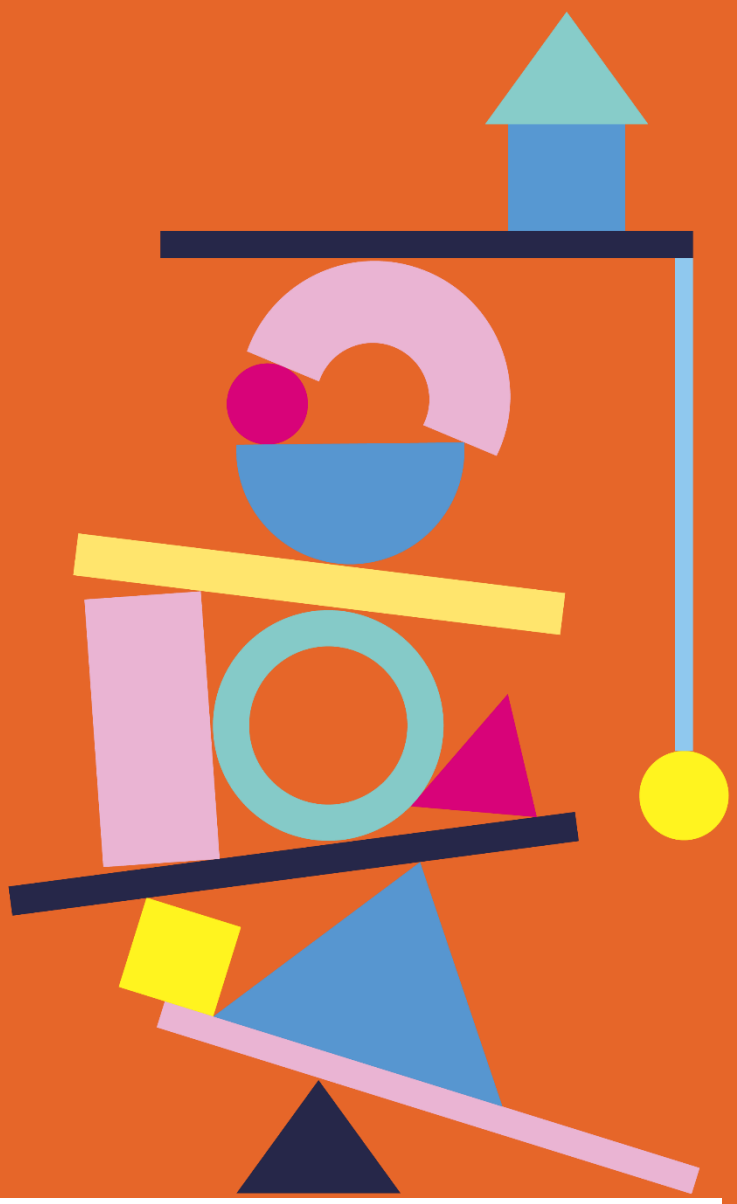
8. Concluding remarks

The information presented in this review suggests that, in terms of Scotland being the best place in the world to grow up, there is plenty of room for improvement.

At present, there is a lack of data to be confident about whether childhood in Scotland is getting better, or worse. However, there is some indication that it is getting better for younger children and worse for older adolescents.

Data from England suggests that the well-being of children in care is similar to that of their non-looked after peers. However, once young people leave care, they appear to fare worse in terms of their well-being than young people in the general population.

Components of Care



'Care Journeys': A review of the evidence on children's moves into, through and out of care

Claire Baker, Dawn Griesbach and Jennifer Waterton

June 2019

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1. Introduction

Background

In spring 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and the workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[261]

The 'care journeys' of children and young people

This report presents a review of the evidence in relation to the following questions:

- What evidence is available about the experience of children and young people's 'journey(s)' through the 'care system'?
- What do we know about (one) the factors which help facilitate 'good journeys' through the 'care system'? And (two) the factors that help

[261] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

to mitigate negative consequences in relation to moves and transitions in the 'care system'?

Scope of the evidence review

The primary focus of this review is on children's 'journeys' whilst in the 'care system'; it explores common pathways and children's experience of 'stability'. However, the 'care system' does not operate in a vacuum. Children's experiences whilst in care are strongly influenced by what has gone before and what plans there are for the future. Despite this reality this paper does not look in detail at the experiences of children and families prior to entering the 'care system', nor does it focus in any depth on how children fare after leaving the 'care system'. Evidence related to children at these 'edges' of the 'care system' are explored in a separate review[262] which covers associated issues such as the children's hearing system and the experiences of care leavers.

Structure of the report

The report is structured as follows:

- Section two reports relevant findings from the Discovery stage of the Care Review;
- Section three provides definitions and background information on the 'care system' and summarises evidence in relation to the purpose of the 'care system' and what is known about who enters care, the reasons for this and where children commonly live;
- Section four looks at the available evidence on 'care journeys' detailing children's experiences of entry into, through and out of care;
- Section five focuses on the importance of stability for children in care and what can promote or inhibit this;

[262] 'Edges of care' ICR evidence review, Jennifer Waterton, Claire Baker, Dawn Griesbach, July 2019

- Section six looks at children's experiences of decision-making about their 'care journeys';
- Section seven outlines some concluding thoughts.

2. Findings from the Discovery stage of the Care Review

The Discovery stage of the Care Review found that:

The importance of 'stability' to children and young people in care was threaded throughout the comments. Many children in care reported they had too many disruptions in their lives: these involved changes to where they lived; where they went to school and who their worker was. They told the Care Review how these experiences impacted negatively on their lives. Moving around notably disrupted their friendships, interrupted their education and affected the relationships they had. (1000 Voices report)

Many who shared their views in the Discovery stage wanted the Care Review to understand further why children in care moved so often, and to minimise unnecessary moves. Children wanted their views to be sought and to have a say when decisions about their lives, such as where they lived or where they went to school, were being made. (1000 Voices report)

In identifying what the best 'care system' in Scotland would look like, one of the key themes to emerge from the views of children, parents and professionals, was making sure connections were made across children's lives. Children's care experiences were inextricably linked to what had happened before entering care, what happened during their time in care and what happened after. It was important to children that these connections were made and there was coherence between their care experiences and other aspects of their lives. (Baker review, 2017a)

The government statistical outcomes for 'looked after' children cover, to some extent, children's experience of movement within the 'care system'. They do not capture the number of placement moves that a child or young person experiences over their full time in care. However, they do report the number of placements 'looked after' children have experienced

in a year. Of the 14,738 children in care the vast majority, nearly four-fifths were recorded as having one placement (79%) in 2018. Of the remainder, 15% (2,270 children) had two placements, and 5% (758 children) had three or more placements in the last year. Currently the national statistics do not provide the reason(s) for placement moves. (Scottish Government, 2019)

3. Setting the scene: The 'care system'

There is no single or easy way to understand the 'care system' in Scotland in its entirety. The available research and statistics tend not to give a complete picture of looked after children's collective experiences. Information tends to focus on particular settings (such as foster or residential care) or individual stages of children's care journeys.

This review paper has attempted to pull together some of this disparate information in order to address the questions identified above. Before doing so definitional issues are addressed followed by a short summary of who enters care, why children need care and the types of places where children live whilst in care.

What is meant by the 'care system' and 'components of care'?

A child or young person has 'care experience' when the state has, or had, a formal role in looking after them during their childhood (Frameworks, 2018). Some commentators have highlighted the unique nature of the relationship established when children are looked after:

> *'When the state decides to take on the responsibility for parenting children who cannot live safely with their birth family, it creates a unique relationship between the child and the state-as-parent that is not replicated elsewhere in the many relationships that exist between citizens and their government.' (Access All Areas, 2012)*

In Scotland most looked after children fall into two broad categories:

1. *Looked after at home*; where a child has been through the Children's Hearings system and is subject to a supervision

requirement involving regular contact with social services with no condition of residence.

2. *Looked after away from home*[263] where a child is cared for away from where they normally live and are looked after in range of settings, e.g. with foster or kinship carers, or in a residential care home.

The children's 'care system' consists of a collection of agencies, departments and individuals responsible for meeting the needs of children for whom the state has intervened to provide care and support who either cannot live safely with their birth family or who need support to do so. It involves coordination between social work services, education, health care, the Children's Hearings System, and others (FrameWorks, 2018).

Acknowledging this complexity the Care Review's Components working group has mapped the different components of the 'care system'[264] in a way which emphasises the many and varied aspects of the 'system', and how these are connected. The group has sought to shift focus from simply looking at children's experiences of their 'placements' to understanding 'all aspects of the life cycle of care in a child's life' including the relationships between children and their environments.

The role of the 'care system' in supporting children and families

Two main approaches to formal State support for children and families are commonly identified (Thoburn, 2014; Bowyer and Wilkinson, 2013). The first

[263] Children looked after away from home have either been through the Children's Hearings system and are subject to a Compulsory Supervision Order with a condition of residence; subject to an order made or warrant granted by virtue of chapter 2, 3 or 4 of Part 2 of the Children (Scotland) Act 1995; being provided with accommodation under Section 25 (a voluntary agreement) or is placed by a local authority which has made a Permanence Order under section 80 of the Adoption and Children Act 2007 https://www.gov.scot/policies/looked-after-children/

[264] The Care Review components of care diagram lists the following components (not listed in any hierarchy or order): legal system; policy/legislation; assessment; record keeping; standards & regulations; education; health (SHANARRI); rights & responsibilities; love; contact & connections; living with others; workforce, people & pets; decision and decision making processes; leaving care/ throughcare; placements, buildings & locations; resource & money; participation; human ecology model; culture & ethos and knowledge & research

approach broadly sees 'care' as part of a continuum of services whilst the second approach tends to support a model of care which is more incident-focused whereby 'care' is largely regarded as a 'last resort' option for children. To expand further:

1. *A 'child and welfare' approach or 'partnership with parents' approach* – here the state provides a range of services to families who are experiencing problems where children are at risk. Predominantly 'care' is viewed as a family support service aiming to keep families together. Care has a positive role to play as part of a range of services to support children in need and their families.
2. *A 'child safety' or 'child protection' approach* – here there is a general belief that welfare services should only be used when absolutely necessary and entry to care should be avoided where possible. 'Care' is usually seen as distinct from a wider continuum of services for children. 'Care' is primarily viewed as a response to allegations of abuse.

These two approaches are not necessarily mutually exclusive, and the dominance of one or other of these approaches within any specific country may vary over time.

Supporting children's resilience and well-being

Once children are 'looked after' a primary aim of the 'care system' is to keep children safe and to support their resilience, well-being and in some cases recovery. The anchor statement of the Care Review components group recognises this, as does the work by Frameworks, 2018, as described below:

> *'When we are navigating the complexities of the 'systems' in the Care Review, a good practice to keep us anchored and centred in our work is the reminder: does this part of the 'system' provide: 'safe, stable emotionally available, consistent, nurturing relationships and*

environments that enable people to reach their full potential?' (Care Review components group, 2019)

'The primary purpose of the 'care system' is to support children's growth and development. All care-experienced children have endured some form of trauma or adversity, but the ways in which they interact with the 'care system' vary considerably across individuals. Experts therefore argued that the 'care system' should be child-centred and flexible. It should not only address the effects of past experiences, but also support individuals to live full and productive lives. According to experts, the 'system's' job is to support children to both 'heal and flourish'. (Frameworks, 2018)

Achieving 'Permanence' and 'Stability'

A core tenet of current Scottish policy on looked after children is 'early permanence' (Mitchell and Porter, 2016; Scottish Government, 2015). This requires the 'care system' to work towards making sure children achieve the best permanent placement for them as quickly as possible. In Scotland all local authorities should be invited to use an improvement methodology as part of the PACE[265] (Permanence and Care Excellence) programme to identify and address drift and delay in permanence processes.

Permanence for looked after children implies that they do not move around the 'care system', but rather have a sense of belonging and connectedness and people they can rely on (Baker, 2006; Sinclair, 2005; Sinclair et al, 2007; Schofield et. al 2012). The concept of 'permanence' emerged in the 1970s in response to concerns that children were 'drifting in care' with no effective planning in place to provide them with long-term stability and continuity in their relationships (Sinclair 2007).

In Scottish policy 'permanence' is defined as providing children with a stable, secure, nurturing home and relationships, where possible within a

[265] https://www.gov.scot/policies/looked-after-children/permanence-and-care-excellence/

family setting, that continues into adulthood' (cited in Mitchell, 2016[266]). Routes to permanence include:

- Returning or remaining at home with or after support, where family functioning has stabilised and the parent(s) can provide a safe, sustainable home which supports the wellbeing of the child. This may require on-going support for the family.
- The use of a Permanence Order. This will specify that permanence is achieved through kinship care, foster care or residential care arrangements.
- A section 11(1) order (for parental responsibilities and rights, residence or guardianship) under the Children (Scotland) Act 1995. From April 2016 (as part of the Children and Young People (Scotland) Act 2014, where kinship carers have such an order these are now known as a Kinship Care Order.
- Adoption, where the child has the potential to become a full member of another family (Scottish Government, 2015).

Recent discourse has called for a shift in the conceptualisation of permanence away from one which mainly conceives of it in relation to 'legal status' towards a principle that underlies planning for all looked after children regardless of the *type* of placement they have or the stage they are at in their care journey (Care Inquiry 2013a). From this wider perspective the main permanence options are expanded and include:

- Returning or remaining at home
- Shared care arrangements (involves children living in different settings but as part of a structured plan)
- Permanence within the looked after 'system' (residential placement, foster care or kinship care)
- Legal permanence (e.g. adoption; permanence orders).

[266] https://www.gov.scot/publications/getting-right-looked-children-young-people-strategy/pages/2/

From either viewpoint what is central to permanence is the quality and continuity of the relationships children have and the quality of care provided to children. Stability is an essential element of 'permanence' and Section five looks at this in more detail (Care Inquiry, 2013a, 2013b).

Why children enter care

Children and young people enter the 'care system' when their parents are unable to provide adequate care or protection, or where the child otherwise requires some form of compulsory supervision.

In 2018, the Scottish Children's Reporter Administration (SCRA) reported that for the year ending 31 March 2018:

- Of the 13,240 children and young people referred to the Children's Reporter, 85% were referred because of care and protection concerns and 23% were referred because of offending. Note that these figures do not total 100% because 8% of children were referred on both care and protection AND offending grounds.
- The most common grounds for referral in this period was 'lack of parental care' (35% of referrals), followed by (the child's) 'offending' (23%), and (the child's) 'close connection with a person who has carried out domestic abuse' (17%).
- Of the 13,240 children referred in this period, 16% were already in the 'care system' – i.e. on a Compulsory Supervision Order.

It's important to keep in mind, though, that not all the children who are referred to the Children's Reporter will go on to become looked after. Many referrals are discharged without a hearing ever taking place, and just 2,918 new Compulsory Supervision Orders were made in the year ending 31 March 2018. However, this information from SCRA provides part of the story that explains why children come into care in Scotland.

In England the reasons for entry to care are recorded in government statistics; the largest group of children are recorded as entering care for reasons connected with 'abuse or neglect'[267].

In reality, a range of factors are likely to inform decisions which lead to children being looked after including maltreatment and neglect associated with parental substance misuse, parental mental health problems, and domestic violence (Whincup, 2019). Multiple family difficulties such as poverty, social exclusion, chronic unemployment, poor housing and lack of community resources can all increase the likelihood that a family will become involved in the 'care system'. These conditions can reduce parents' capacity to look after their own well-being and that of their child(ren) and their ability to create a safe and nurturing environment for their child(ren) (Frameworks, 2018; Care Review Edges paper, 2019; Whincup, 2019).

Unaccompanied asylum seekers, those who have a parent in prison, and children with complex health and behavioural needs are also more likely to become involved with the 'care system' than those without these experiences (Cusworth, 2019; Frameworks, 2018; Care Review Justice paper, 2019).

In summary, a substantial body of research has documented children's pre-care experiences and concludes that:

> *'Entering care is strongly associated with poverty and deprivation including low income, parental unemployment and relationship breakdown, and the majority of children are in care because of abuse or neglect.' (Jones, 2011)*

[267] In 2018 in England 63% of looked after children had a 'primary need code' of 'abuse and neglect'; 15% entered care primarily due to 'family dysfunction' and others because of 'family in acute stress' (8%). Some children were recorded as needing care due to 'absent parenting' (6%). Other reasons related to child disability (3%) or parental illness or disability (3%) https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2017-to-2018

Where do children live in care?

Looked after children can live in a variety of different 'care settings'. Scottish Government Children's Social Work statistics[268] divides these placements into two broad groups:

1. Children living in placements '*in the community*' (looked after at home; kinship care; foster care; prospective adopters; and, other community settings) – 90% of children live in these type of settings
2. Children living in '*residential accommodation*' (all forms of residential care and education) – 10% of children live in this type of setting

In Scotland the largest proportion of looked after children are in foster care (34%). Most foster placements are provided by the local authority, the rest are purchased by the local authority. As will be seen later in this report, not all foster placements are alike.

Kinship care is when a child is looked after by their extended family or close friends. The proportion of looked after children living with friends and relatives is the second largest group of children in Scotland (28%).

One in ten looked after children are in some type of residential care; a term that masks much variation in provision with variation in type provided, purpose and size of home.

Finally, in Scotland about a quarter (26%) of children are 'looked after at home'. In other parts of the UK much lower proportions of looked after children live at home, for example, in England only 6% of the care population are recorded as 'placed with parents'. There is limited research on the experiences of these children and families in Scotland[269].

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[268] https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/

[269] See https://www.celcis.org/knowledge-bank/search-bank/overseen-often-overlooked-children-and-young-people-looked-after-home/ for research looking at the experiences of children looked after at home in Scotland. The findings indicate this group of children have comparable needs and outcomes to other looked after children despite this they and their families may not receive as much support as other looked after children.

Types of care available: the multifaceted nature of the 'care system'

As shown above, children enter care for a variety of reasons, they have many different needs and characteristics and these will be met through different approaches to care. What is provided will be linked to the purpose of care for each child and as a result children will have very different journeys through the 'care system' (Hannon et al, 2010).

Broadly the 'care system' provides: assessment, temporary care (short to medium term) or long-term care. Sinclair and colleagues (2007) describe the general purpose of 'care' or 'role of the 'care system'' for children as covering three main things:

1. to support a family base;
2. to provide an alternative base
3. to act as a 'launch pad' to early adulthood.

To expand further:

- Some children need a shorter-term (temporary) placement before returning home (which may be planned as part of family support service);
- Others require a safe and stable home while longer-term decisions are made;
- For some 'care' becomes where they experience much of their childhood; these children need a long-term home while keeping appropriate links with members of their birth family (Thoburn, 2014; Forrester et al, 2009).

Thoburn (2014), drawing on evidence in England, argues that there has been a change in the balance of what the 'care system' provides; with a shift to more of the placements provided by the 'care system' being

categorised as having a long-term aim (i.e. purpose of 'care for upbringing').[270]

Changes in the 'care system' population over time

The 'care system' is not static.

- The *numbers in care* at any one time will depend on the rate at which children enter the 'system' and the length of time they stay in it. Overall, Scotland had the highest rate of looked after children in the UK in 2018 – with an estimated 143 children per 10,000 of the under 18 population in care. Even after excluding children who are looked after at home, the rate remains the highest in the UK at 107 per 10,000 of the under 18-population. The rate in Scotland is higher than that in Wales (102 per 10,000 under-18s) and considerably higher compared to the rates in Northern Ireland (71 per 10,000) and England (64 per 10,000).[271]
- There are changes in the profile of *who* enters care; in Scotland there has been an increase in very young children entering care; 10% were under 1 in 2008 rising to 16% in 2018; and a corresponding decrease in older young people entering care 38% were aged 12 to 17 in 2008, and in 2018 the figure was 31%.
- There are also changes in the use of certain settings in Scotland; for example, there has been a decline over the last decade in the proportion of children 'looked after at home' from 43% in 2008 to 26% in 2018. An increase in kinship care from 16% in 2008 to 28% in 2018 has been observed (Scottish Social Work Statistics, 2019).

[270] Thoburn cites that previously, in the 1980s, approximately 15% of care placements were categorised as for longer term aims ('care and upbringing') whereas by the early 2000s around half (52%) of placements were described as having longer term aims i.e. for 'care and upbringing'. Though Thoburn urges some caution in her review as the sample criteria between the research studies included differed. However, even taking that into account she asserts 'the change is quite evident'.
[271] https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/

Recognising the diversity of children in care

> *'Looked after children are children first and foremost: becoming 'looked after' is just one aspect of complex identity and experience. There is a need to recognise the diversity and individuality of children who become looked after, and to take account of their characteristics and needs, and their varied pathways and experiences within the 'system', from the point of entry, through childhood, and into adult life' (Care Inquiry, 2013a)*

The care population is characterised by diversity however, the national statistics in Scotland[272] report on only a very a small part of looked after children's lives. The statistics present information on children's gender, age, ethnicity and disability. At a national level we know very little (if anything) about looked after children from their own viewpoints; what do they enjoy doing, are they happy, do they like where they live, do they feel safe and how are they getting on?

Yet to provide quality care experiences the individual needs and wishes of each child must be known and provided for, this is generally understood through building relationships with the child and family and conducting thorough assessment and planning. However, at the same time services must respond to these individual needs and circumstances at the service level to plan and commission services based on collective needs and concerns across the looked after population. The national data appears limited in this regard. The next section of this report will look at what information is available in terms of how different children experience the 'care system' and their 'care journeys'.

[272] ibid

4. What do we know about children's 'care journeys'?

'Care journey' refers to what happens to children whilst in care. This section discusses evidence available about children's 'care journeys', focusing on: (One) entry to care, (Two) what happens after entry to care, (Three) journeys through care and (Four) exits from care.

A note on evidence

Research studies and reviews tend to focus on individual aspects or particular parts of the 'care system'; different types of placements, specific stages or processes or particular groups of children. Few studies look at the 'care system' as a whole in terms of children's overall journeys. The general lack of evidence on this topic means that this section draws on research not just from Scotland, but also from other parts of the UK.

Limitations of 'official' statistics

As discussed earlier government statistics offer only a snapshot of children's lives in care. They do not measure how children progress over time. Nor do they record how children are feeling and their own assessments of their care experience. Some have argued that the usefulness of statistics on looked after children would be enhanced if information on *children looked after away from home* was separated from information on *children looked after at home*. Remaining at home under supervision and being removed from home are very different experiences for children and there are differences in the characteristics and pathways of these two groups of children (Biehal, 2019).

Overall, official statistics do not currently[273] allow a child's journey through the 'care system' to be understood, as acknowledged below:

> *'The current data sets [Scottish Government statistics], and the lack of linkage between them, also make it very difficult to map children's 'care journeys'. Information is available on how many children's panel hearings there were in a year; how many children and young people have had two placements or more; and, how long children had been in care at the time of leaving. But, at present, it is not possible to draw out of the care journeys of individual children.' (Care Review Statistical Briefing, 2017)*

Entry to care

Most children who come into care have experienced complex trauma and faced significant challenges early in life. Entry into care is itself often a distressing experience and brings with it a significant sense of loss (Baker, 2017b). Entry to care may be planned but in many cases it is unplanned. Young people's accounts of their first move into care often recall how the experience was frightening and bewildering. It was a time marked by uncertainty; children recall how they did not know where they would be living and often didn't understand why they were being separated from their families (Mitchell, 2016). Section 5 looks in more detail at children's experiences of moves into and through care.

Support to parents when children enter care

As will be discussed later, many children who enter care return home to live with their families and the success (or otherwise) of this 'reunification' is often dependent on whether things have improved in the family home

[273] One project (work in progress) in Scotland could help fill some of the existing gaps in knowledge. The project looks at the patterns of instability experienced by children looked after away from home over time by applying state sequence analysis (SSA) to administrative data on children's care placements from 2008 to 2017 (about 75,000 placements & 19,500 children) https://www.research.ed.ac.uk/portal/files/82572060/20180405_lac_baspcan_poster_bm_v3.pdf

(Wade et al, 2010). Research shows that *'effective work with parents is critical to improving the well-being of children in care, particularly when considering that the most common outcome for a looked after child is to return home to a parent or relative'* (Thoburn, 2014). Parents (studies have predominantly focused on the experience of mothers) have described their sense of grief following children becoming looked after, which increased difficulties in their lives such as mental health problems and substance misuse (Broadhurst, 2017).[274]

'Early journeys': what happens after entering care

As indicated earlier very few research studies have sought to examine the whole 'care system'. One large study in England[275] which did seek to understand children's pathways in care emphasised that what happens within the first year or so of being looked after is crucial. This is a time of assessment, decision-making and permanence-planning for many looked after children.

'The pursuit of permanence' study

The research showed that, after coming into care:

- There was a rapid sorting of 'long-stay' from 'short-stay' children;
- A child had a relatively good chance of leaving care shortly after their arrival;
- In this study just under half of those who started to be looked after left the 'care system' within a year;

[274] https://www.theguardian.com/society/2015/apr/25/are-we-failing-parents-whose-children-are-taken-into-care

[275] *Pursuit of Permanence: a study of the English Care system* (Sinclair et. al. 2007) – this major study looked at the movements of children in and out of the 'care system'. Data on nearly 7400 children were gathered from 13 local authorities IT system data. This information was supplemented by data from social workers (n=4,600) and team leaders (n=110), foster households (n=1,500) and residential units (n=315). Case studies with 96 children were conducted and 54 managers telephone interviews undertaken. The three main questions for the study were: what kinds of children are looked after? How and why do they move into, out of and within the 'care system'? How far do their chances of stability and well-being depend on their own characteristics, and the particular placements, social work teams or councils they happen to have? NB: the study is now over ten years old, and the data on which it is based even older. However, there appears to be no updated study in the UK available offering the depth of insight available in this one.

- Most of those who left (two-thirds) went home but they did not always remain there;
- The chances of children returning to their family declined as time went by; there was a low chance of return home among those who stayed in care for one year or more;
- The chance of leaving care after a year of being in care varied substantially by the age of the child and dropped for older children; the probability for those under five was 28%, compared to 15% for those aged five-nine and 5% for those aged ten-15. (Sinclair et al, 2007)

Work in Northern Ireland which focused only on younger children (aged under five), also showed that the longer a child remained in care the smaller the chance of their returning home (McSherry et al, 2010).

Scotland evidence on 'early care journeys'

Government statistics in Scotland[276] show that around a quarter (26%) of children who left care in 2018 had been in care for less than a year: 5% had been in care for less than six weeks when they left, a further 7% were in care for between six weeks and six months, and 14% were there for between six months and one year. Most children who leave care (57% in 2018) go home to their parents, whilst 18% go into kinship care (either informally or through the formal use of a kinship care order). Other destinations included: adoption (seven %), supported accommodation (six %), former foster care (two %) and continuing care (three %) (NB: that the proportion of children being looked after for less than a year has fallen from 39% in 2008 to 26% in 2018.)

During this early time in care children may have a series of temporary placements with different carers. Children's movement and stability will be the focus on Section five in this paper.

[276] https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/

Journeys through care

Different 'groups in care'

Based on the large volume of data about the 'care system' gathered in the 'Pursuit of Permanence' study, Sinclair and colleagues (2007) developed a typology of six different 'groups in care' as set out below.

1. **Young entrants** – children first looked after before the age of 11 and still aged under 11 (43% of the sample[277]). These children tended to enter for reasons of abuse and neglect. They typically had less behavioural or school-related problems and rarely used residential care. 29% had returned home at least once.
2. **Adolescent graduates** – children first looked after when aged less than 11 but were now age 11 or over (26% of the sample). This group was more likely to have experienced more than one entry to care (56% of this group had returned home at least once). Their behaviour was reported as more challenging than that of young entrants but less problematic than other adolescents (apart from asylum seeking children). By definition they had spent a long time in care (on average five and a half years since the last time they entered care).
3. **Adolescent entrants** – children first looked after when aged 11 or over and did not have a 'need code' of abuse[278] (14% of the sample). This group was described as primarily needing care for reasons other than abuse; they were described as having challenging

[277] Findings from Pursuit of Permanence are given for each group but caution should be applied in interpreting these findings for 2 reasons: firstly, a long time has elapsed since the study was completed (over ten years since published) and secondly, the fact that the study was based in England which has different legal structures to Scotland.
[278] In England (unlike Scotland) government statistics record the primary reason the child was looked after. There are eight need codes; abuse and neglect; child's disability; parents illness or disability; family in acute stress; family dysfunction; social unacceptable behaviour; low income or absent parenting. In Scotland, the grounds for referral to the Children's Reporter are recorded, but not all children who are referred to the Reporter will go on to be looked after.

behaviour and problems at school. 50% had returned home at least once.

4. **Abused adolescents** – children first looked after when aged 11 or over for reasons of abuse or neglect (nine % of the sample). Often abuse was not new but their entry to care had not happened until they were older. Their behaviour was described as more difficult than adolescent graduates. Few of these children experienced a long placement. 44% of this group had returned home a least once.
5. **Asylum seekers** – children who were seeking asylum (5% of the sample). These children were usually aged 11 or over and were doing comparatively well at school and were described as having less challenging behaviour. 21% of this group had had at least one 'repeat admission' to care.
6. **Disabled children** – children who had a need code of disability (three % of the sample). 46% had returned home at least once.

There were differences between the groups in terms of the length of their placements, the purpose of them and where they moved to after they left the 'care system'. The 'care pathways' the children experienced were related to a number of factors; the child's age, age at entry to care and the reason the child had entered care together with how difficult their behaviour was perceived to be or whether they had been in care previously. All these elements influenced the children's care pathways.

Availability and purpose of placements

The purpose of children's placements (as distinct from earlier discussion in Section 3 on purpose of care) should fit with the assessed plan for the child. The purpose of individual placements may change over time. Sinclair and colleagues (2007) record a range of different purposes that placements can have that apply across different types of care settings:

- Temporary care, e.g. respite or short-term care which may be offered as a form of family support
- Emergency care

- 'Specialist' or task-centred care, e.g. remand fostering, parent and child fostering
- Assessment
- Treatment
- Preparation for long term placement
- Bridge to independence
- Care and upbringing (which has the aim of providing stability for the duration of childhood and beyond)
- Shared care (a more formal arrangement between birth family and care provider)
- Other placement purpose, e.g. concurrent planning placement for a child (usually aged two or under) which can offer short term care until the child can return home or can offer long term permanency (sometimes adoption) if return home not possible. Such an approach aims to minimise moves for children[279].

Placements in the 'care system' are used differently depending on the age and needs of the child and the availability of different placements (Forrester et al, 2009). To use an example from the Sinclair (2007) work, the purpose of the placement (as recorded by the social worker) differed for the groups, for example:

- 60% of 'young entrants', 'adolescent graduates' and 'disabled children' were living in a placement that had an aim of 'care and upbringing'.
- In contrast only 27% of 'adolescent entrants' and 20% of 'asylum seekers' were in a placement with a purpose of 'care and upbringing'.

[279] https://www.celcis.org/knowledge-bank/search-bank/blog/2016/11/concurrency-planning-all-outcomes/

Overall, children in the groups differed in their chances of achieving a long-term placement within the 'care system'. For most children in the study 'permanence' was not the aim of their placement.

Permanently Progressing? Study (Scotland)

One recent large-scale study in Scotland, *Permanently Progressing* (2019), adds to our knowledge of looked after children's care journeys. The study did not look at the entire cohort of children in care. Rather it focused on all children aged five or under who were placed in care (or looked after away from home) during the year 2012-2013, and followed their pathways and progress over four years (from 2012 to 2016)[280].

- A total of 1,836 children aged five and under became looked after in 2012-13 (and this comprised the study sample). Of those children, 1,355 (74%) were looked after away from home and 481 (26%) were looked after at home.
- A large majority of the children had experienced significant abuse and neglect before they entered the 'care system'. Before going into care two-thirds of the children had suffered multiple forms of maltreatment, including neglect and emotional, physical or sexual abuse. For nearly three-quarters of the children, the abuse was rated as severe and half of the children had experienced neglect while in the womb, due to continuing alcohol or drug misuse during pregnancy (Cusworth, 2019).

'Parenting capacity was compromised by alcohol and substance misuse, mental health difficulties, and domestic violence. This was within the context of multiple family difficulties, poor housing conditions and limited financial circumstances.' (Cusworth, 2019)

[280] The study has five strands and looks at: children's pathways, linkage of data on children, outcomes of children, decision-making processes and views of children and carers. Five reports available: Cusworth, 2019; Grant; 2019; Whincup, 2019; Hooper, 2019; Biehal, 2019. https://www.stir.ac.uk/about/faculties/social-sciences/our-research/research-areas/centre-for-child-wellbeing-and-protection/research/permanently-progressing/#panel66517-3

Headline findings from this research in relation to 'care journeys' include:

Looked after away from home group

- Over the four years (2012-2016) the *looked after away from home* group experienced three main pathways: (one) about half (54%) had a 'single admission' to care, and then ceased to be looked after; (two) nearly a fifth (17%) had multiple admissions and exits; and (three) just under one third (29%) were continuously looked after away from home to the end of the study.
- By the end of the study, nearly one-third of the children had returned to their parents and 16% had been adopted. However, there was considerable delay in adoption. Although most of the adopted children had entered care before they were one year old, the majority were not adopted until three to four years later.
- Three to four years after they entered care, nearly one-third of the children still lacked the security of legal permanence. These children had not returned home and had not been adopted, but neither had they acquired a permanent placement with relatives or long-term foster carers.

Looked after at home group

- The age at which the *looked after at home* group started to be looked after tended to be higher than for the away from home group. The key differences between the groups were that the *looked after away from home* group included a far higher proportion of children who started to be looked after before they were one year old, while the proportion of four and five year olds in the *looked after at home* group was double that in the away from home group.
- For children *looked after at home* in the study the time they spent on a Compulsory Supervision Order (CSO) spiked at nine-12 months. This may reflect a response to legal requirements; since the maximum time a CSO can be in place without being reviewed by a Children's Hearing is one year. The research team suggested that

decision making may, in some cases, be system-driven rather than needs-led (Biehal et al., 2019).

- Of the at home group, just under 20% (94) became looked after away from home during the subsequent years of the study.

Participants in the study (social workers, managers, foster carers, kinship carers, adoptive parents) explained that in their view the route and timing of the pathways that children had were influenced by the resources and time workers had available as well as the '*place-ability of child*'. Factors linked to the latter point included the child's age and whether they had brothers and sisters; the type and amount of on-going contact with the birth family; and uncertainty about long-term health conditions.

> *'Disability, experience of maltreatment, age when children became looked after, initial placement, and the childhood experiences of parents were key predictors of children's later permanence status.' (Cusworth, 2019)*

Northern Ireland care pathways and outcomes study

Similar work in Northern Ireland has been underway, again focussed only on following a cohort of young looked after children (n=374; aged five or under at the start of the study). This study identified five care pathways for these children:

1. towards adoption
2. long term non-relative foster care
3. long-term relative foster care
4. residence order
5. return to birth parent.

Similar to the other studies that have looked at care pathways for younger children this work has identified the background factors that influence the care pathways children have. The researchers analysed 60 background variables and found that five were related to care pathways the children

had: age of child, length of time in care, child's health, child's behaviour and regional variation (McSherry, 2010).

Long term care for 'upbringing'

Many children who become looked after away from home return to live with their parents, but some cannot safely return to their families. For this group of children the 'care system' is concerned with how best to provide them with a secure base which provides stability and emotional security (permanence). Therefore for some children the 'care system' is likely to be where they spend much (or a significant part) of their childhood and the primary purpose of the 'care system', in this case, is to provide them with 'care and upbringing'. Research points to two broad experiences children have in relation to this:

1. children who find a *strong base in care* where they are settled, attached to 'care-givers' and are happy
2. children who experience a *weak base in care* where they typically experience instability and uncertain plans.

Sinclair and colleagues (2007) argue that a successful strong base within the 'care system' is related to:

- Child's acceptance or otherwise of the need to be looked after.
- Degree to which previous experiences mean the child finds it easy to trust new relationships.
- Quality of carer and how the child gets on with them.
- Degree to which the child is comfortable with the family contact they have.
- How the child is getting on at school.
- Child's behaviour and carer's perception of this, and whether the carer feels they have support with this.
- Current stage in child's 'care career'.

In Section five we return to issues raised here, namely the importance of stability, in children's lives.

Exiting care

Scottish government figures

Children do not stay in care forever - the length of time a child remains 'looked after' varies from a few weeks to many years. In Scotland, the data on the proportion of children who leave care in a given year has changed over time with more children now appearing to have spent longer in the 'care system' as looked after children (Scottish Government, 2019):

- In 2008, 39% of those exiting care had been looked after for less than a year; a decade later in 2018 this proportion had fallen to 26%.
- The proportion of those exiting care who had been in care for between one and three years was the same in both 2008 and 2018 (35%).
- The proportion of children being looked after for five or more years has been increasing steadily. In 2008, 9% of children ceasing to be looked after in that year had been in care for five or more years. This figure rose to nearly a quarter (24%) for those leaving care in 2018.

This data suggests that, for most children (61% in 2018), an episode of care (i.e. the time between entering and leaving care, on that occasion of leaving) is a relatively medium-term intervention (i.e. a period of their life lasting under three years). An individual child could have had other entries and exits from the 'care system' prior to this exit, but as emphasised previously this cannot currently be established as the data on all episodes of care and thus children's complete care journeys is not currently readily available (Care Review Statistical Briefing, 2017).

Experiences of return home

Legislation and policy are based on the presumption that unless it is unsafe, children will remain or return to their parents.

'Returning home to parents' has consistently been the most common destination for looked after children who leave care in a given year (Scottish Government, 2019). As has been seen earlier, many looked after

children exit the 'care system' and return home. Some of these returns happen quickly whilst for other children the process of return will take longer. Regardless of how long it takes a child to return home, the evidence reviewed showed that not all children who return home stay there. Some children return to the 'care system' on more than one occasion (Wade, 2010)[281].

Children sometimes return to families who continue to have 'severe difficulties'. Social workers report that some children living at home are in situations that are far less safe, materially adequate or satisfactory than children who are adopted or remain in foster care (Wade, 2010). Based on these findings researchers and others have argued that attention needs to be focused on how returns home are assessed, monitored and supported. They should take account of evidence of sustained change in parenting capacity. It is likely that sustained changes in parenting capacity depend on parents getting the support they need from the state.

In England, researchers found that children were more likely to have 'repeat admissions' if their family had 'severe family difficulties'; if the child was 'disabled'; or the child was perceived to have high levels of 'difficult behaviour' (Sinclair, 2007). There was also variation between local authorities in the extent to which 'repeat admissions' occurred (figures varied between 27% and 59% in the local authorities studied).

Factors associated with 'enduring reunifications' include:

- The process of moving home took place over a period of time;
- Planning for reunion was purposeful and inclusive of children and birth families;
- The problems that had led to the child being taken into care had reduced;

[281] In England one study suggested that around half of children were 're-admitted' to care following a period at home; of these over one third of the children re-entered the 'care system' quickly (within six months of returning home) (Wade et al, 2010).

- More family-focused social work interventions had been provided;
- Parents had accessed more services (Biehal, 2019; Wade et al, 2010).

In the recent *Permanently Progressing* study in Scotland most of the children who had ceased to be looked after away from home returned home; the mean time children had spent looked after away from home was just over nine months (Biehal, 2019). In this study return home was influenced by parental motivation to resume care of the child and a reduction in risks and evidence of improvements in the home environment (Cusworth, 2019).

> *'Reunification was influenced by parental motivation to resume care, a reduction in risks, and tangible improvements. In terms of a return home being sustained, the latter two were significant.' (Cusworth, 2019)*

Other exits from care

For children who leave the 'care system' but do not go home, then the child's age and age of entry to care is very influential in terms of the types of 'destinations' they have. Some young children cannot return home because the circumstances that led to them coming into care in the first place are unchanged. In these situations, decisions may be made that permanence will be sought via adoption. Children who are adopted usually enter the 'care system' at a young age, and adoption usually only occurs for relatively young children. Research shows that some children are less likely to be adopted. This includes those who are 'disabled', those who are 'non-white', those with a 'failed return home', or those placed with a relative while in care (Welch et al, 2015; Sinclair et al, 2007; Cusworth, 2019).

If children are not adopted, and they are not able to go home, the 'care system' will work towards finding them 'permanence' elsewhere. These children may be more likely to stay in care long-term and will need to find what Sinclair and colleagues (2007) call a *strong base* in care, defined by

the degree to which they settle and make attachments within care placements.

'Care leavers'

Some looked after children leave the 'care system' when they cease to be 'children', as defined in legislation. In Scotland the usual age for leaving the 'care system' is between 16 and 18 years old. Recent changes in the law mean it is now possible for care leavers to remain living in their current care placements up to age 21 under arrangements known as 'continuing care'[282]. Early evidence suggests take up is relatively low[283] and there are problems with implementation (Scottish Government, 2019; McGhee, 2017).

Research based on young people's views shows that uncertainty over what will happen after they leave care is often a major concern for young people (Baker, 2017c).

It is well recognised that leaving the 'care system' represents a significant risk point for young people as they enter early adulthood: they risk losing important relationships and transition from care can 'undo the positive impact of care' for many children (Forrester et al, 2009; Sinclair, et al 2007). Care leavers who are most likely to successfully move on from the 'care system' are those who have had stability and continuity whilst in care. Aftercare factors that can significantly improve a young person's experience include:

- The age at which young people leave care
- The speed of their transition
- Their preparation before leaving care and the support they receive afterwards
- Maintaining stability and relationships after leaving care (Stein, 2006).

[282] https://www.gov.scot/policies/looked-after-children/children-leaving-care/
[283] 10% of 'care leavers' were living with former foster carers or in residential care in Scotland as part of 'continuing care' arrangements (Social Work Statistics, Scottish government, 2019)

In relation to 'care pathways', late age of entry to care (Sinclair's 'adolescent entrants' group), leaving care at a young age (at age 16 or 17) and not having many sources of support upon leaving were found to be associated with a more 'problematic' transition. Those who experienced a high number of moves during their time in care often went on to also experience significant numbers of unplanned and negative moves in early adulthood. The experiences of care leavers are covered in more detail in a separate Care Review evidence review[284].

Summary

The evidence presented in this section shows that children and young people's pathways into, through and out of care are complex. No two journeys are exactly the same, and these journeys depend on a wide range of circumstances (such as the reason for the child coming into care, etc.), characteristics of the child (such as age, ethnicity, disability, etc.), and the availability (or not) of support from the child's extended family (e.g. in the form of kinship care).

The next section will look at the issue of stability in care, and why this is important to children and young people.

[284] Edges Care Review evidence review, Jennifer Waterman, Claire Baker and Dawn Griesbach, July 2019

5. Stability in care

As shown in the previous section children enter care at different ages, for different lengths of time and when in care live in different placements. However, regardless of how long or brief their period in care is, children are likely to fare better and have a more positive experience if, during their time in care, they have a stable home and consistency of care.

Child development literature underscores this importance, demonstrating that, for healthy development, children need to experience, amongst other things, stability in their lives (Hannon et al, 2010).

Stability in the context of looked after children's lives is a multifaceted phenomenon which includes not just physical placement stability, but also stability of relationships, stability in relation to education, consistency in routines and continuity of contact with family, relatives and friends[285].

Looked after children say that they experience a range of transition points in their lives including: stopping or re-starting contact with their birth family; education transition points (moving between nursery, primary, secondary, further and higher education); leaving education to seek employment or training; moving care placements; moving to supported accommodation or moving into a tenancy; experiencing life changing moments such as being in a relationship, getting married or having children; and leaving the 'care system' (Action for Children, 2017). From the

[285] Recent work in England has demonstrated the multi-dimensional nature of stability and mapped the extent of instability in looked after children's lives: "most children in care experience some kind of instability in one form or another throughout the course of a year. Only 1 in 4 children in care experienced no placement move, no school move and no social worker change within a year" (Office of Children's Commissioner, Stability Index 2018).

perspective of children in care, each of these transitions represents both a risk and an opportunity.

Whilst acknowledging this context, the focus in this paper is primarily on children's experiences of '*placement stability*', rather than all the different moves and transitions they can experience, in the 'care system'.

Importance and impacts of stability

Looked after children often say that having stability in their lives is one of the most important things they want in their lives. A stable environment that nurtures children provides the foundation for children to form healthy, positive relationships that enable them to flourish. Despite the importance of stability in children's lives, a long-standing concern across the 'care system' is its ability to provide it, a challenge reported across all types of placements. Concerns often focus on the extent to which looked after children experience multiple placements before finding a stable environment.

Young people, and others, in many studies and in the Discovery stage of the Care Review overwhelmingly report that looked after children experience too many moves and transitions in and through the 'care system'. Care leavers in one study, reflecting on their experiences, described their childhood as 'nomadic' (Holland, 2010). Some of the moves children had were not, in their view, necessary and happened for reasons other than what was in their own best interests. Research findings appear to confirm this experience, and have found that placement moves are generally not made at the request of the children involved (Hannon et al, 2010). A pervasive theme in the research evidence is the desire to prevent unnecessary moves and increase the amount of stability and continuity in looked after children's lives.

Thoburn (2014) underscores the seriousness of the situation arguing that when the 'care system' is unable to provide stability to looked after children this practice is, in her view, tantamount to maltreatment:

> *'The major abuse of children in care is abuse by the 'system': most obviously multiple placements; precipitate moves; being 'prepared for independence' and moved on when what the young person and their care want is to remain together as a family; being moved in order to cut costs when a child is well settled, and last but not least multiple changes of social worker.'*

Stability and relationships

Stable placements can promote resilience for looked after children in two main ways: (One) by providing the child with a secure attachment (which can help make placement disruption less likely) and (two) by providing continuity in other areas of life such as school or friendships (Stein cited in Hannon et al, 2010).

A strong theme in the literature was the recognition that placement instability reduces children's opportunities and the ability to build and maintain relationships. The evidence emphasises the importance of placement stability as an essential foundation for young people to build stable relationships, develop resilience and achieve their potential. Stability was also described as crucial to recovery from trauma (NICE, 2013; Bazalgette and Rahilly, 2015).

Evidence from children, and others, indicated that, at times, the child's relationships with other people were sometimes arbitrarily cut off (Sinclair, 2005). Some suggested there was a risk of an assumption that 'old relationships must be broken for new ones to be made' (Care Inquiry, 2013a: Winter, 2015).

Stability and outcomes

Overall, it seemed that not having 'placement stability' – i.e. having frequent placement moves and experiencing placement breakdown – had a detrimental impact on a child's well-being and metal health (Bazalgette and Rahilly, 2015; Rahilly and Hendry, 2014). Generally outcomes for those

who had many changes of placement were reported as worse than for those who did not (NICE, 2013).

Risk and protective factors for placement stability

A range of risk and protective factors are associated with placement stability / instability. Many of these issues represented different sides of the same coin (NICE, 2013; Bazalgette and Rahilly, 2015; Rock et al 2015; Sinclair, 2005; Office Children Commissioner, 2018; Sinclair et al, 2005, 2007; Wade et al 2010).

From the evidence reviewed some of the main *protective factors* related to placement stability were:

- *Personal qualities of carer:* carers who were tolerant, emotionally involved and child-centred
- *Positive time at school*: attending school regularly helps stability. School problems, especially frequent or long absences can cause a 'strain' on placements
- *Friends and social networks:* can contribute positively to children's lives
- *Child's attitude to care:* a positive attitude from the child to being in care (and being in a specific placement)
- *Involvement of children in decision-making and paying attention to what they want*
- *Information:* providing carers and children with adequate information prior to placement
- *Match between child and placement:* a key factor in stability is the match between child and carers, which often depends on the 'chemistry' and 'fit' between them.

Factors that increased the *risk of placement instability* included:

- *Age of child:* the age of the child is the most powerful factor in placement stability, the older the child, the greater the risk to

stability. Children who enter care at the beginning of adolescence may be more likely to experience multiple placement moves

- *Children with additional behavioural or emotional needs:* Children who enter care with more mental health difficulties are at greater risk of placement breakdown and children who have 'externalising difficulties' (such as 'challenging behaviours') are at particularly high risk
- *Children with a history of instability in care placements:* are at risk of having it compounded by more instability in the future
- *Separation from siblings*
- *A greater number of changes of social workers*
- *Mutual commitment to the placement:* both from the child and the carers
- *Whether child feels part of the family / home*
- *'Failed attempts at return home':* those who return to their family and then again to care are more likely than others to have unstable care careers.

Children's accounts of movement in the 'care system'

Children thought that moves in care undermined their sense of belonging and usually had a negative emotional impact on them. Unless they were moving from somewhere where they had been unhappy then in these cases children said these moves were needed. If children moved a number of times there could be a cumulative effect; children may begin to believe they were at fault. They may feel rejected and unable to trust others. Often children's accounts showed a high level of anxiety and concern about moving into or through care (Goodyer, 2016; Dickson et al, 2009; Holland, 2010; Grant, 2019).

One study[286] examined how children made sense of their experiences of joining new foster families (Goodyer, 2016). Five themes emerged:

[286] Interviews with 22 young people living in foster care (based in England)

1. *Information about moving to a new home* – there was marked variation in the amount of information and prior knowledge children reported they had about moving to a new placement. The largest group of children said they knew nothing or had received very little information before they moved.
2. *Emotions connected with moving* – going to live somewhere new was described as a time of intense emotions: feelings of injustice, being scared, bewildered or upset were reported as common. The first move into care was often the most frightening said children.
3. *Sudden moves* – for some children moving was a shock and it had disrupted their day-to-day routines and lives.
4. *Loss of people, community, networks and possessions* – children reported variation in how often they saw their family after their moves; some were unhappy with the frequency and felt resentment about this. Some children also felt disorientated as they were unfamiliar with the new area where they lived and unsure of their new environments.
5. *Strategies and skills involved in moving* – children described *"feeling wary, isolated or overwhelmed"* when they joined a new home which often had unfamiliar people, routines. Frequently children felt unable to share their feelings as they did not yet trust people. Some children described how they developed strategies to cope with the move and new environments; sometimes this included avoiding people or retreating into themselves (Goodyer, 2016). Others may 'push boundaries' as a reaction to change and to the feeling of strangeness associated with being somewhere new (Holland, 2010).

Some of the movement described by children was planned and some was not (Baker, 2017a). Children identified from their perspective three main *ways* in which moves happened:

1. Sudden moves

2. Moves where children had some information in advance
3. Well-planned moves were ones when children had the information they wanted before the move, had an opportunity to visit, stay with or meet the people they were going to live with in advance (Goodyer, 2016).

Preparation and information about moves

Having information in advance of a placement move was seen to be one of the factors that contributes to placement stability. However, research studies have reported that children are not always kept fully informed about important aspects of their life such as, for example, the purpose of the placement, and what to expect when living there. Each home was likely to have different routines and expectations and not knowing about these could be unsettling and distressing (Baker, 2017a).

Many children in care felt they were not well prepared at times of transition when they moved into, through, or out of care (Baker, 2017c). Children suggested there were things that could be done to make living in a new place easier from their point of view. For example, children valued the chance to try out where they were moving to and see if they would fit in living there before committing themselves (Coram Voice, 2015; 1000 Voices).

At a minimum they wanted more information on where they were moving to before they moved in (Sinclair, 2005). Young people said they didn't always get enough information before moving, commonly they wanted to know about things such as:

- As they moved into the 'care system'
    - why were they not with their siblings;
    - how long were they going to stay where they were;
    - what were the rules in the new house;
    - would people treat them well and like them
    - what would happen to them while they were in care?

- When moving from one placement to another
    - which other people and children lived in the household;
    - what were the carers' interests;
    - were their pets there? (Baker, 2017a)

Overall, children wanted reassurance. Children explained they were likely to be missing their family and feeling confused and upset[287]. It could feel frightening and unsafe to move into care or move from one place to another[288]. Lack of information increased their worries and anxiety about what was going to happen. (Baker, 2017a)

'Sensitively managed' moves

Reflecting on what would have supported them better during moves, children wanted their moves into, through and out of care to be handled with greater care (Coram Voice, 2015; Sinclair, 2005; Barnardos, 2017). The 'pain of partings' described by some children, were also commonly experienced by their carers, carers' children and wider family. It was important that the wide ranging effects of moves were acknowledged and supported more (Sinclair et al, 2005).

Planned moves were undertaken for many reasons for example, to reunite siblings or to match children to long-term carers. Some moves, as seen in Section 4, were for the purpose of returning home to birth parents. *Unplanned moves* within care were often the result of 'placement breakdown' which was associated with the risk and protective factors identified earlier.

Although moves are unsettling for children and young people, not all movement is 'bad'. There may be a good reason why the child or young

[287] Recently 'Shannon's box' has been launched in Scotland – as welcome gift from a care experienced person to try to ease anxieties for children on their first nights in care https://www.staf.scot/shannons-box

[288] Young people in care in Ireland recently created a booklet that includes everything they feel is important to know before going to live with a new family to help anxiety children can feel about placement moves https://www.epiconline.ie/wp-content/uploads/2019/06/Donegal-Placement-Move-Booklet.pdf

person needs to move, for example to safeguard the child or young person or because they do not get on with their carer; of central importance is the appropriateness of the move and how it is handled and the extent to which the child is involved in and prepared for the move.

One study[289] looked in detail at the experience of children whose foster placement had ended. The researchers made an important differentiation between the *reason for the placement change* and *how the process of changing placements went*. Children's experiences were assessed in relation to whether the event and/or the process were positive or negative (McDermid et al, 2016). This conceptualisation is outlined below. The work echoes children's views that it is important to focus on *how* moves are experienced.

The reason for the placement change event was positive and the process was carried out as a "managed move" (+ve/+ve)	*Placement broke down but the process was carried out as a "managed move" (-ve/+ve)*
The reason for the placement change event was positive but the move was instantaneous (emergency move) (+ve/-ve)	*Placement broke down and the move was instantaneous (emergency move) (-ve/-ve)*

Reason for placement change

Process of placement change

Context in which placements are made and operate

Ensuring availability of placement choice

Decisions about where children live need to be based on effective assessment and planning which take into account the child's views. However, this work operates in the context of a severe shortage of suitable placements. Local authorities need to have a range of placement options available to meet the needs of each child. Without this, there will be limited placement choices which can compromise identifying the right

[289] 165 case files were examined from children who had left their foster placement. Sample drawn from children placed in five LA/ fostering agencies in Scotland and England

placement for the child which is key to promoting stability[290]. Lack of placement choice is associated with placement instability. In addition, placements that are not well matched may be more likely to breakdown leading to instability for the child.

Similarly, children may be placed in homes only ever intended to be temporary due to limited choice or a shortage of placements, and then the children have to move when another more suitable placement is identified.

Promoting stability through supporting placements

Evidence suggests that placement stability can be undermined if the placement is not adequately supported. As a result some placements end in an unplanned way with a 'placement breakdown.'

To minimise the risk of placement breakdown for children it is important both children and those caring for them feel they are getting the support they need. Lack of support can lead to 'carer strain' which may lead to children receiving less sensitive parenting from carers and an increased risk of placement breakdown (Sinclair, 2005).

Carers may need different types of support. For some, help to understand and respond to children's emotional and behavioural needs will be important. Hannon and colleagues (2010) assert that 'a vicious circle' can be in operation whereby those children with poor mental health on entering care may have less chance of having a stable placement (because of challenging behaviour) and their subsequent instability exacerbates their mental health problems.

Identifying and supporting placements at risk of 'disruption' and ensuring adequate support including mental health support was a strong theme in the literature (Hannon et al, 2010). In recent Scottish research children in

[290] The Fostering Network in Scotland emphasises that there is a shortage of foster carers and estimate that fostering services need to recruit a further 580 foster families https://www.thefosteringnetwork.org.uk/advice-information/all-about-fostering/fostering-statistics

kinship care, foster care, and with adoptive parents had similar levels of emotional and behavioural difficulties but the level of support different carers received varied. Kinship carers received less support than others (Cusworth, 2019).

'Cost pathways'

The costs associated with placements will vary according to children's needs, types of placement and local policies or practices (Ward and Holmes, 2008). Research suggests that a child experiencing multiple placements is likely to cost a local authority more money per year while in care (and beyond) than a child in a stable placement (Bowyer and Wilkinson, 2013). Hannon and colleagues (2010) mapped out two different care pathways for young people:

1. *Stable care journey*; cost £352,053 over a 14-year period. An annual cost of £23,470. Costs from age 16 up to age 30: £20,119 (young person attends University and enters graduate level job)
2. *Unstable care journey*; cost £393,579 over a seven-year period. An annual cost £56,225. Costs from age 16 up to age 30: £111,923 (young person experiences unemployment, underemployment and mental health problems).

Unstable care journeys are likely to cost more to the public purse and have poorer outcomes in the longer term. A failure to provide children with a stable and high quality experience of care and transition from the 'care system' not only results in a less positive 'journey' for them but also leads to escalating costs for local authorities.

Summary

The current understanding of care placement stability in Scotland is limited. Understanding placement stability is about more than simply counting the number of moves a child has. As was seen in Section four not all placements are intended to last so the amount of movement and stability within the 'care system' needs to take into account an

understanding of the purpose of the placement. It is also important to look at reasons for moves and *how they happen*, whether they are planned or not. Even when moves happen suddenly or for reasons related to 'placement breakdown' there may be ways that these can be more sensitively managed.

The time children spent in care varied for individual young people. At some point, all young people eventually move on from care. Whatever their individual circumstances young people are keen to know about what was planned for them and to ensure that the relationships they build up whilst in care are not lost when they move.

Ultimately from children's viewpoint what is essential is that any move should involve listening to their views and taking these into account. The next section will explore this important dimension in relation to 'care journeys' in more detail.

6. Children's experiences of decision-making in their care journeys

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) states that: any child who is capable of forming his or her own views has the right to express those views freely in all matters affecting them. The right to express a view on matters that concern them has been highlighted as one of the most important rights to children in care. However, it is one of the UNCRC rights that is not routinely upheld.

Children often report that they are not meaningfully involved in decisions that have an impact on their lives – including decisions relating to care placements and moves. This results in feeling a sense of powerlessness (1000 Voices; Care Review Rights paper, 2019).

Children need to be consulted at all stages of their care journey. Involving children can improve the quality of decisions and lead to more stable placements. Children highlighted the important things in their life where they wanted more influence over what happened, commonly they talked about:

- where they lived and how they moved to and from there;
- day-to-day issues and plans for their future;
- involvement in care planning and review processes;
- and who and how often they saw members of their family (Hung and Appleton, 2016; Hannon et al, 2010; Minnis and Walker, 2012; Sinclair, 2005).

Importance of including children in decisions about their moves in the 'care system'

Research evidence suggests that there are positive impacts for children and young people in feeling that they are being listened to. Being taken seriously by social workers (or others) was found to help children's self-esteem and confidence (Hannon et al, 2010: van Bijleveld et al., 2015). As detailed in Section five, there is an association between children having a choice of placement and involvement in planning where they live and placement stability. Exercising more control over one's own life, including where one lives, can mean that 'care' feels 'more normal' (1000 Voices; Hannon et al, 2010; Goodyer, 2016).

Conversely where children feel they are excluded from key decisions about their own lives, not fully involved, or that their views had not been listened to, this affects their commitment to engage and to be honest about their experiences, and could result in feelings of helplessness, low self-esteem and poor confidence (Thomas, 2011). This can have an on-going impact on their wellbeing and abilities to be involved in decisions later in life.

Children's experiences of involvement in decisions about moves in care

Many studies reported that looked after children and young people had a desire to be listened to and heard, and more involved in planning and decision-making about their lives including where they live (Sinclair, 2005; Coram Voice, 2015). In practice, however:

- Children and young people felt that they were not kept informed, for example around the reasons for them becoming looked after, the purpose of the placement, and what to expect.
- Often they felt that they were not consulted or listened to; there was inconsistent, limited or no opportunity to participate in decision-making about their lives.
- Young people in residential care do not always feel that they can talk to staff, which may lead to their trying to achieve change through

their behaviour such as running away or otherwise disrupting their placement (Thomas, 2011; Hart et al., 2015; van Bijleveld et al., 2015).

Several reviews reported on children and young people's attendance at looked after meetings and reviews. Although they sometimes wished to attend such meetings to find out what was being said about them, children and young people often found these intimidating and commonly described their experience of these sorts of meetings as long, jargon-filled, alienating, boring, pointless, and stressful. Care leavers have reported a lack of agency within the leaving care process and said that attending planning meetings could be stressful (Hiles et al., 2013). Furthermore, children and young people may be reluctant to engage due to concerns around confidentiality (Care Review Stigma paper, 2019).

Generally children and young people reported that they were often allowed to influence 'trivial decisions', but that the professionals involved did not let them participate in the decisions that they considered to be important such as placement moves and who they lived with. Overall, there was evidence that even when the views of the child were sought their views often have little effect on the outcomes of decision-making processes (Elseley *et al,* 2013; van Bijleveld et al., 2015).

What helps improve children's engagement in decision-making about moves in care

In relation to meetings and reviews, a number of approaches were identified as likely to contribute to children and young people's engagement. These included more work in advance (e.g. planning, meeting the child), skilled communication, well organised meetings (possibly in several parts), using toys or stickers to facilitate engagement, and making food and drink available. There are clear resource implications associated with these, however, including the additional time for planning and organising.

The degree to which children are at the centre of assessment and decision-making depends on the capacity of practitioners, supported by the 'systems' in which they train and work, to form relationships and communicate effectively with them. Staff having skills and 'systems' which enable them to focus on direct work with children is important, and some social workers wanted further training specifically to develop their skills in engaging children. Furthermore, evidence suggests that independent advocacy can facilitate children's participation and can help young people in taking part in decision making. Unlike in England, looked after children in Scotland do not have a right to independent advocacy and, as a result, there is mixed provision.

The message from the research reviewed showed that despite legislation and policy efforts to involve them, children and young people's voices can be lost in the decision-making process. While there is generally a desire to ensure engagement and communication, children and young people still feel they are not always given adequate or appropriate opportunities to have their voices heard.

For children to have an effective voice in services requires meaningful, trusting relationships with practitioners. Positive experiences of participation were heavily dependent upon the attitudes that professionals had towards children and young people, and the quality of relationships that were established (Elsley *et al,* 2013).

Improving engagement should therefore focus on enabling the development of good relationships between looked after children and young people, and the professionals they come into contact with. These professionals must be supported to develop good relationships, including through having enough time to spend with them and recognition that this is an important part of their work. They should have access to a range of means through which they can elicit the thoughts and opinions of children and young people and discuss these with them. Professionals

should be able to use these methods and approaches flexibly to help minimise any sense of intimidation or boredom in formal situations.

7. Concluding remarks

A key challenge in the Care Review, and for the Components working group in particular, is how the 'care system' can be understood in its entirety. At present, much of the discourse presents a static picture of care when, in the reality of children's experiences, there is much movement into, through and out of the 'system'.

There is no 'typical' care journey. Every child is different and will need something different from the 'care system'. To respond effectively to these individual requirements the 'care system' needs to be flexible and situated in children's lives. The Care Review in their work to understand what is working well or less well in the looked after 'system' need to map out how the interlocking components of care operate. This paper has reviewed evidence in relation to these issues, in doing so the following main points emerged:

- The evidence base is limited. Generally, studies in the UK tend to focus on particular groups of children in care rather than the 'care system' as a whole. There is limited research that looks at children's progress over time or research that compares those who enter care with those who nearly entered care.
- Evidence that is available and was reviewed here shows how the 'care system' caters for children with very differing needs. As a result there is a need to recognise the varied purposes of the 'care system'.
- As such, it is important to resist attempts to conceptualise 'care' as simply a single 'system'.
- At the same time, local authorities need to ensure they have strategies in place that are appropriate to meet the diverse range of children who need support. Therefore, there may be benefits in

understanding more about different 'groups' of children in care and their journeys (for example, how relevant or useful are concepts such as 'late entrant', 'care graduate' as discussed in Section four in understanding the 'care system' in Scotland).

- Many children are either looked after at home or return to live with their family. This report has not discussed the evidence on the type and level of support needed by parents. However, such support is crucial in helping children in care to return to their families.
- The evidence reviewed shows that improvements are still needed in terms of ensuring children have stability in their lives whilst in care, and are meaningfully involved in decisions about their lives.

Final point: a day, a week, a month, a year – the importance of the everyday within 'care journeys'

The Care Review components group are interested in mapping a day, a week, a month, a year in the life of looked after children. This paper has synthesised information about 'care journeys' and movement. In doing so it was noted that much of the research evidence about looked after children focuses on the care experience itself. Less attention is given to factors beyond the placement. In terms of the daily lives of young people who are looked after by local authorities, the roles of context, culture and community appear to receive little attention in the research literature (Hicks et al, 2012). Yet understanding the everyday lived experiences of looked after children, their routines, activities and how they feel they are doing, is important to understanding how well care is being delivered (Selwyn and Briheim-Crookall, 2017). Whatever the care journeys children experience the importance of the 'everyday ordinary' in young people's lives must not be lost sight of (Baker, 2017a).

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Edges of Care

‘Edges’ of care: entering and leaving the ‘care system’

A review of the evidence about transitions into and out of the ‘care system’, and the impacts of being ‘care experienced’ on life trajectories

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July 2019

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1. Introduction

Background

In May 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[291]

'Edges' of care – entering and leaving the 'care system'

This report presents a review of the evidence in relation to the following questions:

> *What evidence is available in relation to entering and leaving the 'care system'? What do we know about (i) What supports families to stay together so that children do not become looked after? (ii) The outcomes for care leavers over the short, medium and long term? (iii)*

[291] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

The provision of lifelong support to care leavers? (iv) The impacts over the life course of experiencing the 'care system'?

Scope of the evidence review

This review focuses on 'the edges of care', that is the experience of children and families as they enter and leave the 'care system'. Within this overarching framework the review examines (i) how and why children come into care (ii) 'early intervention' measures aimed at supporting children to remain at home (iii) the experience of leaving the 'care system' as a 'care leaver', and the facilitators of a 'good' transition from care to early adulthood and (iv) the impacts of being 'care experienced' on peoples' lives. Whilst for any particular child, there may be multiple 'episodes of care' (and therefore more than one occasion of entering and leaving the 'care system'), the review does not consider these 'pathways' or 'journeys' through care in detail. A separate review paper entitled 'Care Journeys' should be regarded as a companion piece to this review paper.[292]

Structure of the report

The report is structured as follows:

- Section two reports relevant findings from the Discovery stage of the Care Review
- Section three sets out the definitions, terminology and context which are relevant for this review paper
- Section four looks at how and why children come into the 'care system'
- Section five looks at early intervention and preventative approaches which are aimed at providing support to children and families on the 'edge of care'
- Section six describes the experiences of 'care leavers' and their transition from care to adulthood

[292] 'Care journeys', Care Review Evidence Review, Claire Baker, Dawn Griesbach and Jennifer Waterton, July 2019

- Section seven describes the impacts over the lifecourse of experiencing the 'care system'
- Section eight contains some concluding thoughts.

2. Findings from the Discovery stage of the Care Review

In relation to the topic of 'edges of care' the Discovery stage of the Care Review found that:

- Children and young people emphasised the importance of themselves and their families getting the help and support at the right time. For many this meant 'early intervention' and 'making the right decisions earlier'. There was a strong view that if services had been able to intervene earlier – and to provide appropriate support to families sooner – then perhaps there would have been less need for children to enter the 'care system' in the first place. Moreover, even if entry into the 'care system' was the right thing and needed at the time, children still thought that it would be better if services were more proactive and identified the need for support earlier. The kinds of support children felt would have helped included mental health support, parenting support, family support, and financial support. (1000 Voices report, 2019)
- There was a lot of concern expressed about the amount of continuing support available to young people after someone had left the 'care system'. Generally, children thought there was not enough support provided to 'care leavers'. Children and young people thought that since the experience of care could have lifelong consequences, then the support that should be offered to care leavers should also be lifelong. The support that was needed included practical support (cooking, self-care, finance etc.), as well as guidance and emotional support from committed adult(s) who cared about the person and could help them with life decisions about achieving positive employment, education and housing. (1000 Voices report, 2019)

It was vital that children and young people felt that their views were listened to, and that they were involved in decisions about going into, and coming out of, care. There needed to be appropriate information provided and proper planning in place to make sure that children and young people understood what was happening to them and why. (1000 Voices report, 2019)

Official statistics about children on the 'edge of care' are limited. Published information about those coming into care during a specific period covers their age only (and this is complicated by the fact that a single child will be counted more than once if they have more than one 'care episode' in any given year. As far as those ceasing to be looked after is concerned, the official statistics report the length of time they have been looked after and their destination on leaving care. (CELCIS, statistical overview report, 2018)

As far as 'care leavers' are concerned, as of 31 July 2017, there were 5,653 young people (aged 16-25 inclusive) in Scotland who were 'care leavers'.[293] Of these, 3,817 (68%) were in receipt of some form of 'aftercare' support from their local authority. Official statistics also report, for care leavers, their age, gender, accommodation, whether they are in employment, education and / or training and whether or not they have a care plan. (CELCIS, statistical overview report, 2018)

The CELCIS overview paper reports outcomes for looked after children in relation to: education and post-school destinations; premature death; homelessness; and the link between care experience and prison. (CELCIS, statistical overview report, 2018)

Care Review intention: Families on the edge of care will get the support they need to stay and live together where safe to do so.

[293] These are young people who, under the current provisions of Section 29 of the Children (Scotland) Act 1995, are entitled to advice, guidance and assistance (i.e. 'aftercare') from a local authority. Note that the Children and Young People (Scotland) Act 2014 raised the age up to which young people were entitled to assistance from their local authority, from their 21st birthday to their 26th birthday.

Care Review intention: Aftercare will be designed around the needs of the person leaving care supporting them to lead a fulfilling life for as long as they need it.

3. Definitions, terminology and context

This section (Section 3) provides a brief overview of the definitions, terminology and context relevant to the 'edges of care' review.

The emphasis in this section is on the specific arrangements which pertain in Scotland; there are, however many communalities – as well as a range of differences – in relation to the UK (and other) jurisdictions.

What is the 'care system'?

The 'Care Journeys' evidence review has provided a definition of the 'care system' as follows:

> *'The children's 'care system' is a collection of agencies, departments and individuals responsible for meeting the needs of children who, for a wide variety of reasons, cannot live safely with their birth family. It involves coordination between social work services, education, health care, Children's Hearings and others' (FrameWorks, 2018).*

What are the 'edges of care'?

The boundaries around the 'care system' (the 'edges of care') involve several points where transition (into or out of care) may occur; these include (but are not limited to) entry from home, returning home, or moving into independent living or adoption. Children and young people may make several transitions into and out of care as their 'care journey' evolves.

There is no simple agreed definition of the 'edge of care' or the 'edges of care', and the term is used in a variety of ways depending on the context (Ofsted, 2011; IPC 2015). Indeed, the evidence scope by Dixon et al (2015) says that:

> *'... since the term refers to young people and practice activity at the cusp of clearly demarcated statutory services, the 'edge of care' may always be a somewhat nebulous concept.'*

In practice, however, most 'edge of care' provision (i.e. services aimed at the 'edge of care population'), is targeted at vulnerable families that have multiple complex problems and a high level of need such that there is an immediate or imminent risk of family breakdown and a strong possibility of a child or children becoming looked after. 'Edge of care' provision is therefore commonly (although not universally) aimed at preventing children from becoming looked after. It often takes the form of intensive support to assess needs, enhance early intervention, reduce late-stage crisis interventions, and prevent family breakdown (CELCIS, 2017[294]; Dixon et al 2015).

'Edge of care' provision can, however, also includes young people who are returning to the family following a period in care (National Children's Bureau 2013), and care leavers who are experiencing difficulty. Most recently, a broad and inclusive definition of the 'edge of care population' was suggested, based on a synthesis of research and evidence scopes (Bowyer et al, 2018). In this analysis, the 'edge of care population' was defined as children or young people who match one or more of the following criteria:

- Is currently at high risk (professionally judged) of requiring protection from harm
- Has previously been considered for a care placement, which did not go ahead
- Has experienced multiple difficulties in their lives and shows signs of escalating need for support
- Has suffered abuse and/or neglect at some point in their life

[294] https://www.celcis.org/files/3614/8734/9107/CELCIS_15.02.17_Edges_of_care_-__information_sheet_final.pdf

- Has not been successfully supported by a service or multiple services, and has subsequently been moved around the Children's Services 'system'
- Is in an alternative to a long-term care placement with some sort of additional support
- Has very recently left care
- Has previously been in care and is still at risk of personal and accommodation instability.

The above description is used as the 'working definition' in relation to this review paper. As can be seen from the foregoing, this covers children and young people who are both entering and leaving the 'care system'.

Key definitions in relation to the 'edges of care' review

The follow definitions are relevant to the 'care system' in Scotland.

'Looked after' child[295,296]

A child is 'looked after' by a local authority in Scotland when he or she is: (i) provided with accommodation under section 25 of 1995 Act[297]; or (ii) subject to a compulsory supervision order (CSO) made by a children's hearing in respect of whom the local authority are the implementation authority[298]; or (iii) living in Scotland and subject to an order in respect of

[295] Note that, given the definition set out above of children on the 'edges of care', these children are not currently 'looked after'.
[296] Note that in this review, alternative terms used for a 'looked after child' include a 'child in care' or a child in 'out-of-home placement'.
[297] Children (Scotland) Act 1995, Section 93, Article (2) (a). This legal route is often referred to as 'voluntary measures' or a 'voluntary arrangement.
[298] This occurs where a child is considered to be 'at risk', and it is not possible for public services to address that risk in cooperation with the child and / or their parents / carers. This is sometimes referred to as 'compulsion' or 'compulsory measures'. A CSO may contain conditions about who the child should have contact with, and where they must live. Where a CSO requires a child to live away from their usual place of residence (e.g. with their parents), the local authority must provide appropriate accommodation to meet the needs of the child, such as with foster carers, kinship carers, or in a group setting (e.g. residential home or school). Where no condition of residence is attached to a CSO, children become 'looked after' by their local authority but remain living with their parents / carers. This group are often referred to as 'looked after at home'.

whom a Scottish local authority has responsibilities[299]; or (iv) subject to a Permanence Order made following an application by the local authority[300,301].

In respect of the 'care system' in Scotland, a person can be considered a 'looked after child' at any time from birth up to their 18th birthday.[302]

It is important to note that many children in Scotland live in 'alternative care arrangements' (i.e. not with their biological parents) but are **not** considered to be 'looked after'. This group includes children who have been adopted (under an Adoption Order), those who are living with friends and relatives (either in a private family arrangement or under a Kinship Care Order) and those whose placement is secured by a Residence Order[303]. The group also includes children who have been removed to a place of safety under a Child Protection Order.

'Care leaver'

A 'care leaver' in Scotland is a young person aged 16-25 inclusive who meets the descriptions set out in section 29 and section 30 of the 1995 Act (as amended by section 66 of the 2014 Act). From 1st April 2015 a 'care

[299] The four countries of the UK maintain a reciprocal arrangement, set out in law, to recognise the legal orders by which children become 'looked after' in each of the different UK legal jurisdictions.
[300] A Permanence Order transfers certain parental rights to a child's local authority, including the right to regulate the child's residence (up until the child's 18th birthday). It is a long-term measure of care, used to secure permanence for a child who has no reasonable prospect of returning to live with their biological family, but for whom adoption is not appropriate and / or desirable.
[301] Note that these different legal routes lead to differences in the way a child's care is managed (for example in relation to the extent to which parental rights and responsibilities are transferred to the local authority and the way social work processes are mandated).
[302] It is possible for a child to remain 'looked after' by a local authority beyond their 18th birthday, as part of a private arrangement between the family and the local authority. Where this does happen, it is usually due to the child's significant physical and / or mental disabilities, which require the local authority to provide ongoing care.
[303] Section 11 of the 1995 Act

leaver' is a young person who ceased to be looked after on, or at any time after, their sixteenth birthday.[304]

Eligibility for, and scope of 'aftercare'

A 'care leaver' is entitled to advice, guidance and assistance ('aftercare') from a local authority.[305] (Note that eligibility for 'aftercare' was extended from those aged 16-20 inclusive to those aged 16-25 inclusive by the Children and Young People (Scotland) Act, 2014.) The scope of the 'aftercare' available is described in further detail in Guidance on Part 10 (Aftercare) of the Children and Young People (Scotland) Act 2014.

Continuing Care after the age of 16

The Children and Young People (Scotland) Act 2014 introduced new provisions which give care experienced young people over the age of 16 the right to stay in their existing placement until the age of 21.[306]

Specifically, the term 'Continuing Care' refers to a local authority's duty under section 26A of the 1995 Act to provide, subject to a Welfare Assessment, young people - who were (i) born after 1st April 1999 and who are aged at least sixteen but who are not yet 21, and (ii) whose final 'looked after' placement is in foster, kinship or residential care - with the same

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[304] This replaced the previous care leaver definition of a young person who ceased to be looked after on or after their minimum school leaving https://www.gov.scot/publications/guidance-part-10-aftercare-children-young-people-scotland-act-2014/pages/4/

[305] A local authority has a duty under section 29(1) of the 1995 Act to provide advice, guidance and assistance, (i.e. 'Aftercare') for: (i) a compulsorily supported young person (any young person to whom a local authority has that is a young person who has ceased to be looked after on or after their sixteenth birthday but who is under the age of nineteen) and (ii) a discretionarily supported young person (a young person to whom a local authority has agreed, via a written assessment of need, to provide 'Aftercare' who is nineteen years of age or older but not yet twenty-six years of age.)

[306] Early evidence suggests take up of 'Continuing Care' is relatively low and there are problems with implementation (Scottish Government, 2018; McGhee, 2017). In addition, there is some anecdotal evidence to suggest that not all young people in care are being informed of this right, and that (at least some) residential services are still encouraging young people to leave care at age 16 before they feel ready to. (Continuing Care, Together blog, 24 May 2019 https://togetherscotland.blog/2019/05/24/continuing-care/ - accessed June 2019.)

accommodation and other assistance as was being provided by the local authority, at the time the young person ceased to be looked after.[307]

A young person receiving Continuing Care will no longer be defined as 'looked after' but will continue to receive the same support. When Continuing Care ends the young person is then eligible for Aftercare support until they turn 26.

Throughcare

The term 'throughcare' refers to the advice and assistance provided to looked after children with a view to preparing them for when they are no longer looked after by a local authority.[308]

'Care experience'

A child or young person has 'care experience' when the state has or had a formal role in bringing them up (FrameWorks, 2018).

Interventions relevant to children on the 'edge of care'

This review paper will consider the evidence for a wide range of interventions which have been developed to support children on the 'edge of care'. These interventions are variously described as 'early intervention programmes', 'family preservation programmes', 'parental support programmes' etc.

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[307] The aim of Continuing Care is to provide young people with a more graduated transition out of care, reducing the risk of multiple simultaneous disruptions occurring in their lives while maintaining supportive relationships. It is a new term introduced by Part 11 of the 2014 Act. For more information, see guidance on Part 11 (Continuing Care) of the Children and Young People (Scotland) Act 2014.

[308] Local authorities are under a duty to provide such assistance to all looked after children under section 17(2) of the 1995 Act. Note also that In carrying out its duties under section 17(1)(a) of the 1995 Act to prepare for when a young person is no longer looked after, a local authority shall, for every looked after person in respect of whom it is the responsible authority: (i) seek the views of the young person; (ii) carry out a pathway assessment with a view to determining what advice, guidance and assistance it would be appropriate for the local authority to provide when the young person is no longer looked after; (iii) if necessary or desirable to do so, prepare a pathway plan for the young person; and (iv) if necessary or desirable to do so, appoint a pathway co-ordinator for the young person.

CELCIS Programme on 'Edges of Care'[309]

There is an ongoing programme of work at CELCIS on the 'Edges of Care'. The broad aims of the programme are: (i) to improve child and family well-being (ii) to reduce the number of children looked after, and the associated negative impact of family breakdown (iii) to decrease local spend on late-stage, crisis interventions (iv) to develop and enhance preventative and early intervention options within local communities (v) to grow local capacity to support practice improvement and implementation (vi) to expand and/ or introduce effective child-welfare practice and (vii) to accelerate the realisation of GIRFEC[310] for children on the edges of care.

The first phase of the work was a scoping exercise, carried out during 2017 and 2018 to explore access to support for families with children on the edges of care in three areas of Scotland. The current ongoing work involves planning, design and testing of different approaches as well as implementation support to sustain positive change.[311]

[309] https://www.celcis.org/files/3614/8734/9107/CELCIS_15.02.17_Edges_of_care_-__information_sheet_final.pdf
[310] Getting It Right For Every Child (GIRFEC) https://www.gov.scot/policies/girfec/
[311] This programme of work focused on Edges of Care will make an important contribution to the evidence base in Scotland. However, outputs from this programme of work are currently at an early stage and not yet available, and have therefore not been included in this evidence review. Further information from CELCIS will be available in due course.

4. How and why children come into the 'Care System'

This section sets out the evidence on how and why children come into the 'care system'. It briefly describes (i) the legal routes into care (ii) why children come into care (iii) children's experience of going into care (iv) where children live when they are in care and (v) Scotland's Children's Hearings system (CHS), and the programme of work aimed at improving how CHS operates, especially in relation to improving children's experiences.

Where possible, the section includes information based on official statistics about 'entries' into the 'care system' and related processes. However, it should be noted that official statistics on the 'care system' provide only a 'snapshot' of the profile of those looked after in the 'care system' at a point in time; they do not report on individual 'episodes of care', neither do they provide information based on an individual's 'journey' through the 'care system'. This means that the picture of the 'care system' in terms of the numbers entering and leaving is very incomplete. Moreover, in Scotland there is little systematic information collected about the reasons why children enter the 'care system'. These limitations have been recognised in the 2017 CELCIS overview report.

Routes into care

The routes into care depend on complex legal processes. These are summarised briefly below. The different legal routes lead to differences in the way a child's care is managed, reflecting the extent to which parental rights and responsibilities are transferred to the local authority, and, relatedly, the social work processes (such as reviews) which are mandated. (CELCIS overview report, 2017).

A child can enter the 'care system' in Scotland and become 'looked after' when he or she is: (i) provided with accommodation by a local authority under section 25 of the Children (Scotland) Act 1995[312] (ii) subject to a compulsory supervision order or an interim compulsory supervision order made by a children's hearing in respect of whom the local authority are the implementation authority (within the meaning of the Children's Hearings (Scotland) Act 2011[313]) (iii) living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities, as a result of a transfer of an order under regulations made under section 33 of the 1995 Act or section 190 of the 2011 Act or (iv) subject to a Permanence Order made after an application by the local authority under section 80 of the Adoption and Children (Scotland) Act 2007.[314]

Why children enter care

The reasons why children enter care have been described in the 'Care Journeys' review paper[315] as set out below.

> *'Children and young people enter the 'care system' when their parents are unable to provide adequate care or protection. According to statistics from England the largest group of children entered care for reasons connected with 'abuse or neglect'316 (figures record the 'primary need' for care). These data are not readily available in Scotland'[317].*

[312] https://www.legislation.gov.uk/ukpga/1995/36/contents
[313] https://www.legislation.gov.uk/asp/2011/1/contents
[314] https://www.legislation.gov.uk/asp/2007/4/contents
[315] 'Care Journeys': A review of the evidence on children's moves into, through and out of care for the Care Review. Baker, Griesbach and Waterton (July 2017)
[316] In 2018 in England 63% of looked after children had a 'primary need code' of 'abuse and neglect'; 15% entered care primarily due to 'family dysfunction' and others because of 'family in acute stress' (8%). Some children were recorded as needing care due to 'absent parenting' (6%). Other reasons related to child disability (3%) or parental illness or disability (3%) https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2017-to-2018
[317] Statistics in Scotland cover the year 1 August 2017 to 31 July 2018; they record information on the legal reason for 'being looked after' and do not appear to provide data on the factors that led to children becoming looked after https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/

'In reality, a range of factors are likely to inform decisions which lead to children being looked after including maltreatment and neglect associated with parental substance misuse, mental health and domestic violence (Whincup, 2019). Multiple family difficulties such as poverty, social exclusion, chronic unemployment, poor housing and lack of community resources can all increase the likelihood that a family will become involved in the 'care system'. These conditions can reduce parents' capacity to look after their own well-being and that of their child(ren) and their ability to create a safe and nurturing environment for their child(ren)' (Frameworks, 2018; Whincup, 2019; Curtice et al 2019[318]).

'Unaccompanied asylum seekers, those who have a parent in prison and children with complex health and behavioural needs are also more likely to become involved with the 'care system' than those without these experiences' (Cusworth, 2019; Frameworks, 2018; Care Review Justice paper 2019).

'In summary, a substantial body of research has documented children's pre-care experiences and concludes that: "Entering care is strongly associated with poverty and deprivation including low income, parental unemployment and relationship breakdown, and the majority of children are in care because of abuse or neglect".' (Jones, 2011)

Children's experience of going into care

The 'Care Journeys' Care Review paper explains that:

'Most children who come into care have experienced complex trauma and faced significant challenges early in life. Entry into care is itself often a distressing experience and brings with it a significant

[318] https://members.tortoisemedia.com/2019/04/27/punished-for-being-poor-what-the-numbers-tell-us-about-family-separation/content.html?sig=PWFRkx_gA14akpVdLdOYqQU4OHX1BRoot8pgV5rWjqY

sense of loss (Baker, 2017b). Entry to care may be planned but in many cases it is unplanned. Young people's accounts of their first move into care often recall how the experience was frightening and bewildering. It was a time marked by uncertainty; children recall how they did not know where they would be living and often didn't understand why they were being separated from their families' (Mitchell, 2016).

More generally, children report a mixture of emotions in relation to going into care. These include:

- Feeling scared, anxious or stressed because they don't know the people they will be staying with
- Feeling lonely or isolated if they have to move to a different area
- Feeling a loss of control
- Feeling sad, or unsettled about moving out of the family home – especially if they had to move to different placements from their siblings
- Feeling like it has changed who they are
- Settling into their new environment well and preferring living with their new carers
- Feeling more secure, safe and supported, especially if they have moved away from abusive families or carers.[319]

The Care Review 'Justice' review paper highlighted that upon entering care children don't feel they have all the information they need, and this could cause distress and anxiety:

'Children and young people reported a lack of information, at the point of entering care. Some stated that they were not well informed about why they were in care, what they could expect, where they

[319] https://www.childline.org.uk/info-advice/home-families/family-relationships/living-care/#1

> *were being taken, or what was happening to their other family members.' 320, 321*

The Care Review 'Care Journeys' review paper also explained how children felt about moves within the 'care system' as follows:

> *'Overall, children wanted reassurance. Children explained they were likely to be missing their family and feeling confused and upset. It could feel frightening and unsafe to move into care or move from one place to another. Lack of information increased their worries and anxiety about what was going to happen.' (Baker, 2017c)*

Where do children live in care?

Where children live once they have entered care (i.e. once they are no longer on the 'edge of care') is discussed in the Care Review Components of Care 'Care Journeys' review paper.

Children's Hearings System

Overview

The Children's Hearings System (CHS) began operating on 15th April 1971, taking over from the courts the responsibility for deciding how to support children and young people who are in need of care or protection or who have committed alleged offences. The CHS makes decisions that ensure the safety and wellbeing of vulnerable children and young people. The system allows the welfare of a child to be evaluated by people who take into account all circumstances to decide the best course of action for the

[320] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[321] Van Bijleveld *et al* (2015).

child's future.[322] The system is based on the philosophy that those who offend and those who are the victim of an offence are equally deserving of support and should, if necessary, receive intervention in their lives. (Thus, the CHS is about welfare, not punishment. It is about the needs of the young people, rather than the behaviour or actions.) The aim is to let children remain in their own community, where possible, and integrate any measures required. This is because it is recognised that parents are usually the best people to bring up their own children.[323]

As is clear from the description above of the 'routes into care' the CHS is a crucial component of the decision making processes in relation to looked after children who are entering the 'care system'.

A brief account of the structure and processes of the CHS is given below, based on the information provided in the 2017 Education and Skills Committee report on recent reforms to the CHS.[324]

Structure and processes of the Children's Hearing System

The structure of the hearings system is based around (i) Reporters, employed by the Scottish Children's Reporter Administration (SCRA) (ii) volunteer panel members supported by Children's Hearings Scotland (CHS) who make decisions at hearings, and (iii) local authorities which implement hearing decisions. Throughout, procedures are informed by the key principles of the system which are: (i) the welfare of the child is the paramount consideration; (ii) an order will only be made if it is necessary

[322] A 'child' for the purposes of a hearing is a person who is: (i) not yet sixteen years old (no lower age limit other than that the child has been born) (ii) over sixteen years but not yet eighteen and subject to a supervision requirement (iii) over sixteen but has not yet reached the school leaving age and has been referred to a hearing on the grounds that he or she has failed to attend school regularly without reasonable excuse (iv) referred to a children's hearing from a different part of the United Kingdom and is under a similar requirement or order to the ones made in Scotland. All children and young people under the age of 16 and some under the age 18 began to be responded to via the Children's Hearings System when there was care and protection issues. See Justice review (Griesbach et al, 2019) for a discussion of the treatment of 16- and 17-year olds within the justice system.
[323] This description is based on text from the 'Unlock the Law' website. https://www.unlockthelaw.co.uk/childrens-hearings-scotland.html
[324] http://www.parliament.scot/S5_Education/Reports/ESS052017R05.pdf

(i.e. the state should not interfere in a child's life any more than is strictly necessary); and (iii) the views of the child will be considered, with due regard for age and maturity. The hearing is supposed to have the character of a discussion about the child's needs. A sheriff court is generally only involved if grounds of referral are in dispute or not understood, a child protection or child assessment order is required or there is an appeal against a decision of a hearing. The aim is to balance the 'lay' character of the system with the guarantees of individual rights afforded by a court system.

Anyone can make a referral to the Reporter, but in practice most referrals are made by the police.[325] The Reporter investigates and decides whether a hearing is required. This decision is based on whether there is sufficient evidence that a statutory ground for referral has been met and if so, whether compulsory measures of supervision are needed. If a hearing is required, the reporter arranges one, and three members of the children's panel are selected to form the hearing. At the hearing, the grounds for the referral must either be accepted by the relevant persons and child or established by the sheriff in order to proceed. A safeguarder, whose role is to protect the child's interests, can be appointed at any time during the hearings process. A child or relevant person can be represented at a

[325] The Children (Scotland) Act 1995 lists the reasons why a child can be referred to a children's hearing (other than direct referrals from a court). These include where the child: (i) is beyond the control of any relevant person (ii) is falling into bad associations or exposed to moral danger (e.g. joining a gang or if drugs are present in the home) (iii) is likely to either suffer unnecessarily or be impaired seriously in their health or development due to a lack of parental care (iv) has suffered from offences such as those of a sexual nature, neglect or female genital mutilation (or is, or is likely to become, a member of the same household as a child who has suffered from any of these offences, or the same household as a person who has committed any of these offences) (v) is, or is likely to become, a member of the same household as a person who has committed incest or had intercourse with a child (vi) has failed to attend school regularly without a reasonable excuse (vii) has committed an offence (criminal responsibility in Scotland only applies to an offence committed by a child over the age of eight) (viii) has misused alcohol or any drug (for this ground to be satisfied there must be a misuse of alcohol or drugs, not merely use) (ix) has misused a volatile substance by deliberately inhaling its vapour, other than for medicinal purposes (x) is being provided with accommodation by a local authority or is the subject of a parental responsibilities order, and special measures of adequate supervision are in their or another's interest.

hearing and there is state funding available in particular circumstances for legal representation. Interim orders can be made, but the main decision of a Hearing is whether a Compulsory Supervision Order is required. This states where a child is to live and can include other conditions such as contact arrangements or support services required. Because these are compulsory measures there is strict legal oversight of the process including provision for legal representation and appeals.

It is necessary to get the right balance between informality and protecting the legal rights of those involved. This has led to the extension of legal aid in order to protect participants' European Convention on Human Rights (ECHR) rights.[326] The local authority must implement a Compulsory Supervision Order.

Statistics and trends

When the Children's Hearings system started in the early 1970's, there were around 20,000 referrals a year. After years of steady slow increase there was a dramatic increase in the 2000's to a peak of nearly 56,000 in 2006/07. Numbers of referrals have since declined steeply to their current rate of around 13,000 per year.[327] Most referrals, around 75%, continue to be from the police, followed by social work (17%) and the education system (4%).[328]

Since the early 1990s, most referrals have been on 'care and protection' grounds rather than the 'offence' ground. In 2017/18 around a quarter (23%) of referrals were on 'offence' grounds compared to 39% ten years previously.[329]

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[326] S v Miller, 2001 SLT, K v Authority Reporter, 2009 SLT 1019 found that the failure to provide legal aid to the child and relevant person, in some circumstances, breached Article six ECHR. As a result, state funded legal representation was included first in regulations and subsequently in the 2011 Act.
[327] In 2017/18, 13,240 children and young people in Scotland were referred to the Children's Reporter.
[328] Ibid.
[329] In 2017/18 referrals to the children's reporter comprised: 10,180 (77%) on non-offence (care and protection grounds) only; 1,972 (15%) on offence grounds only; and 1,088 (8%) on both non-offence and offence grounds.

By far the most common statutory ground for referral is 'lack of parental care.' In 2017/18, over a third of children (35%) referred were referred on this ground. The next most common ground was the child having committed an offence (23% of children referred), followed by 'close connection with a person who has carried out domestic abuse' (17% of children referred) and 'child's conduct harmful to self or others' (13%).

According to the statistical analysis report produced by SCRA[330] there were 32,553 Hearings held in 2017/18. Most of these (21,347) were to review Compulsory Supervision Orders. Only 8,336 were to consider a statement of grounds. In 2017/18, Hearings made 2,918 new Compulsory Supervision Orders. Compulsory Supervision Orders are not intended as long term arrangements, but can become so in practice. As at March 2018, around a fifth (19%) of the 9,493 CSOs in place had lasted for five years or more.

The Children's Hearings (Scotland) Act 2011[331]

The Children's Hearings (Scotland) Act 2011 ("the 2011 Act") brought about major reforms to the Children's Hearings system in Scotland. The 2011 Act (which came into effect in 2013) made mainly structural changes to the hearings system. The main aims of the changes were to modernise and streamline the operation of the system, deliver greater national consistency and simplify the provisions for warrants and orders.[332]

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[330] https://www.scra.gov.uk/wp-content/uploads/2018/07/Full-statistical-analysis-2017-18.pdf
[331] https://www.legislation.gov.uk/asp/2011/1/contents
[332] The main changes were: (i) creating a national body, Children's Hearings Scotland, to recruit and support panel members, headed by the National Convener (ii) creating a national Children's Panel (in place of separate panels in each local authority), supported by 22 Area Support Teams (iii) creating a national Safeguarder Panel; (iv) providing for the development of an advocacy service for children in the hearings system (this has not been brought into force) (v) providing for the amendment of the Rehabilitation of Offenders Act so that offence grounds accepted or established in children's hearings (other than for certain serious offences) are no longer classed as a conviction (this has not been brought into force); (vi) Introducing access to legal representation through the Scottish Legal Aid Board; (vii) providing for a "feedback loop" to allow collection of information about the implementation of Compulsory Supervision Orders; and (viii) revising some of the grounds for referral to a hearing, including introducing new ground in relation to domestic abuse.

A report of the progress in relation to the changes introduced by the 2011 Act made a range of recommendations.[333] The recommendations were based on a wide range of evidence and submissions, including interviews with children who had experience of the hearings system. Those with specific relevance to this evidence review on edges of care included that: (i) there needs to be greater consistency in the information provided to children and young people before, during and after their Panel meetings; (ii) all children and young people should have the right to have an advocacy worker appointed by them if they wish; (iii) all children and young people who are part of the Hearings system should be provided, in advance, with a short, child-friendly summary of the reports that are going to be used during Panel meetings; (iv) panels can be better informed about the prospect of a greater recourse to kinship care as part of the options available to them when taking decisions. The report also suggested that more attention should be paid to the continuity of membership of a panel so that all or at least some of the panel members are present throughout the entire process for a given child or young person who may have to attend multiple hearings.

Children's experience of Children's Hearing System

The Children's Hearings Improvement Partnership (CHIP) published its report 'The Next Steps Towards Better Hearings' in 2016.[334] The report included a literature review about what children and young people, (and practitioners) have said about their experiences of Children's Hearings, as well as conducting primary research. The report identified a set of 'Proposed Standards for Better Hearings' from areas of consensus between children, young people and practitioners.

The main issues raised by children and young people which are addressed in the proposed standards cover issues relating to aspects before, during

[333] http://www.parliament.scot/S5_Education/Reports/ESS052017R05.pdf
[334] http://www.chip-partnership.co.uk/wp-content/uploads/2016/10/Better-Hearings-Research-Report-2016.pdf

and after the hearing. These are based on a review of the literature and the primary research which identified a range of issues which children and young people (and practitioners) felt could be improved as follows:

Before the hearing

- Better planning in relation to the hearing (including advance warning of the venue, early access to the papers and reports, information about who will attend, access to advocacy, and discussion about whether they will attend in person)
- Improvements to the reports and information that are available before the hearing (including ensuring children's views are incorporated into any reports, using language which is easily understood, a focus on current life situation, keeping information confidential)

During the hearing

- Children's safety and privacy should be better protected during the hearing
- Improvements to the way the hearing is run (including starting and finishing promptly, proper introductions and explanations by the Panel Chair, making sure discussions were important and relevant and as clear as possible etc.)
- Clear processes for consulting children about whether and how they wish to give their views during the hearing
- Better explanations to be provided to children about how their best interests have been met and how decisions have been made

After the hearing

- Ensure that following a hearing there would be someone to answer children's questions; a clear written response, explaining the decision and what would happen next; and a plan which incorporates the information about the decision

- Ensure that children's rights are upheld (including the right to a private space to discuss the decision, the right to ask for the decision to be appealed, help with arranging another hearing etc.).

In addition, in its Programme for Government 2018/19, the Scottish government has committed to improving experiences of the Children's Hearings system, and to responding compassionately to traumatised and neglected children and young people. In this document, the Scottish government also say they will introduce a Family Law Bill to: ensure that the child's best interests are at the centre of any contact or residence case or Children's Hearing; ensure that the voice of the child is heard; and ensure that cases and hearings are dealt with in an efficient way. [335]

Having looked at children's routes into care and experiences of the children's hearing system, this review now turns to the evidence on supporting children to stay with families so they don't need a hearing, or to be looked after.

[335] https://www.gov.scot/programme-for-government/

5. Early intervention and preventative approaches for children and families at the 'edge of care'

This section reviews the evidence on what is known about early intervention and preventative approaches which aim to support children and families at the 'edge of care'. It examines the effectiveness of interventions aimed at preventing children from entering care and / or at supporting parents whose child or children have entered care, and discusses the broad principles which underpin these interventions as well as the outcomes they aim to achieve.

The section starts with some brief remarks about the Scottish Government's approach to supporting children and families at the 'edge of care' through early intervention and prevention approaches.

Scottish Government support for children and families at the 'edge of care'

All the measures described below are expected to result in positive impacts for children and families on the 'edge of care'.

Early intervention and prevention

The Commission on the Future Delivery of Public Services (The 'Christie Report' (2011)), set out the case for public services in Scotland to focus, amongst other things, on prevention and early intervention.[336] The Christie Report has underpinned much of the policy development work in Scotland since its publication, and the focus on prevention and early intervention informs the direction of policy development in Scotland across a wide range of spheres including through the 'getting it right for

[336] https://www2.gov.scot/resource/doc/352649/0118638.pdf

every child' (GIRFEC) approach and through the 'Whole System Approach' (which addresses the needs of young people involved in offending).[337,338]

In relation to looked after children, the Scottish Government's Programme for Scotland 2017-18 made a specific commitment to 'commission a progress review on the use of family support services (which can be seen as a form of 'early intervention and prevention') to prevent children going into care'.[339]

Adverse Childhood Experiences

More broadly, the Scottish Government has emphasised the impact of adverse childhood experiences (ACEs) on peoples' life chances, and has stressed the moral imperative to 'do more, not only to prevent them from happening in the first place, but to limit the damage they do to people, families and communities in the longer term.' It has identified that tackling adverse childhood experiences (ACEs) requires public services to work collaboratively, and with communities, across early years, education, health, justice, social work and more.[340]

The Programme for Scotland 2017/18 reports that:

> *'[The Scottish Government is] working in partnership with the Scottish ACE Hub[341] and a wide range of people and organisations to embed a focus on better preventing ACEs and supporting the*

[337] https://www.gov.scot/policies/girfec/ Significantly, the GIRFEC approach includes provision for every child and young person from birth to 18, (or beyond if still in school), and their parents to have access to a 'named person' to help them get the support they need. This contact will be someone whose existing role already involves providing advice and support to families. As each child grows up, their contact will change, with support usually provided by (i) a health visitor from birth to school age (ii) a head teacher or deputy during primary school years (iii) a head teacher, deputy or guidance teacher during secondary school years. The family may be offered direct support from their named person or access to relevant services offered by the NHS, local authorities and third sector or community groups.
[338] https://www.gov.scot/policies/youth-justice/whole-system-approach/
[339] https://www.gov.scot/publications/nation-ambition-governments-programme-scotland-2017-18/
[340] Note, however that some concern has been expressed about the conceptualisation of ACEs in the context of family policy and decision making (White et al. 2019).
[341] http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

resilience of children and adults to overcome early life adversity. This year we are progressing our commitment to tackling ACEs and focusing our work around four key areas:

- *taking intergenerational approaches to support parents, families and children – including investing in perinatal and infant mental health, expanding support to young mothers through the Family Nurse Partnership, and supporting parent victims and child victims of domestic abuse*
- *preventing and mitigating adverse childhood experiences for children and young people – including investment in school nurses and counsellors in schools, and funding to support health and wellbeing interventions*
- *developing an adversity and trauma-informed workforce – including implementing national trauma training, testing potential approaches for enquiring with adults about ACEs, and supporting schools to embed trauma-informed and nurture approaches in response to ACEs*
- *increasing societal awareness and action across communities – including working with the Scottish Hub to raise awareness and support local areas and communities to address ACEs and enable resilience.'*

Tackling poverty

As has been alluded to elsewhere in these review papers, poverty is a key factor that can contribute to children being taken into care in Scotland. The Programme for Scotland 2017/2018 says that:

'We are taking further steps to tackle child poverty and meet our 2030 targets that would reduce child poverty to the lowest level in Scotland's history. This school year saw the introduction of a new

£100 minimum school clothing grant for families across Scotland. In the year ahead we will:

- *begin work on a £12 million intensive parental employment support programme*
- *invest in innovative approaches to preventing and reducing child poverty, as a start to our £7.5 million Innovation Fund – a partnership with the Hunter Foundation*
- *step up our work to eradicate holiday hunger, providing an additional £2 million of funding to tackle food insecurity among children.'*

Specific initiatives to provide support to families on the 'edge of care'

The Programme for Scotland 2018/19 states that 'We will work with partners to provide support for mothers with complex and challenging needs who have frequent pregnancies, but whose children are taken into care.' However, it was not possible due to the time constraints in this review to explore this initiative further.

Edge of care services – desired outcomes

The 'Edge of Care Cost Calculator' (Bowyer et al, 2018) states that at a strategic level, the general consensus across organisations is that the ultimate desired outcome for an edge of care service is a simple one: to prevent young people from entering or re-entering care (when it is not in their best interest to do so).

Alongside this primary outcome, however, Bowyer *et al* argue that there are multiple other outcomes which also aim to achieve this reduction in care placements. And in addition to contributing to a reduction in the need for episodes in care, these outcomes may themselves have wider societal benefits. These might include, for example:

- Reduction of exposure to domestic violence

- Reduction of alcohol and substance misuse (young person and/or family)
- Reduction in contextual risk of harm / abuse (eg, gang involvement, going missing, etc.)
- Reduction in offending and police involvement
- Improvements in physical and mental health
- Improvements in family relationships and communication
- Improvement of self-efficacy and coping with a crisis
- Improvement of educational outcomes for young people.

The next section looks at the evidence of effectiveness in relation to these outcomes of interventions to support children and families 'on the edge of care'.

Evidence about the effectiveness of interventions to support children and families on the 'edge of care'

A range of programmes have been developed both in the UK and elsewhere to provide support to families on the edge of care, either so that children are prevented from going into care or to support families (and specifically to parents, carers, siblings and the children themselves) while children transition into and out of care.[342]

Looking across these programmes, they are commonly multi-faceted, complex and location specific and combine a range of elements including counselling, social support, decision making support, parenting support, intensive work with parents, relationship-based practice, dedicated key worker support etc. More details of the exact composition of individual programmes are available from the full references.

[342] The Care Review 'Care Journeys' review paper notes that there are two main approaches to supporting children and families (Thorburn, 2014; Bowyer and Wilkinson, 2013). The first approach broadly sees 'care' and the 'care system' as part of a continuum of services whilst the second approach tends to support a model of care which is more incident-focused and 'care' is largely regarded as a 'last resort' option for children. This review paper does not explicitly make these distinctions, although some of the programmes reviewed clearly fall into one or other of these approaches.

A note on the evidence

The key findings from studies on 'early intervention programmes', 'family preservation programmes', 'parental support programmes' etc. from the last ten years or so are set out below. It should be noted that the evidence for the effectiveness of interventions to support children and families on the 'edge of care' is complex, unwieldy and partial, and most programmes are limited to specific care settings and / or are targeted at specific population subgroups (e.g. residential care settings; families where there are substance misuse issues; adolescents; families where there are child protection concerns etc.).

The summary below is drawn from review-level papers and publications, and from substantial programmes of work; individual studies are referred to only where they appear to be of direct relevance to the Care Review. Some of the relevant research is US based, and so questions about 'transferability' to the Scottish (or UK) context are relevant; moreover, the terminology and language is not always easy to 'read across'.

Evidence about the effectiveness of interventions to support children and families on the 'edge of care' – review level studies

Bezeczky et al (2019) Intensive Family Preservation Services to prevent out-of-home placement of children: a systematic review and meta-analysis. London: What Works Centre for Children's Social Care.

Intensive Family Preservation Services (IFPS) are in-depth, concentrated, in-home crisis intervention services, designed to help families with children at imminent risk of out-of-home placement. The aim of these services is to stop children becoming looked after. These services share a number of key characteristics: (i) the service is provided for families with children at imminent risk of an out-of-home placement; (ii) a caseworker contacts the family within 24 hours of a referral being received; (iii) support is provided in the family's home environment for a period of four-six weeks; (iv) caseworkers are available to families 24 hours a day, seven days a week;

(v) caseworkers have a small caseload of two-three families at a time to ensure that they can provide an intensive and flexible service.

The results of the meta-analyses concluded that:

> *'IFPS were effective in preventing children from entering care at three, six, 12 and 24 months after the intervention. Placement outcomes reported at family level demonstrated a significant reduction in out-of-home placements overall but not at the individual time points. The economic analyses reported in the included studies suggest that IFPS could be a cost-saving intervention. However, a full economic evaluation that identifies, measures and values both the costs and outcomes of IFPS and an appropriate comparator is needed to determine the cost-effectiveness of IFPS.'*

Note that the majority of studies included in this review are from the USA, therefore caution should be taken in applying these findings to the UK. The authors conclude that it is likely that key elements of the model such as working with children who are at imminent risk of entering care and offering support within 24 hours of a referral are important in ensuring that the service is effective. The meta-analysis indicates that IFPS are a promising way of preventing care entry and keeping families together.

Institute of Public Care (2015) Effective Interventions and Services for Young People at the Edge of Care Rapid Research Review.

The key messages identified from this rapid review were as follows:

- Young people's needs cut across organisational and service boundaries. There is no single model or approach that will effectively tackle the diverse needs of adolescents in or on the edge of care.
- All young people at risk of care or entering custody should have access to evidence-based interventions which aim to enable them to remain safely at home. At the same time, care including residential

care is the right option for some children. Abused or neglected children tend to do better in care than those who remain with or return to parents who are unable to change.

- There is a predominance of crisis admission into care for this cohort (adolescents). At the same time, the reasons for entering care, and the level and complexity of need, are especially diverse amongst this group. This points to the need for a range of responsive, adaptable and flexible services and interventions on offer across local 'systems'.
- The quality of the relationship between key workers, the young person and their family is consistently found to be the central factor in making the difference between intervention success and failure.
- Intensive, multi-faceted and integrated interventions for families with complex needs are more effective than routine services. Support plans should reflect the need to step-up and to step-down the intensity of support as required. The intensity of whole family interventions should be increased where there is an imminent risk of care for a young person.
- There is clear evidence that disabled children are more likely to be looked after, remain in care for longer and have a higher risk of being placed inappropriately in comparison to non-disabled children. In addition, young people with ASD-related conditions/ADHD and with parents who have mental health problems are at particular risk of late entry to care. The use and impact of interventions to prevent

entry to care not involving residential provision is, however, poorly researched for this cohort at the edge of care.[343]

Dixon et al. (2015) *Supporting Adolescents on the Edge of Care: The role of short term stays in residential care: an evidence scope.*

This evidence scope focused, amongst other things, on the evidence which is available about how best to support families and adolescents with particularly complex and anti-social difficulties who were 'on the edge of care'. The report stated that:

> *'Evidence of the effectiveness of these programmes is often patchy and of varying quality. The clearest message to emerge from evaluations is the importance of a dedicated, well qualified, key worker who works closely, and in partnership with, the family for as long as is necessary, providing continuity and therapeutic, as well as practical, support.'*
>
> *'There is emerging evidence from a few small scale evaluations and local authority internal monitoring reviews that short term respite options can represent cost savings to local authorities by reducing the numbers coming into full time, longer term care. To be most beneficial, however, the current examples suggest that respite should not operate in isolation, but as part of a planned programme of*

[343] Note that the rapid review also comments on more generic parenting programmes as follows: 'A number of parenting programmes and interventions have been extensively and positively evaluated but evidence for their effectiveness concerning the edge of care cohort is more variable. Ward et al (2014) find that the impact of Triple P may have been overstated and, in particular, that the programme may be less effective with disadvantaged parents whose children are on the edge of care. Parenting programmes can also help learning disabled parents to acquire adequate parenting skills to provide sufficient and safe care, but such parents are likely to need long- term support to adapt to new challenges. There is evidence that parents with learning disabilities are able to acquire adequate parenting skills to provide sufficient and safe care for a child through parent training programmes, home based safety interventions and developing supportive peer relationships (Ward et al 2014). Overall, elements of parent training programmes that emphasise the development of self-efficacy through learning the skills of sensitive, responsive parenting tend to have a positive impact on the types of parental problem that increase the risks of maltreatment.'

family and adolescent support to ensure that the safety of the child and support needs of the whole family are addressed.' [344]

Ward et al. (2014) Parental Capacity to Change When Children are on the Edge of Care.

This overview brought together some of the key messages concerning factors which promote or inhibit parental capacity to change in families where there are significant child protection concerns. The key findings of this study were that:

- The Family Partnership Model (FP), Motivational Interviewing (MI) and Family Group Decision-Making (FGDM) offer potential methods of engaging parents who are ambivalent about change, mistrustful of social workers, or not fully ready for change. Such methods can empower parents by giving them an element of control. FGDM also enables families to participate in the decision-making process.
- Interventions designed to increase parenting skills can be effective and can have a positive knock on impact, reducing other parental problems by increasing self-efficacy and self-esteem. However, in cases where parents are facing complex, multi-layered problems, an integrated package of support may be required, tailored to meet the needs of each member of the family.
- Many standardised measures and intensive programmes are still relatively new. They may well prove to be effective but many have not yet been adequately validated in the UK and are not available in all areas of the country.

[344] Note that, in addition, residential care is sometimes viewed as part of a positive intervention at the 'edge of care'. For example, a review by McConkey et al (2011) endorsed a specialist model of short break and intensive outreach support for families and disabled young people presenting with severely challenging behaviour (up to 19 years old) delivered by a national voluntary organisation in three UK cities. The model was found to be effective for families in continuing to manage challenging behaviours within the home environment and in the view of the authors demonstrated the need for specialist short break provision to be included in the network of service supports available to families.

- Finally, interventions take time and change may not always be possible within the child's timeframe, particularly where children are very young or vulnerable, entrenched parental behaviour patterns need to be addressed, progress is slow and relapse is frequent.

Department for Education (2014) *Rethinking Support for Adolescents on the Edge of Care*. Department for Education Children's Social Care Innovation Programme.

This report states that:

> *'The research, inspection evidence and the views of those working directly with troubled adolescents are all strikingly consistent on the most important factors in providing effective support. We hope the following summary will be of use to local authorities and others looking to consider new approaches. The quality of the relationship between the worker and the young person is the factor most often cited as making the difference between success and failure. This requires workers to have a high level of skill in working with this age group, resilience and perseverance in the face of resistance or even aggression. As well as a focus on workforce development, it also requires that service structures give staff the time and consistency to build these relationships.'*

Channa et al. (2012) *A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning*.

The aims of this meta-analysis[345] were, first, to establish the effect of brief, in-home intensive family preservation programs on prevention of out-of-home placement, family functioning, child behaviour problems and social support and, second, to study moderators of these effects. The results show that intensive family preservation programs had a medium and positive effect on family functioning, but were generally not effective in

[345] The results of this meta-analytic study, were based on 20 studies (31,369 participants),

preventing out-of-home placement. Intensive family preservation programs were effective in preventing placement for multi-problem families, but not for families experiencing abuse and neglect. Moreover, the effect on out-of-home placement proved to be moderated by client characteristics (sex and age of the child, parent age, number of children in the family, single-parenthood, non-white ethnicity), program characteristics (caseload), study characteristics (study design and study quality), and publication characteristics (publication type, publication year and journal impact factor).

Evidence about the effectiveness of interventions to support children and families on the 'edge of care' – specific interventions

This review found relevant evidence in relation to a wide range of specific interventions as described below. It should be noted that what follows is a selective, not a comprehensive review.

Multi Systemic Therapy (MST)

Multi Systemic Therapy (MST) is an intensive family intervention for children and young people aged 11-17 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. 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 the whole family 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 rapid review above (Institute of Public Care (2015)) notes that:

> *'A number of randomised control trials of MST have been carried out in the United States and other countries. 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. Bowyer and Wilkinson (2013) cite evidence from a recent randomised control trial undertaken in England by Wiggins et al (2012) with an ethnically diverse sample of 108 families. Results showed that, compared with the control group at 18 month follow-up, MST had provided significantly reduced non-violent offending, youth-reported delinquency and parental reports of aggressive and delinquent behaviours. In a recent review of MST intervention offered by Action for Children (2015) at various sites across the UK, they found performance in all services at the level of national expectation for MST services in that 80%-90% of young people referred will be diverted from care safely.'

However, a recent review of MST published in the Lancet (Fonagy et al 2018) concluded that:

'The findings do not support that multi-systemic therapy should be used over management as usual as the intervention of choice for adolescents with moderate-to-severe antisocial behaviour.'

Multi Systemic Therapy for Child Abuse and Neglect(MST-CAN)

MST-CAN is a variant of MST for families where there is evidence of child abuse and neglect. The evidence for MST-CAN is good, involving one recently completed recent randomised control trial 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 post- traumatic stress disorder and other anxiety related symptoms (Asmussen et al, 2012).

Functional Family Therapy (FFT)

FFT is another evidence-based programme offering intensive, 'whole family' intervention for young people aged ten–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, youth offending forum, institution or clinic. FFT therapists come from a range of professional backgrounds such as mental health workers, probation officers and behavioural therapists. Some recent randomised control trials evaluations have shown reduced recidivism in youth offending and improved family communication, whilst others have not found significant differences (Bowyer and Wilkinson 2013). In a more recent Scottish pilot of FFT, Action for Children (2015) found good results on young people remaining at home and school attendance together with the identification of significant cost savings for the local authority involved.

In a more recent evaluation Humayun et al (2017) found that:

> *'In contrast to most previous trials of FFT, FFT+ Management As Usual (MAU) did not lead to greater reductions in youth anti-social behaviour and offending compared to MAU alone, and did not lead to improvements in parenting or the parent-child relationship. This may be because the trial was more rigorously conducted than prior studies; equally, the possibility that MAU was effective requires further research.'*

Strengthening Families Programme ten-14

The Strengthening Families Programme for young people aged ten–14 and parents/carers (SFP ten–14) is a family-based prevention intervention with positive results in trials in the United States.

But one review by Foxcroft et al (2016) of the effectiveness of SFP ten–14 for preventing substance misuse concluded that there was no evidence for the effectiveness of SFP ten–14 on the prevention of alcohol or tobacco use, parenting behaviour, parent–child relations or child problem behaviour at the 12 or 24 month follow-up in a large cluster randomized controlled trial in Poland.

Family Intervention Projects (FIPS)

FIPS work with families experiencing family dysfunction, socially unacceptable behaviour or low income. While there are important differences between individual FIPs, they tend to share many key features, namely the goals of preventing the placement of children with local authorities and 'strengthening' families achieved through working intensively over a short time period. Although they were originally established with the intention of preventing social exclusion, a significant minority of families that undergo FIPs have child protection issues. The Centre for Evidence and Outcomes (C4EO, 2010)[346] cited evidence for the effectiveness of FIPs including progress in addressing protection concerns and reductions in parental problems linked to family breakdown and maltreatment. However, in a review of interventions for young people, Fox and Ashmore (2014) noted the variations in practice and an overall lack of an extensive evidence base for interventions undertaken under the banner of FIPs, a state of affairs not acknowledged by the earlier Ofsted (2011) review. Fox and Ashmore (2014, p. 4) have drawn attention to published findings which concluded *"that reductions in anti-social behaviour were based on small samples and qualitative measures, and that the FIPs had not delivered sustained reductions in anti-social behaviour in the wider community."*

[346] C4EO (2010) Edge of Care Evidence Pack. Accessed at http://archive.c4eo.org.uk/costeffectiveness/files/edge_of_care_evidence_pack.pdf

Multidimensional Treatment Foster Care-Adolescents (MTFC-A)

MTFC-A was initially developed for young people who were persistent offenders as an alternative to custody, but is now also used extensively as an alternative for long term foster care or residential care (Smith and Chamberlain, 2010). The aim of the programme is to change behaviour, reduce reoffending and if possible, allow the young person to be reunited with their biological family. For a period of nine to 12 months, the child is placed in an MTFC-A foster home. During this time, the child receives 'wrap around' care from the team of highly trained MTFC-A professionals. (See Asmussen et al, 2012 for a full description of MTFC-A.)

According to Asmussen et al, (2012) the evidence for MTFC-A is strong and multiple RCTs suggest that children placed in MTFC homes are significantly less likely to reoffend. However, in the UK, the evaluation by Biehal et al (2012) of an RCT of MTFC against treatment as usual concluded that:

> *'In summary, neither the randomised trial nor the observational study showed evidence that MTFC gave an overall beneficial outcome compared to treatment as usual. There was no overall effect on the primary outcome, nor is there evidence that young people attending MTFC did better in school placements or were less delinquent at outcome or went to placements that were less costly.'*

However, the authors go on to say that:

> *'While we found that no overall additional impact of MTFC on older children and adolescents in the English 'care system' relative to treatment as usual (TAU), there is a suggestion in our study that it may be an effective model to manage behavioural disorder. In particular, there is indication that it may work well with young people broadly defined as antisocial, during the time they are in their MTFC foster placements. The cost and small size of the intervention means that at the moment it can only serve a very small minority of those*

> *who might benefit from it. In this study those who did not show antisocial behaviour did better in alternative placements. If MTFC is to continue in its present form it seems wisest to focus it on young people who have clearly shown anti-social behaviour.'*

Intensive Intervention Programmes (IIP)

The Department of Education (2014) report notes that:

> *'An evaluation of Intensive Intervention Programmes (IIPs) which successfully worked with adolescents with very complex needs on the edge of care found that 88% of those worked with had the same key worker for the whole period of support. This was 8.2 months on average, but up to two years.'*

However, there is no reference provided for this.

No Wrong Door

The North Yorkshire County Council (NYCC) No Wrong Door (NWD) innovation provides an integrated service for young people, aged 12 to 25, who either are in care, edging to or on the edge of care, or have recently moved to supported or independent accommodation whilst being supported under NWD.

The evaluation conducted by Lushey et al in 2017 found that in terms of impacts:

- Accommodation stability: There is emerging evidence to suggest that NWD is contributing to young people remaining out of the 'care system'.
- Education, employment and training (EET): The majority of young people that entered NWD that were in education, employment and training (EET) remained involved in EET (76%). There was also progress for those who were not in education, employment or training (NEET) when they entered NWD with a quarter (25%) going onto to be engaged in EET.

- Criminal activity: There is evidence of a reduction in criminal activity for young people that were supported by the NWD innovation, demonstrating the positive influence of the police liaison role. Conversely, there was an increase in the number of arrests for all young people aged 12 to 25 in NYCC over the past year; this suggests that NWD appears to support a reduction in criminal activity
- High risk behaviours: There has been both cessation and reduction in substance use for some of the NWD cohort.
- Missing incidents: Incidents of NWD young people going missing have halved (from 503 incidents to 253) since the year prior to NWD commencing.
- Relationships: There was evidence to suggest positive relationships between NWD young people and their main NWD hub worker. Young people valued their workers being available to meet their needs, rather than only being available by appointment, and sensed that they were genuinely cared for, rather than just going through the motions.
- Transitions from care to independent living: Outcomes in terms of transitions to independence were mixed. Whilst some young people reported being prepared and supported during their transition to independent living and adulthood, a few others described abrupt moves.
- Wellbeing and resilience: When NWD started, the average SDQ[347] score for young people receiving support under NWD was 19.5. At the end of the evaluation period, the score had reduced to 16.8. SDQ scores over 20 are classed as very high and only 5% of the population are expected to score in this range. For young people who have not

[347] The Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) is a brief emotional and behavioural screening questionnaire for use with children and young people (aged four-17). The tool, which is used throughout the world, can capture the perspective of children and young people, their parents and teachers. The 25 items in the SDQ comprise five scales of five items each. The five subscales cover: (i) Emotional symptoms (ii) Conduct problems (iii) Hyperactivity/inattention (iv) Peer relationships problem (v) Prosocial behaviour. For further details see the ICR H&WB review.

been involved with NWD, the scores have been almost static. In addition, where the life coach or communication support worker has been involved in the young person's case, their SDQ scores have improved. There was also evidence to suggest that there had been improvements in mental wellbeing for some of the interview sample.

- Access to support in a crisis: There is emerging evidence to suggest that NWD is successfully providing many young people with an access point for support.

New Orleans Intervention Model

In a systematic review, the New Orleans Intervention Model (NOIM) was identified as the only evidence-based programme to use an infant mental-health approach to improve the quality of permanent placement decisions for children on the edge of care (Jamieson, 2015). Infant and Family Teams is the name given to the New Orleans Intervention Model in the UK. Evaluation of the New Orleans Intervention Model in the USA has shown promising results in terms of the difference it aimed to make in the lives of children (Zeanah, 2001). Full findings from a randomised controlled trial (RCT) of the service in the UK are due to be published in 2020.[348]

[348] https://learning.nspcc.org.uk/services-children-families/infant-and-family-teams/#heading-top

6. Leaving care and the transition to independent living

This section focuses on the topic of 'leaving care and the transition to independent living'.

It discusses (i) the current policy context within which care leavers (in the UK) leave the 'care system' in order to transition to adulthood and independent living (ii) the challenges of the transition to independent living (iii) care leaver's views about their experience of leaving care and (iv) the factors which promote or inhibit a 'good' transition. Finally, the section describes a model for an 'interdependence transition approach' which it has been suggested offers a possible way forward.

The section begins with a brief overview of the official statistics on this topic in Scotland.

Characteristics of 'care leavers' (those ceasing to be looked after) in Scotland

These descriptive statistics are taken from the Care Review statistical overview report (2017). As has been discussed elsewhere in the suite of evidence papers for the Care Review, these official statistics are limited. They do not measure how individual children progress over time (the statistics are based on cross-sectional 'snapshots', and there is no linkage between episodes of care for a given individual), and neither do they assess the subjective aspects of children and young people's care experience (how are they feeling, and how do they assess their experience in and after care).

How many care leavers are there in Scotland?

On 31st July 2017 there were 5,653 young people (aged 16-25) in Scotland who met the definition of 'care leaver' as set out above (in Section three).[349] This is a substantially higher number than on 31st July 2015 (3,599), reflecting the expansion of aftercare availability (from their 21st birthday to their 26th birthday) following the introduction of the Children and Young People (Scotland) Act 2014.

Likelihood of Scottish care leavers being in receipt of aftercare services

As of 31st July 2017, two-thirds of care leavers in Scotland (68%) were in receipt of aftercare services.[350] The CELCIS overview report (2017) contrasts this with the figures for English and Welsh care leavers (88% and 93% respectively). However, it has been suggested that these comparisons are not necessarily particularly relevant.[351]

Gender and age of care leavers in Scotland

As of 31st July 2017:

Gender

- 53% of care leavers were male
- 47% were female

Age

- 5% of care leavers were 15-16
- 11% were 17
- 19% were 18

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[349] [From Section 3] A 'care leaver' in Scotland is a young person aged 16-25 inclusive who meets the descriptions set out in section 29 and section 30 of the 1995 Act (as amended by section 66 of the 2014 Act). From 1 April 2015 a 'care leaver' is a young person who ceased to be looked after on, or at any time after, their sixteenth birthday.

[350] Note that this figure has decreased to 62% in 2017-18. https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/ (Table 1.7b, p.13)

[351] Comment provided by co-author as follows: 'It is difficult to make comparison with England as statistics only count at age 19, 20 and 21 even though duties to support continue up to 25. Local Authorities do not report on these young people the figure 88% is more about being 'in touch'. The duty to keep in touch continues to 21 and after is negotiated between the young person and their worker.

- 41% were 19-21
- 23% were 22 or over.

Accommodation of care leavers in Scotland

As of 31st July 2017, of the young people in Scotland receiving aftercare for whom their current accommodation was known[352]:

- 30% were living at home with parents or with friends and relatives
- 34% were living in their own tenancy or some form of semi-independent living
- 19% were in supported accommodation
- 8% were living with former foster carers or in residential care
- 4% were officially homeless
- 2% were in custody
- 'Other destination' was recorded for the remaining 3%.

Employment, education and training status of care leavers in Scotland

As of 31st July 2017, of the young people in Scotland receiving aftercare:

- 37% were in education, training or employment
- 42% were not in education, training or employment.

This figure includes:

- 4% who had an illness or disability which prevented them from being in education, training or employment, and
- 3% who were looking after family members

The status of the remaining 21% was 'unknown'.

Note that the equivalent figure for 'not in education, training or employment' for English care leavers (aged 19 to 21) was 40%.

[352] The accommodation status of 14% of those in receipt of aftercare services was not known.

Note that there are no statistics available about the amount of time that care leavers have been in care when they cease to be looked after.[353]

Current policy context for leaving care in the UK

In recent years in the UK, there has been a strong policy focus on strengthening the statutory framework for care leavers, and on providing better support (in terms of both better quality and longer duration) for those who are transitioning to independent living. The specific arrangements in Scotland are described briefly below.

Situation in Scotland

The support for care leavers in Scotland in terms of the 'Continuing care' provisions, and the availability of aftercare has been set out briefly in Section three above. A more detailed description of 'Continuing care' is set out below, based on text provided by CELCIS in their response to Scottish Government consultation on the Continuing Care (Scotland) Amendment Order 2019.[354]

'Continuing care, as established in Part 11 of the Children and Young People (Scotland) Act 2014 (the 2014 Act), provides the legal basis for eligible young people ceasing to be looked after to remain in the same accommodation and receive the same assistance from the local authority as they did immediately prior to ceasing to be looked after, up to the age of 21. Part 11 of the 2014 Act reflects the philosophy of care set out in 2013's Staying Put Scotland guidance, which recognises the importance for future life chances of care experienced young people remaining in safe, supported environments until they are fully prepared for more independent living.[355] The Order will ensure that the current cohort of young people, born after 1st April 1999, continue to be eligible for

[353] Other information is available on those leaving care in Scotland (rather than 'care leavers per se) in a given year covers e.g. the availability of a care plan, and the amount of sibling contact. (Care Review Statistical overview report, 2017)
[354] https://www.celcis.org/knowledge-bank/search-bank/consultation-response-continuing-care-scotland-amendment-order-2019/
[355] https://www.gov.scot/publications/staying-put-scotland-providing-care-leavers-connectness-belonging/

continuing care as they increase in age to twenty-one. As the final annual increase, the Order fully extends the duty to provide continuing care to all eligible sixteen to twenty-one year olds, as per the intentions of the 2014 Act.'

The CELCIS response to Scottish Government consultation on the Continuing Care (Scotland) Amendment Order 2019 also explores the challenges to the full and consistent implementation of continuing care. In particular, the response notes that 'a number of interconnected challenges have affected the full and consistent implementation of continuing care since its initial enactment in 2015. Without resolution, these challenges will continue to undermine the original policy intentions and impact upon the outcomes of some of Scotland's most vulnerable young people.' The challenges they identify relate to (i) lack of clarity in relation to measuring and reporting uptake (ii) inconsistent implementation of the continuing care policy (iii) cultural barriers (including institutional factors and leadership ethos) and decision making (iv) (lack of) recognition of young people's rights (v) inconsistent levels of support for residential workers and foster carers and (vi) financial and funding challenges. [356]

Challenges of transition to independent living

Baker's review for Coram Voice (2017a) of literature on care leavers' views on transition shows generally that it appears that from young people's viewpoints 'leaving care' was seen and experienced in two opposing ways; either as a 'positive step' or conversely as 'unwelcome and happening too soon'.

[356] As has been described earlier in this section, the uptake of 'aftercare services' in Scotland is lower than in England and Wales. This review did not find any literature specifically to address possible reasons for this, or policies to increase uptake. However, CELCIS has a programme of work entitled 'Throughcare and aftercare'. The website entry says that this work 'aims to increase understanding that leaving care is a life event for looked after young people, not just a bureaucratic exercise. [...] The Throughcare and aftercare team works across the country to support all corporate parents to create and implement strategies, policies and practices which provide long-term positive placements and extended support for care leavers.'

A wide variety of challenges for care leavers in relation to their transition to independent living have been identified including:[357,358]

- **Emotional / social challenges**: The transition can be isolating and lonely, and care leavers may feel worried and anxious about the future. They are coping simultaneously with separation from their care setting as well as adjusting to their new, independent living situation. They need to be able to access support 'out of hours' and to have someone who will listen to them, care about them, and support them emotionally. In some cases, access to appropriate mental health services is vital to support their emotional well-being. Both formal and informal relationship support and networks are important in this regard.
- **Practical / Life Skills challenges**: Budgeting, cooking, cleaning, shopping, looking after a tenancy, engaging with administrative bodies (social work, housing, health etc.), are all skills to be supported and developed.
- **Financial challenges:** Accessing timely financial support is imperative. There can be confusion about the eligibility to aftercare services due to strict criteria and care leavers can often face delays in payment, sanctions, and must make difficult decisions between taking up education and employment opportunities (Children's Society, 2017). Financial stress and strain for care leavers can quickly escalate to create a multitude of problems (including mental health problems) and can lead to financial hardship.

These challenges are encapsulated in Baker's 2017a overview, which lists three overarching reasons - based on wide-ranging research - of why the transition towards independent living can be difficult, namely that:

[357] https://www.sciencedirect.com/science/article/pii/S0190740914002710#!
[358] https://www.ncb.org.uk/sites/default/files/uploads/documents/Research_reports/ncb_rsch_9_final_for_web.pdf

- Care leavers are expected to make the transition to independence at a young age
- The quality of the planning and preparation care leavers receive may be inadequate and
- The range of support available may not meet the specific needs of individual care leavers.

Each of these factors is discussed in greater detail in the next section, which examines the experience of leaving care based on the accounts of care leavers themselves.

Care leavers experience of leaving care

The following characterisation of the experience of leaving care was set out in Baker's 2017b overview:

> *'Evidence available shows that many of the children who respond to surveys about their experiences feel that care has made life better for them (Selwyn, 2017; Morgan, 2014). Research shows that the stability and wellbeing of some children in care is better than for those who return home (Wade et al, 2010); for those who have been in care for some time, studies also reveal the beneficial influence on education (Sebba et al, 2015). Young people themselves have been at the forefront of promoting a more balanced picture of the 'care system' and those who live and work within it: one that celebrates the many achievements of children and care leavers, challenges the stigma associated with care and raises aspirations.'*
>
> *'The juncture of leaving care represents a significant risk for young people; there is a danger that the potentially positive impacts of care will be undermined as young people exit the 'system' (Sinclair et al, 2005). We know that the experiences of individual care leavers vary widely; some move on successfully, others merely 'get by' and some face considerable struggles. Disparity in the support offered to care leavers, and in subsequent outcomes for these young people, is*

widely acknowledged; it is a long-standing and entrenched issue and one where there has been much policy focus. [...] Unsurprisingly, when asked to reflect on their experiences many care leavers feel they left care too early.'

This assessment, highlighting the significant risk of leaving care and the difficulties of leaving care when they are not fully prepared for the transition, is echoed and elaborated by Atkinson and Hyde (2019) in their recent review of care leavers' views about their transitions:

'Previous research has indicated that UK care leavers, on entering adulthood, are at heightened risk of homelessness, custody, sexual exploitation, becoming not in education, employment or training (NEET), mental health issues, social exclusion and death in early adulthood' (Greenwood, 2017; Stein, 2005; The Centre for Social Justice, 2015).

'Consistent with past literature, studies within this review all broadly acknowledged Stein's (2008) view that care leavers, relative to their peers, experienced a "compressed and accelerated transition to adulthood" (p. 53), for which many felt ill-prepared. Care leavers understood this in terms of both limited practical skills and psychological readiness for leaving care (Adley and Jupp Kina, 2014; Butterworth et al., 2016; Horrocks, 2002; Matthews and Sykes, 2012; Rogers, 2011). Other than those living semi-independently (Amaral, 2011), care leavers described being catapulted towards independence and struggling to cope with feelings of isolation. The emergent emphasis on unmet emotional support needs highlighted the relevance of Dima and Skehill's (2011) hypothesis to a UK context: the view that psychological dimensions of those leaving care can be "neglected" during transition (p. 2537). Care leavers in this review, particularly in Horrocks's (2002) and Rogers's (2011) studies, experienced transition from care as an instantaneous, age-driven

process, over which they had limited choice or control. These findings again aligned with Stein's (2004, 2008) analysis of the compressed nature of transition, experienced through care leavers having to navigate multiple, simultaneous changes without sufficient time to adjust. With the exception of Amaral's (2011) study, care leavers described inadequate planning to address transitioning to adulthood, including a lack of opportunity to revisit support or skills.'

The 'compressed and accelerated transition to adulthood' is widely recognised. Recent statistics suggested many young people in the general population are now dependent on their families for emotional, financial and practical support into their 20s and 30s (Office for National Statistics, 2016). Care leavers, however, by contrast do not have the option of retreating to a familial safety net (Stein, 2005) and young people leaving care (who are often acutely vulnerable) are expected to cope with the financial demands and complexities of independent living at a much younger age. [359] In Scotland, the average age for leaving care is 17, while the average age for leaving home for non-care experienced young people is 26.[360] Moreover, young people, some of whom are desperate to leave care as soon as they turn 16, often quite quickly come to regret this decision and it has been argued that the door should be left open for them to return to care, at least until their early 20s (Langkelly Chase, 2019; Bywaters et al, 2016). This is, indeed, the policy intention which informs the recent policy developments described above in relation to 'Continuing care'. More broadly, it is recognised that a gradual transition, whereby care leavers move to independence at their own pace is important in facilitating a good transition (NICE, 2013; Liabo et al, 2017; Morton 2019).

[359] Stein, M (2005) Resilience and Young People Leaving Care: Overcoming the odds. Joseph Rowntree Foundation
[360] CELCIS (2015) Housing Options and Care Leavers: Improving Outcomes into Adulthood Glasgow: CELCIS

Key factors affecting the experience of leaving care

It is clear from these overviews that care leavers experiences are very varied and there is no single experience of leaving care. Important influences in determining whether the experience of leaving care is positive have been discussed at length in the literature (Channa et al 2012; Elsley et al 2013; CELCIS 2019b; Atkinson et al 2019; Baker 2017b; Häggman-Laitilaa et al 2019). Key factors identified by care leavers themselves in their own accounts of leaving care include:

- The extent of preparation and planning for independent living and adult life - including emotional preparation, the development of practical skills, financial preparation and planning. For example:
    - Care leavers thought that services had a strong focus on helping them develop practical skills, but that too little attention was given to preparing them emotionally.
    - Care leavers said they often found it difficult to manage their money, and could find themselves struggling with low incomes, and not understanding or knowing what bills to pay.
    - Care leavers said they were not always clear about their rights and entitlements and wanted better information.
    - Care leavers wanted to know they would have suitable high quality accommodation in a safe area after the transition from care.
- The availability of supportive relationships and networks (both professional and social) which would support them on a 'life-long' basis. For example:
    - Many young people felt very lonely and socially isolated since leaving care. They could feel vulnerable and abandoned, and they were acutely aware that there was 'nowhere to return to'. Care leaver testimonies spoke of 'diminishing or lost support networks upon leaving care'. This was highlighted as one of the worst aspects of leaving care.

  - Some care leavers reported that leaving care affected their emotional well-being and triggered mental ill-health. Some care leavers struggled to trust others, because past relationships had been disrupted or they had previously been let down. Some said they needed more help to understand their background and personal history.
  - Coping with transitions was easier for care leavers who had a key person to go to for help. This could be a worker, or a relative, or a caregiver, or a mentor, or someone in their wider circle. Siblings and friends could be important sources of support, but some had lost contact with these important people. However, it was also the case that care leavers often had painful memories of having been in care that made them feel hostile towards child protection social work services, and to not want to be supported by them, at least at the point of leaving care.
  - Findings from Bright spots research highlight care leavers faring worse in terms of well-being in relation to both children in care (age 11-18yrs) and compared to peers in general population.[361]
- The amount of control the young person has over the timing and decision to leave care:
  - Children and young people wanted to be more involved in decision-making in relation to the transition out of care.

The focus on the importance of reliable relationships for care leavers during transition is particularly important. The review by Atkinson et al (2019) summarises this as follows:

[361] https://coramvoice.org.uk/sites/default/files/cv-olbc-snapshot-a2-poster_1.4.19.pdf https://www.communitycare.co.uk/2019/04/01/official-statistics-dont-tell-us-experiences-care-leavers/

'The focus on the importance of reliable relationships for care leavers during transition is consistent with past literature (Ofsted, 2012; Pinkerton and Rooney, 2014). Supportive relationships motivated care leavers with regard to their education, training or personal goals and health needs (Amaral, 2011; Driscoll, 2013; Matthews and Sykes, 2012).'

Barriers and facilitators of good transitions from care

The evidence below summarises what is known about the barriers and facilitators of good transitions from care. These reinforce the messages already set out in the earlier parts of this section.

It should be noted that what happens before entry to care and during care, is important in influencing whether or not a good transition from care is achieved; those children and young people with difficult and unstable experiences before and during care are more likely to experience unsatisfactory transitions out of care. By contrast, care leavers who are most likely to successfully move on from the 'care system' are those who have had stability and continuity whilst in care (Scottish Care Leaver Covenant[362]; Baker, 2017b). Moreover, all of these factors mentioned below as barriers or facilitators are particularly important in relation to the transitions of those with complex needs (FrameWorks, 2018).

What are the barriers to a good transition from care?

The following barriers to a good transition have been identified:

- Insufficient resources and assistance (e.g. Hjort and Backe-Hansen, 2008; Lerch and Stein, 2010; National Audit Office, 2015).
- Insufficient recognition of, and a lack of support for, the psychological and emotional dimensions of transition, exacerbated by insufficient support networks (Atkinson et al, 2019).
- Lack of support (including awareness-raising and training for staff and young people) for relationship-based practice including support

[362] https://www.scottishcareleaverscovenant.org/

beyond the care setting, especially for those leaving residential care (Welch et al, 2018; McGhee, 2016).

- Inadequacy of pathway planning and lack of consistent and coordinated care (Munro et al., 2011; The Centre for Social Justice, 2015, 2016).
- Attitudes and service structures that run counter to the continued provision of support and relationships. (Welch et al, 2018).
- Lack of flexibility in the way that arrangements for leaving care are organised, especially in relation to the speed of the transition, and the age of the individual leaving care (Atkinson et al, 2019, Baker 2017b).
- Perceived shortage of suitable independent or semi-independent living arrangements and insufficient coordination between leaving care and housing teams (The Centre for Social Justice, 2015; DfE, 2017; Dixon et al., 2006; Hiles et al., 2013).
- A lack of input around practical issues such as budgeting advice, cooking and self-management.[363]

What are the facilitators of a good transition from care?

The facilitators of good transitions from care are often related to the barriers in that they address the same themes. Factors that can significantly improve a young person's transition from care include:

- Flexible systems, which accommodate personal readiness for leaving care, can be accessed at any stage of the transition process, which respond to the needs of the individual, and which allow the work with young people to continue for as long as needed. (Department for Education, 2014; Rahilly and Hendry, 2014; Coram Voice, 2015; Atkinson et al 2019; Morton 2019).

[363] E.g. Ayre et al (2016) Available at: https://www.childrenssociety.org.uk/sites/default/files/pcr073_care-leavers-financial-exclusion-final.pdf

- Authentic, consistent, enduring and supportive relationships between care leavers and those acting both in the formal role of corporate parent as well as those in informal or semi-formal networks of support. (Munro et al, 2011; Atkinson et al, 2019; Amaral, 2011; Butterworth et al., 2016; Driscoll, 2013; Matthews and Sykes, 2012; Rogers, 2011; Welch et al 2018; Bakketeig and Backe-Hansen, 2018).
- Mentoring and coaching relationships with supportive adults can help young people to build stronger social networks, enhance their educational and workplace achievements, and encourage them to seek out appropriate support when necessary. These can provide an element of 'relational permanence' (Welch et al, 2018).
- A strong focus on the active preparation for leaving, including developing a pathway plan in collaboration with leavers, which is reflective of their current circumstances and goals, and builds their self-awareness and problem-solving skills (Welch et al, 2018).
- Access to wide ranging practical support and information (including budgeting advice, advice on entitlements, advice on housing and care issues etc.).
- A knowledgeable and skilled workforce, who have been trained to provide high quality support to care leavers across a wide range of areas (Smith 2017; Morton 2019).
- Policies, processes, and practices which listen to the voices of care leavers, enable them to play a full role in the decision making, and increase the agency and control young people have over the transition process (Baker 2017b).

More generally, as indicated earlier in this review some of the strongest evidence is that those who successfully move on from care are more likely to have had stability in care, early education success, and to have stable relationships.

In summary, Baker (2017b) says that:

> *'As the Care Inquiry asserted, relationships are the 'golden thread' in children and young people's lives (Boddy, 2013). Helping young people nurture the whole network of their relationships – including those with family, friends, carers and support workers – is the key to better transition. Relationships were identified as a top issue for young people in research commissioned for Sir Martin Narey's recent review of residential care (Narey, 2016). The lynchpin to effective formal support is the relationships care leavers have with their workers and carers. Trust is central to positive relationships. An absence of trust, inconsistency, high caseloads and irregular visits can all inhibit relationships and the support provided, so addressing these issues is critical.'*

'Interdependence transition approach'

Atkinson et al (2019) examined the potential usefulness of an "interdependence" transition approach for UK care leavers in their recent review of care leavers' views about their transitions. Their review suggested that self-sufficiency – transitioning to adulthood with minimal or inconsistent support – is expected of UK care leavers. (The review also noted that self-sufficiency constituted a deliberate choice by some UK care leavers who, perceiving a lack of adequate or available support, chose to disengage with or reject support.) However, their review argued that care leavers had a preference for 'interdependence-informed approaches' based on the ability to access ongoing support dependent on need. They described this kind of model as resonating with an approach previously described by Propp et al (2003).

The 'interdependence' model was described as 'a state envisaging social connectedness and availing of support as and when needed' which was 'in direct challenge to ideas that self-sufficiency should be the end goal for care leavers on entering adulthood'. This approach would involve

"blending of self-sufficiency and dependency" involving "a process of counting on other people to provide help in coping physically and emotionally with the experience and tasks encountered in the world when one has not [yet] sufficient skill, confidence, energy and or time". Atkinson et al explained that:

> *'Propp et al. (2003) envisaged that interdependent living for care leavers would be operationalised through social support, community connections and supportive relationships. Propp et al.'s (2003) interdependence approach stressed the role of support in empowering care leavers to cope both "physically and emotionally" during transition (p. 263), thus acknowledging the multiple dimensions of transition... [This] approach highlighted a helpful alternative, emphasising the need for a gradual and supported move towards autonomy. [...] Ultimately, UK care leavers wanted to be able to count (but not depend) on reliable others during a (gradual, not instantaneous) journey to independence.'*

7. Impacts on life course trajectories of being care experienced

This section discusses the evidence on the impacts across the life course of being care experienced. It should be noted that there is a dearth of evidence in relation to long term impacts and outcomes.

The 1000 Voices (2019) report emphasised the perspective of care experienced children and young people that the experience of care had life-long consequences. Many of them described a continuing sense of stigma, isolation, and disadvantage as a result of their status as a 'care experienced' person. There is also ample evidence from public inquiries (including the Scottish Child Abuse Inquiry (SCAI)) into the 'care system' that many children and young people have experienced trauma, abuse, neglect and hardship as a consequence of their time in care.

At the same time, as set out earlier in Section six there is also evidence that the experience of care has improved some children's lives (Baker (2017b)).

Impacts of being care experienced

A range of studies identified for this review have found that the experience of being in care is associated with a variety of negative impacts and outcomes. For example:

- A 2016 Joseph Rowntree Foundation evidence review found that being a looked after child can have a sustained impact on a number of socio-economic outcomes including lower socio-economic status, reduced educational attainment, homelessness and unemployment (Bywaters et al, 2016). According to the charity 'Friendship Works', 25% of homeless people have been in care.[364]

[364] https://www.family-action.org.uk/what-we-do/children-families/mentoring/friendshipworks/

- The 'Hard Edges Scotland' report (Lankelly Chase, 2019) found that: former looked after children were overrepresented in the adult homeless population; and they were more likely to have compounded problems of sleeping rough, substance dependency and mental ill-health.
- There is a strong association between offending (including imprisonment) and having been in the 'care system'.
    - Prisoners in Scotland have ten-15 times the baseline risk of care experience, with around 40% of the higher Severe and Multiple Disadvantage (SMD) level prisoners affected (including 27% who had three or more placements) (Langkelly Chase (2019) Table 40; Care Review Justice review paper, 2019).
    - Those with care experience make up 24 per cent of the adult prison population and 11 per cent of homeless young people. They also have a significantly heightened risk of becoming a sex worker (Winterburn, Centre for Social Justice, 2015).
    - Almost a quarter of the adult prison population and almost half of young men under 21-years-old in the criminal justice system have spent time in care (Prisoners' childhood and family backgrounds, Ministry of Justice, 2012).
- A literature review on 'Childhood vulnerabilities and outcomes in early adulthood' Smith, N. and Albakri, M. (2018) found that being taken into care is predictive of economic inactivity in adulthood, reduced earnings in men, increased unemployment in men and homelessness.
- In Scotland, looked after children are more likely to leave school at the earliest opportunity (72% leave school aged 16 or under, compared to 28% of all pupils); and, taken as a whole group, obtain lower qualifications than all school leavers. Children who are looked after 'at home' (those who continue to live with their birth parent(s) under compulsory social work supervision) experience some of the

poorest outcomes, with 33% leaving school with no qualifications (compared to 2% of all children) (Morton, 2019).

- A meta-analysis (Heerde et al, 2018) appraised internationally published literature investigating the impact of transitional programme participation (among youth residing in out-of-home care settings with a baseline age of 15–24 years) on post-transition outcomes of housing, education, employment, mental health and substance use. The meta-analysis was based on US studies only. The study found that: living independently and homelessness were the most commonly described housing outcomes; rates of post-transition employment varied; rates of post-secondary education were low; and depression and alcohol use were commonly reported among transitioning youth.

Completed studies examining longer term outcomes / impacts

In general, the research looking at the impacts of being care experienced are based on a relatively short time horizon following leaving care (i.e. they describe the situation in relation to 'early transition'). It is not clear how or whether the effects described would change if a longer timeframe was adopted.

This review found only two studies which had examined the longer term impacts of being care experienced. In particular:

A study by Camerona et al, (2018) examined the longer term outcomes of young people who experienced out-of-home care (OHC) as children, in Britain, Germany and Finland. The study found evidence for continuing disadvantage (around the age of 30) regarding education and employment for those who were in care as children, but also indications of subjective wellbeing and commitment to family life.

Bengtsson et al, (2018) investigated young care leavers' expectations of their future after discharge from care. They found that the short-term

expectations consisted of worries connected to their approaching discharge and how to cope with challenges of everyday life after discharge from care. However, the informants' long-term expectations were mainly positive.

Current study examining longer term outcomes / impacts

As is clear from the foregoing, systematic evidence on outcomes for looked-after children beyond the early adult years is currently very limited. A current study (Principal Investigator Prof Amanda Sacker, UCL) aims to fill that gap by exploring the long-term consequences of being cared for in institutional or family settings using data from the Office of National Statistics Longitudinal Study (ONS LS). The study will examine the health and social outcomes in adulthood of sequential cohorts of children, comparing the outcomes of children cared for in residential and foster care family situations (either formal or informal) with children living with relatives (parental and other). The outcomes for looked-after and care-givers' children in the same household will also be examined, and the study will identify the extent to which mothers who had lived in different care arrangements as children have their own children living with them or elsewhere. The analysis of sequential cohorts offers potential to explore whether outcomes have changed in the context of different policy and practice contexts, and to identify if there is evidence for resilience and recovery over time.

8. Concluding remarks

Children and young people who are on 'the edge of care' have a range of complex challenges which means they may be at high risk of harm, show signs of an escalating need for support, have suffered abuse and neglect, and require protection.

The Care Review has expressed its intention that these children and young people should get the support they need to stay and live together safely with their families wherever possible and to have 'aftercare' which is designed around their individual needs and available for as long as it is required.

The evidence for this review has indicated that:

- There is a general consensus that the desired outcome for an 'edge of care service' is to prevent young people from entering or re-entering care when it is not in their best interest to do so. This may have wider societal benefits including, for example, reduction of alcohol and substance misuse, reduction in offending, improvements in physical and mental health, improvement in self-efficacy etc.
- A range of programmes have been developed both in the UK and elsewhere to provide support to families on the edge of care. These programmes are commonly multi-faceted, complex and location specific and combine a range of elements including counselling, social support, decision making support, parenting support, intensive work with parents, relationship-based practice, dedicated key worker support etc.
- The evidence on these programmes is complex, context specific and incomplete. However, overall, the evidence suggests that quality of the relationship between key workers, the young person and their

family is the central factor in making the difference between intervention success and failure. Moreover, intensive, multi-faceted and integrated interventions are more effective than routine services.

- Leaving care represents a significant risk for young people and there is a danger that the potentially positive impacts of care will be undermined as young people exit the 'system'.
- The experiences of individual care leavers vary widely; some move on successfully, others merely 'get by' and some face considerable struggles. Leaving care 'too early' and with insufficient planning, preparation and support is common. Important factors in moving on successfully include the quality of the care experience itself, its stability and permanence, and the quality and stability of the relationships whilst in care.
- The evidence on the impacts of being care experienced highlight the deficits for care experienced children and young people in relation to social and economic factors (including poverty, education, employment, homelessness). However, these studies on the whole report on experiences in the 'early phase' after leaving care; evidence about lifelong impacts is sparse. These findings can reinforce the stigma associated with care.

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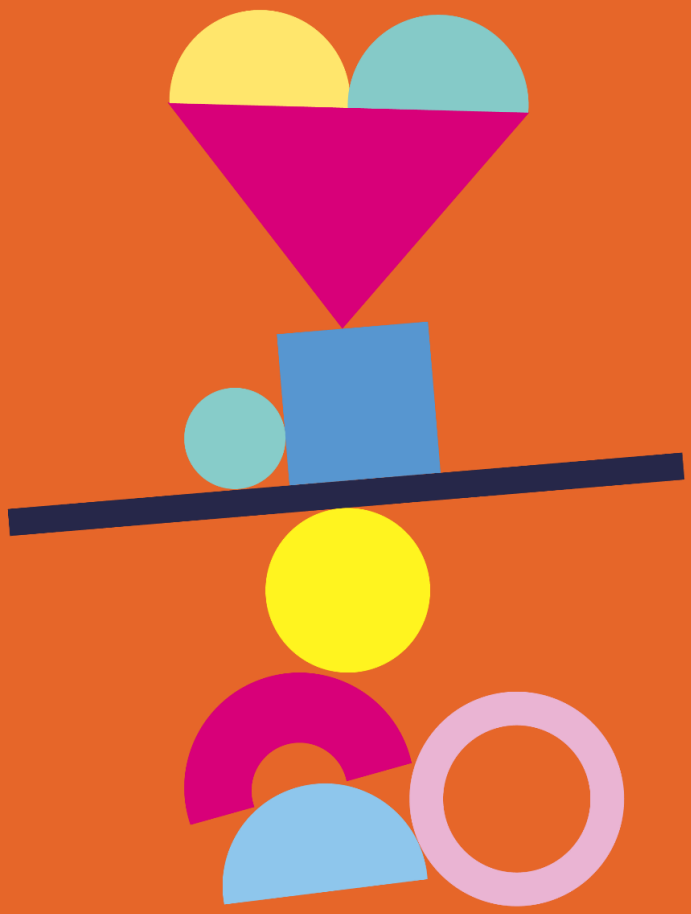
Health and Wellbeing

The health and well-being of children and young people in care



A review of the evidence of what is important to children and young people in care, and the factors which promote or inhibit their health and well-being.

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1. Introduction

Background

In May 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[365]

Health and well-being of children and young people in care

This report presents a review of the evidence in relation to the following questions:

> *What evidence is available about the factors which children and young people within the 'care system' identify as important to their well-being? What do we know about (i) what promotes the factors children and young people identify as important to their health and*

[365] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

well-being?, and (ii) what are the barriers to positive health and well-being among children and young people in care?[366]

Scope of the evidence review

There is an extensive literature on the links between health and well-being, and deprivation and poverty, both in Scotland and elsewhere. [367,368,369,370] However, this review does not set out this evidence. Rather, this review concentrates on examining aspects which are 'internal' to the 'care system', and which are capable of modification through actions which are taken within the 'care system' itself.

Terminology used in the report

The title of the report, and (some of) the questions identified above refer to 'health and well-being'. However, the relevant literature is mostly couched in terms of 'well-being', and the implied assumption is that 'well-being' subsumes 'health'. Thus, in what follows, the discussed is framed mainly in terms of 'well-being'; this should be taken to include 'health'.

Structure of the report

The report is structured as follows:

- Section two reports relevant findings from the Discovery stage of the Care Review.
- Sections three-four set out the definitional, contextual, measurement and policy issues which inform the evidence review. This includes descriptions of the definitions offered by children and young people themselves.

[366] Note that, in this context 'children and young people in care' is taken to **include** care leavers
[367] https://www.scotpho.org.uk/media/1656/sbod2016-deprivation-report-aug18.pdf
[368] https://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf
[369] https://www.jrf.org.uk/report/how-does-money-influence-health
[370] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

- Sections five-six focus on what is known about the barriers and facilitators to the health and well-being of children and young people in care.
- Section seven contains some concluding thoughts.

2. Findings from the Discovery stage of the Care Review

In relation to the topic of the health and well-being of children and young people in care the Discovery stage of the Care Review found that:

- Areas that children and young people in care associated with well-being included: security in personal relationships, feeling safe and secure, feeling loved and valued, living in a child-friendly environment and being communicated to clearly. (1000 Voices report, 2018)
- The link between meaningful attachments and emotional well-being is crucial to children and young people in care. The feeling of being genuinely cared for was described as a kind of 'well-being safety net'. (1000 Voices report, 2018)
- Listening to children and young people in care, and understanding their feelings and concerns, is of vital importance in enhancing their well-being and self-esteem. (Baker literature review, 2017)
- 'Trusting relationships' are crucial to children and young people in care; if these are not available, or if they are often subject to change, there is a negative impact on children and young people's well-being and happiness. (Baker literature review, 2017)
- Systematic reporting by the Scottish Government of the outcomes for children and young people in care are limited, and cover only: the age at which looked after children leave school, their destinations when they leave school, their educational attainment, and their exclusion rate from school. There is no national reporting on well-being for children and young people in care in Scotland. (CELCIS, statistical overview report, 2017)

3. What is well-being and how is it measured and used?

This section (Section three) provides a brief overview of how well-being is defined, measured and used. It highlights the wide range of approaches which have been adopted and the lack of a universally accepted measure.

This section also summarises the extent to which well-being features in public discourse and public policy (including in Scotland), as well as the impact that government(s) can have on well-being. The discussion in this section is based on evidence and research which has been developed largely in relation to the adult population.

The next section (Section four) discusses the status and importance of children and young people's well-being, how it is defined and measured (including for children and young people in care), and the broader context of how the well-being of children and young people features in the discourse around human rights.

How is well-being defined?

Well-being is defined by the Oxford English Dictionary as 'the state of being comfortable, healthy or happy'. More broadly, it can be defined as 'the quality and state of a person's life'. Various terms including 'quality of life', 'happiness' and 'life satisfaction' are all used to refer to well-being (Allin 2007).

Despite extensive study on the topic, there is little available consensus in the literature on the precise definition of well-being (Deci et al, 2008; Linton et al, 2016). However, as set out below, there are a number of dimensions / components of well-being which are generally thought to be relevant.

The components of well-being

Well-being, as discussed in the current literature, is generally agreed to be a multi-dimensional construct[371,372] which includes assessments of individuals':

- physical health / physical well-being
- mental health / mental well-being
- economic and material conditions / social well-being (housing, employment etc.)
- activities and functioning
- personal / emotional / spiritual well-being and circumstances (friendships, family, happiness, life satisfaction, self-esteem, optimism about the future etc.).

Thus, well-being is viewed as a 'positive concept' which focuses not simply on the absence of illness or poverty but on the presence of all the things one needs to live a 'good life' including friendships and self-esteem (Nevill, 2009; WHO 1948).[373]

Well-being in public discourse and public policy

The importance of well-being has been widely acknowledged by governments, public institutions, professionals, policy makers and the general public in the past ten years (Stiglitz et al, 2010, Hicks 2013, Naci 2015). This is partly because research has shown that subjective well-being

[371] In 2016, Linton el al undertook a review of self-report measures of well-being. The study identified a total of 99 different measures of well-being, covering 196 separate dimensions. Six key thematic domains were identified: mental well-being; social well-being; physical well-being; spiritual well-being; activities and functioning; and personal circumstances. The most referenced theories were Diener's model of subjective well-being (2009) and the World Health Organisation (WHO) definition of health (WHO, 1948)

[372] See Ryder et al (2017) for a review of the various definitions of well-being.

[373] Note that some definitions of well-being – though not all – distinguish between the 'subjective' and 'objective' domains of well-being. 'Subjective well-being' tends to be described in terms of an 'affective' component (concerned with emotions) and a 'cognitive' component (concerned with how people evaluate their own lives). 'Objective well-being' by contrast tends to be described in terms of 'factual' assessments in relation to, for example, financial circumstances, quality of housing and education, infant mortality, teen pregnancies, educational attainment etc. (Linton et al, 2016, Diener and Ryan 2009, Rees et al 2010; Coram Voice, 2015).

correlates with other outcomes such as educational attainment, health and employment prospects (Department for Education 2011; Gutman and Vorhaus 2012; Helliwell et al, 2013).

A range of national and international efforts have focused on the measurement, reporting and monitoring of well-being and related concepts. For example:

- a 'World Happiness Report' has been produced by the UN on an annual basis since 2012.[374] These reports 'survey the state of global happiness' and rank 156 countries by how happy their citizens perceive themselves to be.
- the Global Happiness Council (GHC) has produced an annual Global Happiness and Well-being Policy report since 2018.[375] The report provides evidence and policy recommendations on best practices to promote happiness and well-being.
- the UK Office for National Statistics (ONS) produces quarterly statistical bulletins based on its 'National Well-being Dashboard' which measures well-being in relation to ten 'domains' including personal well-being, relationships, health, education and finance.[376]
- the annual Scottish Health Survey includes data on mental well-being as measured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).[377] (Further details of the Scottish Government's approach to measuring and reporting health and well-being are set out below.)

More recently, in May 2019, the government of New Zealand has announced the introduction of its first 'well-being budget'.[378] The budget requires all new spending to go toward five specific well-being goals:

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[374] https://worldhappiness.report/
[375] http://www.happinesscouncil.org/
[376] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing
[377] https://www2.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey
[378] https://www.theguardian.com/world/2019/may/30/new-zealand-wellbeing-budget-jacinda-ardern-unveils-billions-to-care-for-most-vulnerable

bolstering mental health, reducing child poverty, supporting indigenous peoples, moving to a low-carbon-emission economy, and flourishing in a digital age.[379] According to New Zealand's prime minister, 'the purpose of government spending is to ensure citizens' health and life satisfaction, and that — not wealth or economic growth — is the metric by which a country's progress should be measured.'

The idea that the progress of a country should be judged by a 'broader dashboard of indicators' that reflect wider concerns including the distribution of well-being and sustainability in all of its dimensions – rather than simply relying on Gross Domestic Product (GDP) – was first mooted in the work undertaken by the Commission on the Measurement of Economic Performance and Social Progress ("Stiglitz-Sen-Fitoussi" Commission) initiated by the French Government in 2008.[380] 'Multidimensional subjective well-being' was one of the four substantive areas of progress considered by this commission (the others were income and wealth inequality; multidimensional and global inequalities; and sustainability).

The work of the Stiglitz-Sen-Fitoussi Commission is ongoing. In 2019, the High Level Expert Group (HLEG) which oversees the work, issued two reports on (international) progress on this ambitious agenda entitled 'Beyond GDP: Measuring what Counts for Economic and Social performance' and 'For Good Measure: Advancing Research on Well-being Metrics Beyond GDP'.[381] The executive summary covering both reports states that:

> *'While different measures are clearly needed, alone they are not enough. What also matters is to anchor these indicators in the policy process, in ways that survive the vagaries of electoral cycles. This*

[379] https://www.vox.com/future-perfect/2019/6/8/18656710/new-zealand-wellbeing-budget-bhutan-happiness
[380] https://www.oecd.org/statistics/measuring-economic-social-progress/
[381] https://www.oecd.org/statistics/measuring-economic-social-progress/HLEG-reports.pdf

> *book draws on country-experiences to show how well-being indicators are being used in the different stages in the policy cycle, from identifying priorities for action, to assessing the advantages and disadvantages of different strategies to achieve a given policy goal, to help allocate the resources needed to implement the selected strategy, to monitor interventions in real time as they are implemented, and to audit the results achieved by policies and programmes to help decide how to change them in the future. Steps taken by several countries in this direction are described in this book. While these experiences are recent, they hold the promise of delivering policies that, by going beyond traditional silos, are more effective in achieving their goals and that could help in restoring people's trust that public policies can deliver what we all care about: an equitable and sustainable society.'*

This kind of approach finds some favour in the UK (notably in relation to the 'Happiness Index' first developed in 2010)[382,383], and also in Scotland. Indeed, the description of Scotland's National Performance Framework (see below) notes that 'while economic progress is important, success is about more than Gross Domestic Product (GDP). That's why the purpose [at the heart of the National Performance Framework] is opportunities for all**, improved wellbeing** and sustainable and inclusive economic growth.'

Impact of government(s) on well-being

The links between government(s) and well-being operate in both directions: what governments do affects well-being (for example, in relation to education, housing and employment), and in turn the well-being of citizens determines what kind of government(s) they support. However, the effects of government actions on well-being are often difficult to separate from the

[382] https://www.theguardian.com/politics/2019/may/24/wellbeing-should-replace-growth-as-main-aim-of-uk-spending
[383] https://www.theguardian.com/politics/2010/nov/14/david-cameron-wellbeing-inquiry

influences of other things happening at the same time, and the research evidence on these effects is currently limited.[384]

Clearly, given the very recent introduction of New Zealand's well-being budget, no evidence is yet available about whether this approach has been effective in improving well-being.

Scotland's National Performance Framework[385]

In 2007 the Scottish Government introduced its 'National Performance Framework' (NPF). The NPF sets out a vision for Scotland, and is an 'outcomes-based performance model'. Following its introduction, the NPF was updated twice (in 2011 and 2016). The current version of the framework (2019) comprises four elements: (i) a statement of the Government's purpose and its associated targets (ii) a description of the five strategic objectives which determine where action is focused (iii) the 11 national outcomes which set out what the Government wishes to achieve and (iv) the 81 national indicators which allow the Government to track its progress.

These (81) indicators are described as being '**national well-being**' indicators. They range across a very wide range of topics and include, for example, access to broadband, cost of living, educational attainment, quality of care experience etc. We return to this in the next section (Section four) where more detail is provided in relation to the Scottish Government national indicators which relate to children's well-being.

[384] https://worldhappiness.report/ed/2019/
[385] https://nationalperformance.gov.scot/

4. The well-being of children and young people – its status, importance, definition and measurement

This section summarises what is known about the status, importance, definition and measurement of well-being for children and young people, including for those in care.

The section comprises four elements as follows:

- A discussion of the broader context relating to the rights of children and young people (including those in the 'care system'), with an explicit focus on how this broader context links to well-being.
- A discussion of the issues relating to the definition and measurement of well-being for (all) children and young people, summarising how these differ from the measurements developed in relation to adults, and setting out in detail what matters to children and young people in terms of their own well-being.
- A commentary on how the Scottish Government has approached the 'positioning', development, monitoring and reporting of measurements of (all) children and young people's well-being.
- A discussion on the well-being of children and young people in care, including a description of work undertaken recently (in England and Wales) in relation to measurement and monitoring, and a description of the current availability of well-being monitoring data within the UK.

(Additional material relating to this section is also provided in Annexes one-three.)

United Nations Convention for the Rights of the Child (UNCRC)[386]

The UNCRC is an international human rights treaty which provides the basis for children's rights everywhere in the world. The Convention recognises that children and young people need special care and protection that adults do not. The UNCRC contains 54 articles setting out the civil, political, economic, social and cultural rights that all children under the age of 18 are entitled to everywhere in the world. The UK government ratified the UNCRC in December 1991 and it came into force in the UK, including Scotland, in 1992.

The role of well-being in the UNCRC

Much of the UNCRC focuses either directly or indirectly on children's well-being. Two of the most relevant articles are as follows:

- **Best interest of the child (article three)**: Article three states that, if certain organisations (public or private social welfare institutions, administrative authorities, courts of law, etc.) take any actions concerning children, they should always do what is in the best interest of the child. Article three also says that governments should take appropriate legal and administrative steps to provide for the protection and **well-being** of children. (Note: The child-friendly version of article three is 'All adults should always do what is best for you'.)
- **Right to be heard (article 12):** Article 12 states that any child who is capable of forming his or her own views has the right to express those views freely in all matters affecting them. In addition, the views of the child should be given due weight in accordance with the age and maturity of the child. Article 12 also says that, in circumstances involving judicial or administrative proceedings affecting the child, the child should be given an opportunity to be heard (either directly

[386] as set out in the UN Convention on the Rights of the Child https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

or through a representative or other appropriate body). (As will be seen later in this section, children say 'being heard' is essential to their **well-being**.) (Note: The child-friendly version of article 12 is 'You have the right to an opinion and for it to be listened to and taken seriously'.)

Children and Young People (Scotland) Act and the UNCRC

In 2014, the Scottish Parliament passed the Children and Young People (Scotland) Act.[387] This legislation introduced an extensive range of measures intended to strengthen implementation of the UNCRC and to **promote the well-being of children and young people**. Part one of the 2014 Act placed new duties on Scottish Ministers and public bodies to report on the steps they have taken to give further effect to the UNCRC requirements.

Children's rights vs children's well-being

Tisdall (2015) presented a critical analysis of the Parliamentary debates and submissions relating to the development of the Children and Young People (Scotland) Bill.[388] Her analysis highlighted the tension that arose during the bill's passage through Parliament between the concepts of children's rights and children's well-being. Tisdall argued that the original focus of the bill – on children's rights – was gradually replaced over time by a greater focus on children's well-being. Her analysis was that the children's rights arguments failed because of (i) political concerns about litigation if the UNCRC were incorporated fully into Scot's Law, (ii) a lack of evidence that children's rights improved children's lives, and (iii) differences of opinion among legal experts about the value and feasibility of greater incorporation of the UNCRC.

Tisdall suggested that the arguments in favour of a focus in the legislation on children's well-being (rather than children's rights) were largely

[387] http://www.legislation.gov.uk/asp/2014/8/contents/enacted
[388] Now the Children and Young People (Scotland) Act 2014.

successful because these arguments '*continue the familiar trajectory of a needs-based approach*' to providing services to children and young people. She also argued that a focus on well-being also sat more comfortably within an outcomes-oriented approach to delivering public policy as it could be more easily measured, and had the advantage of supporting an emphasis on early intervention and prevention.

It can be seen from the foregoing account that the concept of **children's well-being** is of central importance to public policy in Scotland.

What matters to (all) children and young people in terms of well-being?

Over the last decade or so, there has been a growing recognition that the measures of well-being discussed in Section three, have been largely developed with adult perspectives in mind. These measures do not necessarily 'translate' when they are applied to children and young people, and issues of (i) the age-appropriateness of questions (ii) the level of language used and (iii) the underlying concepts have been highlighted as requiring specific attention (Dex and Hollingworth, 2012; Statham and Chase, 2010).[389]

A range of organisations have undertaken development work specifically in relation to understanding what matters to children and young people in relation to their well-being and how this can be measured. Two of the key initiatives are described below. Annex one contains further details of other relevant tools and material.[390]

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[389] Dex and Hollingworth (2012) write that 'Evidence of differences in adults' and children's views can be found in Sixsmith et al (2007), who specifically set out to compare the wellbeing schemas devised by children, their parents and their teachers using photographs taken by children of what was important to them. Differences between adults and children are also noted in Watson et al (2012, Chapter nine) in relation to the meaning of play and playfulness; in ten to 15 year-old children's understanding, language and definitions of crime (Fitzpatrick et al, 2010); in their views about health and health services (LaValle et al, 2012), community issues (NAPCAN, 2008); ten-15 year olds understanding and use of the concept of 'satisfaction' in comparison with adult usage (Taylor et al, 2010); and Thomas (2009, p5) outlines some other ways.'

[390] No information was found in relation to the development of indicators for young people aged 16-25.

The Good Childhood Index (The Children's Society)

Developed by The Children's Society in 2010, The Good Childhood Index is a short questionnaire that can be completed by children themselves and used to measure well-being overall and in relation to ten aspects of life. The Good Childhood Index works well for boys and girls and for children of different ages in the UK from age eight and above.

The index includes a single-item measure of happiness with life as a whole, a five-item measure of overall life satisfaction, and questions about happiness with ten different aspects of life including school life and relationships with family and friends (Rees et al, 2010). These measures were derived from consultation with young people, previous research on child well-being, and statistical analysis of two surveys conducted in England.

Components of the index

- Single-item measure of happiness with life as a whole: 'How happy are you with your life as a whole?' (Scale from zero-ten)
- Five-item measure of overall life satisfaction: (Agree / Disagree scale)
    - 'I have what I want in life'
    - 'I have a good life'
    - 'I wish I had a different kind of life'
    - 'My life is just right' and
    - 'My life is going well'.

(These statements were formulated as a multi-item measure of life satisfaction based on a scale originally developed in the US by Scott Huebner (1991).

- Ten domains of life: 'How happy are you with…' (Scale from one-ten)
    - your relationships with your family?
    - the home you live in?
    - how much choice you have in life?
    - your relationships with your friends?

- the things that you have?
- your health?
- your appearance?
- what may happen to you later in your life?
- the school that you go to? and
- the way that you spend your time?

These ten domains were (i) identified as important by children and young people, and (ii) most strongly linked to their overall well-being.

An annual Good Childhood Report based on the Good Childhood Index has been produced since 2012.[391]

UK Office for National Statistics (ONS)

Building on the work of the Children's Society, the UK Office for National Statistics (ONS) developed a suite of indicators for assessing the well-being of UK children aged zero-15. These indicators have been designed to shed light both on children's current well-being and on their future prospects.[392]

The dataset contains 31 measures (indicators) across seven domains, and include both objective data (for example, participated in sport in the last week) and subjective data (such as happiness with appearance). The seven domains cover: personal well-being, relationships, health, activities, home and neighbourhood, finance, and education and skills.

Reports on these indicators are published on an annual basis. The most recent report was published in March 2018.[393] These indicators, and the approach to publication, are currently under review.

[391] https://www.childrenssociety.org.uk/what-we-do/resources-and-publications/the-good-childhood-report-2018
[392] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/childrenswellbeingmeasures
[393] file:///C:/Users/Lenovo/Downloads/Children%20s%20well-being%20and%20social%20relationships,%20UK%20%202018.pdf

Status and measurement of (all) children's well-being in Scotland

Scottish Government National Performance Framework

As has been noted earlier (see Section three above), the Scottish Government's National Performance Framework (NPF) is described as 'Scotland's well-being framework'. The NPF explicitly includes 'increased well-being' as part of its purpose, and combines measurement of how well Scotland is doing in economic terms with a broader range of 'well-being measures'.

One of the (11) National Outcomes identified in the NPF relates to children and young people. This outcome is described as 'We grow up loved, safe and respected so that we realise our full potential.' The vision for children and young people identified in the NPF is:

> *'We do all we can to ensure our children grow up in an atmosphere of happiness, love and understanding. We enhance their life chances through our early years provision and by supporting families when they need it. We ensure childhood is free from abuse, tobacco, alcohol, drugs, poverty and hunger. Our children are not left worried or isolated. We include and involve children in decisions about their lives and world, and protect their rights, dignity and wellbeing. Our communities are safe places where children are valued, nurtured and treated with kindness. We provide stimulating activities and encourage children to engage positively with the built and natural environment and to play their part in its care. We provide the conditions in which all children can be healthy and active. Our schools are loving, respectful and encouraging places where everyone can learn, play and flourish. We provide children and young people with hope for the future and create opportunities for them to fulfil their dreams.'*

The NPF contains seven indicators linked to the national outcome for children and young people. These are:

- **Child social and physical development:** The % of eligible children with no concerns identified at their 27-30 month review[394].
- **Child well-being and happiness:** The proportion of children aged four-12 who had a borderline or abnormal total difficulties score (as determined by the Strength and Difficulties Questionnaire[395]).
- **Children's voices:** Percentage of young people who feel adults take their views into account in decisions that affect their lives.
- **Healthy start:** Perinatal Mortality Rate per 1,000 births.
- **Quality of children's services:** Percentage of settings providing funded Early Learning and Childcare (ELC) achieving good or better across all four quality themes.
- **Children have positive relationships:** Percentage of S2 and S4 pupils who report to have "three or more" close friends.
- **Child material deprivation:** Percentage of children in combined material deprivation and low income after housing costs (below 70% of UK median income).

In addition, indicators which measure aspects of, for example, the environment, rights, and access to justice are also relevant to children's well-being.

[394] https://www2.gov.scot/Resource/0041/00410922.pdf
[395] See Annex 1 for details of the Strength and Difficulties Questionnaire (SDQ)

Children and Young People (Scotland) Act (2014)[396] / 'Getting it Right for Every Child' (GIRFEC)[397]

The Children and Young People (Scotland) Act 2014, which includes key parts of the 'Getting it Right for Every Child' approach (GIRFEC), defines child well-being in terms of eight indicators (often referred to as the 'SHANARRI' indicators of well-being) namely:

Safe: Protected from abuse neglect or harm at home, at school and in the community;

Healthy: Having the highest attainable standards of physical and mental health, access to suitable health care, and support in learning to make healthy and safe choices;

Active: Having opportunities to take part in activities such as play, recreation, and sport which contribute to healthy growth, and development both at home and in the community;

Nurtured: Having a nurturing place to live, in a family setting with additional help if needed, or where this is not possible, in a care setting;

Achieving: Being supported and guided in their learning and in the development of their skills, confidence and self-esteem, at home, at school, and in the community;

Respected: Having the opportunity, along with carers, to be heard and involved in decisions which affect them;

Responsible: Having opportunities and encouragement to play active and responsible roles in their schools and communities, and, where necessary, having appropriate guidance and supervision and being involved in decisions that affect them; and

[396] http://www.legislation.gov.uk/asp/2014/8/contents/enacted
[397] https://www.gov.scot/policies/girfec/

Included: Having help to overcome social, educational, physical and economic inequalities, and being accepted as part of the community in which they live and learn.

These domains have been developed from child development theory and a children's rights perspective.[398]

A recent evidence review (September 2018) by Scottish Government has summarised the available evidence on child and adolescent health and well-being in Scotland in relation to the SHANARRI domains, and has reviewed progress in relation to 143 indicators.[399] The main areas of success over the last decade or so are identified as improvements in: (i) maternal smoking and babies exposure to second hand smoking (ii) substance abuse amongst young people (iii) hospital admissions for accidental injury (iv) child deaths (v) referrals for offending behaviours and (vi) educational qualifications and positive destinations. By contrast, areas which show considerable 'room for improvement', and which have been either not improving, or getting worse include (i) breastfeeding rates (ii) maternal obesity (iii) childhood obesity (iv) physical activity (v) mental well-being (SDQ, WEMWBS[400], confidence) (vi) peer relationships (vii) bullying (viii) family relationships and (ix) child poverty.

Well-being for children and young people in care

The well-being of children and young people in care has been an important focus within the literature in recent years, especially since children in care are more likely than their peers to experience mental health problems and related negative outcomes (Meltzer et al, 2003; Department for Education, 2014). A number of organisations have called for a greater focus on well-being within the 'care system', and, as part of this, better approaches for measuring well-being in order to (i) better

[398] https://www.gov.scot/policies/girfec/wellbeing-indicators-shanarri/
[399] https://www.gov.scot/publications/child-adolescent-health-wellbeing-scotland-evidence-review/
[400] See Annex 1 for details of the SDQ and WEMBWS scales

inform the care planning process and (ii) assess the extent to which services delivered to children in care are supporting them to have a 'happy childhood' (Bazalgette et al 2015; Ryder et al, 2017).

In tandem with this, there has also been an increasing emphasis on enabling children and young people in care to define and articulate their own views on what matters to them in relation to their well-being. (Dickson et al, 2009; Coram Voice, 2015; Selwyn and Wood, 2017; Ryder et al 2017).

The 2015 literature review by Coram Voice commented specifically on the differences in perspective between children and young people in care and those in the general population in relation to what aspects of well-being were most important to them as follows:

> *'The surveys and research on looked after children and young people's well-being include many of the same domains that are important to children in the general population. However, missing from surveys of looked after children are: the worlds of imagination, creativity, play and children's spiritual lives. A domain that is of central importance in all surveys is relationships with family and friends. Looked after young people however, seem to place greater emphasis on the importance of trusting relationships. Most children in the general population will have parents who give their love unconditionally and children learn from infancy that their parents will be there for them and on their side. For many looked after children early neglect and abuse disrupts the normal development of trust and insecure attachment patterns develop. Once looked after, children's placements are often unstable and children move placements frequently and have frequent changes of social worker. Relationships are disrupted and trust in carers and professionals are damaged. It is therefore not surprising that trust was mentioned so often by looked after children. There was also greater emphasis on 'having a say', being able to participate in decisions and autonomy.'*

Defining and measuring well-being for children and young people in care

Below, brief details are provided of two recent initiatives to measure well-being for children and young people in care which have drawn on the views of children and young people themselves. Annex two provides information in relation to a number of other, less comprehensive, approaches which have been identified.

The Bright Spots programme (Coram Voice and the University of Bristol)[401] (2013-)

The Bright Spots programme, developed by Coram Voice and the University of Bristol, has created a set of well-being indicators to allow services to design their work around what children and young people say is important to them. Two online surveys – Your Life, Your Care (YLYC) and Your Life Your Care (YLBC) – have now been used widely by both English and Welsh local authorities, and national reports have been published on an annual basis since 2015[402] (Selwyn and Wood, 2017, Coram Voice and Hadley Centre for Adoption and Foster Care Studies, 2015). The intention is that these surveys will continue to be rolled out to further local authorities in England and Wales.

The theoretical underpinning for the work programme was provided by a children's rights perspective (Pona and Hounsel 2012). The programme began in 2013, and used a framework of well-being to guide the research, 'accepting that [well-being] is a multifaceted concept with different domains identified and emphasised (e.g. Ryff 1989, Seligman 2011)' (Selwyn and Wood, 2017). There have been five phases to the development of the surveys: (i) literature reviews (ii) expert roundtable (iii) focus groups with

[401] https://coramvoice.org.uk/brightspots

[402] To date, the YLYC surveys have been used in 28 English and six Welsh local authorities. The most recent national report is based on the views of 2,684 children (aged 4-18) from 17 local authorities in England. The YLBC survey covered 474 children and young people from six local authorities in 2018.

young people (iv) survey development and (v) piloting (including cognitive testing).

This programme of work identified four key domains:

Relationships (Indicators include: contact with birth parents, siblings and pets; trusting relationships with social workers, carers and friends; stability of placements; continuity with social workers);

Resilience (Indicators include: having a key trusted adult; opportunities to play, have hobbies and access to the natural world; getting second chances; enjoying school; support for learning; learning life skills);

Rights (Indicators include: feeling free and safe from bullying; knowing and being able to contact your social worker; having the right to speak in private; feeling included in social work decision making; not being made to feel different because looked after);

Recovery (Indicators include: feeling settled, liking bedroom and having sensitive carers; being trusted; parity with peers; access to computers / tablets; support services to help with difficulties; having an age appropriate account of personal history; happiness with appearance; feeling that life is getting better).

Questions were created from each of the indicators and to these were added four questions used in community surveys of children and adults. The four questions, using a scale of zero-ten, ask about overall life satisfaction, happiness, feeling that life is worthwhile and feeling positive about the future.

The authors, in their description of the surveys say that 'our surveys are the only ones to capture 'subjective well-being' – how children in care feel about their relationships, the support they receive and how things are going'. They also emphasise the importance of the concept of 'flourishing' (Seligman, 2011) – which they describe as related to (good) relationships,

self-efficacy, and life 'getting better' – as an appropriate way to think of how children fare in the 'care system'.[403]

Note that this is the only programme of work identified in this evidence review which has developed a specific approach for the measurement of the subjective well-being of care leavers.

National Society for the Prevention of Cruelty to Children (NSPCC) 'Achieving emotional well-being for looked after children' (Bazalgette, Rahilly and Trevelyan, 2015)

In partnership with four local authorities in England and Wales, the NSPCC conducted a programme of fieldwork, interviewing looked after children and care leavers, their carers and professionals from health and social care services, to understand their views on how the 'care system' currently supports young people's emotional well-being and what changes they would like to see.

The NSPCC report notes that there is 'no consensus about how looked after children's wellbeing should be understood and defined.' In the fieldwork for this project, the NSPCC used the phrase 'emotional well-being'.[404]

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[403] The full list of current indicators for children in care can be viewed at https://coramvoice.org.uk/sites/default/files/1249-cv-oloc-snapshot-visionindicators.pdf. (Note that Your Life, Your Care comprises a set of three surveys for children in care as follows: (i) children aged between four and seven years (16 questions) (ii) children aged between eight and ten/11 years junior school (31 questions) and (iii) young people of secondary school age 11-18 years (46 questions). The full list of current indicators for care leavers can be viewed at https://coramvoice.org.uk/sites/default/files/cv-olbc-snapshot-visionindicators_1.4.19.pdf

[404] 'Emotional well-being' was intended to encompass all three dimensions (emotional wellbeing, psychological wellbeing and social wellbeing) identified in earlier work by the National Institute for Health and Care Excellence (NICE) in its work on children's mental health. The NSPCC discussed the meaning of both 'good' and 'poor' emotional wellbeing with looked after children and found that they did not distinguish between these different dimensions of wellbeing but found them all to be inextricably linked. Thus, in this context, 'emotional well-being' was taken to encompass happiness and confidence, and the opposite of depression/anxiety; resilience, mastery, confidence, autonomy, attentiveness/involvement and the capacity to manage conflict and to problem solve; and good relationships with others, and the opposite of conduct disorder, delinquency, interpersonal violence and bullying.

When discussing emotional well-being with the NSPCC, young people defined good emotional wellbeing according to their feelings; thoughts; behaviours; activities and achievements; relationships; and the importance of safety and stability. These can be considered to be six different 'domains of good emotional well-being'. For example:

Feelings: Feelings described by young people included upbeat states of mind, such as "happy", "joyful" and "excited", as well as more neutral states like "feeling OK" or "stable emotions". Young people also discussed how good emotional well-being meant "feeling good about yourself". Others referred to qualities like "confidence" and "self-esteem".

Thoughts: Young people also discussed how they would think when they had good emotional well-being, using terms like "positive thinking" and examples like "having positive thoughts that I can pass an exam" and "noticing the positive things instead of the negatives".

Behaviours: Behaviours that young people associated with good emotional well-being included "smiling", "happy expressions", "laughing" and "looking well".

Activities and achievements: Many descriptions of good well-being focused on being active and outward-facing; young people spoke about "having fun", "going outside" and "getting out of my room" or participating in favoured activities (e.g. swimming, preparing food).

Relationships: Relationships were essential to most young people's emotional well-being. Some explained that if they feel good, they want to "socialise" and "be with mates" or "see my family". Others talked about the importance of "having support" and "talking about your problem".

Safety and stability: Some children in care spoke of "feeling secure" and having "a safe environment", while a male care leaver said that good well-being means "having a secure, warm, comfortable place where you can go home and relax".

Similarly, young people defined poor emotional well-being according to their feelings; thoughts; behaviours, relationships and experiences of instability.[405]

Monitoring / assessment of the health (and well-being) of children and young people in care in the UK

In 2014, the Guidance on Health Assessments for Looked after Children and Young People in Scotland recommended that children should be 'screened for emotional and mental health difficulties using Goodman's Strengths and Difficulties Questionnaire (SDQ)'.[406] The guidance recommends that if children are thought to have 'significant' difficulties, they should be referred to a specialist service for full assessment. This is similar to the approach set out in the statutory guidance for England.

[405] See Annex three for more details on the NSPCC's account of the descriptions given by children and young people in care of 'poor emotional well-being'.
[406] https://www.gov.scot/publications/guidance-health-assessments-looked-children-scotland/

5. What are the barriers to positive health and well-being for children and young people in care?

This section summarises the evidence relating to the barriers to health and well-being which exist for children and young people in care.

As will be seen in what follows, these barriers link strongly back to the factors children identified in the literature in Section four as important to their well-being.

Barriers for children and young people in care in developing high quality relationships

There is a strong focus in the literature on the barriers that children and young people in care face in developing high quality relationships - especially with carers and professionals, although also with birth families, siblings, friends and peers. Since health and well-being is intricately bound up with having positive relationships, then barriers to developing high quality relationships will also act as barriers to positive health and well-being.

This literature focuses on three main types of barrier to developing high quality relationships, (i) systemic barriers (ii) professional barriers and (iii) barriers from the perspective of the children and young people (Winter, 2015). These are discussed in turn below.

- *Systemic barriers include*: management styles which reproduce managerialist, objective, emotionally detached ways of working (Ruch, 2012); the requirements of bureaucracy / paperwork and the lack of time which is available for relationships to be developed (Coram Voice 2015); pressure of work inhibiting quality time (Baker, 2017).

- *Professional barriers include*: lack of time, training and tools; caseloads that are too high; seeing relationships as linear and sequential rather than as a network (Care Inquiry 2013); too much emphasis on the bureaucratic form filling aspects of the job; a fear of complaints; accusations of over-involvement and an adverse emotional impact on them by forming close relationships with children and young people (Siebelt et al, 2008; Laming, 2009; Broadhurst et al, 2010; Morgan 2012; Ruch 2014).
- *Barriers from the perspective of young people include*: attachment, relationships may have been disrupted in the past, and as a result some children can find it difficult to trust adults in the face of previously negative and abusive encounters (Leeson 2007; Munro 2011; Winter 2011); mistrust of professionals (including that professionals will not respect their confidentiality), exacerbated by constant changes of worker, the lack of time to form relationships, and by professional decisions that are made about the lives of children and young people with which a child or young person does not agree. Furthermore, children and young people may have developed coping mechanisms that result in them not taking opportunities to form relationships through fear of rejection (Reimer, 2010; Care Inquiry, 2013). In addition, children report a lack of love and affection, which has a detrimental impact on emotional well-being and especially on self-esteem (Dickson et al, 2009). Finally, children who experience the 'care system' face a range of stereotypes and stigma; these have a direct effect on their well-being, shaping identity and self-expectations in ways that impact on outcomes and life chances (Scottish Social Attitudes, 2018).

Barriers for children and young people in care in developing positive health and well-being

More generally, a wide variety of barriers for children and young people in care developing positive health and well-being have been identified as follows[407]:

- *Barriers relating to permanence and stability*: Frequent moves, lack of permanence and stability, lack of certainty about the future, lack of feeling settled and secure, lack of continuity in placements and lack of continuity with professionals which diminishes trust, makes it more difficult to engage with education, and has a detrimental impact on well-being more generally (Dickson et al, 2009; Wood and Selwyn, 2017; Coram Voice 2015; Biehal et al, 2010).
- *Barriers relating to children and young people's voice being heard*: Not being properly listened to or involved in decision making about their own lives. Not understanding why key decisions (e.g. about contact with families and siblings) have been made (Baker, 2017).
- *Barriers relating to the inadequate training of professional staff*, especially in relation to emotional well-being. Staff lack confidence in their knowledge and skills and sometimes have very low aspirations for the children and young people in their care (Ryder et al 2017; Gracie et al, 2018).
- *Barriers relating to the physical environment:* Children's physical environment can have a negative impact on their well-being if there are problems - for example if they don't like their bedroom, or can't have a pet (Baker, 2017).
- *The complexity and inadequate funding of the 'care system'*: Services (health, social care, education etc.) are not properly 'joined up' (Gracie et al, 2018). Government policy arbitrarily curtails support and supportive relationships when children leave the 'care system'

[407] Note that there is a great deal of overlap between these different categories, and individual elements could be assigned to a wide range of different categories. Thus, to some degree, the categorisation described here is arbitrary.

which is highly detrimental to care leavers' well-being (Rahilly and Hendry, 2014). There is a lack of access to funding and support for creative (and especially musical) activities (Gracie et al, 2018).

Contextual factors as barriers to positive health and well-being

As has been noted earlier, many of the children and young people who enter the 'care system' come from inherently difficult backgrounds and circumstances. They may have experienced poor parenting, trauma, bereavement, or serious illness, as well as difficult transitions and the loss of schools, friends and treasured possessions (Gracie et al, 2018). There is evidence that children who have higher levels of emotional and behavioural difficulties when they enter care are at greater risk of experiencing unstable placements, which in turn can have a negative impact on their well-being and mental health (Hannon et al, 2010). In addition, children who have been subjected to traumatic experiences are less able to use their own resources, and rely much more on external factors to improve their health and well-being (Ungar, 2013).

Evidence about barriers from the Bright Spots Programme

As set out earlier (Section four), the Bright Spots programme, developed by Coram Voice and the University of Bristol, has created a set of well-being indicators to allow services to be designed around what children and young people say is important to them. As noted earlier, to date these surveys have been carried out in local authorities in England and Wales only.

Our Lives, Our Care (2017) [408]

The report published in 2018 (which describes the findings from the 2017 'Your Life, Your Care' survey) included the following age-specific factors as barriers to well-being:

[408] https://coramvoice.org.uk/sites/default/files/1053-CV-Our-Lives-Our-Care-report5.pdf (page 42 onwards)

Age four-seven:

- Not knowing why they are in care
- Not knowing who their social worker is

Age eight-ten:

- Not feeling safe or settled in their placements
- Not having a trusted adult in their lives
- Not feeling included in decision making
- Not trusting their social worker
- Not having a good friend

Age 11-18

- Being unhappy with their appearance
- Not being given opportunities to be trusted
- Not liking their bedrooms
- Not feeling safe in their placements
- Not having a trusted adult in their lives.

Your Life, Beyond Care

The unpublished data from the 2018 'Your Life, Beyond Care' survey (conducted in 2017), suggests that the key barriers to well-being for care-leavers include[409]: feeling lonely (often or always); not feeling settled or safe where they live; not having a trusted person in their life; being unhappy with their appearance; and not having a good friend.

[409] Correspondence with author, June 2019.

6. What promotes health and well-being for children and young people in care?

This section summarises the evidence on what promotes the health and well-being of children and young people in care.

The findings have been grouped under eight headings: (i) positive and meaningful relationships (ii) the voice of children and young people is heard (iii) a focus on stability, permanence and continuity (iv) a supportive and positive wider environment (v) lifelong support (vi) a well-trained and supported workforce and (vii) a 'joined up' 'care system' and (viii) a holistic approach. As will be seen from what follows, these elements are often interconnected.[410]

It should be noted that, as suggested by Bazalgette et al (2015), ideas of good (and poor) emotional well-being are very different for each child in care. Thus, in addition to the (eight) themes discussed below, Bazalgette et al suggest that:

> *'it is vital that each looked after child is recognised as an individual and provided with the consistent relationships and personalised support they need to realise their own definition of good emotional well-being [....] high-quality caregiving, with added interventions targeted either directly at the child or indirectly (through the carer or those around the child), providing support where necessary, might effect positive change in children's well-being.'*

Positive and meaningful relationships

The experience of positive, safe, stable, trusting and affectionate relationships is vital for the health and well-being of children and young

[410] Note that all of these factors are mentioned in the reports of the Bright Spots programme. (See https://coramvoice.org.uk/sites/default/files/cv-oloc-snapshot-a2-poster.pdf for children in care and https://coramvoice.org.uk/sites/default/files/cv-olbc-snapshot-a2-poster_1.4.19.pdf for care leavers.)

people in care. (Gracie et al, 2018; Winter, 2015; Coram Voice, 2015). Indeed, from children and young people's perspectives, the thing which has the greatest impact on them whilst they are in the 'care system' is the quality of the relationships that they have with carers, workers and family members; it is vital that these relationships are supported and sustained (Baker, 2017; Rahilly and Hendry, 2014; Bazalgette et al, 2015). These relationships help children and young people to build secure attachments, develop self-confidence, self-esteem and self-reliance, and contribute to a strong sense of identity and belonging (Fahlberg, 1994; Ryan 2012; Care Inquiry 2013). As Winter (2015) writes:

> *'... with these foundations in place, children and young people are afforded the best chance to secure positive long-term outcomes in education, health and overall well-being (Happer et al, 2006; Siebelt et al, 2008; DCSF, 2009; Ryan, 2012). From the perspective of children and young people, stable, significant relationships are beneficial as they provide someone to turn to at points of crisis and change, they provide encouragement and guidance and they provide endorsement at key life events such as graduation or marriage (Singer et al, 2013). Longstanding relationships can also provide a platform to making sense of the past, filling in gaps regarding one's own personal narrative. Such relationships, therefore, perform an important role in identity formation, particularly when children cannot return home.' (Neill and Howe, 2004; Schofield and Stevenson, 2009; Winter, 2013)*

The voice of children and young people is heard

Ensuring that children and young people's voices are heard throughout the 'care system' is of paramount importance in promoting health and well-being. Children and young people emphasised the importance of having one named person responsible for their well-being, who involved them in decision-making and listened to their views (Coram Voice, 2015). Moreover, being involved in decision making on placement moves, contact

arrangements and care plans were central to the happiness of looked after children and young people, and to their understanding of why they are in care and the rationale behind their care plans (Wood and Selwyn, 2017; Baker 2107). This is also linked to ensuring that children and young people are given choice, voice, influence and control in relation to expressing their wishes, giving feedback on their care, and participating in decision making about their own lives; these aspects have been shown to be very important to them (House of Commons Education Committee 2016; Bazalgette et al 2015).

Allowing the voice of children and young people in care to be heard is also closely linked to ensuring that children's rights (as defined by the UN convention) are upheld. This issue is discussed at length within the evidence review paper in this series which focuses specifically on children's rights,[411] and is also referred to in the review by Bazalgette et al (2015) where it is linked explicitly to a requirement for advocacy.

A focus on stability, permanence and continuity

There is a strong theme in the literature on the importance of stability, permanence, and continuity in promoting the well-being of children and young people in care. These factors relate both to the stability and continuity of the placements, and to the stability and continuity of relationships (Moran et al 2017; Lerpiniere et al, 2015).

According to Moran et al (2017):

> *'This focus on continuity is relevant regardless of the age of the child on entry into care, the length of time they spend in a placement, or other factors identified in the literature as potentially affecting permanence and stability (e.g. gender, ethnicity). By continuity of relationships, we refer mainly to the child's relationships with fosters*

[411] Griesbach D (2019) for the Care Review. The rights of children in care. A review of evidence on the state of children's rights in Scotland, and the benefits, challenges and facilitators of implementing the UN Convention on the Rights of the Child.

> *carers, family of origin, and social workers and support workers. However, the continuity of other relationships also affects permanence and stability, such as between families of origin and foster families.... The study shows the potential to improve outcomes for permanence and stability through an approach that places the young person firmly at the centre of social work practice.'*

The concept of 'relational permanence' has been shown to be of particular importance to young people who have been looked after on home supervision, acting as a key to access a wider range of outcomes (Lerpiniere et al, 2015), and also in relation to care leavers where the need to build enduring relationships that provide an element of permanence has been emphasised (Fowler et al, 2018). It has also been noted that the stability and well-being of some children in care is better than those who return home (Wade, 2010).

A supportive and positive wider environment

The literature identifies a range of features of the wider environment which children and young people in care say help to promote their health and well-being. These range from the local and specific (for example, 'having a bedroom I like', or 'being able to have a pet') to the more systemic and generic (for example, 'getting help with homework' or 'having someone who cares about my education') and are relevant within the home environment, the school environment, and the wider communities within which children and young people are involved.[412]

The following factors relating to the wider environment have been identified as promoting health and well-being: being able to go out with friends; being able to access social media and the internet; having a safe place to live; doing activities I like (swimming, preparing food); getting

[412] Findings from the Bright Spots Programme https://coramvoice.org.uk/brightspots

recognition for my achievements; being helped to budget; being treated the same as other people.

Lifelong support

There is repeated reference in the literature to the importance of the availability of 'lifelong support' for children and young people who have been in the 'care system'. This requirement is most often voiced in relation to the needs of care leavers.

The support for (i) transitions out of the 'care system', and (ii) ongoing access to services are widely judged to be inadequate or lacking (Moran et al, 2017; Baker 2017; Bazalgette et al 2015; Welch et al, 2018). Children, young people and (especially) care leavers have identified the need for ongoing support in relation to a range of factors including: emotional support for friendships and relationships which may be disrupted and to combat loneliness and isolation; mental health and well-being support including access to mental health services; financial planning and financial security; access to suitable accommodation and housing; advice on education and employment.

Overall, it was clear that children, young people and care leavers experienced variable planning arrangements in relation to the transition from care, and a limited focus on emotional and psychological preparation (Matthews and Sykes, 2012). It was argued that mentoring and coaching relationships with supportive adults could help in this regard (Plunkett et al, 2019) and that care leavers should be able to make the transition at their own pace (NICE, 2013). Fundamentally, however, the requirement is for a 'system' which does not require arbitrary (age-related) cut offs on the access to support to be imposed (Rahilly and Hendry, 2014).

A well-trained and supported workforce

The selection, training, supervising and quality assuring of the workforce, (including foster carers, social workers, residential staff and other volunteers and professionals) is crucial to the health and well-being of

children and young people in care (Luke et al, 2014). More specifically, the literature proposes that the workforce needs to be fully equipped to positively address the needs and requirements of those in the 'care system', many of whom have experience of adverse situations and traumatic life circumstances. This may require training in therapeutic practices, reflective functioning, mental health awareness and the capacity to work creatively to enhance well-being (Coram Voice 2015, Bazalgette et al, 2015; Steels and Simpson, 2017; Gracie et al 2018).

A fuller account of this aspect is provided in the evidence review paper which focuses on the 'care system' workforce.[413]

A 'joined up' 'care system'

If the health and well-being of children and young people in the 'care system' is to be improved, then there is a requirement for the 'care system' to be more 'joined up' (Luke et al, 2014, Department of Health & Department of Education, 2015). This 'joining up' requires effective coordination by both national and local authorities across the fields of health, social care, education, housing, and justice. A 'joined up' 'care system', which adheres to clear standards and facilitates co-ordination, communication, integration and accessibility will help to (i) identify at the earliest opportunity, through better assessment of young people's emotional and mental health needs, when a child or young person may be at risk, and requiring support or assistance (i.e. adopt a preventative approach) (ii) 'smooth' the pathways between placements (iii) improve the transitions out of care and (iv) facilitate access to support and services on a lifelong basis as set out above (Mullan et al, 2006; Luke et al, 2014; Bazalgette et al, 2015).

A holistic approach

There is a requirement for the 'care system' to take a holistic approach to the promotion of the health and well-being of children and young people

[413] Baker C (2019) for the Care Review.

in care (Matthews and Sykes, 2012; Mullan et al 2006). This approach puts the child at the centre of social work practice, and at the centre of the 'care system' itself, and makes the health and well-being of looked after children and young people a strategic priority for the 'care system' (Moran et al, 2017, Baker 2017; Bazalgette et al, 2015, Luke et al 2014). This has been described as 'embedding emotional well-being in 'system''; rather than seeing well-being as something that is the responsibility of specialist (mental health) services alone, there needs to be a 'whole 'system' approach' that prioritises the emotional wellbeing of children in care, across social care and health (Bazalgette et al, 2015).

7. Concluding remarks

The evidence reviewed for this paper shows that the health and well-being of all children and young people, including those in care, is a vital area for public policy both in Scotland and elsewhere. In Scotland, improving the health and well-being of children is seen to be central to the government's purpose as set out in its National Performance Framework.

However, this is a complex area. Well-being is not straightforward to define, and there are many components to well-being which make it difficult to measure and monitor. In addition, it has become clear that the things which matter to children and young people in relation to well-being are different to the things which matter to adults; and this difference is even more pronounced when it is the well-being of those in care who are being considered. Recent efforts towards enabling children and young people – including those in care – to define well-being in their own terms are welcome, but there is still much to be done to embed these measurements into the 'care system' and to use them for improvement.

Nevertheless, it is clear that there are some key elements which promote the health and well-being of children and young people in care: positive, safe, stable, trusting and affectionate relationships with carers, workers and family members; children's voices being heard in decision making; emotional support at times of transition in, out and through care; a focus on the child, rather than on the paperwork; and the creation of an environment where friendships with peers, carers, workers and family members can flourish.

The evidence has identified specific gaps which future work could address as follows:

- **Official government statistics on children and young people in care (including care leavers) are insufficiently focused on (subjective) well-being:** official measures focus on objective measures (education, employment, accommodation etc.). However, if services are to respond to needs and aspirations, then more needs to be known about how young people feel about their lives in care. (Are they happy and safe? Do they feel positive about the future? Do they feel they have been prepared and supported to move successfully into adulthood?)
- **Well-being indicators for those aged 16-25 are underdeveloped:** While there is a growing body of work relating to developing indicators for children and young people, the evidence review identified little specific work in relation to those aged 16-25.
- **A more diverse range of looked after children and young people should be included in the development of measures of well-being:** There is relatively little evidence on the factors contributing to well-being for children with disabilities, learning difficulties, special needs etc.

More broadly, the evidence review has uncovered evidence that the effect of government actions on well-being is not well understood. These effects are difficult to separate from the influences of other things happening at the same time, and the research evidence on these effects is currently limited. It will be useful to keep a watching brief on the "Stiglitz-Sen-Fintoussi" Commission to see what learning arises from their sustained and detailed focus on the value of metrics relating to well-being, inequality and sustainability.

8. Appendices

Annex One: Measures of well-being for children and young people

Section three provided details of two key initiatives (instigated by The Children's Society and the UK Office for National Statistics) to develop measures of well-being for children and young people.

A range of other relevant measurement tools and approaches are described in brief below.

Child poverty in perspective: An overview of child well-being in rich countries (UNICEF, 2007)[414]

UNICEF's 2007 report presents a new index of childhood well-being, constructed around six domains, one of which was subjective well-being (defined in terms of self-reported satisfaction with health, school and life overall).

Strength and Difficulties Questionnaire (SDQ)[415]

The Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) is a brief emotional and behavioural screening questionnaire for use with children and young people (aged four-17). The tool, which is used throughout the world, can capture the perspective of children and young people, their parents and teachers. The 25 items in the SDQ comprise five scales of five items each. The five subscales cover: (i) Emotional symptoms (ii) Conduct problems (iii) Hyperactivity/inattention (iv) Peer relationships problem (v) Prosocial behaviour.

The SDQ can be used for various purposes, including clinical assessment, evaluation of outcomes, research and screening. There are a range of views on its' usefulness and use. Ryder et al (2017) says 'it was never intended to be a measure of children's well-being' and recommends that the

[414] https://www.unicef.org/media/files/ChildPovertyReport.pdf
[415] https://www.corc.uk.net/outcome-experience-measures/strengths-and-difficulties-questionnaire/

Government 'reviews, tailors and supplements the SDQ to create a suite of tools that can fulfil the distinct functions of screening for mental health conditions and measuring wellbeing more effectively'. However, Luke et al (2014) note that 'the SDQ provides an easy way of monitoring children's wellbeing over time; it could give a broad indication of those who are having significant difficulties and may need further assessment, though the data collected could be much more extensively used.'

In England, (but not, it appears, in Scotland), the SDQ 'scores' form part of the national data collected on children and young people in care. The most recent findings in relation to looked after children's SDQ scores have been reported in December 2017 in the Department for Education's publication about looked after children in England (SFR 50/2017).[416]

The Warwick-Edinburgh Mental Well-being Scales (WEMWBS)[417]

The Warwick Edinburgh Mental Well-being Scale (WEMWBS) is a 14 item instrument that was developed for NHS Health Scotland and (from 2008) is included in the core module of the annual Scottish Health Survey.

On the bright side: Developing a questionnaire for charities to measure children's well-being. New Philanthropy Capital. Heady, L. and Oliveira, A. (2008)[418]

New Philanthropy Capital developed a multi-dimensional questionnaire for charities to measure the subjective well-being of 11 to 16 year-old children. This had ten domains covering: physical, psychological, behaviour, school, family, friends, resilience, living, subjective, material.

Childhood Well-being Research Centre (2011)

The Childhood Well-being Research Centre (Holder et al, 2011) set out to develop a generic self-report instrument that could measure outcomes for those using Children's services. Eight domains were identified namely:

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[416] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664998/SFR50_2017_Additional_Tables_Text.pdf
[417] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/
[418] https://www.thinknpc.org/wp-content/uploads/2018/07/Feelings-count.pdf

provision for physical needs; feeling safe and secure; whether children and young people can go to school; receipt of help and encouragement; being able to express yourself; being listened to; having enough time to do the things you want to do; relationships with family and friends. However, it was concluded that these domains required further conceptual development.

A guide to measuring children's well-being (New Economics Foundation / Action for Children)[419]

In 2009 the New Economics Foundation in collaboration with Action for Children published a guide to measuring children's well-being (Thompson and Aked, 2009). The guide looks specifically at the scope of subjective indicators (e.g., life satisfaction, optimism about the future) to complement objective indicators of well-being (e.g., child obesity, numeracy and literacy, household income) to better understand how children experience their lives – from their own perspectives. It covers some of the practical approaches to measuring child well-being that have been implemented and it discusses some of the considerations that need to be made when designing a wellbeing measurement tool for children, which includes subjective indicators.

[419] https://neweconomics.org/2009/09/guide-measuring-childrens-wellbeing

Annex Two: Measures of well-being for children and young people in care

Section four provided details of two approaches to measuring well-being for children and young people in care (Bright Spots Programme and NSPCC report). Below, a range of other, less comprehensive approaches, are set out briefly.

UNICEF (2009)

UNICEF (2009) has developed a set of 15 indicators for children in formal care (institutional or foster) for use throughout the world.[420] The 15 core indicators are divided into 12 objective indicators (such as the number of children entering care, ratio of children in residential and foster care, number of child deaths) and three indicators that show (i) the existence of policies and a framework for dealing with children's complaints, (ii) registration and regulation of providers and (iii) a legal and policy framework for children in formal care. However, this set of indicators does not include any measures of the subjective well-being of children and young people in care.

National Institute for Health and Clinical Excellence (NICE) (2009)

The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) were asked by the Department of Health (DH) to develop joint guidance on improving the physical and emotional health and wellbeing outcomes for children and young people in care. As part of this work, a systematic review was commissioned to examine the views, experiences and preferences of children and young people, their families and carers, about the 'care system' (Dickson et al 2009). A total of 35 individual research studies were identified.

The review grouped children's response into nine domains of outcomes that mattered to them: love, a sense of belonging, being supported, having someone to talk to, contact with birth parents, stigma and prejudice,

[420] https://www.unicef.org/protection/Formal_Care20Guide20FINAL.pdf

education, relationships with professionals, preparation and support for leaving care.

Voice of Young People in Care (VOYPIC) (2011-2013)

VOYPIC introduced 'Our Life in Care' in 2011, as a three-year pilot project to collect the views and experiences of children aged eight to 18 looked after by a Health and Social Care Trust in Northern Ireland, using a computer assisted self-interview (CASI) survey approach (VOYPIC, 2014). Three surveys were conducted in 2011, 2012, and 2013. 'Our Life in Care' has three age appropriate questionnaires which were developed in consultation with young people. Key questions focus on the care experience - the quality of care; safety and stability, key relationships and participation in care planning. Other questions reflect all the (six) high level outcomes in the Office of the First Minister and Deputy First Minister children's strategy. (VOYPIC 2014).

Annex Three: Examples of 'poor emotional well-being'

Section three contains details of the domains identified as contributing to 'good emotional well-being' in the NSPCC report (NSPCC, Balzagette et al, 2015). Below, a summary of the comments which reflect these same domains[421], but identified as contributing to 'poor emotional well-being' are set out.

- **Feelings:** Feelings identified by young people included "sad", "feeling down", "depression", "unloved" "stress", "angry", "frustration", "tearful", "confused", "mood swings" and "feeling bad about yourself".
- **Thoughts:** Thoughts that young people associated with poor emotional wellbeing included "horrific memories" and "weird fears", such as "fear my family members died or left me". One care leaver said that for him poor wellbeing was "waking up and thinking 'oh is it today already?'" Young people also referred to "thinking too much" and "keep looking into the past".
- **Behaviours:** Behaviours that some young people associated with poor emotional wellbeing included "taking it out on other people", "violence", "putting a hole in the window", "throw stuff about" and "do criminal damage". Some young also people discussed directing harmful behaviours toward themselves, such as self-harm and suicidal thoughts: "I used to think about hanging myself, jumping off a bridge." Other examples included destructive drug and alcohol use: "getting stoned every day" or "getting drunk and ending up in hospital". Other young people said that they signalled their poor wellbeing through quiet and withdrawn behaviours: "Staying in, slumping around in the same clothes" or "I might just want everyone to go away". Young people were sometimes only able to express their feelings through harmful or self-isolating behaviours but this was not always well understood by the adults around them.

[421] Comments relating to the 'activities and achievements' were not covered in relation to poor emotional well-being.

- **Relationships:** Relationships with other people were central to young people's ideas about poor emotional wellbeing. This time, discussion of poor emotional wellbeing often focused on keeping other people at a distance: "keeping things to yourself", "bottling things up" and "not talking about problems". One young person said that poor wellbeing was "Pretending you are feeling in a certain way, like happy, content". Another referred to "putting on a fake face". If young people did want to confide, poor wellbeing was when "no-one listens". Some young people discussed the sadness of separation from loved ones: "My brother and sister were adopted, like three years ago." However, family relationships were not always seen as a positive thing; one care leaver felt that his difficult relationship with his brother was an ongoing cause of his poor emotional wellbeing. Young people also pointed to the impact of "moving around" and feeling rejected when placements broke down.

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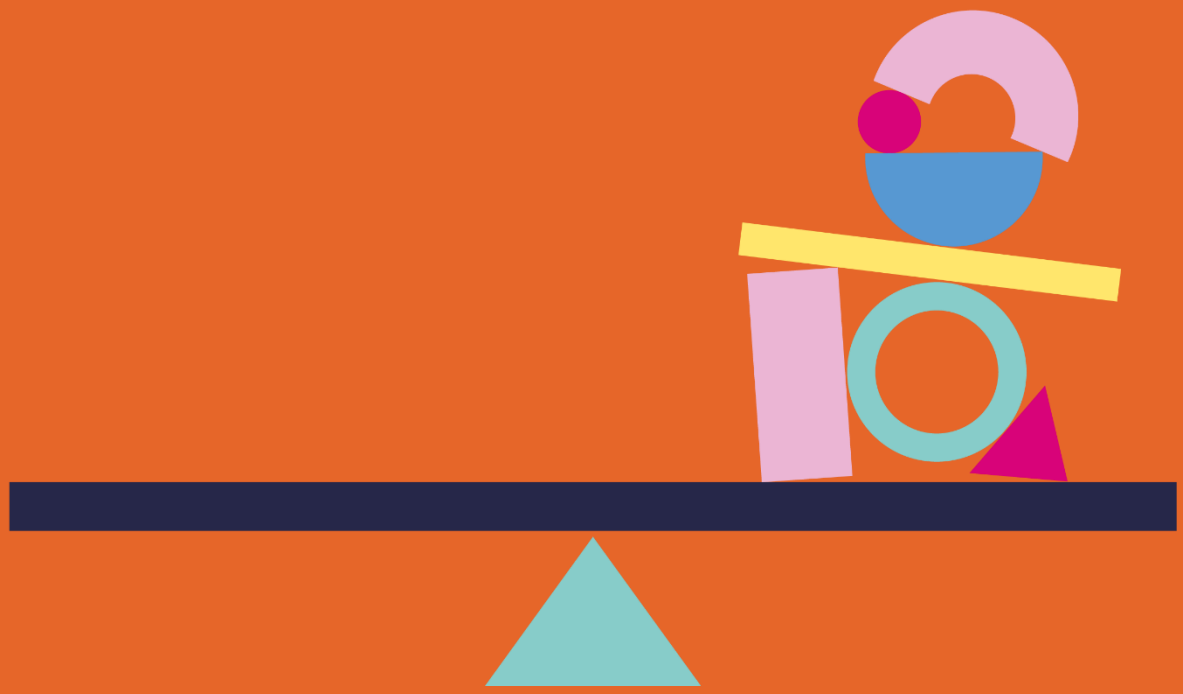
Justice and Care

Where the justice system meets the 'care system': Evidence for improvement



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1. Introduction

Background

In May 2019, as part of the Journey Stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a rapid review approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[422]

Aim of this review

The aim of this review was to answer the following questions:

- What evidence is available about children and young people's experiences at the point where the justice system interacts with the 'care system'?
- What do we know about how the justice system contributes to children and young people going into care?

[422] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

- What do we know about the ways that the 'care system' can contribute to the criminalisation of children and young people?
- What are the implications for children and young people of having a criminal record?
- How can the 'care system' and justice system work better together in the best interests of children and young people in Scotland?

The approach to answering these questions has been informed by consultation with the Care Review Justice workgroup. Thus a decision has been taken to focus on three specific issues of interest to the group, where children and young people with significant welfare needs come into direct or indirect contact with the justice system. These issues concern:

1. The unnecessary criminalisation of children and young people in care.
2. Inconsistencies in the way in which 16 and 17 year old offenders are dealt with by the justice system.
3. The imprisonment of parents.

The second point above will touch upon certain specific aspects of the way in which the children's hearings system operates with respect to 16 and 17 year olds. However, this review does **not** discuss wider aspects of the operation of the children's hearings system.[423]

Some aspects of this review will relate specifically to children and young people in care (or care leavers) (point one). Other aspects (points two and three) concern both looked after and non-looked after children.

Structure of the report

The report is structured as follows:

[423] The Scottish Children's Reporter Administration (SCRA), which is responsible for the operation of the children's hearings system, is involved, through the Children Hearings Improvement Partnership (CHIP), in a programme of continuous improvement informed by ongoing research.

- Section two places this evidence review in the context of findings from the Discovery stage of the Care Review.
- Section three presents information about young offenders in Scotland and an overview of what happens when a young person commits an offence.
- Section four presents evidence on the unnecessary criminalisation of children and young people within (and by) the 'care system' and considers ways that the 'care system' and justice system could respond more appropriately to offending and challenging behaviour by young people in care.
- Section five discusses an anomaly in the way in which 16 and 17 year old offenders are dealt with in the justice system in Scotland, the implications of this anomaly for this group of vulnerable young people, and how it can be addressed.
- Section six looks at the issue of parental imprisonment, the impacts of this on children and young people in Scotland, and what can be done to ensure that the needs of children and young people are considered when sentencing offenders who have dependent children.
- Finally, Section seven provides some concluding remarks.

2. What the Care Review has learned so far

This section summarises the main findings from the Discovery stage of the Care Review in relation to the issue of care experienced children and young people's contact with the criminal justice system.

These findings were that:

- In relation to the issue of 'justice and care', the 1000 Voices report (2018) identified themes in relation to: (i) experiences of the children's hearings system; (ii) the need for early intervention and prevention; (iii) experiences of secure care; (iv) the transition between secure care and prison; (v) experiences of the courts; (vi) experiences of restraint and solitary confinement; (vii) stigma, blame and criminalisation; (viii) experiences of prison vs secure care; (ix) the importance of looking to the future; (x) the need for access to reliable data; and (xii) the need for cohesive legal and regulatory processes. Children and young people with experience of the children's hearings system, secure accommodation and young offenders institutions highlighted the importance of placement decisions being made fairly, based on accurate information and for the right reasons. Some young people expressed the view that young people in care were being criminalised for behaviours which they would not get into trouble for if they were living at home.
- The review carried out by Baker (2017) did not directly address the issue of offending among children in care, or more generally, children and young people's involvement in the justice system. It did, however, provide some information about the views of young people in secure care.[424]

[424] Note that the issue of secure care will not be covered in this review.

- The CELCIS statistical overview report (2017) noted that robust data on the link between care experience and experience of prison is limited. However, data from a range of sources suggest that the proportion of the prison population with care experience is substantial. Specifically, the Prison Reform Trust (England and Wales) found that 25% of prisoners in 2015 reported that they had been in care at some point in their childhood. In Scotland, the figures appear to be higher. In 2015, the Scottish Prison Service recorded 31% of adult prisoners as having 'care experience'. A similar proportion of those in Polmont Young Offenders Institute reported having care experiences.
- A range of Care Review intentions (including intentions relating to relationships, the protection of children, decision-making and planning) are relevant in the context of the interaction of the 'care system' with the justice system.

3. Young offenders in Scotland

This section presents information about young offenders (under 18) in Scotland, and what we know about the characteristics of children who offend. A brief summary of what happens when a child commits a crime in Scotland is also provided.

How many children and young people in Scotland are offenders?

In 2017/18, 3,060 children and young people (under 18) were referred to the Children's Reporter in Scotland on offence grounds. This figure represents 23% of all referrals made to the reporter in that year, and it includes 1,088 children and young people who were referred on both offence and non-offence (care and protection) grounds.[425]

Over the past decade, there has been a dramatic reduction in offending by children and young people in Scotland.[426] Offence-related referrals to the Children's Reporter, court prosecutions and sentences have all followed the same downward trend:

- 3,060 children were referred to the Children's Reporter on offence grounds in 2017/18, a 78% decrease since 2007-08, but a 2.2% increase from 2016/17.[427]
- 2,203 young people aged 12-18 were prosecuted in Scotland's courts in 2015/16, a 78% reduction since 2006/07.[428]

[425] Scottish Children's Reporter Administration (2018) *Statistical analysis 2017/18*. See https://www.scra.gov.uk/wp-content/uploads/2018/07/Full-statistical-analysis-2017-18.pdf - access June 2019.
[426] Inspectorate of Prosecution in Scotland (2018) *Thematic report on the prosecution of young people*.
[427] Scottish Children's Reporter Administration (SCRA) (2018) *Statistical analysis, 2017/18*. See https://www.scra.gov.uk/wp-content/uploads/2018/07/Full-statistical-analysis-2017-18.pdf - accessed June 2019.
[428] Youth Justice Improvement Board (2017) *Children and young people in custody in Scotland: Looking behind the data (REVISED June 18)*. See https://www.cycj.org.uk/resource/children-and-young-people-in-custody-in-scotland-looking-behind-the-data/ - accessed June 2019.

- 51 young people under the age of 18 were detained in custody in 2016/17, a 77% reduction since 2006/07.[429]

These trends have been attributed to a combination of factors, including changes in young people's behaviour; environmental and technical changes affecting the prosecution of the sorts of low level crimes that young people have traditionally been involved in; changes in support available to young people; and changes in the types and levels of response from the justice system.[430] Nolan *et al* (2018) highlights the significant shift in policy and attitudes towards young people who are involved in offending in Scotland which has taken place in the past decade. This shift has been characterised by a move **away** from the punitive approach that was prevalent in Scotland (and elsewhere in the UK) in the late 1990s and 2000s which resulted in rising custody rates and an increasing focus on anti-social behaviour; and a move **towards** a more holistic approach to addressing young offenders' needs, vulnerability and behaviour – where possible with minimal formal intervention and maximum diversion to programmes outside the criminal justice system.[431] The latter approach is embodied in the Scottish Government's current policy framework, the 'Whole System Approach' (WSA).[432]

Under the WSA, there is an emphasis on managing the behaviour presented by high-risk young people safely and cost-effectively in their communities – with custody being seen as a last resort. In relation to the very small number of young people who cannot be managed safely in their communities, preference is given to the use of secure care rather than imprisonment in a young offenders' institution (YOI). Nolan *et al*

[429] Ibid.
[430] Ibid.
[431] Nolan D, Dyer F and Vaswani N (2018) 'Just a wee boy not cut out for prison': Policy and reality in children and young people's journeys through justice in Scotland. *Criminology and Criminal Justice, 18(5):* 533-547.
[432] See Scottish Government: Whole system approach to young offending, https://www.gov.scot/policies/youth-justice/whole-system-approach/ - accessed June 2019.

(2018) comments that *'while both facilities deprive a child of their liberty, secure care establishments are based on different values to a YOI, providing more relationship-based and therapeutic trauma and attachment informed support'*.

While published statistics indicate that Scotland is prosecuting fewer young offenders than previously, nevertheless, the rate of prosecution and imprisonment of young people in Scotland continues to be higher than in most other European countries.[433] In addition, this group of young offenders includes a disproportionate number of looked after or formerly looked after children and young people.[434]

[433] Inspectorate of Prosecution in Scotland (2018) *Thematic report on the prosecution of young people*. See https://www.gov.scot/publications/thematic-report-prosecution-young-people/ - accessed June 2019.
[434] Youth Justice Improvement Board (2017) *Children and young people in custody in Scotland: Looking behind the data (REVISED June 18)*. See https://www.cycj.org.uk/resource/children-and-young-people-in-custody-in-scotland-looking-behind-the-data/ - accessed June 2019.

What do we know about children in Scotland who offend?

There is a large body of evidence which shows a strong link between adverse childhood experiences (ACEs) and offending by young people.[435,436,437,438,439] Young offenders (especially violent offenders) are more likely than their non-offending peers to have experienced emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, domestic violence, household substance misuse, household mental illness, parental separation / divorce and / or the imprisonment of a member of the household. One Scottish study cited research which found that more than one-third of the boys and half of the girls in a secure care unit had experienced six or more of these issues.[440]

A review carried out by the Youth Justice Improvement Board (2017) explored the lives of children and young people involved in offending in Scotland. This review cited evidence from the Edinburgh Youth Transitions and Crime study that 15-year olds involved in violent offending in Scotland were significantly more likely than their non-violent peers to:

- Be victims of crime and adult harassment
- Be involved in self-harming and para-suicidal behaviour
- Have problematic health risk behaviours
- Have weak bonds (with parents and at school)

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[435] Bellis M, Ashton K, Hughes K, Ford K, Bishop J and & Paranjothy S (2015). Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population. Cardiff: Public Health Wales.
[436] Reavis JA, Looman J, Franco KA and Rojas B. (2013). Adverse childhood experiences and adult criminality: How long must we live before we possess our own lives? *The Permanente Journal, 17(2),* 44.
[437] Levenson JS, Willis GM and Prescott DS (2016) Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. *Sexual Abuse, 28(4),* 340-359.
[438] Baglivio MT, Epps N, Swartz K, Huq MS, Sheer A and Hardt NS (2014) The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice, 3(2).*
[439] Fox BH, Perez N, Cass E, Baglivio MT and Epps N (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child abuse & neglect, 46,* 163-173.
[440] Youth Justice Improvement Board (2017) *Children and young people in custody in Scotland: Looking behind the data.*

- Have personality issues (particularly impulsivity and risk taking)
- Have been involved in bullying others
- Have experienced family turbulence and social deprivation
- Have friends involved in offending.[441]

Other evidence cited in this review related to a study of 103 young offenders at Polmont Young Offenders Institution (YOI). This study found that three-fifths of young people who were interviewed reported that their family had been involved with the children's hearings system and one-third (33%) reported being removed from their family and placed in supported accommodation.[442] Participants in this study reported that they had been exposed to multiple types of trauma, including sexual abuse (10%), physical abuse (15%), fear that they or someone close to them might be badly hurt (58%), being physically assaulted / injured in their community (64%), being threatened with a weapon (76%), witnessing serious violence in their neighbourhood (74%) and witnessing violence in their home (22%). A third of the young men in this study reported that they had experienced a head injury and a fifth reported two or more head injuries. Of those who had experienced a head injury, almost a quarter said that this was received in a fight (involving bricks, bottles, baseball bats, golf clubs, hammer, etc.).

There is also a strong association between offending as a young person and childhood deprivation and exclusion. The Edinburgh Study of Youth Transitions and Crime identified school exclusion, in particular, as one of the strongest predictors of future offending. Children who had been excluded from school before the age of 12 were four times more likely than their non-excluded peers to be imprisoned by the age of 22.[443]

[441] Ibid.
[442] Ibid.
[443] Youth Justice Improvement Board (2017) *Children and young people in custody in Scotland: Looking behind the data.*

This evidence clearly indicates that there are significant welfare needs among children and young people who offend.

What happens when a child commits a crime in Scotland?

The legal framework which governs the prosecution of young offenders in Scotland is complex. However, a summary of the process has been provided by the Inspectorate of Prosecution in Scotland (2018).[444] In relation to **children under 16,** current legislation provides that:

- No child **under the age of 12** can be prosecuted.[445] Any offending behaviour for a child under 12 is dealt with through:
    - The application of Early and Effective Intervention (EEI) (a key element of the Whole System Approach)
    - Police direct measures[446] (i.e. the matter is dealt with directly by the police without referral to anyone else), or
    - The children's hearings system if compulsory measures may be required.
- Children **aged 12 to 16** can be prosecuted in accordance with the relevant guidelines from Scotland's Lord Advocate.[447] These state that:
    - Children should only be **jointly reported** to the Procurator Fiscal and the Children's Reporter if the offence is so serious it will normally give rise to solemn proceedings or, for children

[444] Inspectorate of Prosecution in Scotland (2018) *Thematic report on the prosecution of young people*. Scottish Government. See, in particular, pages 15-17.
[445] Criminal Proceedings (Scotland) Act 1995, section 41A. Note that section 40 of the 1995 Act states that no child under the age of eight may be guilty of an offence. This provision is currently being amended by the Scottish Parliament to raise the age of criminal responsibility to 12.
[446] Police direct measures include verbal or written warnings, or restorative justice. See Inspectorate of Prosecution in Scotland (2018) *Thematic Report on the Prosecution of Young People*.
[447] Specifically, *Lord Advocate's Guidelines to the Chief Constable on the Reporting to Procurators Fiscal of Offences Alleged to have been Committed by Children,* March 2014. See https://www.copfs.gov.uk/images/Documents/Prosecution_Policy_Guidance/Lord_Advocates_Guidelines/Lord%20Advocates%20Guidelines%20offences%20committed%20by%20children.pdf – accessed June 2019.

aged 15 and above, where the offence may result in disqualification from driving. Otherwise, the police may use direct measures, EEI, or submit a report to the Children's Reporter.

- Children in this age group can be prosecuted only on the instructions of the Lord Advocate or at his / her instance (if the authority to do so has been delegated).

The legal framework governing the prosecution of young offenders, **aged 16 and 17**, is complex and is discussed in Section five of this report. Annex one of this report provides a graphical representation of the possible criminal justice responses when a child in Scotland commits a crime.

What are the implications for a child or young person of being convicted of a crime in Scotland?

Having a criminal record as a child or young person has far-reaching consequences which, in some cases, can last far into adulthood. This is because of the (now) relatively common use of criminal record checks by prospective employers and others.[448]

Any individual (including a child) convicted of a crime in Scotland has to go through a period of 'rehabilitation'. The more serious the crime, the longer the period of rehabilitation. The length of the rehabilitation period is set out in the Rehabilitation of Offenders Act 1974.[449] Once the period of rehabilitation is over, the individual's conviction is 'spent'. Under current legislation, any conviction resulting in a prison sentence of more than 30 months will never be spent.[450] However, if the individual was aged under 18 at the date of conviction, they are subject to rehabilitation periods that are

[448] Criminal record checks and the Protecting Vulnerable Groups Scheme is managed by Disclosure Scotland - https://www.mygov.scot/disclosure-types/ - accessed June 2019.
[449] Rehabilitation of Offenders Act 1974. See https://www.legislation.gov.uk/ukpga/1974/53 - accessed June 2019.
[450] McCallum F (2018) *Management of offenders (Scotland) Bill.* SPICe Briefing, Scottish Parliament.

half those for people aged 18 and over, although the same rule applies for under-18s sentenced to prison for more than 30 months.

In general, when a conviction is spent, the individual who committed the offence is no longer required to mention it when asked by a prospective employer if they have ever had any convictions. However, in certain situations and for certain jobs – where a higher level of disclosure is required – the individual is still required to disclose their history of offending to a prospective employer even if their conviction has been spent.

The requirement to self-disclose previous offending for long periods of time after the original offence can have an ongoing impact on people's ability to gain employment, attend university or college, volunteer, get an apprenticeship or get insurance or a bank account.[451]

Higher level disclosure checks are required for anyone who wants to work as (for example) an accountant, a solicitor, or a care home assistant.[452] In addition, certain types of higher education courses will require high level disclosure checks including those in nursing, early childhood studies, social care and medical sciences. Some voluntary roles (i.e. those involving work with children or vulnerable adults) also require high level disclosure checks.

There is a large body of evidence which shows that people can and do stop offending, and that employment is a key factor in this.[453] Furthermore, in general, people commit less crime as they age – although the relationship between age, (un)employment, offending and desistance is complex.[454]

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[451] McCallum F (2018) *Management of Offenders (Scotland) Bill.* SPICe Briefing. Scottish Parliament.
[452] Young Scot website. *How a criminal record impacts your life.* See https://young.scot/get-informed/national/how-a-criminal-record-impacts-your-life - accessed June 2019.
[453] Weaver E (2018) Time for policy redemption? A review of the evidence on disclosure of criminal records. Scottish Centre for Crime and Justice Research. See: https://strathprints.strath.ac.uk/64981/ - accessed June 2019.
[454] Ibid.

While it is clear that employment has an important role in supporting desistance from offending, there are nevertheless many obstacles for people with convictions accessing and sustaining employment – chief of which is the stigma of having a criminal record and the associated vetting and disclosure practices.[455]

Given these issues, and evidence which suggests that over one-third of the adult male population and one-tenth of the adult female population in Scotland are likely to have at least one criminal conviction,[456] the Scottish Government is currently in the process of reforming the legislation which governs rehabilitation periods.[457] The Management of Offenders (Scotland) Bill aims to (i) reduce the length of time most people with convictions have to disclose their offending history, (ii) bring more people within the scope of protections not to disclose, and (iii) make the rehabilitation regime more transparent and easier to understand. It does not, however, seek to make any changes to current arrangements under which spent convictions are required to be disclosed.[458] An analysis of responses to a public consultation on the proposals found broad support for reform in this area.[459]

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[455] Weaver E (2018) Time for policy redemption?
[456] McGuinness P, McNeill F and Armstrong S (2013) *The use and impact of the Rehabilitation of Offenders Act 1974. Final report. Report No. 02/2013.* Scottish Centre for Crime & Justice Research. See http://www.sccjr.ac.uk/wp-content/uploads/2013/07/SCCJR-ROA-Final-Report-26-June-2013.pdf – accessed July 2019.
[457] Management of Offenders (Scotland) Bill.
[458] McCallum F (2018) *Management of Offenders (Scotland) Bill.* Table 2 of this report summarises how the rehabilitation and disclosure periods will change for children and young people who were under 18 at the time of conviction.
[459] Platts A and Griesbach D (2015) *Consultation on the Rehabilitation of Offenders Act 1974. An analysis of responses.* See *https://www2.gov.scot/Resource/0049/00491532.pdf - accessed June 2019.*

4. The criminalisation of looked after children and young people

This section explores the ways in which processes and practices within the 'care system' contribute to the criminalisation of children and young people.

Findings are presented from research in England and Wales which found that looked after young people – especially those living in residential care – are more likely to come into contact with the criminal justice system than their non-looked after peers. Young people's experiences of this issue are discussed, and the end of this section highlights ways that the 'care system' and the police can (separately and together) respond to offending and / or challenging behaviour among children and young people in care in a way that criminalises them less.

Why is this issue important?

There has been a longstanding concern about the disproportionate representation of care experienced children and young people in the criminal justice system. There has been further concern that children and young people in care are more likely to be criminalised (i.e. to come to the attention of the police and receive a conviction, or be subject to a final warning or official police reprimand) for relatively minor offences, which would not attract such a response if they were committed by children living in their own homes.[460] This concern has been based mainly on recent research in England and Wales (discussed below). Evidence from Scotland (also discussed below) is more limited.

[460] Nolan D and Gibb J (2018) Mind the gap: Factors that can support responses to offending in residential child care and the challenges of implementation. *Scottish Journal of Residential Child Care, 17(3).* See https://www.celcis.org/files/2915/3717/6626/2018_Vol_17_No_3_Nolan_D_Gibb_J_Mind_the_Gap.pdf - accessed June 2019.

This issue is important because of the consequences of having a criminal record on children's future life chances (as discussed in Section three).

The experience of England

In England, around one percent of all children and young people are looked after by the local authority. However, for children and young people aged 15-18 in custody in England, around one third of boys (33%) and three-fifths of girls (61%) are 'care experienced'.[461] This shows a striking over-representation of those with care experience in custody.

Between 2016 and 2018, the Howard League published a series of reports about the unnecessary criminalisation of children living in children's homes in England. These reports highlighted that:

- Looked after children living in children's homes are coming into contact with the criminal justice system at excessively high rates compared to all other groups of children, including those in other types of care.[462] Children aged 16 and 17 living in children's homes are at least 15 times more likely to be criminalised than children of the same age living elsewhere.[463]
- Staff in children's homes call out the police frequently, often over minor incidents which would never come to police attention if they took place in family homes.[464]
- Many calls to the police from children's homes related to children who were 'missing' or 'absent' from the home. Children looked after in children's homes are more likely to go missing from their placement than from any other type of placement. This behaviour is

[461] Staines J (2016) *Risk, adverse influence and criminalisation. Understanding the over-representation of looked after children in the youth justice system.* Prison Reform Trust. See http://www.prisonreformtrust.org.uk/Portals/0/Documents/risk_adverse_influence_criminalisation_lit_review_lo.pdf - accessed June 2019.
[462] Howard League for Penal Reform (2016) *Criminal care. Children's homes and criminalising children.*
[463] Howard League (2017) *Ending the criminalisation of children in residential care. Briefing one.*
[464] Howard League (2016) *Criminal care.*

often linked to the distance between the care home and the child's own home, family and friends.[465, 466]

- Seventy-one per cent of children living in children's homes who were criminalised in 2015/16, for whom data are available, were found to have emotional and behavioural health problems that were of borderline or actual concern.[467]
- Seventy per cent of children who were criminalised in children's homes 2015/16 had been taken into care because of acute family stress, family dysfunction, parental illness / disability or absent parenting. An additional 14 per cent were taken into care primarily because of abuse or neglect.[468]
- Exposure to the criminal justice system affects the already damaged life chances of these highly vulnerable children.[469]

This situation in Scotland

In Scotland, there are no official statistics available about the responses of residential childcare institutions to offending and challenging behaviour among young people in their care. This issue has also received relatively less research attention in Scotland.[470]

What is clear, however, is that Scotland has a very different context to England. In Scotland, most residential childcare homes are operated by local authorities rather than outsourced and run by the private sector as they are in England. This has been reported to support better levels of co-operation between homes and social services, and in the opportunities for

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[465] Ibid.
[466] Repeated police-led missing person investigations can result in children being stigmatised and criminalised for what is generally seen as typical behaviour among their non-looked after peers. See McIver L and Welch V (2018) *Just out having a good time? Evaluation of the pilot National Partnership Agreement for looked after children who go missing from residential and foster care in Scotland*. See https://strathprints.strath.ac.uk/65980/ - accessed July 2019.
[467] Howard League (2017) *Ending the criminalisation of children in residential care*.
[468] Ibid.
[469] Howard League (2016) *Criminal care*.
[470] Moodie K and Nolan D (2016) *'Between a rock and a hard place': Responses to offending in residential childcare*. Centre for Youth and Criminal Justice. See https://strathprints.strath.ac.uk/61203/ - accessed June 2019.

close multi-agency working.[471] In addition, children in Scotland are less likely to be placed far from home (and their home local authority), which helps for maintaining relationships and accessing services outside the children's homes.[472]

Nevertheless, there is also evidence to suggest that Scotland also has a serious problem with the unnecessary criminalisation of children living in residential care services. Research carried out by Moodie and Nolan (2016) in residential children's homes in two local authorities found:[473]

- In one of the local authorities, 43% of the children (n=18) living in children's homes came to the attention of the police during the six-month period of the study – with 71 recorded 'police incidents'. Forty-six percent (46%) of the incidents (n=33) that led to police contact took place within the home. Of these, 70% (n=23) resulted in the young person being charged. Incidents taking place within the children's home related to vandalism (33%), breach of the peace / threatening behaviour (31%), assault (17%), breach of bail (11%), drugs (5%) and taxi fraud (3%). Offences the young people were charged with for behaviour outside the children's home included theft (34%), breach of the peace / threatening behaviour (23%), violence (14%), vandalism (7%), carrying a weapon (7%), breach of bail (6%), drugs offences (5%), taxi fraud (2%) and sexual offences (2%). It was also found that most of offences where the police were involved were committed by just three young people.
- In the other local authority, 50% of the children (n=nine) living in children's homes came to the attention of the police (17 'police incidents'), with 88% of these contacts (n=15) relating to incidents taking place within the home.

[471] Howard League (2018) *Scottish experiences of children criminalised in residential care.* See https://howardleague.org/blog/scottish-experiences-of-children-criminalised-in-residential-care/ - accessed July 2019.
[472] Ibid.
[473] Moodie K and Nolan D (2016) 'Between a rock and a hard place'.

The way in which staff in children's homes respond to incidents is an important factor in determining whether or not children come into contact with the police. The study by Moodie and Noland mentioned above, included interviews with 27 residential staff in these children's homes, and found that decision-making processes when responding to offending behaviour were complex. They involved the application of protocols and professional judgement, which was shaped by the organisational culture and ethos, and the support available to staff.[474]

What do children and young people in the 'care system' say about this issue?

This review identified three qualitative research studies (all in England) which gathered the views and experiences of children and young people who had come into contact with the criminal justice system whilst in care over the past few years.[475, 476, 477] All these studies involved small samples of young people, all of whom had experience of multiple care placements (including within residential care) over a number of years. However, the messages across all three were broadly consistent.

Research carried out by Blades (2011) among 23 young people (eight girls, 15 boys) aged 13 to 17 found that there was no simple, universal answer to the question of whether and how much being in care impacts on the likelihood of offending. The young people in this study identified the

[474] Moodie K and Nolan D (2016) *'Between a rock and a hard place'*.
[475] Blades R, Hart D, Lea J and Willmott N (2011) *Care – a stepping stone to custody? The views of children in care on the links between care, offending and custody.* Prison Reform Trust. See http://www.prisonreformtrust.org.uk/Portals/0/Documents/careasteppingstonetocustody.pdf - Accessed June 2019.
[476] Howard League for Penal Reform (2018) *Ending the criminalisation of children in residential care. 'This is our story': Children and young people on criminalisation in residential care. Briefing four.* See https://howardleague.org/publications/this-is-our-story-children-and-young-people-on-criminalisation-in-residential-care/ - accessed June 2019.
[477] Prison Reform Trust (2016) *In care, out of trouble. How the life chances of children in care can be transformed by protecting them from unnecessary involvement in the criminal justice system. An independent review chaired by Lord Laming.* See http://www.prisonreformtrust.org.uk/WhatWeDo/Projectsresearch/CareReview - accessed June 2019.

following main risk factors which they believed would increase the likelihood of offending:

- Loss of or infrequent contact with friends and / or family
- Poor relationships with carers and social workers
- Challenging relationships with peers and / or peer pressure (in and outside of the 'care system').
- Type and number of placements (in particular children's homes and frequent placement changes)
- A lack of money.

Young people giving evidence to the Laming Review (2016) reported a broad variety of experiences. However,

> *'...many described feelings of frustration, anger and sometimes despair at having every significant aspect of their lives determined by a bureaucratic system, with a lack of consistent, long-term relationships with adults either within the system or independent from it, who could be trusted to care about them unconditionally, to prioritise their interests and represent them, to offer them practical and emotional support, and to listen and respond to what they want.' (Prison Reform Trust, 2016)*

Research conducted by the Howard League for Penal Reform (2018) involving four looked after young people (three girls and one boy) found that contact with the criminal justice system was often preceded by multiple experiences of rejection and the anger that arises from feelings of rejection. Frequent placement moves and other instabilities, such as changes of social worker and school, exacerbated these feelings. Young people explained that they needed to test the adults around them to see if they will be rejected again.[478] When the adults around them called the

[478] Howard League (2017) *Ending the criminalisation of children in residential care. Briefing one.* See https://howardleague.org/publications/ending-the-criminalisation-of-children-in-residential-care/ - accessed June 2019.

police, rather than providing support and acceptance, this simply compounds the young person's feelings of rejection.

How can the 'care system' and the justice system work together to prevent the criminalisation of children in care?

In a review of the literature commissioned by the Prison Reform Trust, Staines (2016) identified that the key elements for achieving positive outcomes for looked after children and preventing the criminalisation of children in care related to placement stability, involvement in education (and possibly extra-curricular activities), promoting resilience, capitalising on the protective capacity of relationships – not just with caregivers but also relatives, friends, professionals such as social workers, Youth Offending Team workers, teachers and activity leaders, and timely and appropriate leaving care provision.[479] The evidence suggested that, if looked after children do not receive sensitive and committed care, or their behavioural or emotional problems overwhelm carers, then highly-targeted therapeutic and educational support is likely to be necessary to manage young people's behaviour effectively. Collaboration between professional systems – children's services, education, mental health support, substance misuse services, youth justice and so on – is essential to ensure that positive outcomes can be achieved.

The Howard League identified that improving practices in policing could help to reduce unnecessary criminalisation of looked after children.[480] These involved:

- Implementation of a child-focused policing strategy which treats children under the age of 18 as children first, rather than as offenders

[479] Staines J (2016) *Risk, adverse influence and criminalisation. Understanding the over-representation of looked after children in the youth justice system.*
[480] Howard League for Penal Reform (2017) *Ending the criminalisation of children in residential care. Briefing two: best practice in policing.* See https://howardleague.org/publications/ending-the-criminalisation-of-children-in-residential-care-briefing-two-best-practice-in-policing/ - accessed June 2019.

- Improved data collection and management which allows the police to better understand and monitor the issue
- Working in collaboration with children's homes to highlight issues and provide guidance, for example, on behaviour management and the parental responsibilities of the home
- Working in partnership with the relevant care regulator
- Taking steps to avoid all unnecessary interaction between children in care and the police which might contribute to a process of criminalisation.

The Howard League also highlighted the role that children's homes must play in this issue.[481] In particular, children's homes must:

- Consider the **emotional** needs of children by
  - Adopting a child-centred culture which is opposed to criminalisation
  - Making a commitment to good parenting (asking the question, 'Would this be good enough for my child?')
  - Creating a homely environment within residential care services
  - Listening to children and treating them with dignity and respect.
- Make improvements in the business side of running a home, including through
  - Robust matching and managing of moves to provide stable placements
  - Valuing, training and supporting staff
  - Developing protocols to prevent unnecessary use of the police.

[481] Howard League for Penal Reform (2018) *Ending the criminalisation of children in residential care. Briefing three: 'Hearts and heads' – Good practice in children's homes.* See https://howardleague.org/publications/ending-the-criminalisation-of-children-in-residential-care-briefing-three-hearts-and-heads-good-practice-in-childrens-homes/ - accessed June 2019.

In relation to the last point, it is worth noting that, in England, a new national protocol has recently been published by the UK Government Department of Education, the Home Office and the Ministry of Justice.[482] The protocol is aimed at local authority children's services, local care providers (fostering services, children's homes and other arrangements), police forces, Youth Offending Teams (YOTs), the Crown Prosecution Service (CPS) and HM Courts and Tribunal Service (HMCTS), local Youth Panel (Magistrates), and local health services including mental health. Its purpose is to encourage and provide a framework for these agencies to co-develop local arrangements to reduce the unnecessary criminalisation of looked-after children and care leavers.

Research carried out in Scotland has similarly identified a range of factors which can support good quality, consistent and confident decision making within residential child care services to avoid unnecessary contact with police.[483] These include:

- **Good relationships:** This includes relationships between residential care staff, and between practitioner and managers; relationships between residential care staff and the children in their care and their families; relationships between residential care services and the police, social work, health and education. Multi-agency working is essential.
- **A joined-up approach:** Each agency must have a clear understanding of their own role and responsibilities in responding to offending behaviour, which can be shared with other agencies. There must be a shared understanding of what each agency can do, what they cannot do, and what they can expect from each other.

[482] UK Government (2018) *The national protocol on reducing unnecessary criminalisation of looked-after children and care leavers*. See https://www.gov.uk/government/publications/national-protocol-on-reducing-criminalisation-of-looked-after-children - accessed July 2019.
[483] Nolan D and Gibb J (2018) Mind the gap: Factors that can support responses to offending in residential child care and the challenges of implementation. *Scottish Journal of Residential Child Care, 17(3).*

Other aspects of a joined-up approach include having a shared understanding across agencies about the needs and experiences of looked after children and the impact of criminalisation.

- **Agreed policies, protocols and principles:** Although it may be argued that the responses to offending and challenging behaviour within residential care homes should be individualised, and should be a matter of professional judgement, at the same time, the development of an agreed multi-agency set of goals and principles could help to inform responses in this area. Such principles might include that: (i) police contact is the option of last resort; (ii) no child is unnecessarily criminalised; (iii) any decision to contact the police is made in a thoughtful and considered manner; (iv) efforts are made to understand behaviour; (v) diversionary and de-escalation measures and restorative approaches are used where possible; and (vi) any children who are criminalised are given support through the justice process.
- **Positive organisational culture and ethos:** The culture and ethos of residential care homes for children should be positive, supportive, respectful and child-centred. This culture and ethos should be understood and shared by all staff. Children should be provided with a caring, safe, calm, nurturing, loving and therapeutic environment.
- **Data:** The need for better data on this issue was highlighted. A lack of locally and nationally collected and consistent data is hampering the ability to understand the extent to which looked after children in Scotland are criminalised, how this varies by gender, placement type, and other relevant factors (including the child's history of offending before entering care).

5. The treatment of 16 and 17 year olds in the justice system

This section discusses an anomaly in the way in which 16 and 17 year old offenders are dealt with in the justice system. It highlights that there are differences in the way young offenders of this age are treated, depending on whether or not they are already in contact with the children's hearings system when they commit an offence.

The reasons for these differences and their associated impacts – particularly in relation to the use of custody for 16 and 17 year olds – are discussed. Finally, this section considers how this issue may be addressed so that the 'care system' and the justice system work more effectively together to promote the best interests of **all** 16 and 17 year old children in Scotland.

Why is this issue important?[484]

Despite the progress made in the past decade in reducing youth offending, and despite the policy intentions of 'Whole System Approach' (discussed in section three of this report), there have been ongoing concerns about the number of young people under 18 who continue to be prosecuted and punished as adults within the criminal justice system.

Statistics published by the Scottish Government[485] indicate that:

[484] Much of the information provided in this section has been set out by N Hunter (Scottish Children's Hearing Administration) and R Gibson (Centre for Youth and Criminal Justice) in a report to the Children's Hearings Improvement Partnership (CHIP), dated 20 June 2018.

[485] Scottish Government (2017) *Preventing offending. Getting it right for children and young people. Progress report*. See https://www.gov.scot/publications/youth-justice-strategy-preventing-offending-getting-right-children-young-people/ - accessed June 2019.

- In 2016/17, 2,203 children and young people aged 12-17 were prosecuted in Scotland's courts.
- Of these, 20 (<1%) were under 16, and the remaining 2,183 (99%) were aged 16 or 17.
- On 31 May 2017, 46 under-18s were in custody.

Most young offenders in Scotland are dealt with through the children's hearings system. One of the fundamental principles of the children's hearings system is that children and young people who commit offences, and children and young people who need care and protection, are supported through the same 'system'.[486] The children's hearings system takes an integrated and holistic approach to care and justice, in which the child's best interests are the paramount consideration.

However, among 16 and 17 year old offenders, there is an inconsistency. **Some** are dealt with through the children's hearings system. **Others** are dealt with through the adult justice system. The reasons for this inconsistency and the implications of it are discussed below.

Why are there inconsistencies in the way 16 and 17 year old offenders are treated in Scotland?

Article One of the United Nations Convention on the Rights of the Child (UNCRC) defines a child as: '*...a human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier*'.

However, current legislation in Scotland defines 'a child' (and 'an adult') in a number of different ways for different purposes. For example, at age 16, a young person in Scotland is legally permitted to marry.[487] At age 16, a

[486] Children's Hearings Scotland: http://www.chscotland.gov.uk/the-childrens-hearings-system/

[487] Marriage (Scotland) Act 1977, section 1. Note that the UN Committee on the Rights of the Child has expressed concern about the legal age of marriage in Scotland – particularly with respect to the practice of forced marriage – and has encouraged the Scottish Government to amend existing legislation to restrict marriage to people over 18. See UN Committee on the Rights of the Child (2016) *Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland,* Section B, paragraph 19. CRC/C/GBR/CO/5.

young person may also serve in the armed forces – although he / she would require consent from a parent or other appropriate adult to do so up to the age of 18.[488] A young person in Scotland may not purchase cigarettes until their 18th birthday,[489] and furthermore, it is also illegal for an adult (defined as a person aged 18 or over) to smoke in a car where a child (defined as a person aged under 18) is present.[490]

More relevant for the purposes of this review, the Children's Hearing (Scotland) Act 2011 allows for a child to be referred to the Children's Reporter if:

- The child is in need of protection, guidance, treatment or control AND
- It might be necessary for a Compulsory Supervision Order (CSO) to be made in relation to the child.[491]

The definition of 'a child' for the purposes of the 2011 Act is a person **under the age of 16 or, if over 16**, a person subject to:

- A referral already under consideration
- Children's Hearing proceeding, or
- A Compulsory Supervision Order.[492]

It should be noted that the definition of a child set out in the 2011 Children's Hearings Act is not the same as that used in more recent legislation – the Children and Young People (Scotland) Act 2014 – with its wide-ranging provisions for the well-being of children, corporate parenting, etc. In the 2014 Act, a child is defined as a person under age 18.[493]

[488] Armed Forces (Enlistment) Regulations 2009, sections four and five.
[489] Tobacco and Primary Medical Services (Scotland) Act 2010, section four.
[490] Smoking Prohibition (Motor Vehicles)(Scotland) Act 2016, section four.
[491] Children's Hearings (Scotland) Act 2011, section 60.
[492] Children's Hearings (Scotland) Act 2011, section 199 (Meaning of 'child').
[493] Children and Young People (Scotland) Act 2014, section 97.

What are the implications of this issue for 16 and 17 year old offenders?

The inconsistencies in the way a 'child' is defined in these different laws give rise to an anomaly in the way 16 and 17 year olds are treated when they offend. Specifically, young people who commit a crime, aged 16 or 17, may be dealt with **either** within the children's hearings system **or** within the adult justice system, depending on whether they are already in contact with the children's hearings system when they commit a crime.[494]

There are two main difficulties with this. First, the adult justice system does not have the same focus on the **welfare** of the child that the children's hearings system has. This is a concern because of the evidence (discussed in section three) that offending among young people is closely linked to adverse childhood experiences, trauma and deprivation. Thus, some young people aged 16 or 17 (those who were not in contact with the children's hearing system when the crime was committed) do not have access to the same help and support that is available to others their age (who are already in contact with the children's hearing system).

Second, (as discussed in section three) the prosecution – and potential conviction – of a young person within the adult justice system has consequences for the young person that can persist far into adulthood – in terms of a having a criminal record and the associated impact of this on future educational or employment opportunities.

Findings from a study carried out by the Inspectorate of Prosecution in Scotland showed that, compared to young offenders who are still on a CSO (Compulsory Supervision Order) at age 16 or 17, those who are **not** on a CSO and who come in contact with the adult justice system at the age of 16 or 17 are more likely to face prosecution, more likely to be given a

[494] The legal framework governing the prosecution of children and young people is complex and will not be discussed here in detail. An excellent summary of this framework is provided by the Inspectorate of Prosecution in Scotland (2018) *Thematic report on the prosecution of young people*, page 16.

harsher sentence upon conviction, and less likely to have information about their background and family circumstances made available to the court:[495]

- 16/17 year olds not on a CSO were twice as likely to be prosecuted as 16/17 year olds subject to an ongoing CSO.
- Of those 16/17 year olds prosecuted in the sheriff summary and Justice of the Peace courts, the sentence imposed in 41% of cases could have been achieved by an alternative to prosecution.
- Compared to the police reports for offenders under 16 or 16/17 year olds who were subject to a CSO, there was a significantly higher percentage of police reports where no information was provided about the offender's individual or family circumstances or vulnerabilities for those not on a CSO.

This study also found that delays (by the police) in reporting or taking decisions when an offender is approaching their 16th birthday have the potential to create a different outcome for young people who are older by a few days or weeks.

At the same time, there have also been concerns that the children's hearings system may be deciding to terminate CSOs for some young people too early – i.e. **before** their 16th birthday. If the young person then goes on to offend **after** their 16th birthday, the effect of this – **if** it were occurring – would be that the young person would be prosecuted through the adult system, rather than continuing to be dealt with through the children's hearings system.

However, research carried out by the Scottish Children's Reporter Administration (SCRA) to examine whether CSOs were being terminated 'too early' concluded that there was little evidence to support this suggestion. The study found that, in fact, most young people (72%) on a

[495] Inspectorate of Prosecution in Scotland (2018) *Thematic report on the prosecution of young people.*

CSO at their 16th birthday **remained** on a CSO after their birthday – in each case because their social worker had recommended this.[496] For most of those whose CSOs were terminated **just before** their 16th birthdays, the reasons for this were that the young person (and their family) had agreed to continue to receive support on a voluntary basis and / or that the young person had addressed their problems. All of the young people whose CSOs were continued and three-quarters of those whose CSOs were terminated were recorded by SCRA as receiving on-going support from services after they were 16.

These findings from SCRA suggest that the children's hearing system is not **contributing** in any substantial way to the problem of 16 and 17 year olds coming into contact with the adult justice system. Rather, the legal definition of a child set out in the legislation governing the operation of the children's hearings system is the primary cause of this problem.

How can this issue be addressed?

The current legislative position has been described as 'confusing' and 'potentially contradictory' insofar as 16 and 17 year olds are concerned.[497] Hunter and Gibson (2018), in a report to the Child Protection Improvement Programme, note that the main change that would be required is an amendment to the definition of a 'child' in section 199 of the 2011 Act, to replace '16' with '18'. This change would:

- Enable any person, including a police officer, social worker, etc. to refer a young person to the Principal Reporter due to concerns over their welfare or behaviour if that young person is aged under 18.
- Require the Police to report to the Principal Reporter (or jointly report to the Procurator Fiscal and Principal Reporter) anyone up to

[496] SCRA (2017) *16 and 17 year olds in the Children's Hearings System. Decision making on continuation of Compulsory Supervision Orders past young people's 16th birthdays.* See https://www.scra.gov.uk/wp-content/uploads/2017/08/16-and-17-year-olds-in-the-Children%E2%80%99s-Hearings-System.pdf – accessed June 2019.
[497] Hunter N and Gibson R (2018) Report to the Children's Hearings Improvement Partnership.

the age of 18 years who is charged with an offence – unless the Police decide that an alternative option would be more appropriate (such as dealing with the matter through early and effective intervention protocols).

- Enable the Principal Reporter to refer anyone up to the age of 18 to a children's hearing.

Would this change affect any other legislation?

An amendment to the definition of a child in the 2011 Act would have effects on other existing legislation and legal guidance in Scotland.[498] In particular, the definition of a child in the Criminal Procedure (Scotland) Act 1995 would also need to be changed from under 16 to under 18. In addition, a change to the definition in the 2011 Act would mean that the provisions of section 49 of the Criminal Procedure (Scotland) Act 1995 (Reference or remit to children's hearing) would apply to anyone up to the age of 18 years, in the same way that it applies at present to someone up to the age of 16.

Changes may also be required to:

- Schedule one of the Criminal Procedure (Scotland) Act 1995 (some offences listed within Schedule one only apply when the victim of the offence is a child under the age of 17 years)
- Criminal Justice (Scotland) Act 2016 – rights of parents and relevant persons to be informed of Children's Hearings proceedings, treatment of children subject to interim or compulsory supervision
- Adult Support and Protection (Scotland) Act 2007
- Lord Advocate's guidelines on the use of Antisocial Behaviour Fixed Penalty Tickets
- Guidance relating to Police Scotland presence during Children's Hearings
- Rehabilitation of Offenders Act 1974

[498] Ibid

- Protection of Vulnerable Groups (Scotland) Act 2007.

Hunter and Gibson suggest that further detailed work to map the legal implications of changing the definition of a child in the 2011 Act would be required.

How would services be affected by a change in legislation?

Amending the 2011 Act would also have implications in terms of the resources required to support it.[499] In particular, there may be a significant impact on the workload of SCRA, Children's Hearings Scotland (who recruit, train and support children's panel members), and local authority social work services. Although the number of young people who will be affected by the change is relatively small, this is a very vulnerable group, and there would also likely be implications for the ongoing resourcing of relevant care and protection services provided by local authorities and their partners at a local level. There may also be implications for:

- The training of the workforce (both paid and volunteer)
- The design and delivery of appropriate, effective, age-relevant interventions for this older population.
- The capacity (and possible need for expansion) of residential and foster care services, secure care and other specialist facilities, and community-based youth support services – all of which may experience additional demand and require to be redesigned to fully meet the needs of a slightly older population.

At the same time, however, there may also be a reduction in demand for the adult services and resources which are currently provided to young people under 18. The number of under 18s serving custodial sentences and remand periods at Polmont YOI would also decrease.

[499] Hunter N and Gibson R (2018) Report to the Children's Hearings Improvement Partnership.

What would be the benefits of changing the 2011 Act?

Widening access to the children's hearings system to all 16 and 17 year olds would offer greater protection, guidance and care to a group of vulnerable young people some of whom are currently receiving very little support through the adult justice system.[500, 501] This change would also result in better alignment of the youth justice system with the UNCRC; with the Children and Young People (Scotland) Act 2014 and its underlying 'Getting It Right For Every Child' policy; and with a raft of other legislation that has a focus on the welfare and protection of children and young people, including the Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005; Sexual Offences (Scotland) Act 2009; the Trafficking and Exploitation (Scotland) Act 2015, the Criminal Justice (Scotland) Act, etc.[502]

In addition, it should be noted that this proposed change would also benefit young people at risk of abuse and / or exploitation, those with significant mental health issues, and those who are homeless. A child under 16 may be subject to a child protection investigation. Over the age of 16, these provisions no longer apply – even if a young person continues to be at risk of abuse, exploitation or serious harm. The Adult Support and Protection (Scotland) Act 2007 applies to young people over the age of 16 who are 'at risk' if they meet **all** of the following criteria: (a) unable to safeguard their own well-being, property, rights or other interests, (b) at risk of harm, **and** (c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.[503] This legislation allows

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[500] Youth Justice Improvement Board (2017) *Children and young people in custody in Scotland: Looking behind the data. (Revised June 2018)*. See https://www.cycj.org.uk/resource/children-and-young-people-in-custody-in-scotland-looking-behind-the-data/ - accessed July 2019.
[501] Inspectorate of Prosecution in Scotland (2018) *Thematic Report on the Prosecution of Young People*. See https://www.gov.scot/publications/thematic-report-prosecution-young-people/ - accessed July 2019.
[502] Hunter N and Gibson R (2018) Report to the Children's Hearings Improvement Partnership.
[503] Adult Support and Protection (Scotland) Act 2007, section 3.

local authorities to make inquiries about a person's well-being, property or financial affairs if the person is an adult at risk, and if the local authority may need to intervene to protect the person's interests.[504] However, in many cases, young people who may be considered at risk of abuse, exploitation or other harms do not meet the full criteria for statutory intervention.[505] The proposed change would mean that **all** young people between the ages of 16 and 18 who are at risk of abuse, exploitation or serious harm could be made subject to a child protection investigation, and have the benefit of greater access to protection, support and other services.

[504] Ibid, section 4.
[505] Hunter N and Gibson R (2018) Report to the Children's Hearings Improvement Partnership.

6. Parents in prison

This chapter addresses the issue of children who have a parent in prison. The scale of this problem and the significant negative impacts on children of having a parent in prison are discussed.

The views and experiences of children and young people who have (or have had) a parent in prison are reported, and evidence about ways of reducing the impacts of parental imprisonment on children and young people are discussed at the end of this chapter.

Why is this issue important?

This issue is important for the Care Review to consider, not only because parental imprisonment can result in some children being taken into care, but also because any decision by a court in Scotland to imprison an offender who has dependent children may result in a breach of the rights of those children.

The United Nations Convention on the Rights of the Child (UNCRC) provides for the right of a child to live with his / her parents unless it is not in the best interests of the child to do so (article nine), and for the child's right to be brought up by both his / her parents, if possible (article 18). In addition, article three requires that:

> *'[A]ll actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration' (UNCRC, article three)*

Given the evidence of serious adverse impacts on children of parental imprisonment (discussed below), concerns have been expressed about whether imprisoning parents – and particularly mothers – can be justified as being in the best interests of a child.

What is the scale of the problem?

It has been estimated that more children in the UK experience the imprisonment of a parent than a parent's divorce.[506] In Scotland, it is estimated that the imprisonment of a parent affects 20,000 children and young people every year.[507]

Findings from the Scottish Prison Service's 2017 Prisoner Survey (of all prisoners including remand prisoners, male and female, in custody at the time of the survey) found that nearly two thirds (62%) of prisoners taking part in the survey said they had children.[508, 509] Around a quarter (25%) of prisoners had one child, one in five (19%) had two children and one in five (18%) had more than two children. These figures had changed little since the previous survey in 2015.[510, 511]

The number of children affected by **maternal** imprisonment each year is not known, as this information is not systematically recorded. Recent research commissioned by the Prison Reform Trust in England and Wales (2018) estimated that 17,240 children in England and Wales are affected by

[506] Families Outside (2009) *Support and information for children affected by parental imprisonment*. See https://www.familiesoutside.org.uk/content/uploads/2017/11/families-outside-in-brief-4.pdf - accessed June 2019.
[507] Scottish Government (2017) *Justice in Scotland. Vision and Priorities*. See page 18. https://www2.gov.scot/Resource/0052/00522274.pdf - accessed July 2019.
[508] Scottish Prison Service (2017) *16th Prisoner Survey 2017 – Main Bulletin*. Available at: http://www.sps.gov.uk/Corporate/Publications/Publication-6399.aspx - accessed June 2019.
[509] The survey does not provide information about how old the children are.
[510] Scottish Prison Service (2015) *Prisoner Survey 2015*. Available at: http://www.sps.gov.uk/Corporate/Publications/Publication-4565.aspx - accessed June 2019.
[511] Note that the 2015 Prisoner Survey had a response rate of 55% of the total prison population in that year at the time of the survey. The 2017 Prisoner Survey had a response rate of 46% of the total prison population. As the prisoners who take part in the survey are self-selected, it is not clear the extent to which the reported proportion of parents in prison are representative of the wider prison population.

a mother going to prison each year.[512] There are no corresponding statistics from Scotland on the number of children who have a mother in custody.[513]

What is the impact on children of having a parent in prison?

It is acknowledged that, in certain situations, the removal of a dangerous or chaotic parent from the family home can have a positive and protective effect on that individual's children.[514, 515] However, much of the international research on this issue highlights the serious adverse impact that parental imprisonment can have on offender's dependent children.[516]

Children who have a parent in custody are at increased risk of poverty,[517] victimisation and criminal involvement.[518] Some may end up in the care of the state (particularly if the parent in custody is their mother).[519] The shame and stigma associated with their parent's crime and conviction may have severe psychological and developmental consequences.[520] The children of prisoners are three times more likely than their peers to suffer from mental health problems.[521] Children who have witnessed a parent's arrest may develop a post-traumatic stress response.[522] There is some evidence to

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[512] Beresford S (2018) *What about me? The impact on children when mothers are involved in the criminal justice system.* Prison Reform Trust. See: http://www.prisonreformtrust.org.uk/portals/0/documents/what%20about%20me.pdf – accessed June 2019.
[513] An estimate for Scotland could assume 10% of the figures for England and Wales – thus between 1,500 and 2,000 children. (Personal correspondence: Families Outside)
[514] Ibid.
[515] Loureiro T (2010) *Perspectives of children and young people with a parent in prison.* Scotland's Commissioner for Children and Young People and Families Outside. See https://www.familiesoutside.org.uk/content/uploads/2019/03/perspectives.pdf - accessed June 2019
[516] Millar H and Dandurand Y (2018) The best interests of the child and the sentencing of offenders with parental responsibilities. *Criminal Law Forum, 29:* 227-277.
[517] Dickie D (2013) *The financial impact of imprisonment on families.* Families Outside.
[518] Families Outside (2009) *Support and information for children affected by parental imprisonment.* See https://www.familiesoutside.org.uk/content/uploads/2017/11/families-outside-in-brief-4.pdf - accessed June 2019.
[519] Millar H and Dandurand Y (2018) The best interests of the child and the sentencing of offenders with parental responsibilities.
[520] Millar H and Dandurand Y (2018) The best interests of the child and the sentencing of offenders with parental responsibilities.
[521] Families Outside (2009) *Support and information for children affected by parental imprisonment.*
[522] Loureiro T (2010) *Perspectives of children and young people with a parent in prison.*

suggest that a father's imprisonment may be associated with early sexual activity (before age 15), particularly among boys.[523] Recent research has also demonstrated that children of imprisoned parents are significantly more likely to die prematurely than children of both non-criminal and criminal but non-imprisoned parents.[524]

Evidence about the effects of parental imprisonment on children seldom distinguishes between the parent as a father or a mother, and few studies draw direct comparisons between children's experience of having a mother in prison compared to a father. However, since, for most children, their mother is their primary carer, the imprisonment of a child's mother has a particularly significant impact.[525] A mother's imprisonment not only damages the child's relationship with her,[526] but can also affect the child's housing, education, health and wellbeing.[527, 528]

In England and Wales, it has been estimated that only 5% of children remain in their family home when a mother goes to prison.[529,530] As well as a change of home and carer, many children encounter other significant

[523] Turney K and Goldberg RE (2018) Paternal incarceration and early sexual onset among adolescents. *Population Research and Policy Review, 38(1):* 95-123.
[524] van de Weijer SGA, Smallbone HS and Bouwman V (2018) Parental imprisonment and premature mortality in adulthood. *Journal of Developmental and Life-Course Criminology, 4(2):* 148-161.
[525] Beresford S (2018) *What about me?*
[526] Besemer KL and Dennison SM (2018) Family imprisonment, maternal parenting stress and its impact on mother-child relationship satisfaction. *Journal of Child and Family Studies, 27:* 3897-3908.
[527] Families Outside (2009) *Support and information for children affected by parental imprisonment*
[528] Loureiro T (2010) *Perspectives of children and young people with a parent in prison.*
[529] Minson S (2017) *The sentencing of parents of dependent children.* Presentation to the Scottish Sentencing Council, 6 March 2017. See https://www.scottishsentencingcouncil.org.uk/media/1498/20170710-presentation-to-scottish-sentencing-council-dr-shona-minson.pdf - accessed June 2019.
[530] This figure of 5% is based on research undertaken by the UK Home Office in 1997: D Caddle & D Crisp (1997) *Imprisoned women and mothers: Home Office Research Study 162.* A summary of the main findings of this research are available at: http://www.birthcompanions.info/media/Public/Resources/Extpublications/Mothers_in_prison.pdf - accessed June 2019.

changes such as having to move school and being separated from siblings.[531]

What do children and young people say are the biggest impacts for them of having a parent in prison?

This review identified three qualitative research studies that sought to hear directly from children and young people who have experienced the imprisonment of a parent. Two of these studies were from Scotland[532, 533] and one from England / Wales.[534] All involved relatively small samples of children and young people, and some also involved interviews with carers (a non-imprisoned parent, grandparent, or other carer). There were some common themes in the views expressed by the children and young people across these studies.

All these studies highlighted the shock, anxiety, sadness, grief, stigma, lack of support and feelings of isolation that children and young people felt after their parent was sentenced to prison. Feelings of loss were common. Children and young people said that they not only lost a parent, they also lost friends, family members, financial income and a sense of belonging and identity. The social isolation experienced by some children and young people also affected their interest in school.

Because of the stigma associated with having a parent in prison, some children said they felt ashamed and felt they had to keep their parent's circumstances a secret from other people. Others said there was no one who asked them how they felt, and no one they could talk to, although some young people did feel there were people in their lives who supported

[531] Beresford S (2018) *What about me?*
[532] McGinley M (2018) *The impact of parental imprisonment: an exploration into the perspectives and experiences of children and young people affected.* Families Outside. See: https://www.familiesoutside.org.uk/content/uploads/2019/04/In-Brief-13-digital.pdf - accessed June 2019.
[533] Loureiro T (2010) *Perspectives of children and young people with a parent in prison*.
[534] Beresford S (2018) *What about me?*

them – and in this respect, grandparents often played a key role. At the same time, grandparents could not always entirely replace a parent.[535]

Some children were taken into care when their mother was imprisoned and, in some cases, this also involved the separation of siblings.[536]

Some children reported feeling worried about their imprisoned parent, or worried about their parent after they were released from prison.[537]

Finally, in all three of these studies, there were also children who said that there had been little or no impact in their lives as a result of a parent being imprisoned. In these situations, this was usually because the child did not live with the parent (usually the father, occasionally the mother) before that parent was imprisoned.[538]

One of the studies (Loureiro, 2010) asked children and young people if the court should listen to the feelings of children and young people regarding their parent's imprisonment. The most common view among the children and young people interviewed directly was that it was important for the judge to know what the children thought. The children and young people in this study suggested that they would want to speak to the judge directly, write a letter, or have their mother (non-imprisoned parent) speak for them.

How can this issue be addressed and improved?

There is widespread agreement among those calling for action in this area that the justice system must find ways to take into consideration the rights of children when sentencing individuals who have responsibility for the care of dependent children. Research, analysis and policy development on this issue have generally focused on two types of response. One response is to consider sentencing reforms – i.e. responses to adult offending which

[535] Ibid.
[536] Ibid.
[537] Loureiro T (2010) *Perspectives of children and young people with a parent in prison*.
[538] Ibid.

take better account of the welfare of any dependent children. The second (related) response is for the state to provide better information and support to strengthen the resilience of children and young people who are affected by parental imprisonment. Each of these is discussed briefly below.

Sentencing reforms

In relation to sentencing reforms, there has been a call for the justice system in Scotland to take more of a child-rights approach in the sentencing of parents who have been convicted of a criminal offence.[539] In particular:

- Under the UN Convention on the Rights of the Child, there is an international legal obligation on States Parties to take account of the best interests of the child when sentencing or taking pre-trial measures in relation to parents or primary carers.
- Best practice would be to ensure that:
    - This is mandatory (not merely guidelines) for courts / judges making such decisions;
    - Courts / judges have to set out in their decisions how they have done so; and
    - Failure to take account of the best interests of the child in such circumstances may be grounds to appeal such decisions
    - This requirement applies to all measures, not only in relation to custody (detention or imprisonment).

The scope should cover all parents and all sole or primary carers, given that the child has a right to maintain contact with both parents even when they are not acting as primary carers (provided it is not contrary to the

[539] Brett R (2018) *Best interests of the child when sentencing a parent. Some reflections on international and regional standards of practice.* Families Outside. See https://www.familiesoutside.org.uk/content/uploads/2018/05/Best-Interests-of-the-Child-when-Sentencing-a-Parent-UPDATD.pdf - accessed July 2019.

child's best interests to do so). How the child's best interests are affected will be different depending on the nature of existing relationship.

Suggested sentencing reforms could include:[540]

- Restricting the use of custody for children's primary caregivers.
- Amending statutory sentencing principles (either through legislation or formal guidance).
- Expanding or clarifying mitigating factors or reasons for departing from standing sentencing guidelines.
- Expanding diversionary options.
- Expanding the use of alternatives to imprisonment.
- Expanding gender-responsive alternatives to imprisonment.
- Restricting or eliminating the use of short sentences of imprisonment.
- Requiring family or child impact assessments.

It is worth noting that, in March 2017, the Scottish Sentencing Council hosted an event to explore this issue with stakeholders.[541] The Council agreed to give further consideration to four specific points in taking forward the development of future guidelines:

- How caring responsibilities should be taken into account during the sentencing process – whether as a mitigating factor, a factor to be considered alongside other offender and offence specific factors, or at a separate stage altogether;
- To what extent such responsibilities should influence sentencing decisions, particularly where separation of a child and their primary carer is a possibility;

[540] Millar H and Dandurand Y (2018) The best interests of the child and the sentencing of offenders with parental responsibilities. *Criminal Law Forum, 29:* 227-277.
[541] Scottish Sentencing Council (2017) Children and the sentencing of parents: report on discussion event with Scottish Sentencing Council. See: https://www.scottishsentencingcouncil.org.uk/media/1497/sentencing-of-parents-discussion-report.pdf - Accessed June 2019.

- How other jurisdictions have addressed this issue and the potential applicability of these approaches to Scotland;
- Whether there may be a role for the court in seeking additional information about children who may be affected by sentencing decisions, including whether any provision has been made for their care and welfare.

In June 2019 (at the time of writing this review), the Scottish Sentencing Council published a public consultation paper and a proposed draft guideline on the sentencing process.[542] The purpose of the consultation was to invite views on the draft guideline. Included with the draft guideline is a list of mitigating factors which (it is proposed) the courts should take into account when making sentencing decisions. The family circumstances of the offender are one of the mitigating factors in the list. This consultation closes on 6th September 2019, and therefore, there is opportunity for the Care Review to respond to this consultation.

Providing better information and support to children and young people

The organisation, Families Outside, has highlighted a range of other ways to better support children and young people affected by parental imprisonment.[543] These include:

- The development of age-specific information and resources to explain to children what is happening when a parent is imprisoned, and resources that carers can use to discuss imprisonment with children
- Training for youth workers in community projects and in schools to better understand the needs of children affected by parental imprisonment
- Provision of counselling / therapy

[542] Scottish Sentencing Council (2019) *The sentencing process*. See (https://consultations.scottishsentencingcouncil.org.uk/ssc/the-sentencing-process/) – accessed June 2019.
[543] Families Outside (2009) *Support and information for children affected by imprisonment*.

- The creation of child-friendly rooms in prisons for children visiting a parent in prison, with a support worker who can help children link to peers in similar situations
- Provision of advocacy support to children upon the arrest of a parent.
- Nursery and family units.

Other more indirect ways of supporting children are through mandatory parenting classes, family counselling, and preparation for release for parents in custody.

In general, studies have also emphasised the importance of **listening** to the child (and / or giving greater recognition to their well-being and best interests) – both during criminal proceedings, but also in cases where a parent will inevitably have to serve a custodial sentence due to the nature of the crime committed.[544, 545]

The evidence on this topic clearly indicates that much more can and should be done to ensure that the best interests of children and young people are considered when a parent is sentenced to prison.

[544] Beresford S (2018) *What about me?*
[545] McGinley M (2018) *The impact of parental imprisonment: an exploration into the perspectives and experiences of children and young people affected.*

7. Concluding remarks

This review has focused on three issues where children and young people with significant welfare needs come into contact with the justice system – either directly or indirectly. In all three, children and young people are not coming out particularly well as a result of these contacts.

Care-experienced young people are disproportionately represented in the criminal justice system. The reasons for this may (at least partly) be explained by findings in this review that children in care are being unnecessarily criminalised by the 'care system'. Addressing this issue requires that children's residential homes work closely with local authorities and the police to develop better responses to children and young people in their care when their behaviour is challenging. These responses should include (among other things) the prioritisation of relationships within the home and between the home and other agencies; joined-up, multi-agency working; and the development of a shared set of principles across agencies. Having a positive and supportive organisational culture and ethos which puts the child at the centre is also key. The development of better data (by children's homes and the police) is also needed.

This review has not looked in detail at the responses of care providers (i.e. residential homes and foster carers) when children in care go missing from their placements. However, it has highlighted that this situation is one where children are also coming into contact (in many cases unnecessary) with the police. Agreed multi-agency responses are likely to be required in

these situations as well, and recent work undertaken in Edinburgh, Dundee and South Lanarkshire may be instructive.[546]

In relation to 16 and 17 year old offenders in Scotland, inconsistencies in the way in which 'a child' is defined in Scots Law means that some vulnerable 16 and 17 year olds are getting the support they need through the children's hearings system, and some are not. Addressing this issue would require a change in legislation – in particular, the legislation which governs the children's hearings system. This may seem to be a relatively straightforward solution; however, it is likely to have significant implications for other legislation, and for the provision of services. Further work is required (and is currently ongoing) to understand these implications.

Children whose parents offend are often forgotten about in the justice system. Greater attention needs to be paid to the needs of this very vulnerable group. In particular, processes need to be put in place at sentencing to ensure that the sentence handed down to a parent does not have adverse consequences for their children. The solutions, here, are likely to involve sentencing reform and more consistent use of child impact statements. When a custodial sentence is handed down to a parent, services also need to be in place to help support and strengthen the resilience of children and young people affected by parental imprisonment.

The evidence presented in this review indicates that there is much that can be done to improve the points at which the 'care system' and justice system meet. Different responses will be necessary at different points to improve outcomes for children and young people in relation to each of the three issues discussed. The solutions, in all cases, however, involve giving greater consideration to the best interests of children.

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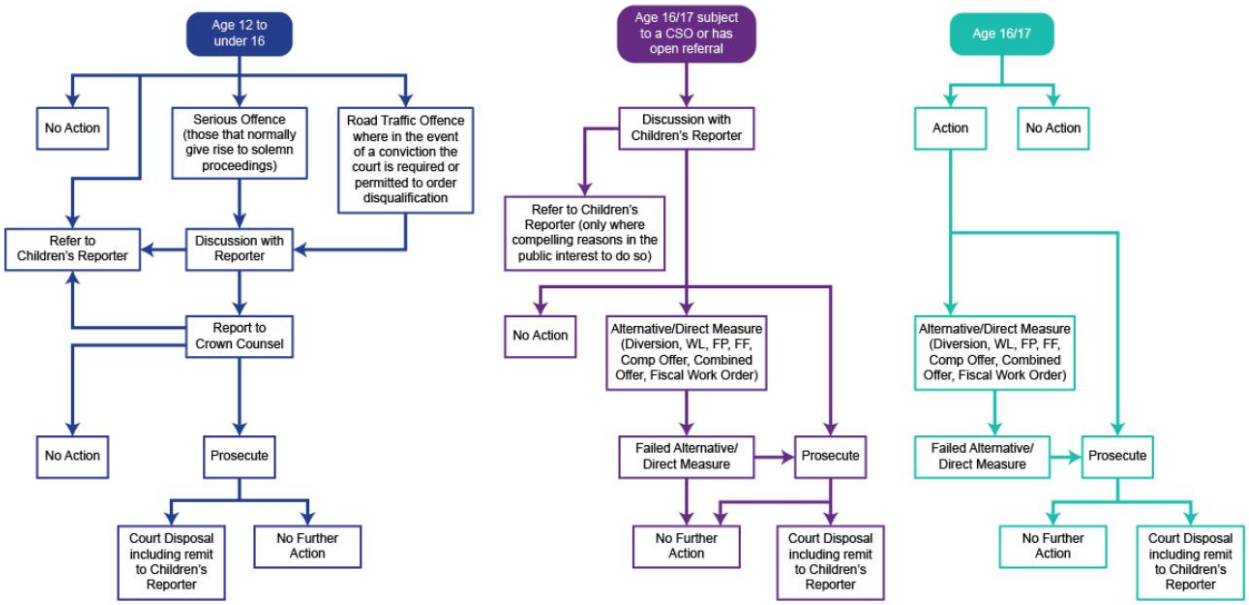
[546] McIver L & Welch V (2018) *Just out having a good time? Evaluation of the pilot National Partnership Agreement for Looked After Children who go missing from residential and foster care in Scotland.* See https://strathprints.strath.ac.uk/65980/

8. Appendices

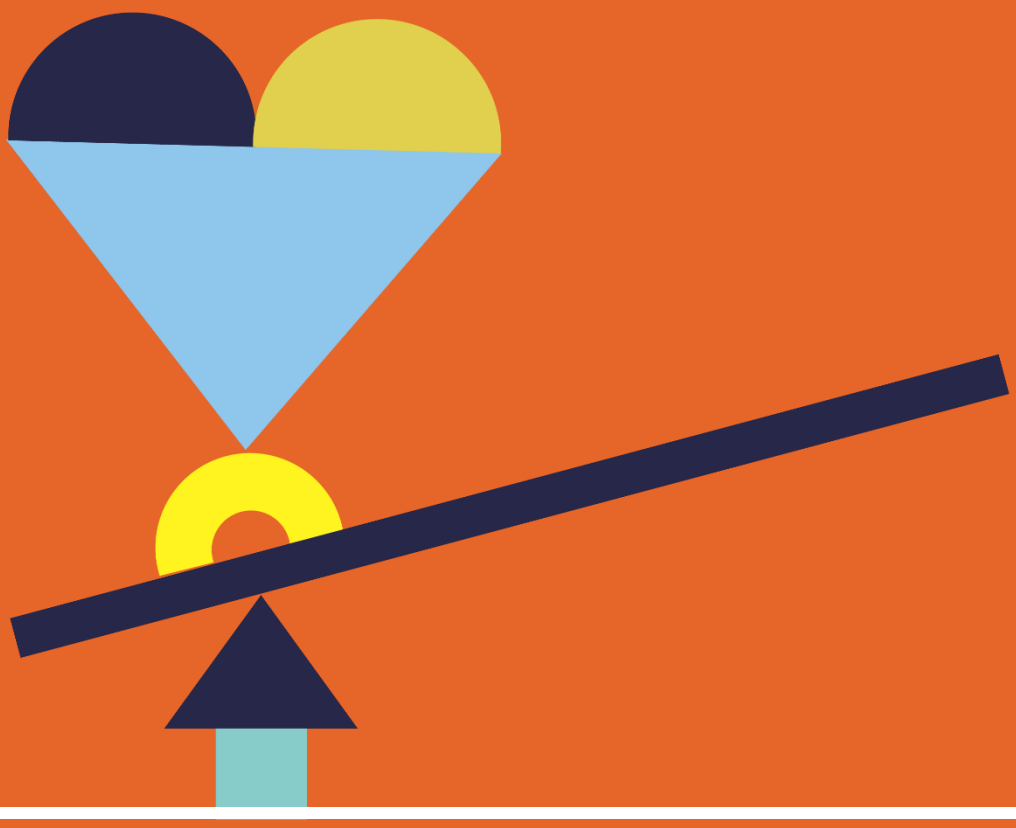
Annex One: What happens when a child commits an offence?



Source: Inspectorate of Prosecution in Scotland (2018) Thematic report on the prosecution of young people. See https://www.gov.scot/publications/thematic-report-prosecution-young-people/

Love

The experience of love for children and young people in care



A review of the evidence of what promotes a loving environment for children and young people in and beyond care

Jennifer Waterton, Claire Baker and Dawn Griesbach

July 2019

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1. Introduction

Background

In Spring 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[547]

The experience of love for children and young people in and beyond care

This report presents a review of the evidence in relation to the following questions:

> *What evidence is available on the experience of love for children in care? What do we know about (i) what promotes a loving environment for children in and beyond care? (ii) what are the barriers to providing a loving environment for children in and beyond*

[547] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

care? (iii) what can the workforce do to create the conditions to allow children to flourish?

Structure of the report

The report is structured as follows:

- Section two reports relevant findings from the Discovery stage of the Care Review.
- Sections three-five provide background, context and 'scene setting' material on why love in the 'care system' is important (Section three), what love in the 'care system' looks like (Section four), and the role of love in public policy (Section five).
- Sections six-seven examine the factors which promote and inhibit love in the 'care system'.
- Section eight contains some concluding thoughts.

2. Findings from the Discovery stage of the Care Review

The Discovery stage of the Care Review found that:

- The theme of love, and the importance of loving relationships to children and young people in care, was threaded throughout the comments offered by both care experienced people themselves and by the other groups of people consulted in the Discovery stage (parents, carers, families, paid and unpaid workers, and organisational stakeholders). (1000 Voices report, 2018)
- Love was described as a wide range of positive feelings children and young people experience through a caring relationship. For example, this included feeling safe, listened to, genuinely cared for, happy, hopeful, trusted and believed in, being treated the same as other children, belonging and being with family. (1000 Voices report, 2018)
- Children and young people said that experiencing (or not experiencing) love, affected their ability to give love and show love in their later lives. (1000 Voices report, 2018)
- Factors that helped to promote love in the 'care system' were seen to be: a workforce that genuinely cares and has the capacity to love; being able to show, sustain and protect the love they have with their birth families, especially their brothers and sisters; using the word 'love' and embedding love within the 'care system'; and the importance of belonging and a 'forever home'. (1000 Voices report, 2018)
- Looked after children considered that feeling loved and safe was essential for their well-being and future prospects; conversely, the lack of love and affection was seen to have a significant negative impact on looked after children's emotional well-being, especially their self-esteem. (Baker review, 2017)

- The reporting of the outcomes for looked after children are limited, and do not cover experience of 'love' or the availability of 'loving relationships'. (CELCIS, statistical overview report, 2017)
- Care Review intention: *Scotland's infants, children and young people will be nurtured, loved and cared for in ways that meet their unique needs.*

3. Why is Love important?

This section sets out the main arguments about why love matters for children and young people.

These cover: (i) looked after children's views of why love is important to them (ii) the role of love in aiding recovery from trauma and adverse child experiences (iii) the contribution of love to the emotional and social development of children and young people and (iv) the importance of loving relationships for the adult lives of care experienced children and young people.

Looked after children and young people say love is important to them

The Discovery stage of the Care Review took place between May 2017 and May 2018. Two of the elements of the Discovery stage – the 1000 Voices report and the Baker review – provided evidence about the extent to which looked after children say love is important to them.[548] Further evidence on this topic was provided in a review by Dickson et al (2009). Each of these evidence sources is described in further detail below.[549]

Discovery stage - 1000 Voices report (2018)

As set out in Section two above, looked after children and young people who contributed to the 1000 Voices report emphasised that the 'care system' had to have love at its heart.

[548] Note that, as a direct result of the frequent references to love throughout the Discovery stage of the Care Review, a workgroup specifically focused on love was established. The remit for this group (as well as the remits for the 'stigma' and 'rights' workgroups), crosscuts all Care Review activity and underpins the work of all the (nine) Care Review workgroups.

[549] Note that many of the points made in these three reports are also echoed in the 2015 literature review by Coram Voice and Hadley Centre for Adoption and Foster Care Studies https://coramvoice.org.uk/sites/default/files/Children's%20views%20lit%20review%20FINAL.pdf

The following voices, heard during the Discovery stage, illustrate the kinds of behaviours, actions and attitudes that were seen by children and young people as demonstrating 'love'.

> *'My person [name of person] believes in me completely. Always there for me. Don't get to see her often but I know that she loves me. I trust her with everything. She's my rock and has never judged me. Stood by me even in my darkest memories. She taught me how to trust again. Continually reminds me of how strong I am and gives me hope. Regardless of what happens I know I'll get through it. She loves me and it's the best feeling in the world.'*

> *'You feel loved. Carers want the best for you. Someone to talk to and someone who listens. Keep you from harm and make you feel safe. Someone who helps you understand the past and tells you you're not to blame.'*

> *'Social worker didn't care about professional boundaries. I knew that I mattered more than a rule book to her. She hugged me when I needed a hug. She was patient, kind and made time for me no matter how busy she was. She made sure that I knew I was loved. She championed me, believed in me. Told me every day how much I could achieve until I believed it myself.'*

Discovery stage - Baker literature review (2017)

Based on the accounts of looked after children, carers, parents and professionals, the Baker literature review identified six cross-cutting themes which were thought to be important in building 'the best 'care system''.[550] Two of these themes were particularly pertinent in relation to developing a 'care system' with love at its heart:

[550] The Baker review was based on a non-systematic examination of around 80 individual studies and research reviews from the UK.

- Trusting relationships – the best 'care system' identifies and nurtures the bonds that are important.
- Aspiration, love and feeling safe – the best 'care system' provides opportunities to grow and flourish.

The conclusions stated that 'the quality of the child's relationships was by far the most important influence on the quality of care, and the child's well-being and happiness' and that 'at the heart of much of what children talked about as essential for their well-being and future prospects was making sure children and young people felt loved and safe'.

Dickson et al review (2009)[551]

In a review about the experiences, views and preferences of looked after children and young people and their families and carers carried out by Dickson et al in 2009, a total of seven studies were found which talked directly about the importance of 'love'. This extensive review, based on the accounts of care experienced children and young people, and their families and carers found that:

- love and affection is desired by looked after children and young people but is often lacking in their lives;
- love, or the lack of it, has a significant impact on their emotional well-being, in particular their self-esteem;
- for some care experienced children and young people, training and payment for foster carers undermines the sense that they are wanted or loved, and
- an unmet need for love and affection is perceived by some looked after children and young people to have a profound and lasting impact on their future outcomes.

[551] The Dickson et al review was based on 50 studies and research reviews from the UK.

Love aids recovery from trauma and adverse childhood experiences

Many children in the 'care system' have experienced trauma, neglect, loss, grief, pain or other adverse circumstances and situations. There is a large literature on the impact these traumatic events have on the developing brain and body, including on cognition, language and identity, and on the long-term consequences of failing to address these (McLean 2016; Bremner, J.D. 2006). There is also a growing literature on the extent to which loving, supportive relationships can provide a buffer against this, although the therapeutic work is complex and difficult and takes time, commitment and resources (Evans, 2019; NHS Highland 2018[552]; Carter 2019[553]).

Love is crucial for the emotional and social development of children and young people

In a text for practitioners working with children, Kellmer Pringle (1996) identified the needs of (all) children as being: love and security, praise and recognition, new experiences and responsibility. According to Kellmer Pringle, these needs are the cornerstones of any young person's emotional development. In a much earlier text, Klein (1937) highlighted the importance of experiencing love for physical, emotional and social development, and to develop the ability to form healthy attachments. In another much-quoted paper, Honneth has argued that love is required for all human beings in order to develop into self-confident, fulfilled individuals (Honneth, 1995). Thrana emphasises the role that love plays in the development of youth identity and participation in society (Thrana, 2016).

Within the 'care system', Luke and Coyne (2008) argue that 'there is a basic human need to feel loved, wanted, accepted, warmth'. This is reinforced by

[552] https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_(web-version).pdf
[553] https://www.eventbrite.co.uk/e/love-vs-trauma-the-frontiers-of-healing-childhood-trauma-a-symposium-tickets-59754586577

Smith (2009) who argues that residential care needs to move beyond the dominant discourses of protection, rights and outcomes to embrace those of care and upbringing so that children can be helped to grow and develop through the establishment of personal relationships (although he does not specifically mention 'love' in this regard).

Thus, there is a wide literature on the importance of love in the positive social and emotional development of children and young people. The converse is also true – a lack of love can prevent or stunt development. For example, research carried out on Romanian orphans adopted in Britain showed that the lack of love in infancy for these orphans had a bigger (negative) impact on their development than the infants' physical neglect (Rutter et al, 2009). And as Luke and Coyne (2008) explain, if love and acceptance are missing in the 'care system', then there are likely to be problems with the outcomes for looked after children and young people in later life.

More broadly, many authors have commented on the importance of 'secure attachment relationships'[554] to the healthy emotional development of children. These relationships provide children and young people with skills, competence and capacity to regulate their own emotions, understand others and to form healthy relationships (Shemmings, 2011; Furnivall, 2011). In the absence of a 'secure attachment relationship', some children can find it difficult to trust adults in the face of previously negative and abusive encounters (Leeson, 2007; Munro, 2011; Winter, 2011). Furthermore, children and young people may have developed coping mechanisms that result in them not taking opportunities to form relationships through fear of rejection (Reimer, 2010; Care Inquiry, 2013).

[554] These 'secure attachment relationships' are not necessarily described as 'loving relationships', although they are similar in many regards.

Loving relationships enhance the adult lives of care experienced children and young people

As set out in the 'Edges of Care' paper for the Care Review:

> *'authentic, consistent, enduring and supportive relationships between care leavers and those acting both in the formal role of corporate parent as well as those in informal or semi-formal networks of support' are vital to enable successful transitions from care to independent living and adult life.' (Munro et al, 2011; Atkinson et al, 2019; Amaral, 2011; Butterworth et al., 2016; Driscoll, 2013; Matthews and Sykes, 2012; Rogers, 2011; Welch et al 2018; Bakketeig et al, 2018).*

Relationships with these types of features are often described by children and young people as 'loving relationships'. These kinds of relationships help children and young people to develop resilience as they move beyond care, and to be more successful in their adult lives. Conversely, there is evidence that if loving relationships are not available, then some will not be able to form positive intimate relationships in later life (Hyde, 2017).

4. Love in the 'care system'

This section (i) considers how love in the 'care system' is defined and described both in the research literature and by children and young people, (ii) introduces a range of other related and relevant concepts, (iii) discusses the status of love within the 'care system' (iv) provides some examples of how love in the 'care system' is and can be expressed and enacted, and (v) examines whether and how love is (and can be) measured.

It will be seen in this section that personal relationships are the vehicles through which love is perceived and felt. Whilst there is a vast literature on the centrality of relationships to children and young people (and this is a key theme in all nine Care Review evidence review papers), this evidence review attempts to provide a narrower focus by concentrating on one specific aspect of positive relationships – namely love.[555] Maintaining this distinction, however, is not straightforward, (partly because the literature on the specific topic of love is sparse), and therefore has not been rigidly applied.

Love in the 'care system' – definitions and descriptions

One of the most – if not **the** most – fundamental question(s) which needs to be addressed within the context of this review is 'what do we mean when we talk about 'love' in the 'care system''? Whilst this is an easy question to pose, there is no handy, 'off the shelf' answer. The difficulty relates – at least in part – to the subjective nature of love.

[555] There is a wide literature on the concept of 'the relationship as the intervention', including, Ruch, G. (2005) *Relationship-based practice and reflective practice: holistic approaches to contemporary child care social work,* Child and Family Social Work, ten.

Professional perspectives

Volume 15 of the Scottish Journal of Residential Care, published in 2016, was devoted to a discussion on 'love in professional practice'.[556] This special issue explored the theme of love in the context of children in out of home care, and the complexity of what loving children in care means in a professional context.

In her piece for the special issue, entitled 'Perspectives on love as a component of professional practice' Vincent (2016) explains that:

> *'In Western, English speaking cultures, the word love is used and understood with multiple interrelated meanings. We do not have one shared understanding of the meaning of love, and hence meaning is often lost or misinterpreted in conversations on the topic (Stickley & Freshwater, 2002) [.....] The risks and challenges of talking about and defining love within professional practice have been expressed throughout the literature (Arman & Rensfeldt, 2006; Hargreaves, 2000; Hoyle & Slater, 2001; Loreman, 2011; Smith, 2006; Stickley & Freshwater, 2002).*

Vincent goes on to say that:

> *'There is strong consensus throughout the literature that love is not simply an emotion or idea; it is not a passive engagement. Love is active and intentional, and it is communicated through behaviours as well as words (Arman & Rehnsfeldt, 2006; Hooks, 2000; Jacono, 1993; Lanas & Zembylas, 2014; Määttä & Uusiautti, 2013; Smith, 2011). Love is not simply present, it is "embodied and performative...brought into existence by doing" (Lanas & Zembylas, 2014, p. 36).*

Thus, articulating what is meant when we talk about the presence or absence of love in the 'care system' is not straightforward. Indeed, when

[556] Note that this section focuses on those parts of the 'care workforce' who are professionals (employed by local authorities etc.) to look after children in care.

staff employed in the organisation Barnardos were asked to reflect on the findings of the Discovery stage of the Care Review, the key issue that they identified was 'uncertainty about what is meant when people talk about love in this context'.

What does love mean for children and young people in care?

As set out earlier (in Section three), children and young people are adamant that love matters, and they have no difficulty in expressing very clear views about whether or not they have been loved. Whilst they do not offer specific definitions, their descriptions and associations (as set out in the evidence discussed in the first part of Section three above) return repeatedly to ideas of:

- Being cared for, listened to, talked to, not judged
- Being given time
- Being trusted and believed in, being supported and 'stuck by' when times are hard
- Feeling safe and kept from harm
- Having physical affection, touch, warmth and hugs
- Feeling a sense of belonging – to a 'forever home' and to a family.

Thus, children and young people describe love as something which arises out of their personal relationships, and is made manifest through the expression of feelings, attitudes, actions, words and behaviours of those with whom they are emotionally close. These personal relationships can be with people working in a professional capacity, but are also described in relation to birth families, friends, peers, other caregivers, and a wide range of formal and informal relationships (including teachers, kinship carers, foster carers, volunteers who work in the 'care system' etc.).

In summary, then, children and young people's accounts of love focus on their perceptions of the presence or absence in their lives of positive emotional relationships. These can be both with professionals and / or with those outwith the 'care system' itself. Their accounts are not defined in

terms of organisational processes and procedures even although, as we will see later (in Section six), organisational factors can act as barriers to love being present and expressed.

Other concepts related to love

There is a large literature about other concepts which are similar to, or related to love. These include attachment, affection, trust, recognition, care, compassion and empathy. As Vincent writes in her article quoted above:

> *'In contemplating the role of love in professional practice, many authors have drawn attention to related concepts, such as care, compassion and empathy (Arman & Rehnsfeldt, 2006; Giata, 2012; Hooks, 2000; Smith, 2011). Perhaps this is because throughout modern history there has been a greater sense of openness and comfort with talking about how these concepts fit within the realm of public relationships. [....] Care, acceptance, empathy, sympathy, compassion, presence, recognition, respect, honesty, commitment, trust, and a sense of community are all identified throughout the literature as key components of loving interactions and loving relationships (Giata, 2012; hooks, 2000; Arman & Rehnsfeldt, 2006; Määttä & Uusiautti, 2013; Hoyle & Slater, 2001). While related, these concepts individually, represent only pieces of a larger picture. Yet, without them, we cannot achieve a complete understanding of loving in professional practice.'*

Distinguishing these other concepts from love is not straightforward.

The status of love in the 'care system'

As set out earlier, the Care Review is focusing strongly on love in the 'care system'; the remit for the love workgroup crosscuts all Care Review activity and underpins the work of all (nine) Care Review workgroups.

However, this focus is not (yet) shared in the wider literature about the 'care system'. For example, the review on 'Supporting positive relationships for children and young people who have experience of care' (Winter, 2015) does not contain a single mention of the word 'love'. [557]

Is love a right?

There is no clear consensus on whether love – and love in the 'care system' – should be a right. Some of the main arguments and perspectives are set out briefly below.

UN Convention on the Rights of the Child (UNCRC)

It is notable that the word 'love' does not feature in any of the articles of the UN Convention on the Rights of the Child[558], and is mentioned only once in its preamble. The statement contained in the preamble is as follows: 'Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,…'. Thus, the UNCRC asserts that the rightful source of love in a child's life is their family.

Article 20 of the UNCRC says that children have the right to 'special protection and assistance' from the State if they are unable to live with their families. In such circumstances, the State must ensure that appropriate 'alternative care' is provided for the child. The word 'love' is not mentioned at all in the Guidelines for Alternative Care. However, the guidelines strongly emphasise that alternative care should be provided in

[557] There are, however, some signs that the debate and discussion about love in the 'care system' are starting to be more widespread. In particular, Who Cares? Scotland have a strategic plan entitled 'A Lifetime Of Equality, Respect And Love For Care Experienced People' which has a firm focus on love. https://www.whocaresscotland.org/wp-content/uploads/2018/01/Strategic-plan-2018-2022-new-final-version.pdf And the voluntary sector organisation Aberlour,has recently launched its Love InC project which aims to 'develop an approach which ensures love is an integral and fundamental aspect of any child or young person's care experience'. https://www.aberlour.org.uk/services/love-inc-project/

[558] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

a 'family context' – ideally the child's own family or another (foster) family – and that there should be a presumption against 'institutional' care.

Arguments in favour of all (care experienced) children having a right to be loved

A range of authors have recently argued that all care experienced children have the right to be loved (Furnivall 2017[559]; Johnston 2018; Evans 2019).

The arguments made in favour of all children having a right to be loved include:

- Liao (2005) who argued that the claim that children have a right to be loved is not merely empty rhetoric, and proposed that this right can be grounded as a human right and by showing that love can be an appropriate object of a duty. He also challenged the common notion that the duty to love a child belongs only to the biological parents.[560]
- Ferracioli (2014) who argued in favour of children having a right to be loved on two grounds: first that the right of children to be loved is grounded in the value of children leading meaningful lives; and second that the right of children to be loved gives rise to a duty on the part of the state to do all that it legitimately can to ensure that procreation and parenting follow from a truly voluntary decision on the part of its citizens.[561]

Arguments that a right to be loved for all children is not appropriate / cannot be sustained

Mark Smith in his 2016 editorial in the special issue of the Scottish Journal of Residential Child Care argued that 'a simplistic and overly enthusiastic application of rights-based approaches actually became part of the

[559] https://www.celcis.org/knowledge-bank/search-bank/blog/2017/03/loving-unlovable-child/
[560] http://www.smatthewliao.com/wp-content/uploads/2008/06/liaorctbl.pdf
[561] https://jesp.org/index.php/jesp/article/view/80

problem, which made love, or even just everyday relationships with children, more difficult' (Smith editorial, 2016).

Grahle (2016) concluded that 'the claim that love is a reliable source of the epistemic care a child needs in order to acquire meaning during childhood does not withstand scrutiny. There might be another argument in support of a right of children to be loved, but the argument from meaning fails to support its conclusion.'[562]

Love is not a panacea

The foregoing discussion has provided a strong evidence base for the importance of love within the 'care system'. However, it is also important to ask the question 'Is love enough'? For those who have written on this topic the answer is almost certainly 'No, love is not enough'. Love is not a panacea, it will not 'fix' all the problems with the 'care system'. It is a necessary, but not sufficient condition for improving the 'care system'. It doesn't 'fix' poverty and inequality or any of the other elements which are needed to ensure positive care experience.

As the 2016 Smith editorial in the Scottish Journal for Residential Care quoted above says:

> *'Having identified an absence of love in care, it can be an easy next step to draw the simplistic conclusion that if only we loved kids then all would be well. Such a lazy understanding of love has a tendency to sentimentalise it and to downplay its complexity, its duplicity even. I am reminded, again, of the Jonathan Hearn article I cited earlier. In it he concludes that sentiment needs to be augmented by structural concerns for justice – love on its own is not enough.' (Smith editorial, Scottish Journal of Residential Care).*

[562] https://jesp.org/index.php/jesp/article/view/184

Studies which directly address love in the 'care system'

Very few studies which directly address love in the 'care system' were found during the course of this review. Those few identified are described below.

Do you love me? An empirical analysis of the feeling of love amongst children in out-of-home care (Lausten and Frederiksen, 2016)

This study drew on a Danish survey of 1,400 children in out-of-home care. The authors use 'critical recognition theory', developed by Honneth (1995) which characterises love as 'a complex site of emotional interactions in which affection, attachment, trust and the struggle to achieve a balance between symbiosis and self-assertion is important'. The authors conclude that 'the results from our analysis suggest that if the care settings are able to provide social support to the child – in our case social support is defined as trust, guidance, and accountability, the three questions that form the indicator of social support – the children in out-of-home care do feel loved.'

Love: Recognising relationships in work with vulnerable youth (Thrana, 2016)

This study focused on the role love can play in professional child welfare services (CWS) in Norway. (Note that CWS includes, but is not restricted to, looked after children and young people.) The study collected data based on participant observation and interviews with 14 young people in contact with CWS in Norway. The author explains that 'The interviews showed that the youths did not expect 'parental love' from the social workers. They experienced love through small signs and through 'the little extra', such as a hug when you needed it, a warm smile from the social worker, or that the social worker spend extra time when the youth need someone who can stay by their side in different situations.'

Is it love? A study of young people's personal impressions and experiences of relationships in residential care in a Norwegian treatment collective (Lone and Paulson, 2018)

In this study, eight young people living in a social pedagogy-based Norwegian treatment collective were interviewed regarding their emotional relationships with the treatment staff. The findings revealed three dimensions of importance for the youths: emotional involvement from staff; an ability to put the youth in centre of attention: and an experience of subject-subject relations between staff and youths in an environment without use of physical restraint. The youths all reported that they had experienced emotional relations they characterised as containing love.

We don't feel that love (Scott, 2007)

This study explored the retrospective reflections of 20 former youth in care, between the ages of 19-24 years, in Lower Vancouver Island, British Columbia in relation to their experiences of removals and transitions through the child welfare 'system'. Five key psycho-social processes (not knowing, loss or absence of belonging, relational fragmenting, deforming identity and dis-spiriting) were identified which contributed to an overall sense the participants had of 'not feeling that love'. In this context 'that love' was described as the love that they thought was learned and developed through deep, caring connections with others, especially adult carers.

Fostering Restoration - The impact of love and second families in residential care (Obenque and Jones, 2016)

This study reports on a fundamental restructuring of the environment in which survivors of commercial sexual exploitation and abuse in a refuge house in the Philippines are looked after. The restructuring developed a loving, family-like environment between staff and girls (including removal of the 'no-touching' policy), drawing on their Filipino culture and way of life. The study reports that love as mutual affection has developed between

the staff and the girls and that there has been a decrease in aggressive behaviours and the need for psychiatric medication, as well as improved participation in education and home life as a result.

Aroha: 'Loving' within a statutory and bi-cultural residential environment (Sutherland, 2016)

This article explores the concept of 'Aroha', the closest Maori language equivalent of the English word 'love'. Sutherland explains that Aroha concept is now ingrained in youth residential work as part of a social services framework. Aroha does not have a simple definition. It is a multi-faceted concept. It's meaning can change according to the context and it 'can include synonyms of pity, concern, compassion, empathy, affection, and care (Moorfield, 2016)'. However, Sutherland notes that authors have also 'positioned Aroha on a wider scale as the active element of hospitality – the process of caring for and upholding the dignity, self-esteem and spirit of others, especially visitors and wider family (University of Otago, 2016)'. This is often seen to extend to the wider community setting through the ancestral bonds that tie groups together.' It is an active concept, and the focus is on practising it. Sutherland describes some of the ways that this 'love' has been put into practice while maintaining professional standards (using examples relating to one situation where a young person is seen to be 'acting out', and another where physical affection, praise and encouragement are offered). The article also links the discussion of Aroha to similar strands of thought from the discipline of social pedagogy.

Record keeping

The way records of children and young people's experience in care are compiled and accessed can act as a barrier to love within the 'care system'. As described by Hoyle in her 2019 blog 'Recordkeeping with Love'[563]:

> *'records are so often the product of loveless or careless 'care': they are the tangible evidence of the way a child or young person has been*

[563] https://blogs.ucl.ac.uk/mirra/2019/01/21/recordkeeping-with-love/

> *turned into a task, a job and a statistic [....] the long waiting times, lost files, heavy redactions, and poor (or non-existent) aftercare seem to underline the message that you're not important. Several people have shared common experiences of being told 'oh we can't find you, according to the 'system' you don't exist'. Others have been advised, at the point of accessing their records, that 'there's nothing very interesting in there' or 'I've seen much worse.'*

Looking across these studies, it can be seen that a 'care system' with love at its heart would include the following actions, attitudes and behaviours:

- Offer social support (including trust, guidance and accountability)
- Provide those 'little extras' which can make all the difference (a hug, a warm smile, a bit of extra time)
- Enable and encourage staff to get emotionally involved with the children in its care
- Put the child or young person at the centre of its work
- Allow physical contact and touch between carers and children
- Create a sense of belonging
- Ban the use of physical restraint.

By contrast a 'care system' which did not have love at its heart would include the following actions, attitudes and behaviours:

- Withhold information from children and not tell them what was happening and why
- Focus on the bureaucracy and paper work of the 'care system'
- Create an environment which did not make children feel safe or that they belong
- Allow relationships to be disrupted and fragmented
- Prevent the children in its care from forming a positive identity.

Measuring love

As has been set out in Section two above, official statistics (CELCIS statistical overview report, 2017), do not cover the presence or experience of 'love', or the availability of 'loving relationships' for looked after children.

More broadly, this review has not uncovered any evidence either in the UK or further afield of how to 'measure love' or its absence, either in the 'care system' or more broadly throughout society. However, based on the accounts of academics and professionals working in the 'care system', the following dimensions can be identified as relevant to the development of any measurement:

- The availability and presence of 'emotionally close' relationships
- The extent and expression of (welcomed and appropriate) physical touch and affection
- The degree to which 'lifelong' relationships, which bring a sense of belonging and lifelong commitment have been established
- The extent to which relationships are developed which meet the unique needs of each individual child and young person at every stage of their lives
- The extent to which the 'care system' itself promotes or inhibits the development of these kinds of loving relationships
- The extent to which the 'care system' itself is able to enact love within the structures and frameworks of its policies, practices and procedures.

Within each of these domains, indicators would have to be developed to capture the behaviour, attitudes, words, actions and intentions which might be taken to signify the presence (or absence) of love.

This point about measurement is returned to later, in Section five.

5. The role of Love in public policy

This section examines the extent to which love features explicitly in recent public policy statements.

The Care Review

At the launch of the Care Review on 30th May 2017, First Minister Nicola Sturgeon said:

> *'Every young person should have an equal opportunity to succeed in life, no matter their circumstances. We should celebrate the progress that has been made that has allowed many of our young people who grow up in care to do great things in life - and those who work with looked after children do an amazing job. However, we know that there are still many challenges facing young people in care and that their opportunities are all too often not the same as other young people in Scotland. The 'care system' must and can do better by our most vulnerable children and young people. They need to know they are loved and feel cared for – this review is not about determining if this can be achieved, but how we create a 'system' that puts love for the children it cares for at its heart.'*

This emphasis on love is what differentiates this review from other efforts to improve the 'care system'. Indeed, the 'Programme for Government 2018-19',[564] says that:

> *'The Care Review will identify and deliver lasting change to the 'care system', transforming the life chances and wellbeing of children and young people in care, and providing the kind of preventative support which the Christie Report envisaged. As the work of the Care Review continues we will continue to improve the support available for*

[564] https://www.gov.scot/programme-for-government/

children and their families investing time, money and love in their future.'

Does love feature in public policy?

There are few other instances of love being discussed in the context of public policy. Only two explicit mentions of love came to light in this evidence review. These are described below.

Norway

Lone and Paulson (2018) write that:

'During the last few years, the term 'love' has been introduced into the debate in Norway concerning the quality of work within the Child Protection Services, both through research (Thrana, 2015), and also from user-groups of former youth clients in residential care (Barnevernsproffene). The term 'love' has even made its way into official government documents: 'The Child Protection Services shall meet them (the children) with care, empathy and acknowledging children needs for security and love' – without giving the term a definition.'

Scotland

The Scottish Government's National Performance Framework[565], (NPF) identifies a National Outcome for its children and young people that they should grow up 'loved, safe and respected so they realise their full potential'. The NPF explains this further as follows:

'We are dedicated to providing the essential conditions of love, respect and understanding through which our children can become the happy, fulfilled and successful adults they all have a right to be.

We do all we can to ensure our children grow up in an atmosphere of happiness, love and understanding. We enhance their life chances

[565] https://nationalperformance.gov.scot/

through our early years provision and by supporting families when they need it. We ensure childhood is free from abuse, tobacco, alcohol, drugs, poverty and hunger. Our children are not left worried or isolated. We include and involve children in decisions about their lives and world, and protect their rights, dignity and wellbeing. Our communities are safe places where children are valued, nurtured and treated with kindness. We provide stimulating activities and encourage children to engage positively with the built and natural environment and to play their part in its care. We provide the conditions in which all children can be healthy and active. Our schools are loving, respectful and encouraging places where everyone can learn, play and flourish. We provide children and young people with hope for the future and create opportunities for them to fulfil their dreams.'

Seven indicators have been developed in relation to this National Outcome. These are:

- **Child social and physical development**: The percentage of eligible children with no concerns, at their 27-30 month child health review[566]
- **Child well-being and happiness**: The proportion of children aged four-12 who had a borderline or abnormal total difficulties score[567]
- **Children's voices**: Percentage of young people who feel adults take their views into account in decisions that affect their lives
- **Healthy start**: Perinatal Mortality Rate per 1,000 births (stillbirths plus deaths in the first week of life)

[566] https://www2.gov.scot/Resource/0041/00410922.pdf
[567] Based on the Strength and Difficulties Questionnaire (SDQ) https://www.corc.uk.net/outcome-experience-measures/strengths-and-difficulties-questionnaire/

- **Quality of children's services**: Percentage of settings providing funded Early Learning and Childcare (ELC) achieving good or better across all four quality themes
- **Children have positive relationships**: Percentage of S2 and S4 pupils who report having three or more close friends
- **Child material deprivation**: Percentage of children in combined material deprivation and low income after housing costs (below 70% of UK median income).

As can be seen in the descriptors of the indicators above, only one of these (% of S2 and S4 pupils who report having three or more close friends) has an explicit focus on 'positive relationships' and even this indicator does not capture the kinds of 'loving relationships' which children and young people say they want. As of 17th July 2019, only one data point (from 2015) is available for this indicator; at this time, 81% of the relevant cohort reported that they had three or more close friends.[568]

Kindness in public policy

Whilst love itself has not been greatly discussed more widely in relation to public policy – beyond that already set out above in relation to the Care Review – there has been a recent focus on developing kindness in policy making.

A recent report (Unwin, 2018) commissioned by the Carnegie UK Trust has explored the role of kindness in public policy. The report builds on a programme of work undertaken over several years (2015-) by the Carnegie UK Trust and the Joseph Rowntree Foundation on the power of kindness and everyday relationships to affect change and support the well-being of individuals and communities.

[568] Note that of the (eight) Well-being SHANARRI indicators 'nurtured' is the one which has been described as 'closest to love'. However, love itself does not feature in this list of indicators. (See the Care Review Health and Well-being evidence review paper for a full description of the SHANARRI indicators.)

The foreword to the report says that:

> *'There is growing recognition of the importance of human connection and relationships for individual and societal wellbeing. Values that were previously considered 'out-of-scope' – such as kindness, love and compassion – just might form part of the solution to some of our most intractable social problems. However, talking about kindness doesn't fit easily within the rational, dispassionate, evidence based language of public policy. This is a challenge for many of us working within this current tradition.'*

The report suggests that, whilst talking about kindness in this context is profoundly uncomfortable and potentially highly disruptive, the great public policy challenges of our time – rebuilding public trust and confidence, encouraging behaviour change – demand an approach that is far more centred on relationships and human connection.

The National Performance Framework (NPF) for Scotland (mentioned above) identifies the values which underpin its approach as 'treat all our people with kindness, dignity and compassion; respect the rule of law; act in an open and transparent way'. Brownlie and Anderson (2019) note that, whilst the inclusion of kindness within public policy making has been welcomed, the challenges for institutions, policy makers and public service professionals which it raises are profound. In particular, the key feature of kindness – that it is unobligated – means that it cannot be demanded, mandated, or legislated for.[569]

However, as Unwin explains, introducing kindness into the NPF means that government and public services intend to be known for kindness, and all Scotland's citizens can expect to be treated with kindness. This means that kindness must be measured and audited, policy must be designed for kindness, and kindness must be regulated for. Similar issues – about

[569] https://www.carnegieuktrust.org.uk/blog/not-random-but-radical-beyond-bumper-sticker-versions-of-kindness/

measurement, auditing and regulation – would arise in considering how to develop a 'care system' with love at its heart, and what acts as a barrier to love.

It is also notable that Unwin identifies what she calls 'the shadow side of kindness – kindness and rights'. Her argument is as follows:

> *'Kindness can seem like an unquestionable good, but it is frequently associated with a patronising and pitying approach and – for very good reasons – resisted strongly by those on the receiving end. It can seem sentimental and, critically, to undermine a culture of rights and entitlement. There is fundraising material for example, which seeks to appeal to emotions of compassion and empathy without allowing any sense of agency, or humanity, to those so depicted. There are descriptions of older people, people with disabilities and abused children that derive their power and impact by triggering a sense of pity. This in turn is experienced as condescending. But it is also built on a premise of passivity and lack of agency, seeing people who use services as entirely objects, passive recipients of support without the ability to make their own choices and decisions. It also makes them seem different, and denies our common humanity. Talk of kindness risks further entrenching these attitudes. There is a lazy narrative that equates kindness with a reduced demand on the state, and the replacement of entitlement and rights with a reliance on random acts of quixotic generosity.'*

Measuring kindness

In parallel with Unwin's report, UK Carnegie Trust also commissioned work on measuring kindness. Findings from the first quantitative survey on kindness in communities and public services was published in November 2018, based on fieldwork conducted using random sampling methods in

each of the five legislative jurisdictions in the UK and Ireland.[570] The questionnaire covered the following topics:

- Personal experience of kindness within your local area (including amount of kindness experienced, extent of help offered to neighbours, interactions with neighbours, reliance on neighbours for practical help and advice as well as emotional support)
- The kindness people experience when using local public services (including public libraries, GP surgeries, police services, transport, social care services)
- The amount of control people have over local services
- Responsiveness of services to local concerns
- Likelihood of taking particular actions to improve local services.

Key findings in relation to the questions on kindness included that:

- Over 90% think people in their area are generally kind (but less than half feel strongly about this)
- Experiences of kindness were most common in Scotland and least common in England
- Over 80% reported experiencing kindness in relation to all five public services they were asked about (but less than half feel strongly about this)
- Experiences of kindness in services were highest in Scotland and lowest in England.

The work which underpins the development of this survey questionnaire on 'kindness' may be relevant in relation to measuring love.

The impact of love in public policy

Given the limited extent to which love currently features in public policy, there is no evidence base to support what impact it might have if adopted.

[570] https://www.carnegieuktrust.org.uk/publications/quantifying-kindness-public-engagement-and-place/

A current initiative funded by an ESRC impact grant (Brownlie and Anderson) involves a series of seminars for policymakers and practitioners which looks at the relationship between kindness and policy; and the implications for policy[571]; findings will be available in October 2019.

[571] http://www.sps.ed.ac.uk/staff/sociology/brownlie_julie

6. What are the barriers to love in the 'care system'?

This section summarises the evidence about the barriers which prevent or inhibit love being at the heart of the 'care system'. As can be seen in the discussion which follows, these barriers are overlapping and interrelated.

There is a wide variety of ways in which the whole 'machinery', culture and bureaucracy of the 'care system' militates against the expression of love for looked after children and young people. Barriers include (aspects of) legislation, policy, practice, measurement and culture. Placing the concept of 'love' at the heart of the 'care system' will require a re-orientation of the entire regulatory 'system' and the repositioning of the 'care system' within wider society and institutional structures. The barriers to these sweeping social changes are not discussed here. Rather, this review concerns itself with required changes to the 'care system' which have been identified by children and young people. In what follows, the most commonly discussed areas are set out under the headings of (i) defining and maintaining professional boundaries (ii) a culture of suspicion (iii) risk, risk management and child protection and (iv) other issues.

Defining and maintaining professional boundaries

A strong theme in the literature is that the way 'professionalism' and in particular 'professional boundaries' are currently defined for social workers, carers and others working with looked after children and young people, is not appropriate if the intention is to have love at the heart of the 'care system'. For example, in her 2016 review, Vincent writes that:

> *'Fear of being misrepresented as exploitative, unprofessional or possessing poor boundaries leads some to feel discomfort with identifying child and youth care (CYC) practice as loving (Ranahan,*

> *2000; Smith 2006). In contemplating the role of love in her own practice, Ranahan (2000) questions whether it is possible to have appropriate boundaries and also bring love into her practice as a CYC practitioner.'*

This comment plays into a wider and longstanding debate about how professionalism, and professional boundaries should be understood within the context of the care professions (and by extension, the 'care system'). It is argued that a legalistic, or 'instrumental', or over- regulated approach to practice prevents relational social work; indeed, it is suggested that 'adherence to professional guidelines can restrict the potential for connection and paradoxically limit the effectiveness of our contribution to the client's desired change (Alexander and Grant, 2009; Smith 2009; Sutherland 2016; Anon 2016).' However, there are profound concerns that 'a requirement for love' to be offered can undermine professionalism, by expecting professional employees to perform tasks which belong within the 'care and love dimension' of the family (Neumann, 2012).

In addition, the extent to which drawing on values from medicine and the law to define professionalism – which rely on the maintenance of appropriate boundaries and distance – is appropriate in the context of the 'care system' has been questioned (Furnivall, 2017)[572].

In his piece reflecting on love and social care, Byrne (2016) writes that:

> *'to argue that to feel love for a client is somehow a blurring of professional boundaries is simply wrong.' [Rather, he says, that feeling love for a client is] 'holding the boundary in a complex relationship that is based on emotion, not intellect, and which cannot be clinically sanitised by rules, boundaries or regulations without losing the love'.*

[572] https://www.celcis.org/knowledge-bank/search-bank/blog/2017/03/loving-unlovable-child/

Byrne's perspective is consistent with the social pedagogy approach, which argues that 'we can't be professional without being personal, so we have to do both. What we must avoid is not the personal but the private self'.[573] It is recognised within social pedagogy that this can cause challenges for professionals about what it means to be professional.

A culture of suspicion

A second theme in the literature is that enacting love in the 'care system' can be fraught with danger and suspicion, because of the possibility of children being abused or harmed. As Furnivall writes in her 2017 blog:

> *'Bubbling beneath the surface of any interaction between children and adults who are not related to them, lurk anxieties about abuse and allegations. This has contributed to the development of policies and procedures that inhibit and constrain the possibility of adults confidently enacting and expressing their love for the children or young people in their care. [....] Many practitioners have been encouraged to minimise the importance of relationships they develop with children and a willingness to sustain relationships beyond a particular placement or into adulthood has been viewed with suspicion'.*[574]

This point is echoed by Evans (2019) who argues that, because of the culture of suspicion and surveillance, many adults working with traumatised young people feel that love, and even talking about love, is taboo. Moreover, if children and young people are raised in an environment where they are taught that the potential for abuse must be at the forefront of their mind in every human encounter, then they will not be able to develop relationships of love and trust (Byrne, 2016); and if carers are operating in a climate of fear and suspicion then they won't cuddle up

[573] http://www.thempra.org.uk/social-pedagogy/key-concepts-in-social-pedagogy/the-3-ps/ Especially in Denmark this distinction is referred to as the three Ps: the professional, the personal and the private self of the social pedagogue.
[574] Ibid

too close to their children because of the risk of being accused of inappropriately touching them, or speak of loving their foster children, for fear of creating a lie in case they had to move on (Evans, 2019). The evidence on this issue has been set out in Winter (2015) as follows:

> *'Accusations of over-involvement and an adverse emotional impact on professionals by forming close relationships with children and young people also contributes to the culture of suspicion' (SWIA, 2006; Siebelt et al, 2008; Laming, 2009; Smith 2009; Broadhurst et al, 2010; Morgan, 2012; Ruch, 2014).*

Risk, risk management and child protection

A third theme considers the approach to risk within the 'care system', and focuses in particular on whether and how loving care can be combined with child protection. A range of authors have raised questions about whether love can be offered in out-of-home care settings and whether loving care can be combined with child protection (e.g. Cameron, 2013; Jakobsen, 2010; Smith et al, 2013 as reported in Lausten and Fredrikson, 2016).

Given these concerns, professional social care practice has been very focused on risk assessment, risk management, and the reduction of risk (Dunlop, 2017; Byrne 2016; Cahill et al, 2016). The vulnerability of looked after children and young people, and the possibility that their only experience of emotional and physical intimacy has been abusive, has meant that the temptation is to protect them from all risk. However, a child's independence – and their emotional development – cannot be achieved without risk.

Moreover, love involves risk; it comes with negative emotions as well as positive ones. The negative emotions are often linked to the instability of the relationships between young people and their carers, which can arise because of (frequent) changes in placements and carers. As Evans (2019) writes:

> *'Many children in care cannot begin to understand what love is unless their new carers take the risk of 'falling in love' with them. The paradox is that foster carers will often unconsciously, and even consciously, avoid 'falling in love', to protect themselves and their foster children against the extreme pain of taking a child into their hearts when there is a possibility of losing him or her. Foster carers who do manage to take that risk will often be met by children and young people who cannot bear to be loved, who will reject them. The children are wary of love and so are the foster carers.'*

If the risks associated with love are avoided, then the consequence for the child will be that they never learn intimacy or physical contact; thus the challenge for professionals in child protection, is to calculate and work with risk, not to try to eliminate it (Byrne 2016).

The impacts of basing practice around risk aversion and 'safer caring' for workers (to minimise risk of allegations and / or unnecessary contact), is set out in the study by Brown et al (2018) of residential child care workers. This study found that the approach to risk management in practice went beyond essential requirements and suppressed even the most basic acts of kindness.

Other issues

A range of other issues, described briefly below, were also identified as barriers to love in the 'care system':

- The disrupted attachment relationships of those entering the 'care system' (these have been described in Section three above where it has been argued that these types of relationship are crucial for the healthy emotional development of children).
- The lack of clarity about the 'organisational stance' for institutions (and professions) in relation to love - and whether it should be encouraged - means that the workforce is not empowered to express love. One aspect of this is described by Smith (2016) as

follows: 'cultural and emotional scripts are at play which act as a disincentive to raise the existence of love or even its possibility in child care settings within child and youth care / social pedagogy'.

- The lack of willingness or lack of emotional capacity amongst the (trained and untrained) workforce to love all the children in the 'care system'.
- The (inadequate) training and development of social workers; for example nothing is taught about love in social work degree courses (Barnardos, 2017). (Note, this review was not able to consider any issues relating to the training and development of the wider workforce including foster carers, kinship carers etc.).
- The ambivalent view of the place (or not) of physical affection and touch in the relationships between carers and looked after children and young people. (Recent reports have confirmed that foster parents should feel able to demonstrate physical affection where this is right for the child.) [575,576]
- Carers and workers need permission to go 'above and beyond' statutory care (Brown et al, 2018).
- The complexities and challenges of love being able to flourish, or be felt, within a relationship between a young person and a paid professional (Smith, 1988; Mason 2019).
- The predominance of 'rules' within the 'care system', and the utilisation of performance measurement can also act as a barrier to love.

[575] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/727613/Fostering_better_outcomes_.pdf
[576] https://www.fosteringhandbook.com/tact/safer_policy.html#show_affection

7. What promotes love in the 'care system'?

This section summarises the evidence about what promotes love in the 'care system'.

The introduction of love to the heart of the 'care system' is viewed by those who have initiated the Care Review as 'transformational' and 'revolutionary' rather than evolutionary.[577] As set out earlier (Section six above) this kind of transformation will require radical change throughout every layer of social and economic life - culture, custom, practice, legislation and policy; however, the factors which promote these broad societal changes are beyond the scope of this review.

Therefore, the discussion below focuses on factors which are more 'internal' to the 'care system'. The evidence is presented under the headings (i) permission to love (ii) redefining professionalism within the 'care system' (iii) therapeutic care for children, young people and the workforce (iv) continuity and stability (v) changing attitudes and (vi) training and development of the workforce. It will be seen that these themes overlap.[578]

[577] As set out in the Scottish Government's Programme for Government 2018-2019: 'The Care Review will identify and deliver lasting change to the 'care system', transforming the life chances and wellbeing of children and young people in care, and providing the kind of preventative support which the Christie Report envisaged. As the work of the Care Review continues we will continue to improve the support available for children and their families investing time, money and love in their future.' https://www.gov.scot/publications/delivering-today-investing-tomorrow-governments-programme-scotland-2018-19/

[578] It should be noted if love links to well-being, then the factors which promote the health and well-being of children and young people in care are also important for love. This section should therefore be read in conjunction with the Care Review evidence review paper on Health and Well-being (H&WB). To recap, the factors identified as promoting H&WB cover: (i) positive and meaningful relationships (ii) voice of C&YP heard (iii) stability, permanence and continuity (iv) supportive and positive wider environment (v) lifelong support (vi) well-trained and supported workforce (vii) a 'joined up' 'care system' and (viii) a holistic approach

Permission to love

If the 'care system' is to have love at its heart, then all those who work within it, whether on a paid or voluntary basis need to be given 'permission' to love the children and young people in its care. This will mean changing the way 'risk' is conceptualised and assessed within the 'care system', putting an end to the culture of suspicion and surveillance, and removing the current 'taboo' on talking about, and enacting love in the 'care system' (Byrne, 2016; Keys, 2017; Johnston 2018; Evans 2019).

With the permission to love will come further displays of physical affection and intimacy, the embracing of lifelong attachments, the permission to more fully contribute to the whole needs of a young person, the removal of restrictions in relation to the giving and receiving of gifts and mementos, the development of loving and trusting relationships throughout the 'care system' and the reframing of practice guidelines. These changes would allow the workforce to more fully contribute to the needs of the children and young people in its care, and form part of the core 'ask' articulated widely by children and young people themselves (Winter, 2015; Sutherland, 2016; Furnivall, 2017[579]; 1000 Voices report, 2018; Dunlop, 2017; Evans, 2019).

Redefining professionalism within the 'care system'

As has been noted in Section six above, one of the barriers to love being at the heart of the 'care system' is 'defining and maintaining professional boundaries'. This means that if the 'care system' is to have love at its heart then the conceptualisation of professionalism within the 'care system' will have to change. According to Furnivall (2017) this kind of change is already underway. Furnivall writes that:

> *'Within Scotland, legislation, policy and practice is shifting and we are now moving towards a professionalism that is defined by passion*

[579] https://www.celcis.org/knowledge-bank/search-bank/blog/2017/03/loving-unlovable-child/

> *and commitment expressed through the transparent and responsible use of relationships.'* [580]

Smith (2006) suggests that this redefined professionalism will require children and youth care practitioners to 'act justly in expressing that love, especially in our relationships with those less powerful than ourselves'. This will require them to be 'constantly mindful of their own thoughts, values and intentions, while also being aware and respectful of the boundaries between themselves and the children and youth they work with' (Smith, 2006, p. 11).

Therapeutic care for children, young people and the workforce

As has been set out earlier, children and young people in care have often experienced abuse, neglect and trauma. Working with these children, and helping them to reach loving feelings and develop positive warm and loving relationships, takes time, resources, understanding, knowledge and skill. This is complex and demanding work. Moreover, the adults, carers and professionals who work with these children and young people will themselves need support to recognise and process their own emotions. Thus, therapeutic care is needed, not only for the children and young people, but also for the workforce who support them; and it is vital that policy makers should be more aware of this complex and powerful work so that they can support it more effectively (Evans, 2019). Indeed, Evans goes on to say that a supply of child and adolescent psychotherapists will be required to 'help the growth of love through containment, attention to detail, and working closely with social workers, foster carers, key workers and teachers with a view to modifying the impact of trauma'. Moreover, Keys (2017) suggests that, since the culture of suspicion and surveillance can be problematic, having a theory of loving in therapeutic relationships will help to 'ensure the highest standards of professional accountability'.

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[580] Ibid

Continuity and stability

When children and young people discuss the presence of love within the 'care system', they do this in the context of describing relationships which are enduring, permanent and stable (1000 Voices report, 2018). Children and young people are looking for people in their lives who will be regular, available and dependable; these are qualities which are required for the growth of love (Evans, 2019). The Care Inquiry's 2013 report emphasised the importance of achieving 'permanence' for children in care, which was defined as 'security, stability, love and a strong sense of identity and belonging' (Care Inquiry, 2013, p2). Lausten and Frederikson (2016) also found that 'stable and long-term placements' were a key factor in looked after children feeling loved. [581]

Stability within the workforce is an extremely difficult challenge. In relation to children and family social workers, the turnover rate (defined as number of workers who left in the previous 12 months divided by the number of workers in place at 30 September 2018) was 16% (headcount) compared to 15% in the previous year.[582]

Changing attitudes

The re-orientation towards love in the 'care system' will require a fundamental change in attitudes, not just within the 'system' but outwith it too. The attitude changes which are required – and how this might be achieved – are discussed in the Care Review 'Stigma' evidence review paper.

One specific element which needs to be challenged relates to the use of language. Young people have asked for more sensitivity in relation to the terminology which is used in the 'care system' (1000 Voice report, 2018).

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[581] Note that the Care Review 'Care Journeys' evidence review paper discusses the importance of stability and permanence within the 'care system' at length. The references quoted here are the ones that make an explicit link to love.
[582] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/782154/Children_s_social_work_workforce_2018_text.pdf

This point is also made by Ferguson and Thurman (2018)[583] in their work on the 'practice of kindness' where they say that talking about 'offenders' or 'the unemployed' can reduce people to labels; and thinking about 'housing units' instead of 'homes' can disengage our emotional intelligence, and encourage artificial and transactional behaviours. Ferguson and Thurman (2018) argue that 'this sort of language can disincentivise kindness, especially in environments where relationships are more challenging due to the level of risk, need and demand' this observation is also relevant in relation to love.

Training and development of workforce

The training and development of the workforce (both paid and unpaid) is crucial to creating a 'system' with love at its heart. The Care Review 'Workforce' evidence review paper has discussed the evidence regarding 'relationship based practice' (including the investment by the Scottish Government to develop an 'adversity and trauma informed workforce'), this evidence is not repeated here.

[583] https://www.carnegieuktrust.org.uk/publications/the-practice-of-kindness-learning-from-kin-and-north-ayrshire/

8. Concluding remarks

The literature on 'love in the 'care system'' is at an emergent, embryonic stage. There is little relevant literature, and only a very few studies which directly address the experience of love for looked after children and young people. Moreover, there is as yet no body of work to address major issues in relation to defining and measuring love in the 'care system', monitoring and auditing love, developing policy for love, and orienting regulatory frameworks towards love.

It is clear, though, that children and young people believe that the presence of love is vital, and that its enactment in the 'care system' is important in relation to their well-being, their recovery from trauma, for their emotional and social development, for their ability to give and receive love in later life, and to lead loving fulfilling lives. The Care Review, along with related work by others (including Who Cares? Scotland) are now seeking to provide the momentum and platform for this fundamental change.

This evidence review has highlighted some of the challenges for this agenda and has provided some material which may help with the next steps in relation to developing a 'care system' with love at its heart.

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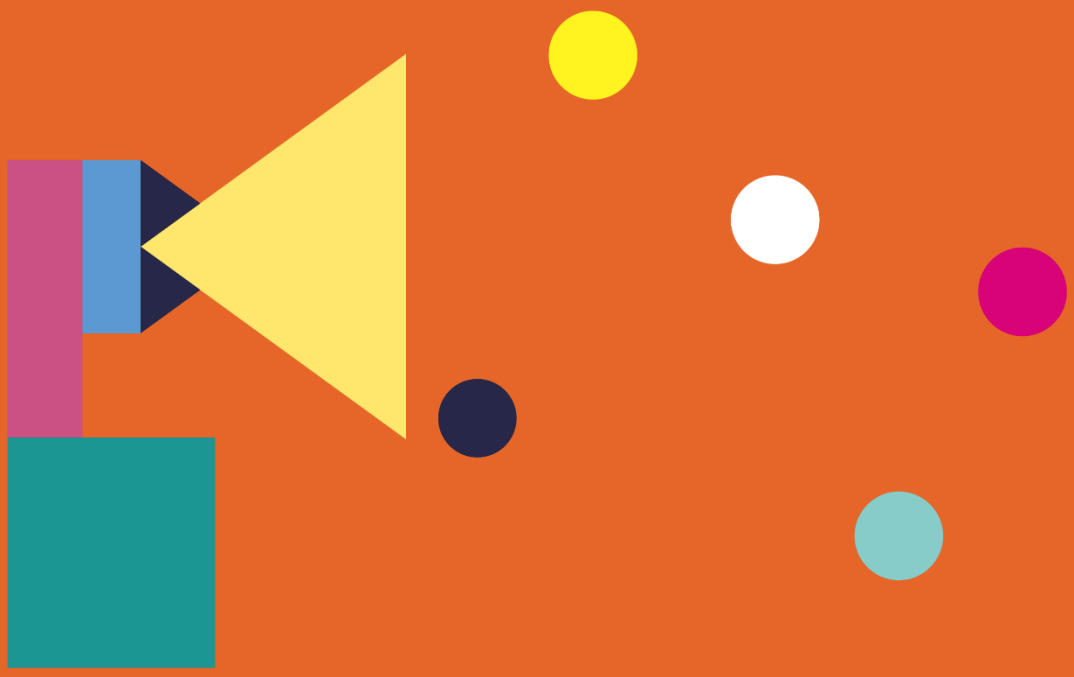
Rights

The rights of children in care



A review of evidence on the state of children's rights in Scotland, and the benefits, challenges, and facilitators of implementing the UN Convention on the Rights of the Child.

Dawn Griesbach, Claire Baker and Jennifer Waterton

July 2019

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1. Introduction

Background

In May 2019, as part of the Journey Stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a rapid review approach was adopted which involved: (i) identifying relevant review / overview papers (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers) and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[584]

The aim and scope of this review

This review will answer the following questions which have been agreed through discussion with the Rights work group:

- What evidence is available about the extent to which current international legislation / guidance / frameworks on the rights of children are being upheld for children in care?
- What do we know about the impacts / benefits of upholding / respecting the rights of children in care?

[584] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

- What do we know about (i) the challenges / barriers and (ii) what helps to support / facilitate respecting the rights of children in care?[585]

Structure of the report

The report is structured as follows:

- Section 2 places this evidence review in the context of other findings from the Care Review.
- Sections 3 and 4 provide an overview of international legislative frameworks / guidelines relating to the rights of children and young people in care, and a summary of current situation in Scotland regarding implementation of these.
- Section 5 presents children's and young people's perspectives on where improvements may be needed in the 'care system' to ensure that they experience their rights.
- Section 6 looks at the impacts (particularly for children and young people in care) of implementing children's rights.
- Sections 7 and 8 present evidence on, respectively, (i) the barriers to upholding / respecting the rights of children in care and (iii) what helps to support upholding / respecting the rights of children in care.
- Section 9 summarises the review with some concluding thoughts.

[585] Note that, in this context 'children and young people in care' is taken to include care leavers

2. What the review has learned so far

This section summarises the main findings from the Discovery stage of the Care Review in relation to the issue of children's rights.

These findings were that:

- Children and young people explained they did not always have the information they needed about their rights whilst in care. They were not always kept fully informed about important aspects of their life. For example, not being informed of the reasons for them becoming looked after, the purpose of the placement, and what to expect. The lack of information could be distressing (Baker literature review, 2017).
- The right to express a view on matters that concern them (UNCRC, article 12: The right to be heard) has been highlighted as one of the most important rights to children, young people and care-experienced adults – and one of the rights that is not always upheld. This group often reported that they were not meaningfully involved in decisions which had an impact on their lives – including decisions relating to care placements and moves. This resulted in feeling a sense of powerlessness. It was common for this group to say they were "not kept informed", "not listened to" when they did speak up, and that they felt "abandoned" when they left the 'care system'. There was also a view among this group that the 'care system' put the rights of adults and the views of professionals over their own (1000 Voices Discovery report).
- In addition, children, young people and care-experienced adults also highlighted the importance of privacy (UNCRC, article 16 – the right to privacy). Concerns were expressed that too many people have

access to sensitive information about them (1000 Voices Discovery report).

- Parents, carers and professionals suggested that the 'care system' was designed for adults and was not equipped to meaningfully engage with infants, children and young people, echoing the view, mentioned above, that the existing 'care system' risks prioritising the rights of parents over children's rights (1000 Voices Discovery report).
- Most of the twelve intentions of the Care Review could be met fully or in part through a better focus on the rights of children and young people in policy and practice. However, six of the intentions have direct links to articles of the UN Convention on the Rights of the Child:
    - Families on the edge of care will get the support they need to stay and live together where safe to do so *(UNCRC, article 18: Children have the right to be brought up by their parents if possible).*
    - Scotland's infants, children and young people will be nurtured, loved and cared for in ways that meet their unique needs *(UNCRC, article 3: All adults should always do what is in the best interests of the child).*
    - Relationships which are significant to infants, children and young people will be protected and supported to continue unless it is not safe to do so. This recognises the importance of brothers and sisters, parents, extended family and trusted adults *(UNCRC, article 8: Children have the right to preserve their identity, including nationality, name and family relations as recognised by law without unlawful interference).*
    - Care experienced infants, children and young people will thrive in supportive and stable learning and work environments, ensuring they have the same opportunities as others *(UNCRC, articles 29: Children have the right to education which tries to develop their personality and abilities*

as much as possible and encourages them to respect other people's rights and values and to respect the environment)

- Infants, children and young people's rights will be part of normal everyday life, practice and decision-making *(UNCRC, article 42: all adults and children should know about this convention. Children have the right to learn about their rights, and adults should learn about them too.)*
- Infants, children and young people's voices will have a visible and meaningful impact on decision making and care planning.*(UNCRC, article 12: Children have the right to an opinion and for it to be listened to and taken seriously).*

3. The rights of children in care – the international legislative framework

This section provides information about two international frameworks which provide the basis for children's rights (including the rights of disabled children) in Scotland, and indeed elsewhere in the world. Information is also provided about an internationally agreed set of guidelines for the care of looked after children.

This section covers:

- The United Nations Convention on the Rights of the Child (UNCRC) - which provides the foundation for children's rights around the world
- The Guidelines for the Alternative Care of Children - which is intended to improve implementation of the rights of children and young people in care.
- The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) - which gives persons with disabilities (including children with disabilities) the same fundamental human rights and freedoms as other people.

United Nations Convention on the Rights of the Child (UNCRC)

The UNCRC is an international human rights treaty which provides the basis for children's rights everywhere in the world. The Convention recognises that children and young people need special care and protection that adults do not.

The UNCRC contains 54 articles setting out the civil, political, economic, social and cultural rights to which all children under the age of 18 are

entitled.[586] The Convention also explains how adults and governments must work together to ensure that all children can enjoy all their rights. The rights provided by the UNCRC can be grouped into three types: (i) rights of **protection** (ii) rights of **provision** (which relate to finance and resource distribution) and (iii) rights of **participation**. These are often referred to as the '3 P's of the UNCRC'.

The UNCRC was adopted by the United Nations General Assembly in November 1989 –making 2019 its 30th anniversary.[587] All UN member states except the United States have ratified the Convention.[588] Thus, it is frequently described as 'the world's most widely ratified human rights treaty in history'. The UK government ratified the UNCRC in December 1991 and it came into force in the UK, including Scotland, in 1992. Countries that have ratified the treaty (referred to as 'States Parties' within the text of the treaty) are bound to it by international law.

The UNCRC is widely considered to be a landmark achievement for human rights legislation. The organisation, UNICEF, which provides support and guidance to countries on how to implement the Convention, has stated that:

> *"Contained in [the UNCRC] is a profound idea: that children are not just objects who belong to their parents and for whom decisions are made, or adults in training. Rather, they are human beings and individuals with their own rights. The Convention says childhood is separate from adulthood, and lasts until 18; it is a special, protected*

[586] The UNCRC defines a 'child' as a person under the age of 18 – unless, under the country's laws applicable to the child, majority (i.e. adulthood) is attained earlier.
[587] UNICEF: What is the UNCRC? See www.unicef.org.uk/what-we-do/un-convention-child-rights/ - accessed May 2019.
[588] UN OHCHR, Status of ratification of international human rights treaties. See http://indicators.ohchr.org/ - accessed May 2019.

time, in which children must be allowed to grow, learn, play, develop and flourish with dignity" [589]

The UNCRC General Principles

There are four articles in the Convention that are referred to as the 'General Principles' or 'Core Principles'. They are **not** considered to be the most important articles – since all the articles are equally important. However, these four articles provide the basis for interpreting all the other articles.[590] These are:

- **Non-discrimination (article 2):** This article states that **all** children are entitled to the rights set out on the Convention regardless of their (or their parents' or guardians') race; colour; sex; language; religion; political or other opinion; national, ethnic or social origin; property; disability; birth or other status. Article 2 also states that governments must take steps to prevent discrimination against children on the basis of these characteristics.
- **Best interest of the child (article 3):** This article states that, if certain organisations (public or private social welfare institutions, administrative authorities, courts of law, etc.) take any actions concerning children, they should always do what is in the best interest of the child. Article 3 also says that governments should take appropriate legal and administrative steps to provide for the protection and well-being of children.
- **Right to life, survival and development (article 6):** This article states that every child has the right to life, and that governments must take whatever steps are necessary to support the survival and development of children.

[589] UNICEF, What is the Convention on the Rights of the Child? See https://www.unicef.org/child-rights-convention/what-is-the-convention - accessed May 2019.
[590] UNICEF, About the Convention. See https://www.unicef.org/rightsite/237_202.htm - accessed May 2019.

- **Right to be heard (article 12):** This article states that any child who is capable of forming his or her own views has the right to express those views freely in all matters affecting them. In addition, the views of the child should be given due weight in accordance with the age and maturity of the child. Article 12 also says that, in circumstances involving judicial or administrative proceedings affecting the child, the child should be given an opportunity to be heard (either directly or through a representative or other appropriate body).

Table 1 below provides a list of Articles 1-42 of the UNCRC. *Source: A summary of the UN Convention on the Rights of the Child. https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_summary-1.pdf*. [591]

[591] A copy of the full Convention on the Rights of the Child is available from: https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf - accessed May 2019.

Table 1: United Nations Convention on the Rights of the Child (child-friendly version)

Article 1	Everyone under 18 has all these rights.
Article 2	You have the right to protection against discrimination. This means that nobody can treat you badly because of your colour, sex or religion, if you speak another language, have a disability, or are rich or poor.
Article 3	All adults should always do what is best for you.
Article 4	You have the right to have your rights made a reality by the government.
Article 5	You have the right to be given guidance by your parents and family.
Article 6	You have the right to life.
Article 7	You have the right to have a name and a nationality.
Article 8	You have the right to an identity.
Article 9	You have the right to live with your parents, unless it is bad for you.
Article 10	If you and your parents are living in separate countries, you have the right to get back together and live in the same place.
Article 11	You should not be kidnapped.
Article 12	You have the right to an opinion and for it to be listened to and taken seriously.
Article 13	You have the right to find out things and say what you think, through making art, speaking and writing, unless it breaks the rights of others.
Article 14	You have the right to think what you like and be whatever religion you want to be, with your parents' guidance.
Article 15	You have the right to be with friends and join or set up clubs, unless this breaks the rights of others.
Article 16	You have the right to a private life. For instance, you can keep a diary that other people are not allowed to see.
Article 17	You have the right to collect information from the media – radios, newspapers, television, etc – from all around the world. You should also be protected from information that could harm you.

Article 18	You have the right to be brought up by your parents, if possible.
Article 19	You have the right to be protected from being hurt or badly treated.
Article 20	You have the right to special protection and help if you can't live with your parents.
Article 21	You have the right to have the best care for you if you are adopted or fostered or living in care.
Article 22	You have the right to special protection and help if you are a refugee. A refugee is someone who has had to leave their country because it is not safe for them to live there.
Article 23	If you are disabled, either mentally or physically, you have the right to special care and education to help you develop and lead a full life.
Article 24	You have a right to the best health possible and to medical care and to information that will help you to stay well.
Article 25	You have the right to have your living arrangements checked regularly if you have to be looked after away from home.
Article 26	You have the right to help from the government if you are poor or in need.
Article 27	You have the right to a good enough standard of living. This means you should have food, clothes and a place to live.
Article 28	You have the right to education.
Article 29	You have the right to education which tries to develop your personality and abilities as much as possible and encourages you to respect other people's rights and values and to respect the environment.
Article 30	If you come from a minority group, because of your race, religion or language, you have the right to enjoy your own culture, practise your own religion, and use your own language.
Article 31	You have the right to play and relax by doing things like sports, music and drama.
Article 32	You have the right to protection from work that is bad for your health or education.
Article 33	You have the right to be protected from dangerous drugs.
Article 34	You have the right to be protected from sexual abuse.

Article 35	No-one is allowed to kidnap you or sell you.
Article 36	You have the right to protection from of any other kind of exploitation.
Article 37	You have the right not to be punished in a cruel or hurtful way.
Article 38	You have a right to protection in times of war. If you are under 15, you should never have to be in an army or take part in a battle.
Article 39	You have the right to help if you have been hurt, neglected, or badly treated.
Article 40	You have the right to help in defending yourself if you are accused of breaking the law.
Article 41	You have the right to any rights in laws in your country or internationally that give you better rights than these.
Article 42	All adults and children should know about this convention. You have a right to learn about your rights and adults should learn about them too.

The convention has 54 articles in total. Articles 43 – 54 are about how governments and international organisations will work to give children their rights.

UNCRC optional protocols

As mentioned above, the UNCRC was adopted by the United Nations General Assembly in 1989. Two optional protocols were added to the treaty in 2000. These concern (i) the involvement of children in armed conflicts and (ii) the sale and sexual exploitation of children. A third optional protocol (added in 2011) provides for a process for children whose rights have been violated to submit a written complaint to the Committee on the

Rights of the Child, and to have this complaint investigated. The UK has ratified the first two but not the third optional protocol.[592,593]

Monitoring compliance with the UNCRC

Implementation of the UNCRC is monitored by the UN Committee on the Rights of the Child – an elected group of 18 independent experts chosen from countries around the world[594]. All countries that have signed up to the UNCRC must submit regular reports to the Committee explaining how the rights of children are being implemented. The first report must be submitted two years after ratifying the Convention, and then periodic reports are required every five years following this[595]. A working group of the Committee examines each report and carries out discussions with representatives of the reporting States. In addition to the periodic reports (which are normally produced by the government), the Committee also considers information provided by other human rights treaty bodies. For example, the most recent periodic report from the UK (the fifth periodic report)[596] was accompanied by separate submissions from the UK's Children and Young People's Commissioners[597]. Other organisations in Scotland – including Together (the Scottish Alliance for Children's

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[592] United Nations Office of the High Commissioner on Human Rights (UN OHCHR), Status of ratification of international human rights treaties (webpage, interactive dashboard). See http://indicators.ohchr.org/ - accessed May 2019.
[593] Note, however, that in Scotland, the Children and Young People (Scotland) Act 2014, section 5 gives powers to Scotland's Children's Commissioner to carry out investigations where there is information to suggest that the rights of children may have been, or are, being violated by service providers.
[594] UN OHCHR, Committee on the Rights of the Child. See https://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx - accessed May 2019.
[595] UNICEF, Implementing and monitoring the Convention on the Rights of the Child. See https://www.unicef.org/child-rights-convention/implementing-monitoring - accessed May 2019.
[596] The most recent UK report to the Committee on the Rights of the Child was the fifth periodic report (CRC/C/GBR/5), submitted in May 2014. A copy of this is available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G15/044/91/PDF/G1504491.pdf?OpenElement – accessed July 2019.
[597] The joint report from the UK Children's Commissioners which accompanied the UK's fifth periodic report is available here: *Report of the UK Children's Commissioners. UN Committee on the Rights of the Child. Examination of the Fifth Periodic Report of the United Kingdom of Great Britain and Northern Ireland.* See https://www.cypcs.org.uk/ufiles/UKreport.pdf - accessed July 2019.

Rights)[598] and the Scottish Human Rights Commission[599] – also submitted separate reports.

After reviewing all this information, if the Committee has any concerns or recommendations for improvement, it addresses these to the government in the form of 'concluding observations'. However, the Committee's recommendations are not legally binding, and there is no enforcement process if governments do not comply with the Committee's recommendations.[600]

The Committee's responses to the periodic reports submitted by each country provide a useful barometer of the state of children's rights in that country. Thus, the Committee's most recent 'concluding observations' (dated July 2016) will provide the basis for the discussion in section 4 of this report on the 'official' state of children's rights in Scotland.

United Nations Guidelines for the Alternative Care of Children

Article 20 of the UNCRC says that children have the right to 'special protection and assistance' from the State if they are unable to live with their families. In such circumstances, the State must ensure that

[598] Together (2015) *NGO alternative report to the Committee on the Rights of the Child. Implementation of the UN Convention on the Rights of the Child. Scotland (UK).* See https://www.togetherscotland.org.uk/pdfs/UNCRC_Scotland_NGO_Alternative_Report_2015.pdf - accessed July 2019.

[599] Scottish Human Rights Commission (2016) *The Scottish Human Rights Commission Submission to the United Nations Committee on the Rights of the Child. Report on the United Kingdom's period report under the Convention on the Rights of the Child (CRC).* See http://www.scottishhumanrights.com/media/1063/shrc-report-to-crc-april-2016_final.docx – accessed July 2019.

[600] Copies of the Committee's concluding observations on the United Kingdom's periodic reports relating to the UNCRC are publicly available on the website of the Office of the High Commissioner on Human Rights (UN OHCHR) – together with the concluding observations on reports submitted in relation to other human rights treaties ratified by the United Kingdom – at https://www.ohchr.org/EN/Countries/ENACARegion/Pages/GBIndex.aspx - accessed May 2019.

appropriate 'alternative care' is provided for the child[601]. The full text of Article 20 is as follows:

> *1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.*
>
> *2. States Parties shall in accordance with their national laws ensure alternative care for such a child.*
>
> *3. Such care could include, inter alia, foster placement, kafalah of Islamic law[602], adoption or, if necessary, placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.*

As a result of their programme of monitoring the implementation of the UNCRC in countries around the world, the Committee on the Rights of the Child had become particularly concerned that the rights of children in alternative care are often not being upheld. The Committee's concerns were related to several issues: (i) the large number of children living in alternative care (ii) the fact that many children in alternative care were there for unnecessary reasons (i.e. because of the poverty of their families) (iii) the poor quality of the care provided to these children and (iv) the slow progress being made by countries to improve the conditions in services

[601] Two other articles of the UNCRC also concern the rights of looked after children in alternative care arrangements. These are: article 21 (right to the best care for a child who is adopted, fostered or living in care) and article 25 (right of a child to have his / her living arrangements checked regularly by the state if he / she is looked after away from home).
[602] Information about Islamic *kafalah* is provided in Assim UM and Sloth-Nielsen J (2014) Islamic *kafalah* as an alternative care option for children deprived of a family environment. *African Human Rights Law Journal, 14:* 322-345. Full text is available from: https://bettercarenetwork.org/sites/default/files/Islamic%20Kafalah.pdf – accessed May 2019.

providing alternative care, or to address the reasons that children were coming into these services[603].

Following a period of international collaboration involving representatives of governments, UNICEF, non-governmental organisations, specialists and young people with experience of alternative care from around the world, the *Guidelines for the Alternative Care of Children* were produced in 2009 as a way of supporting countries to address these issues. The Guidelines were adopted by the UN General Assembly in December 2009[604].

The Guidelines offer a rights-based framework and a set of standards for providing services to children and young people who are unable to live with their families. Their purpose is to enhance implementation of the Convention on the Rights of the Child for children who are deprived of parental care, or who are at risk of being so (see Guidelines, paragraph 1). The Guidelines are not intended to cover situations in which a child is 'looked after' by the State but continues to live with his / her parents. They also do not cover situations relating to: young offenders who have been deprived of their liberty; care by adoptive parents (although they are applicable to the pre-adoption or probationary placement of a child with prospective adoptive parents); or informal arrangements where a child voluntarily stays with relatives or friends for reasons not connected with the parents' inability or unwillingness to provide adequate care.

The Guidelines are underpinned by two basic principles:

- **The Principle of Necessity:** The Guidelines emphasise that, first and foremost, all efforts should be made to strengthen vulnerable

[603] Davidson J (2015) Closing the implementation gap: moving forward the UN Guidelines for the Alternative Care of Children. *International Journal of Child, Youth and Family Studies, 6(3):* 379-387.
[604] *Guidelines for the Alternative Care of Children,* UN General Assembly 64th session, A/RES/64/142. Available from: https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf. A formal, printed version of the guidelines is available from SOS Children's Villages: https://www.sos-childrensvillages.org/getmedia/4972cb2e-62e1-4ae8-a0bc-b0e27fe3ea97/101203-UN-Guidelines-en-WEB.pdf - accessed May 2019.

families with a view to keeping the child with their family. If such efforts are not successful or not appropriate then, only in cases of necessity, should the child be placed in 'alternative care'. This principle establishes a clear requirement for the State to provide supportive social work services that aim to prevent the separation of children from their families.

- **The Principle of Appropriateness:** The second principle comes to bear in cases where alternative care is deemed to be necessary, and in the child's best interests. In this situation then the choice of care setting and the period spent in care must be appropriate for each child and must seek to promote stability and permanence. The Guidelines emphasise there should be a presumption in favour of providing alternative care in family-based settings (such as kinship care or foster care), and that the use of residential care should be limited to cases where such a setting is "specifically appropriate, necessary and constructive for the child and in his / her best interests".

The Guidelines clearly set out the responsibility of States to take all necessary steps to ensure that "the legislative, policy and financial conditions exist to provide for adequate alternative care options, with priority to family- and community-based solutions" (Guidelines, paragraph 53). The State must also ensure that there is a range of options available which can be used for emergency, short-term and long-term care (paragraph 54). The issues addressed by the Guidelines include (among other things):

- Family reintegration
- Informal care (i.e. care provided by the child's extended family or friends)[605]

[605] The Guidelines treat formal and informal care distinctively, setting very different thresholds of obligation.

- The conditions / standards which should be met by all forms of **formal** alternative care arrangements (i.e. foster care or residential care facilities)
- The regulation and training of individuals involved in providing alternative care
- The requirement for inspection and monitoring of agencies, facilities and professionals involved in alternative care provision
- The support required by young people making the transition from care to adulthood.

The Guidelines are a non-binding instrument. In other words, they do not have the same status as the UNCRC which is legally binding for those countries that have ratified it. However, the Guidelines were developed through an international collaboration of expert organisations, children and young people, and they were unanimously endorsed by the UN General Assembly - which gives them considerable weight. In addition, the Committee on the Rights of the Child routinely refers to the standards provided by the Guidelines in their concluding observations, as they did in their latest concluding observations on the fifth periodic report from the United Kingdom in 2016[606] (The Committee's comments regarding alternative care provision in Scotland will be discussed in Section 4 of this report).

It is worth noting that the Guidelines may be used, not only at a national level (i.e. in relation to the development and implementation of national policy and / or legislation), but also at a regional and local level – in relation to service planning and delivery. The Guidelines are also relevant to the needs of children with disabilities who are looked after outside of their own families.

[606] Committee on the Rights of the Child (2016) *Concluding observations on the fifth period report of the United Kingdom of Great Britain and Northern Ireland,* CRC/C/GBR/CO/5 – accessed May 2019.

Not long after the Guidelines were published, further work was commissioned to provide a resource to support their implementation[607]. This resource *Moving Forward: Implementing the Guidelines for the Alternative Care of Children,* was developed by researchers at the Centre for Excellence for Looked After Children in Scotland (CELCIS) in Scotland, in collaboration with hundreds of professionals from governments, non-governmental organisations, UN agencies and universities. It reflects practice from more than 70 countries around the world. [608,609] The resource includes a handbook and 43 examples of 'promising practices'. It explores each section of the Guidelines in detail, discusses the implications for policy and practice development and provides a set of international case studies to demonstrate what implementation of the Guidelines might look like in different contexts.

UN Convention on the Rights of Persons with Disabilities (UNCRPD)

Like the UNCRC, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is an international human rights treaty. It aims to "*promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity*". It gives persons with disabilities the same fundamental human rights and freedoms as other people to participate in the civil, political, economic, social and cultural life of their communities[610]. It clearly sets out what public and private

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[607] Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012). *Moving Forward: Implementing the Guidelines for the Alternative Care of Children*. UK: Centre for Excellence for Looked After Children in Scotland. Available from: https://www.alternativecareguidelines.org/ - accessed May 2019.
[608] *Moving Forward: Implementing the Guidelines for the Alternative Care of Children* is available from: https://www.alternativecareguidelines.org/ - accessed May 2019.
[609] Background to Moving Forward, https://www.alternativecareguidelines.org/About/Background/tabid/2814/language/en-GB/Default.aspx - accessed May 2019.
[610] The full text (in English) of the Convention on the Rights of Persons with Disabilities is available from: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html – accessed May 2019.

authorities must do to ensure and promote the full enjoyment of these rights by all people with disabilities.

The UNCRPD applies not only to adults but also to children and young people with disabilities. Thus, it is relevant to disabled children and young people who are looked after. Several articles of the UNCRPD specifically refer to the rights of children with disabilities, including:

- Article 7 states that children with disabilities have the right to express their views freely on all matters affecting them, with their views being given due weight in accordance with their age and maturity, and that States should provide such children with disability and age-appropriate assistance to realise that right.
- Article 23 provides for the right to a family life for children with disabilities. It places an obligation upon the State to provide 'early and comprehensive information, services and support' to children with disabilities and their families – with the aim of preventing neglect or segregation of such children. In addition, in cases where a child's immediate family is unable to care for the child, the State should undertake to provide alternative care within the child's wider family, or within the community in a family setting.

These articles thus echo and reiterate provisions contained in the UNCRC and the standards set out in the *Guidelines for the Alternative Care of Children*. The UNCRPD was adopted by the United Nations General Assembly in 2006 and was ratified by the United Kingdom (including Scotland) in June 2009.

UNCRPD optional protocol

An optional protocol to the UNCRPD provides for a process for people with disabilities whose rights have been violated to submit a written complaint to the Committee on the Rights of the Persons with Disabilities, and to have this complaint investigated. The United Kingdom has not ratified the optional protocol.

Monitoring compliance with the UNCRPD

The monitoring procedures for the UNCRPD are similar to those described above for the UNCRC – i.e. countries are required to submit periodic reports to the relevant UN committee (in this case, the Committee on the Rights of Persons with Disabilities); further information is also gathered by a working group of the committee from official bodies within the country, and then the committee publishes its 'concluding observations'.

The UK submitted its initial report in 2011[611]. This report was accompanied by a joint submission from the UK's main human rights bodies (the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Scottish Human Rights Commission and the Northern Ireland Human Rights Commission). A separate report was also submitted by Scottish Human Rights Commission focusing specifically on the progress in Scotland.[612] The 'concluding observations' of the Committee on the Rights of Persons with Disabilities were published on 3 October 2017.[613] No further reports to the Committee appear to have been submitted by the UK to-date.

United Nations CRC General Comment No. 9 (2006)

While the UNCRPD is the main international legal framework governing the rights of people (including children) with disabilities, the Committee on the Rights of the Child has also been particularly concerned about the failure of countries around the world to protect the rights of children with disabilities. In 2006, the Committee published guidance to assist States in their efforts to implement the rights of children with disabilities. This document 'General Comment No. 9 (2006)' highlights the Committee's

[611] See CRPD/C/GBR/1.
[612] Copies of these reports (and their revised versions) are available at: http://www.scottishhumanrights.com/health-social-care/disability/ - accessed July 2019.
[613] Committee on the Rights of Persons with Disabilities (2017) Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland. CRPD/C/GBR/C0/1. See *https://www.ohchr.org/EN/Countries/ENACARegion/Pages/GBIndex.aspx* - accessed June 2019.

concern that "children with disabilities are still experiencing serious difficulties and facing barriers to the full enjoyment of the rights enshrined in the Convention" (i.e. the UNCRC)[614].

Section VI of General Comment No. 9 specifically addresses the rights of children with disabilities in relation to family environment and alternative care. It highlights that:

- Children with disabilities are best looked after by their own families, provided the family is supported to do so (the nature of the support required is discussed).
- Children with disabilities are vulnerable to all forms of abuse (mental, physical and sexual) in all settings including the family, schools, private and public institutions (*inter alia* alternative care), work environment and community at large.
- There are challenges and difficulties in providing foster care for disabled children (thus requiring the State to provide all necessarily training, encouragement and support to foster carers).
- The use of institutions to provide alternative care for disabled children continues to be a concern, and this type of placement should be considered only as last resort.

General Comment No. 9 is thus, intended to address the concerns that the Committee on the Rights of the Child has about: (i) the lack of adequate support available to families to keep children with disabilities out of alternative care (ii) the lack of suitable placement options for a child to live safely if they cannot live with their families and (iii) the reliance on institutional care for this group of very vulnerable children.

Summary

This section has provided information about the three main international human rights instruments (two legally-binding treaties, and a set of

[614] Committee on the Rights of the Child (2006) *General Comment No. 9*. CRC/C/GC/9. Available from: https://undocs.org/CRC/C/GC/9 - Accessed May 2019.

internationally endorsed guidelines) which are relevant to all children in Scotland – including those who are looked after outside their family home.

The next section will provide a brief summary of how Scotland is doing in relation to its commitments to uphold these instruments – based on the 'concluding observations' of the relevant UN Committees and steps taken by the Scottish Government to implement children's rights in Scotland.

4. The 'official' state of children's rights in Scotland

This section considers the steps taken in Scotland to implement the UNCRC, the Guidelines on the Alternative Care of Children and the UNCRPD in Scottish law, policy and practice.

It addresses the question: 'To what extent are the rights of children being upheld?' The findings presented here are based on reports produced by the Scottish Government and the 'concluding observations' of the UN committees responsible for monitoring implementation of the UNCRC and the UNCRPD. There is a specific focus in this section on the efforts (being) made to uphold the rights of looked after children.

Implementing the UNCRC in Scotland

All governments that have ratified the UNCRC have committed to implementing its principles and provisions in law and practice. However, there is no one single way that this must be done and thus, different governments have taken different approaches to implementation.

The UN Committee on the Rights of the Child, which (as previously noted) has a role in monitoring implementation of the UNCRC around the world, encourages direct and full incorporation of the UNCRC into domestic law – either through statute (i.e. the creation of a new law or laws within the country), or by incorporating it into the country's constitution. These two types of approaches are preferred by the Committee because they give full legal effect to the commitments made by governments. Some countries, including Spain and Belgium, have taken these types of approaches.[615] The Scottish Government (but not the UK Government) is currently

[615] Lundy L, Kilkelly U and Byrne B (2013) Incorporation of the United Nations Convention on the Rights of the Child in law: a comparative review. *International Journal of Children's Rights, 21(3):* 442-463.

considering what full implementation of the UNCRC might look like in Scotland, as will be discussed below.

Other countries have used other legal means to incorporate the UNCRC.[616] For example:

- Some have incorporated the UNCRC **indirectly** into their laws. This mechanism has been used in Scotland, where – under the Children and Young People (Scotland) Act 2014 – there is a duty upon Scottish Ministers to give 'consideration' to the UNCRC across all government functions.[617]
- Some countries have incorporated **selected provisions** of the UNCRC into relevant laws, such as those relating to education or family, rather than incorporating the full UNCRC. Scotland has also used this type of approach, in certain areas, to implementation.

There is also the option to use **non-legal** measures to implement the UNCRC. Such measures might include: (i) the use of national strategies and action plans for children, (ii) the use of 'child impact assessment' processes which require governments to consider the possible impacts on children of new laws, policies and budgetary decisions, (iii) the establishment of the role of 'children's commissioner' or other similar independent ombudsman for children's rights, (iv) the use of 'child budgeting' processes involving the identification, allocation and monitoring of resources spent on children, (v) children's rights training and awareness raising for all those working with and on behalf of children, and

[616] Lundy L, Kilkelly U, Byrne B and Kang J (2012) *The UN Convention on the Rights of the Child: a study of legal implementation in 12 countries*. Queens University Belfast and UNICEF. https://downloads.unicef.org.uk/wp-content/uploads/2012/11/UNICEFUK_2012CRCimplementationreport-FINAL-PDF-version.pdf

[617] Scotland's Commissioner for Children and Young People and Together (2019) *Briefing Paper. Incorporation in Context*. Available at: https://www.cypcs.org.uk/downloads/Incorporation_/Briefing_-_Scottish_Context.pdf – accessed May 2019.

(vi) the collection of data on children's lives.[618] In Scotland, many of these other measures have also been used to support implementation of the UNCRC.

Progress in implementing the UNCRC in Scotland

Over the past decade, Scottish Government Ministers have frequently emphasised and reiterated Scotland's commitment to implement the UNCRC, and highlighted the steps being taken to ensure that the rights of all children and young people in Scotland are realised. The Scottish Youth Parliament (the democratically elected voice of Scotland's young people) has also made the issue of children's rights a high priority – most recently, through its 'Right Here, Right Now' campaign.[619] The main developments over the last decade are set out below.

In 2009, the Scottish Government published 'Do the Right Thing' in response to the 2008 concluding observations of the Committee on the Rights of the Child.[620, 621] This document set out the Scottish Government's plan for progressing children's rights in Scotland, specifically including actions to better secure the rights of looked after children and young people. Some of the commitments were to: (i) support local authorities and community planning partners to strengthen their role as corporate parents, (ii) review the impact of existing regulations that govern the support and assistance provided to care leavers, (iii) work with stakeholders on a campaign to challenge stigma / reduce discrimination, and (iv) improve commissioning processes relating to residential care and secure care.

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[618] Lundy L, Kilkelly U, Byrne B and Kang J (2012) *The UN Convention on the Rights of the Child: a study of legal implementation in 12 countries.*
[619] Scottish Youth Parliament, *Right Here, Right Now'*. See https://www.syp.org.uk/right_here_right_now.
[620] Scottish Government (2019) *Do the Right Thing*. Available at https://www2.gov.scot/Resource/Doc/282927/0085645.pdf - accessed May 2019.
[621] UN Committee on the Rights of the Child (2008) *Consideration of reports submitted by States Parties under Article 44 of the Convention. Concluding observations: United Kingdom of Great Britain and Northern Ireland*, 20 October, CRC/C/GBR/CO/4.

Four years later, in 2013, Scotland's first 'National Action Plan for Human Rights 2013-2017' was published.[622] This document highlighted several areas where further steps were needed to progress the rights of children in Scotland – and the rights of looked after children in particular. The Action Plan stated:

> *"There is a need to improve the support for children and young people leaving care. Similarly, looked after children continue to experience a range of poorer social outcomes and further progress is needed to ensure family contact for looked after children as well as those with parents in prison. Most children in kinship care arrangements are not considered 'looked after children', and therefore do not have access to the same forms of State support." (SNAP, 2013, p. 36.)*

In 2014, the Scottish Parliament passed the Children and Young People (Scotland) Act. This legislation introduced an extensive range of measures intended to strengthen implementation of the UNCRC and to promote the well-being of children and young people. Part 1 of the 2014 Act placed new duties on Scottish Ministers and public bodies to report, every three years, on the steps they have taken to give further effect to the UNCRC requirements (Information about the first of these reports, published in 2018, is discussed below).

The 2014 Act includes additional protections for the rights of children in care or those at risk of being looked after. It does this by:

- Placing corporate parenting duties on a range of publicly funded organisations in respect of looked after children and care leavers, increasing the breadth and depth of support available to those groups of children and young people. (Part 9)

[622] Scottish Human Rights Commission (2013) *Scotland's National Action Plan for Human Rights (SNAP).* Available at: http://www.snaprights.info/wp-content/uploads/2016/01/SNAPpdfWeb.pdf - accessed May 2019.

- Extending eligibility to aftercare assistance up to an individual's 26th birthday. (Part 10)
- Introducing 'continuing care', through which eligible care leavers will have the opportunity to continue, after age 16, with the accommodation and assistance they were provided with before they ceased to be looked after. (Part 11)
- Increasing the support available to children who are at risk of becoming looked after. (Part 12)

Shortly after the 2014 Act received royal assent, the Scottish Government published its 'Getting it Right for Looked After Children and Young People Strategy' (2015) to improve outcomes for looked after children.[623] The strategy explicitly stated that it was based on the UNCRC and aimed to make clear what children can expect from the State and what the State's responsibilities to them are. The emphasis in this strategy was on looked after children's rights to care and protection and their rights to have their views heard. The strategy focused on three priority areas: (i) early engagement with families (also referred to as 'early intervention'), (ii) early permanence for looked after children, and (iii) improving the quality of care. Implementation of this plan is still ongoing.

The state of children's rights among children in care in Scotland – according to the Committee on the Rights of the Child

As noted in Section 3 of this report, having ratified the UNCRC, the UK is required to submit periodic reports to the Committee on the Rights of the Child every five years, explaining how the rights of children are being implemented. As a devolved nation, Scotland's contribution is included as part of the UK periodic reports.

[623] Scottish Government (2015) *Getting it right for looked after children and young people strategy*. Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2015/11/getting-right-looked-children-young-people-strategy/documents/00489805-pdf/00489805-pdf/govscot%3Adocument/00489805.pdf - accessed May 2019.

The Committee's response to these reports provide an indication of how the UK is doing with regards to the implementation of children's rights. In their concluding observations (2016) on the UK's fifth periodic report (the most recent report),[624] the Committee made a number of recommendations specifically in relation to children's rights in Scotland. These included, among others, that:

- Steps should be taken to ensure the full implementation of the action plan entitled Do the Right Thing (2009) and the National Action Plan for Human Rights (2013-2017).
- Steps should be taken to expedite bringing domestic legislation in line with the UNCRC – to "ensure that the principles and provisions of the Convention are directly applicable and justiciable under domestic law".
- A statutory obligation should be introduced to systematically: conduct a child rights impact assessment (CRIA) when developing laws and policies affecting children; ensure the results of these assessments should be published, and that it should be demonstrated how these assessments have been taken into consideration in developing new laws and policies.
- The maximum extent of available resources should be allocated for the implementation of children's rights, with a special focus on eradicating child poverty and reducing inequalities across all jurisdictions.

Specifically, in relation to the implementation of UNCRC article 20 (children deprived of a family environment and thus requiring alternative care), the Committee expressed concerns about the high proportion of children in Scotland who are in care. In their recommendations, the

[624] Committee on the Rights of the Child (2016) Concluding observations on the fifth period report of the United Kingdom of Great Britain and Northern Ireland, CRC/C/GBR/CO/5. See https://www.ohchr.org/EN/Countries/ENACARegion/Pages/GBIndex.aspx - accessed May 2019.

Committee referred to the 'Guidelines for the Alternative Care of Children', highlighting the need to address issues such as:

- The inadequacy of early intervention / support for families
- Frequent change of social workers
- Lack of placement permanency for looked after children
- Children in care being placed at a distance from their biological families
- Inadequate support for care leavers[625]

The committee also raised concerns, and made additional recommendations, about the implementation of other articles of the UNCRC. Those which are particularly relevant to children in alternative care included the following (note that the paragraph numbers cited here relate to the paragraph numbers in the 2016 concluding observations):

- **The use of restraint:** The Committee were concerned about the use of physical restraint on children to maintain good order and discipline in young offenders' institutions and of pain-inducing techniques on children in institutional settings. They recommended that all methods of restraint against children for disciplinary purposes be abolished in all institutional settings – both residential and non-residential; that any technique designed to inflict pain on children should be banned; that the use of restraint should be exclusively for the purpose of preventing harm to the child or others and only as a last resort; and that data on the use of restraint in all institutions should be systematically collected and published. (paragraphs 39 and 40)
- **The use of corporal punishment:** The Committee was concerned about the continuing use of corporal punishment to discipline children and called for the prohibition – as a matter of priority – of all corporal punishment in the family, including through the repeal of

[625] See paragraphs 52 and 53 of the 2016 concluding observations – CRC/C/GBR/CO/5.

legal defences such as 'reasonable chastisement'. They also recommended that corporal punishment be explicitly prohibited in all schools and educational institutions and all other institutions and forms of alternative care. (paragraph 41)

- **Best interests of the child:** The Committee was concerned that the right of a child to have their best interests taken as a primary consideration is still not reflected in all legislative and policy matters and judicial decisions affecting children, especially in the area of alternative care, child welfare, immigration, asylum and refugee status, criminal justice and in the armed forces. They recommended that this right is appropriately integrated and consistently interpreted and applied in all legislative, administrative and judicial proceedings and decisions and in all policies, programmes and projects that are relevant to and have an impact on children. (paragraph 26) (Note that this issue is discussed at length in the evidence review carried out for the Justice work group.)
- **Right of the child to be heard:** The Committee was concerned that children's views are not systematically heard in policy-making processes; and there is inadequate support to enable children to offer their views (particularly in legal proceedings). They recommended that structures are established to support the meaningful participation of children in all matters that concern them. (paragraph 31)
- **Mental health:** The Committee was concerned that children with mental health conditions are often treated far from home, do not receive adequate child-specific attention and support, are placed in adult facilities or may even be detained in police custody because of a shortage of places in mental health clinics. They made a range of recommendations to improve the availability, capacity and quality of child-specific mental health services. (paragraphs 60 and 61)
- **Young offenders:** The Committee made recommendations to address, a wide range of issues in relation to the administration of

juvenile justice, including (i) age of criminal responsibility (currently 8 years old in Scotland, but new legislation will change this to 12); (ii) the reality that some children are tried in adult courts; (iii) the mandatory use in Scotland of 'detention without limit of time' as a sentence for murder committed under the age of 18; (iv) the high proportion of children (including those with psychosocial disabilities) in custody; (v) the imprisonment of children in custody together with adult prisoners; (vi) insufficient access to education and health services for children in custody; and (vii) the use of segregation and solitary confinement for children in custody. (paragraphs 78 and 79) (Note that some of these issues are discussed in the Justice and Care evidence review.)

The state of children's rights among disabled children in care – according to the Committee on the Rights of Persons with Disabilities

In their 2017 concluding observations on the initial report submitted by the United Kingdom under its duties as a State party to the UNCRPD, the Committee on the Rights of Persons with Disabilities expressed concern that parents with disabilities do not receive appropriate services and support, and that this is resulting in children being removed from the family environment and placed in foster care, group homes or institutions.[626] The Committee recommended that appropriate support is provided to parents with disabilities so that they can effectively fulfil their role as parents and ensure that disability is not used as a reason to place their children in care or remove them from the family home.

Scotland compared to the rest of the UK

As discussed in Section 3 of this report, the periodic reports submitted by the UK to the UN Committee on the Rights of the Child present the

[626] UN Committee on the Rights of Persons with Disabilities (2017) *Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland*. CRPD/C/GBR/CO/1.

'official' government perspective on progress in implementing the UNCRC. However, in producing their 'concluding observations', the Committee on the Rights of the Child also takes into account alternative perspectives available in reports from a range of independent, non-governmental bodies.

One of these reports is submitted (jointly) by the Children's Commissioners from the four nations of the UK.[627] This report highlights areas where there are similarities and differences in progress (or lack of progress) between Scotland, England, Wales and Northern Ireland. The most recent report notes that "in Scotland and Wales there has been some progress towards incorporation since 2008", but that these developments have not been mirrored in England or Northern Ireland.[628]

Scottish Government's response to concluding observations – (UNCRC) 2016 and (UNCRPD) 2017

Full incorporation of UNCRC in Scots law

In 2018 – partly in response to the 2016 concluding observations from the UN Committee on the Rights of the Child, and partly as a result of consistent calls from civil society, academia and children and young people – the Scottish Government began to take steps towards full incorporation of the UNCRC, announcing in its Programme for Government (2018-2019) a commitment to 'incorporate the principles of the UNCRC into Scots law'.[629] A joint briefing paper (2019) published by Scotland's Children and Young People's Commissioner and the organisation, Together, noted that the Scottish Government has since clarified that this commitment is about incorporating the full intent of

[627] *Report of the UK Children's Commissioners. UN Committee on the Rights of the Child. Examination of the Fifth Periodic Report of the United Kingdom of Great Britain and Northern Ireland.* See https://www.cypcs.org.uk/ufiles/UKreport.pdf - accessed July 2019.
[628] Ibid, see Chapter 2.
[629] Scottish Government (2018) *Delivering for today, investing for tomorrow. The government's programme for Scotland 2018-2019. See page 5 and page 83. Available at:* https://www.gov.scot/publications/delivering-today-investing-tomorrow-governments-programme-scotland-2018-19/ *- accessed May 2019.*

every article, and not just the (four) General Principles.[630] At the time of writing this report, the Scottish Government was carrying out a public consultation on this issue. This consultation closes on 14 August and therefore, there would be an opportunity for the Independent Care Review to respond.

Progress in implementing the rights of looked after children

In 2018, the Scottish Government also produced its first three-year report on its progress in implementing children's rights in Scotland, in line with the new duties on Scottish Ministers set out in Part 1 of the Children and Young People's (Scotland) Act 2014.[631] Section 5.4 of the report discussed work undertaken to better uphold the rights of looked after children. Specifically, the report described progress to-date in relation to the Government's *Getting It Right for Looked After Children and Young People* strategy (mentioned above), highlighting work undertaken with local authorities and other statutory bodies to improve permanence for looked after children. The report also covered: (i) the establishment of Scotland's Adoption Register (it was noted that in 2017, there were 371 adoptions – the highest annual number of adoptions on record in Scotland); (ii) work to support kinship carers, as well as children and young people living with kinship carers; (iii) new continuing care and aftercare provisions available through the 2014 Act; and (iv) improvements made in educational outcomes for looked after children. Regarding the last point, it was acknowledged that looked after children are still more likely to have poorer educational attainment, and less likely to be in a positive destination nine months after leaving school than their non-looked after

[630] Children and Young People's Commissioner Scotland and Together (2019) *Briefing paper: Incorporation in context*. See https://www.cypcs.org.uk/downloads/Incorporation_/Briefing_-_Scottish_Context.pdf - accessed May 2019.
[631] Scottish Government (2018) *Progressing the human rights of children in Scotland: A report 2015-2018. Report to the Scottish Parliament under Part 1 of The Children and Young People (Scotland) Act 2014*. Available from: https://www.gov.scot/publications/progressing-human-rights-children-scotland-report-2015-2018/ - accessed May 2019.

peers – the gap in educational attainment had narrowed, and a higher proportion of looked after children were in positive destinations than in any previous year since 2009-10.

New three-year action plan on children's rights

This report was accompanied by a new three-year action plan to progress children's rights in Scotland.[632] The action plan includes commitments in four areas: (i) to incorporate the principles of the UNCRC into Scots law; (ii) to evaluate the Child Rights and Well-being Impact Assessment (CRWIA) process and further support and promote its use; (iii) to develop and deliver through co-production, a programme to raise awareness and understanding of children's rights across all sectors of society in Scotland; and (iv) to develop a strategic approach to children and young people's participation in decision-making across all areas of Scottish society.

Development of guidance on the use of CRWIAs

More recently, the government published guidance for public bodies and children's services on when and how to make best use of the children's rights and well-being impact assessment (CRWIA) process.[633]

Legislative change

Finally, in 2019, at the time of writing this report, three new pieces of legislation were being considered by the Scottish Parliament. All three are intended to bring Scottish domestic legislation in line with the aspirations and expectations of the UNCRC by (i) raising the age of criminal responsibility in Scotland from 8 to 12, (ii) providing equal protection to children from assault and abolishing the defence of 'reasonable chastisement' or 'justifiable assault' that parents (and others caring for or in charge of children) can use to justify the use of physical force to

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[632] Scottish Government (2018) *Progressing the human rights of children in Scotland: An action plan 2018-2021*. Available from: https://www.gov.scot/publications/progressing-human-rights-children-scotland-action-plan-2018-2021/ - accessed May 2019.
[633] Scottish Government (2019) *Children's rights and wellbeing impact assessments: guidance*. See https://www.gov.scot/publications/childrens-rights-wellbeing-impact-assessments-crwia-guidance/ - accessed May 2019.

discipline a child, and (iii) ensuring that the information sharing provisions of Parts 4 and 5 of the 2014 Act are in accordance with the law; and the rights of children, young people and parents are respected when information is shared under Part 4 and 5 of the 2014 Act.

Children with disabilities in care

According to information published by the Scottish Government in April 2014, there were no specific actions being taken for disabled children, or disabled children in care, to better safeguard, protect and promote their rights.[634] In addition, the Scottish Government's five-year delivery plan for implementing the UNCRPD (published in 2016) included a small number of actions intended to better support families with disabled children, but gave almost no attention to disabled children in the care system.[635]

Baker (2011) has pointed out that disabled children constitute a significant group in the 'care system'. There is evidence that they are more likely than non-disabled children to be looked after, to remain in care for longer and have a higher risk of being placed inappropriately. Whilst in care there may be particular barriers to achieving permanency and stability for disabled looked after children.[636] In addition, communication difficulties may

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[634] Scottish Government (2019) *Supporting disabled children, young people and their families: guidance*. See the section on 'Rights Awareness: How are we supporting the rights of disabled children in Scotland?' See https://www.gov.scot/publications/supporting-disabled-children-young-people-and-their-families/pages/rights-awareness/#How%20are%20we%20supporting%20the%20rights%20of%20disabled%20children%20in%20Scotland? – accessed May 2019.

[635] Scottish Government (2016) *A Fairer Scotland for Disabled People. Our Delivery Plan to 2021 for the United Nations Convention on the Rights of Persons with Disabilities*. See *https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2016/12/fairer-scotland-disabled-people-delivery-plan-2021-united-nations-convention/documents/00510948-pdf/00510948-pdf/govscot%3Adocument/00510948.pdf* - accessed May 2019. A single action, relating specifically to children with a learning disability and / or autism, involves the introduction of an 'enhanced learning and development framework for foster carers which is intended to support them to develop and enhance skills to care for all children, **including disabled children**, looked after in foster care'. (See page 16, action 25.)

[636] C Baker (2011) Permanence and stability for disabled looked after children. IRISS Insight 11. See https://www.iriss.org.uk/resources/insights/permanence-stability-disabled-looked-after-children - accessed July 2019.

present significant challenges in relation to being heard and in upholding the rights of disabled children in care.

Although a range of action plans, policy initiatives and legislative changes have been taken forward in Scotland to ensure that the rights of children and young people are better protected and respected, the rights of disabled children in care have received relatively limited attention. Despite this group being at greater risk of their rights not being upheld.

Summary

Over the past decade, the Scottish Government has worked towards raising awareness of the issue of children's rights and improving compliance with the UNCRC. To date, children's rights have been incorporated into domestic law in a piecemeal fashion, largely through inserting certain articles of the UNCRC into domestic legislation. As of 2019, the Scottish Government is now considering how best to fully incorporate the UNCRC into Scots law.

The evidence presented in this chapter indicates that efforts have been made to address areas of concern highlighted by UN Committee on the Rights of the Child regarding the implementation of children's rights in Scotland – and the implementation of rights for looked after children, in particular. Less evidence was available about the ways in which the Scottish Government is responding to the particular challenges of implementing the rights of looked after children who are disabled.

5. The reality of children's rights for children and young people in care

This section discusses what children and young people in care say about the reality of children's rights. Specifically, it highlights aspects of the 'care system' where children and young people say that their rights are not always being respected or upheld.[637]

The focus here is on the experiences and views of looked after children and care leavers – based mainly on two major reviews carried out in Scotland[638] and England,[639] and one international review which included 20 primary research studies and one review paper.[640] None of these reviews reported on the experiences and views of disabled children in care.

The reviews highlighted specific areas where children and young people in care felt that their rights are not always respected or upheld, including: the right to expect adults to always do what is in their (the children's) best interest (article 3); the right of the child to preserve their identity, including nationality, name and family relations as recognised by law without unlawful interference (article 8); the right of a child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best

[637] Note that these reviews do also report positive experiences of children's rights being upheld for children in care. These experiences will be discussed in Section 8 of this report.
[638] Elsley S, Tisdall EKM and Davidson E (2013). *Children and young people's experiences of, and views on, issues relating to the implementation of the United Nations Convention on the Rights of the Child.* Scottish Government. See https://www2.gov.scot/resource/0042/00427287.pdf - accessed July 2019.
[639] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015) *Children and young people's views on being in care. A literature review.* See https://coramvoice.org.uk/sites/default/files/Children%27s%20views%20lit%20review%20FINAL.pdf – accessed July 2019.
[640] Van Bijleveld GG, Dedding CWM and Bunders-Aelen JFG (2015) Children's and young people's participation within child welfare and child protection services: a state-of-the art review. *Child and Family Social Work, 20:* 129-138. Sixteen of the 20 primary research studies covered in this review were undertaken in the UK between 1995 and 2012.

interests (article 9); the right to spend time with friends (article 15); and the right to privacy (article 16) (among others).

These are discussed below in relation to the experiences of (i) coming into care, (ii) placements, and (iii) the transition out of care (including aftercare support).

Coming into care

Children and young people reported a lack of information, especially at the point of entering care. Some stated that they were not well informed about why they were in care, what they could expect, where they were being taken, or what was happening to their other family members.[641, 642]

Young people wanted information to help them understand why they were in care, but some reported having had to fight to access their files – they thought – because of adults' perceptions that it would upset them.[643]

Placements

The importance of relationships

Children and young people consider relationships to be important but feel that their relationships are not prioritised by professionals or carers. They highlight that little attention is paid to enabling them to maintain long-standing relationships with birth family members, previous carers or social workers.[644]

Children and young people reported experiences of being placed far from family members and / or friends and being separated from siblings.[645] Separation from siblings is described as particularly devastating for children whose siblings had previously had responsibility for caring for them (e.g. when their parents were misusing substances).[646]

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[641] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[642] Van Bijleveld *et al* (2015).
[643] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[644] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[645] Elsley *et al* (2013).
[646] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).

In addition, those living in residential care highlighted the restrictive culture in this type of placement which impacted on relationships with friends.[647] These restrictions made it impossible to have friends over for meals or sleepovers, or to stay with friends unless police checks took place. Taking part in activities could also be hindered due to health and safety requirements.

Young people wanted to be kept informed about their birth family and some wanted more contact – although notably this does not always mean they necessarily want to return to their birth families.[648] Missing their families / siblings sometimes resulted in some young people going missing from their placements, or taking steps to see their family members without the knowledge of their social worker. At the same time, some young people want **less** contact with their birth families and may run away from a placement to avoid contact with their birth parents. Children highlighted the importance of being listened to with respect to their wishes about family contact.

Lack of permanence in care placements

Children and young people reported experiencing too many moves whilst in care, and having little involvement in planning decisions about placement moves.[649] At the same time, they said that their sense of belonging was adversely affected by frequent placement moves as well as by the places they lived, such as residential units.

Lack of choice

Some reported a lack of choice and control in relation to aspects of their placements including the type of placement, where they would live, and the food available to them.[650]

Need for privacy and security

[647] Elsley *et al* (2013).
[648] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[649] Elsley *et al* (2013).
[650] Elsley *et al* (2013).

Being able to make spaces their own (having their own bedroom) was important to children and young people, as was a need for privacy and security whilst in care.[651, 652]

Care standards and quality

Children and young people in foster care said that their experiences were varied and inconsistent in quality.[653] Some said that they were not always treated in the same way as other members of the foster carer's family.

Young people found it difficult to make complaints about their placements due to the possible consequences if they complained – whether that involved having to continue to live in the same place, or being moved into a worse situation.[654]

Educational needs during placements

Children and young people with additional support needs said that they did not always know what to do if they had concerns about school. They were also anxious about being bullied if other pupils knew they were receiving additional support at school.[655]

Health and wellbeing

Young people identified a lack of therapeutic support and wanted counselling to be more available to looked after children.[656] This was seen as particularly important by young people who had suffered a family bereavement.

Involvement in decision-making

Some children and young people reported feeling that they had limited opportunities to participate in decision-making processes involving their lives, or they had no opportunities at all.[657] Others said that, when they

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[651] Elsley *et al* (2013).
[652] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[653] Elsley *et al* (2013).
[654] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[655] Elsley *et al* (2013).
[656] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[657] Van Bijleveld *et al* (2015).

were consulted they did not feel that their views were necessarily valued or acted upon, or that they had insufficient or inconsistent opportunity to express their views. Some said that they were allowed to influence trivial decisions, but that professionals did not let them participate in decisions that they considered to be important, such as where they lived, contact with parents and siblings and choice of school.

Other issues relating to placements

Young people living in secure care said that they did not get enough information or were insufficiently consulted about the move to secure care.[658] Young people in secure care welcomed contact with their families but said that the opportunities for contact were limited.

Children and young people with a Home Supervision Requirement (HSR) did not always understand why they had an HSR.[659] While some welcomed the mentoring, informal coaching and other forms of support that HSRs provided, other complained about the frequent changes in social workers and other staff.

Transitions out of care

Children and young people wanted to be more involved in decision-making in relation to the transition out of care, and they highlighted a need for more support, both in preparing to leave care and after they had left care.[660] Care experienced children and young people who had additional needs often struggled with transitions into adult services and were poorly supported.[661] Having insufficient financial resources was a particular concern for children and young people's in their transitions to independent living.[662]

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[658] Elsley *et al* (2013).
[659] Ibid.
[660] Ibid.
[661] Elsley *et al* (2013)
[662] Ibid.

Experiences of recent changes in Scotland to better support care leavers

More recently, the Children and Young People (Scotland) Act 2014 introduced new provisions which give care experienced young people over the age of 16 the right to stay in their existing placement until the age of 21. However, there is some anecdotal evidence to suggest that not all young people in care are being informed of this right, and that (at least some) residential services are still encouraging young people to leave care at age 16 before they feel ready to.[663] In addition, a lack of clear guidance in relation to other entitlements for care experienced children and young people has resulted in inconsistencies in practice. For example, the entitlement to the 'Care Experienced Bursary'– with some young recipients being asked to pay for accommodation or food in residential children's homes which were previously provided free of charge.[664]

Summary

Reviews which gathered information about the experiences and views of children and young people in care identified that children's rights are not always being respected and upheld. A recurring theme in these studies was that children and young people often do not have sufficient information or opportunity to participate meaningfully in decisions that concern them.

[663] Continuing Care, Together blog, 24 May 2019 https://togetherscotland.blog/2019/05/24/continuing-care/ - accessed June 2019.
[664] Care Experienced Bursary, Together blog, 20 May 2019, https://togetherscotland.blog/2019/05/20/care-experienced-bursary/ - accessed June 2019.

6. Impacts / benefits of implementing children's rights

As discussed in Section 4, there is a policy intention in Scotland to implement the UNCRC and other related international rights frameworks and guidelines, and there have been a range of action plans, strategies and changes in legislation to support this intention. However, as discussed in Section 5, the reality for children and young people involved in the care system is that their rights are not already respected or upheld.

This section discusses the difference that it makes to children and young people if their rights **are** respected and upheld. The focus here is specifically on UNCRC Article 12 (the right of the child to be heard in matters that concern them) and their participation in decision-making. There are three reasons for this focus.

- First, the UNCRC contains 54 articles which set out the civil, political, economic, social and cultural rights that all children are entitled to. It is not within the scope of this report to examine the evidence (or lack of evidence) of impact relating to the totality of the UNCRC.
- Second, there is good evidence available in relation to the impact for children and young people of participating in decisions that affect them. Numerous studies (including some reviews) have looked at young people's experiences of participation in child protection and

child welfare contexts,[665, 666, 667] in looked after child reviews,[668, 669] in family and civil law proceedings,[670, 671] in youth justice contexts,[672] and in the planning of services (including services for looked after children),[673] among others.

- Third, and most importantly, care experienced children and young people consistently identify the right to participate and be consulted in decisions that affect them as fundamental in their lives (refer back to section 5 of this report).

Both the benefits of participation and the negative impacts of a lack of participation are considered. First, however, this section will briefly consider what is known about the impact on children and young people of implementing the UNCRC **at a national level**, and (ii) evidence on the links between children's **knowledge and perceptions** of their rights and their **self-reported** well-being.

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[665] Van Bijleveld GG, Dedding CWM and Bunders-Aelen JFG (2015) Children's participation within child welfare and child protection services: a state-of-the-art review. *Child and Family Social Work, 20*: 129-138.
[666] Heimer M, Näsman E and Palme J (2018) Vulnerable children's rights to participation, protection and provision: The process of defining the problem in Swedish child and family welfare. *Child and Family Social Work, 23:* 316-323.
[667] Cossar J, Brandon M and Jordan P (2014) 'You've got to trust her and she's got to trust you': children's views on participation in the child protection system. *Child and Family Social Work,* doi:10.1111/cfs. 12115.
[668] Pert H, Diaz C and Thomas N (2017) Children's participation in LAC reviews: a study in one English local authority. *Child and Family Social Work, 22:* 1-10.
[669] Roesch-Marsh A, Gillies A and Green D (2017) Nurturing the virtuous circle: Looked After Children's participation in reviews, a cyclical and relational process. *Child and Family Social Work, 22:* 904-913.
[670] Daly A and Rap S (2018) Children's participation in youth justice and civil court proceedings. In Kilkelly U and Liefaard T (eds.) *International Human Rights of Children.* Springer, pp. 1-21.
[671] McCarthy F (2015) The rights of the child in Scotland. In: Cvejic-Jancic O (ed.) *The Rights of the Child in a Changing World: 25 Years after the UN Convention on the Rights of the Child.* Series: Ius Comparatum - global studies in comparative law (13). Springer, pp. 235-250.
[672] Daly A and Rap S (2018) Children's participation in youth justice and civil court proceedings. In Kilkelly U and Liefaard T (eds.) *International Human Rights of Children.* Springer, pp. 1-21.
[673] Thomas N and Percy-Smith B (2012) 'It's about changing services and building relationships': evaluating the development of Children in Care Councils. *Child and Family Social Work, 17:* 487-496.

UNCRC implementation in national law – evidence of impact on children

Lundy *et al* (2013) undertook research for UNICEF UK which involved comparing the legal implementation of the UNCRC in 12 countries (Australia, Belgium, Canada, Denmark, Germany, Iceland, Ireland, New Zealand, Norway, South Africa, Spain and Sweden). The overall purpose of the study was to research examples of incorporation of the UNCRC in countries other than the UK, to identify the most effective and practical ways of embedding children's rights into domestic law. One of the main objectives of this study was to determine what, if any, impact legal incorporation of the UNCRC had on children's lives.[674] The research involved the examination of available childhood data sets (including international indices such as UNICEF scorecards, the PISA survey and WHO statistics). However, the researchers concluded that *"it was impossible to track chains of causation between legal implementation of the CRC and improved children's outcomes"*. On the other hand, through interviews with key stakeholders,[675] it was possible to explore the **perceived** impacts of legal implementation – and the extent to which these developments played a role (or not) in building a culture of respect for children's rights.

Some of the findings of this study were that:

- The legal and policy responses to implementation of the UNCRC varied from one country to another and were largely determined by each country's legal and administrative structures, and the political

[674] Lundy l, Kilkelly U and Byrne B (2013) Incorporation of the United Nations Convention on the Rights of the Child in Law: A Comparative Review. *International Journal of Children's Rights, 21(3):* 442-463.
[675] Stakeholders included representatives from the relevant government department or agency responsible for children's rights; the Children's Commissioner / Ombudsperson (where established); leading academics and researchers; lawyers; children's sector organisations; service providers and practitioners; and individuals directly involved in the development and out-workings of the legislative model as appropriate.

and public attitudes to international human rights law in general, and to children's rights in particular.

- In countries where there had been specific, high-level incorporation of the UNCRC (for example, in the constitution or through an act of general implementation), interviewees were more likely to say that children were perceived as rights-holders and that there was a culture of respect for children's rights. However, it was not clear whether a (pre-existing) respect for children's rights prompted a more systematic incorporation of the UNCRC, or vice-versa – whether incorporation of the UNCRC resulted in an enhanced culture of respect.
- The process of discussion and consultation which took place in countries in relation to the question of incorporation was reported to have a positive impact in raising awareness, advancing understanding and engaging with key stakeholders (including young people), even when the outcome of that did not result in incorporation.
- Where it had taken place, incorporation provided the basis for a range of other (legal and non-legal) measures and initiatives to support implementation of the UNCRC within the country.
- Incorporation provided opportunities for the UNCRC to be used in litigation in relation to 'strategic cases' and had resulted in the UNCRC being perceived as part of the legal discussion in court cases but had not 'opened a floodgate of strategic litigation involving children'.
- In all countries in the study, the most vulnerable groups of children (those separated from their families, asylum seekers, indigenous children and those involved in the criminal justice system) continued to fare less well that their peers, irrespective of the steps taken to incorporate the UNCRC. However, this finding was generally linked by interviewees to higher levels of poverty and social exclusion among these groups. At the same time, some interviewees

suggested that a benefit of incorporation was that it provided "a line over which government could not step in relation to the introduction of austerity measures".

- A recurring theme in relation to impact was the fact that the implementation of children's rights was not consistent across different regions within a single country, even where there had been significant steps to incorporate the UNCRC at a high level. This was because the key responsibility for ensuring implementation in law, policy and practice rested with devolved or federated regions which were responsible for areas such as education, health and social care.

Children's perceptions of their rights and their subjective well-being

Casas *et al* (2018) explored the relationship between children's knowledge and perceptions about their rights and their subjective well-being in children aged 8, 10 and 12, in 18 countries. The study found that children who said they knew their rights, knew about the CRC, or thought that children's rights were respected by adults in their country had higher (i.e. better) scores on an international measure of children's life satisfaction.[676] In fact, the effect of **perceiving** that adults respected the rights children in their country had a stronger association with subjective well-being than knowing about children's rights or knowing about the UNCRC.

The impact of participation on looked after children and care leavers

The remainder of this section summarises key findings from reviews that have investigated the impacts on care experienced children and young people of participating in decisions that affect their lives whilst in care. This issue is identified in the research literature as being directly related to the realisation of UNCRC Article 12 (the right of the child to be heard) in the

[676] Casas F, Gonzalez-Carrasco M and Luna X (2018) Children's rights and their subjective well-being from a multinational perspective. *European Journal of Education Research, Development and Policy*. https://doi.org/10.1111/ejed.12294.

lives of looked after children. The Committee on the Rights of the Child discusses this concept of 'participation' in their General Comment No. 12 (2009)[677]:

> *'A widespread practice has emerged in recent years, which has been broadly conceptualized as 'participation', although this term itself does not appear in the text of article 12. This term has evolved and is now widely used to describe ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes.' (paragraph 3)*

Positive impacts of participation in decision-making

A review carried out by van Bijleveld *et al* (2015) reported that participation in decisions about their lives helps children feel connected and committed to the decisions that are taken. It may lead to an increase in self-esteem and is associated with an increased feeling of mastery and control.[678] This same review found that children and young people said they 'felt good about themselves and valued' when social workers took their concerns seriously.

Being involved in decision-making processes was also perceived by children and young people as "a way of showing care and of building a positive relationship" between young people and professionals.[679] Children reported more positive experiences of participation in general when they felt that their social worker had listened to their views. In fact, children said

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[677] Committee on the Rights of the Child (2009) *General comment no. 12: The right of the child to be heard.* CRC/C/GC/12. See https://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf - accessed July 2019.
[678] Van Bijleveld *et al* (2015).
[679] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015) *Children and young people's views on being in care. A literature review.* See https://coramvoice.org.uk/sites/default/files/Children%27s%20views%20lit%20review%20FINAL.pdf – accessed July 2019.

it was more important to them that they were listened to than that they got what they wanted.[680]

Young people who had experienced sexual abuse emphasised the importance of information and explanations. This group often felt isolated, confused and had low self-esteem. Being involved in decision-making was seen as crucial, since it helped them feel they had regained some power after a particularly powerless experience.[681]

Positive experiences of participation among looked after children were reported to be dependent to a large extent on whether the young person trusted and had a good relationship with their social worker.[682, 683] Children and young people in care emphasised the importance of having trusted adults to help them to speak out – whether these are independent advocates, other professionals or family and friends.[684]

Negative impacts from lack of participation

On the other hand, Van Bijleveld *et al* (2015) found that the lack of opportunity to participate in decision-making resulted in children feeling 'ignored and overlooked' and led to reduced self-esteem.[685]

Lack of information / discussion had a negative impact on children and young people's feelings of power and control.[686] Some said they felt scared and unsafe when moving to a new placement because they did not know where they were going and whom they would be living with.[687] Others

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[680] Van Bijleveld *et al* (2015).
[681] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[682] Van Bijleveld *et al* (2015),
[683] Wood M and Selwyn (2017) Looked after children and young people's views on what matters to their subjective well-being. *Adoption & Fostering, 41(1):* 20-34.
[684] Elseley S, Tisdall EKM and Davidson E (2013) *Children and young people's experiences of, and views on, issues relating to the implementation of the United Nations Convention on the Rights of the Child.* Scottish Government. See https://www2.gov.scot/resource/0042/00427287.pdf - accessed July 2019.
[685] Van Bijleveld *et al* (2015).
[686] Elsley *et al* (2013).
[687] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).

reported feeling 'helpless' and 'desperate' as a consequence of not being involved in decision-making processes.[688]

Children and young people also said that they felt powerless when plans were not implemented as agreed and when, having raised their concerns, their concerns were not addressed.[689] They said they felt 'frustrated' when their choices were not addressed or acted upon, often with no explanation given. When children had the feeling issues they considered to be important were being ignored or rejected as irrelevant, some reported exercising choice in other ways, such as through rebelling or withdrawing. Among younger children (aged 4 to 7) lack of consultation and / or opportunity to participate led to feelings of guilt, sadness, anger and worry.[690]

Some pointed out that if they only had the opportunity to have a say, there would be a greater likelihood of a successful placement, a positive relationship with their social worker, and more positive experiences at school[691] – a view which is (at least partly) supported by evidence from Sweden.[692]

Summary

The systematic incorporation of the UNCRC into national laws can have positive effects in terms of how children's rights are perceived and implemented in practice. However, it is difficult to demonstrate the impact of national laws on children and young people in care because legislation provides only part of the jigsaw. In relation to children and young people in care, the delivery of children's rights generally takes place at a regional / local level, and through service providers.

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[688] Van Bijleveld *et al* (2015).
[689] Ibid.
[690] Ibid.
[691] Van Bijleveld *et al* (2015).
[692] Heimer M, Näsman E and Palme J (2018) Vulnerable children's rights to participation, protection and provision: The process of defining the problem in Swedish child and family welfare. *Child & Family Social Work, 23:* 316-323

Studies that demonstrated positive impacts on children's well-being where children perceive that their rights are generally respected by adults, and (for looked after children) where they have actively participated in decision-making processes.

7. Barriers and challenges to upholding the rights of children in care

This section sets out some of the barriers to and challenges of upholding children's rights. The next section (Section 7) discusses what helps to support upholding children's rights.

The focus in both these sections will be on the rights of children and young people in care and care leavers. However, it is important to emphasise that **all of the rights** set out in the UNCRC apply to looked after children as much as they do to children who are not looked after. Therefore, any barriers and challenges in upholding the rights of children and young people in general will undoubtedly also be experienced by children and young people in care. At the same time, children and young people in care may experience **additional** barriers and challenges in having their rights upheld simply because of their involvement with statutory processes and the larger number of professionals involved in their lives.

The evidence indicates that barriers and challenges to upholding the rights of children in care exist in a number of different forms and at different levels. This section discusses four of these:

- The non-compliance of Scottish legislation with the UNCRC (or the UNCRPD)
- Lack of knowledge of children's rights and the UNCRC by children and young people in care
- Professional attitudes / practices
- Media attitudes towards human rights / children's rights.

Non-compliance of existing legislation with UNCRC

As discussed in Section 3 of this report, part of the approach taken by the Scottish Government to-date in relation to the implementation of the UNCRC has involved inserting certain provisions of the UNCRC into relevant new or existing laws – rather than taking the approach of full incorporation. New laws (e.g. the Children and Young People (Scotland) Act 2014, the Human Trafficking and Exploitation (Scotland) Act 2015) have had the aim of giving greater statutory protection to children's rights, and the rights of looked after children in particular.

However, those who have been calling for the full incorporation of the UNCRC in Scots law, have pointed out that the current approach has resulted in a lack of alignment between the UNCRC and children's rights within Scottish legislation. One of the most fundamental of these disparities is in relation to the definition of 'a child'. Article 1 of the UNCRC states that:

> *'For the purposes of the present Convention, a child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.'*

Thus, according to the UNCRC, childhood lasts until age 18.

In England, Northern Ireland and Wales, a child is someone who has not yet reached their 18th birthday. Once they turn 18, they are legally an adult. However, in Scotland, the legal definition of 'a child' varies according to the legal circumstances.[693] Part 1 of the National guidance for child protection in Scotland explains that a child is generally defined as someone under the age of 18. But in some child protection contexts, including in children's hearings and in relation to child protection orders, a child is someone who

[693] National Society for the Protection of Cruelty to Children (NSPCC) *A child's legal rights. Legal definitions*. See https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/legal-definitions/ - accessed July 2019.

is under 16.[694] There are also different laws across the UK that specify age limits for young people in different circumstances. These include leaving care; the age of consent; and the age of criminal responsibility. The lack of consistency in the legal definition of 'childhood' in Scots Law has significant implications for young offenders aged 16 and 17 in particular. (The impact of the way in which a 'child' is defined in the Children's Hearings (Scotland) Act 2011 is discussed at length in the review carried out for the Justice and Care workgroup.)

It is also worth noting that, in Scotland, current legislation also defines the minimum age for marriage as 16.[695] Historically, the minimum age for marriage in Scotland has been lower than in England.[696] Nevertheless, in their 2016 concluding observations, the UN Committee on the Rights of the Child raised concerns about the practice of forced marriage in the UK, and specifically recommended that the minimum age of marriage should be raised to 18 years across all the UK's devolved administrations, overseas territories and Crown dependencies.[697]

Barriers to greater implementation of the UNCRC in Scots law

Tisdall (2015) presents a critical analysis of the Parliamentary debates and submissions relating to the development of the Children and Young People (Scotland) Bill.[698] Her analysis highlights the tension that arose during the bill's passage through Parliament between the concepts of children's rights and children's well-being. Tisdall noted that the original focus of the bill – on children's rights – was gradually replaced over time by a greater focus on children's well-being. She suggested that the arguments in favour of a focus on children's well-being were largely

[694] Scottish Government (2014) *National Guidance for Child Protection in Scotland*. See https://www2.gov.scot/Resource/0045/00450733.pdf - accessed July 2019.
[695] Marriage (Scotland) Act 1977, section 1.
[696] A fact which explains the popularity of the village of Gretna Green (on the border between England and Scotland) as a wedding venue.
[697] Committee on the Rights of Child (2016) *Concluding observations*. CRC/C/GBR/CO/5, paragraph 20.
[698] Tisdall EKM (2015) Children's wellbeing and children's rights in tension? *International Journal of Children's Rights, 23:* 769-789.

successful because these arguments "*continue the familiar trajectory of a needs-based approach*" to providing services to children and young people. A focus on well-being also sits more comfortably within an outcomes-oriented approach to delivering public policy as it can be more easily measured, and it has the advantage of supporting an emphasis on early intervention and prevention.

It is worth noting that this same argument has been made by the Children's Rights Alliance for England (CRAE)in relation to the barriers to legislative implementation of the UNCRC in England. CRAE have suggested that a well-being / welfare / needs-based framework is sometimes seen as more acceptable to policy makers. This may be because a rights-based framework 'puts the child on an equal footing to adults and provides a clearer accountability mechanism, which could be seen as unpalatable' to politicians and policy makers.[699]

Children and young people's lack of awareness of their rights and the UNCRC

Elseley *et al* (2013) found that children and young people (in general) had low levels of awareness and knowledge of both human rights institutions (including the Children and Young People's Commissioner in Scotland) and the UNCRC. Moreover, an understanding of the relevance of the UNCRC was lowest amongst those with the highest needs and greatest use of services.[700] Wood and Selwyn (2017) found that children and young people wanted to be more involved in decision-making but were unaware of their rights according to Article 12 of the UNCRC.[701]

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[699] Children's Rights Alliance for England (2017) *Barriers and solutions to using children's rights approaches in policy*. See http://www.crae.org.uk/media/123572/Barriers-and-solutions-to-using-childrens-rights-in-policy-E.pdf - accessed July 2019.
[700] Elsley S, Tisdall EKM and Davidson E (2013), *Children and young people's experiences of, and views on, issues relating to the implementation of the United Nations Convention on the Rights of the Child*. Scottish Government. See paragraph 3.1, https://www2.gov.scot/resource/0042/00427287.pdf - accessed July 2019.
[701] Wood M and Selwyn J (2017) Looked after children and young people's views on what matters to their subjective well-being. *Adoption & Fostering, 41(1):* 20-34.

Professional attitudes, practices and level of experience

Public services play a key role in the lives of **all** children and young people, but especially so in relation to the lives of children and young people in care. However, the Unicef UK Child Rights Partners (2014) have noted that services, by approaching children as passive recipients defined by a set of needs and undervaluing their contributions as capable and resourceful individuals entitled to legally enshrined rights, risk systematically excluding the group they aim to support.[702] Central to this issue is the power dynamics in the relationships between adults (as duty bearers) and children and young people (as rights holders) – and the way in which these power dynamics play out – which can affect children and young people's everyday experiences.

Van Bijleveld *et al* (2015) has highlighted the complexity of the work which is done by social workers working in the area of child welfare and child protection.[703] Social workers are required by law to act in the best interest of and to safeguard the child. They are also expected to listen to the child and liaise with families and carers and with a range of other organisations on behalf of the child. Thus, social workers have to determine what is in the child's best interests while also dealing with numerous other stakeholders who have their own (sometimes) conflicting interests, rights and needs.

Specifically, in relation to the child's right to be heard in decisions that affect them, social workers must find a way of balancing the child's right to participation with the child's right to protection. Van Bijleveld *et al* (2015) highlighted that one of the main reasons that social workers give for **not** involving children in decision-making processes relates to a desire to

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[702] Unicef UK Child Rights Partners (2014) *Local authorities as child rights champions. Transforming services, improving outcomes. Event report. Executive Summary.* See https://www.unicef.org.uk/child-rights-partners/wp-content/uploads/sites/3/2015/12/CRP_event_executive_summary_final.pdf - accessed July 2019.

[703] Van Bijleveld GG, Dedding CWM and Bunders-Aelen JFG (2015) Children's and young people's participation within child welfare and child protection services: a state-of-the-art review. *Child & Family Social Work, 20:* 129-138.

protect them. If social workers generally perceive children to be 'vulnerable' and 'in need of protection', the child's opportunities to participate in decision-making processes are limited. Studies have shown that case managers are less likely to encourage children to participate if the case relates to abuse or neglect, or if the child is very young (particularly those under five).

At the same time, social workers understand the concept of 'participation' in different ways, and this can result in very different experiences among children. Some social workers see participation as giving the child an opportunity to express his or her views; others see it simply as giving the child information about what has been decided, or what is going to happen. Some social workers see participation as consulting the child, but don't think that it means the child should be able to influence decision-making.[704]

Social workers' attitudes towards individual children also have an effect. Van Bijleveld *et al* report that studies have shown that if the social worker describes the child as 'sensible', the child's views are more likely to be taken seriously and given more weight than children whose views do not appear to the social worker to be rationale or sensible, or where the child is perceived to not know about alternative ways of living, or to have an 'untrustworthy' character.

Finally, studies have consistently reported that the child's relationship with his / her social worker is the key to meaningful participation by the child in decision-making – both children and social workers agree on this point.[705, 706, 707] However, not all social workers find it easy to create good relationships with children; some do not feel competent or comfortable carrying out individual consultations with children. Where there is **not** a

[704] Ibid.
[705] Ibid.
[706] Elsley *et al* (2013).
[707] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015) *Children and young people's views on being in care. A literature review.*

good relationship, it becomes difficult for social workers to know whether the child is telling the truth, or whether the child's perspective has been unduly influenced by parents or other adults.[708]

Barriers and challenges in hearing the views of disabled care experienced young people

With regards to the participation of disabled children and young people in child welfare and child protection proceedings, the issues above are likely to also apply. However, there are other challenges which are specific to this group.

Taylor *et al* (2014), in a series of interviews and focus groups with child care professionals found that some practitioners recognised and respected disabled children's rights and abilities to express their views and contribute to decision-making in child protection processes, and had taken appropriate steps to facilitate this.[709] However, others expressed anxiety and low levels of confidence in working with disabled children, especially children with communication impairments.

> *'There was anxiety about 'getting it wrong'. for example, failing to recognise significant harm, fear of missing vital information or making an incorrect judgment and additional concerns that any failure by practitioners would contribute to or heighten the risk faced by the child. This was also cited as a reason why some practitioners failed to involve disabled children in the process.' (page 4)*

Children in Scotland (2013) commented that 'enabling disabled children to play a more meaningful role, with their parents / carers and professionals, in planning for their needs will help ensure they become more than

[708] Van Bijleveld *et al* (2015).
[709] Taylor J, Stalker K, Fry D and Stewart ABR (2014) *An investigation into the relationship between professional practice, child protection and disability.* Scottish Government. Available from: https://www2.gov.scot/Publications/2014/04/4363/downloads - accessed May 2019.

passive recipients of services'.[710] However, there are a number of barriers to meaningful participation of disabled children in decision-making:

- The child/adult relationship is seen as an equal partnership. Adults are seen as, and deferred to, as the 'experts' and controllers of resources.
- Even those closest to the child may be over-protective and not in the habit of giving them the space to express their own views or make their own decisions.
- The child may have communication impairments, and social workers may not have the skills or knowledge to be able to communicate effectively with him or her.
- It takes time to engage disabled children in this sort of discussion, something that social workers often do not feel they have.

Media attitudes towards human rights / children's rights

Research among key experts in the areas of children's and human rights policy and law, the Children's Rights Alliance for England (2017), found that one of the barriers to better implementation of children's rights in law and policy related to a 'toxic anti-human rights rhetoric' which was common among some politicians and certain sectors of the media.[711] This type of rhetoric is being intensified by Brexit which has further exacerbated anti-international / anti-European feelings about the European Convention on Human Rights and, by association, the Convention on the Rights of the Child. Human rights are portrayed in certain sectors of the press as

[710] Children in Scotland (2013) *Developing an outcomes model for disabled children and young people in Scotland*. Scottish Government. Available from: https://www.gov.scot/publications/developing-outcomes-model-disabled-children-scotland/ - accessed May 2019.
[711] Children's Rights Alliance for England (2017) *Barriers and solutions to using children's rights approaches in policy*. See http://www.crae.org.uk/media/123572/Barriers-and-solutions-to-using-childrens-rights-in-policy-E.pdf - accessed July 2019. The study involved interviews and a roundtable event with attendees the field of children's and human rights policy and law in the UK and Europe, policy experts from large children's charities and representatives from the mental health and homelessness sectors.

unconditional 'freebies for undeserving people' – not something for everyone.

Those who took part in this study highlighted the media's influence on public attitudes to human rights, noting that the feeling of 'why do we need international organisations telling us what to do?' appeared to be increasingly common amongst members of the public.

Summary

This section has highlighted a number of barriers and challenges in relation to respecting and upholding the rights of children and young people in care, including disparities between the UNCRC and current Scottish legislation, lack of knowledge of their rights among children and young people in care, professional attitudes, practices and level of experience, and media attitudes towards human rights / children's rights.

8. Things that support the realisation of children's rights for children in care

This section touches upon several things that the evidence has highlighted as important in helping to support the realisation of children's rights for children in care. This is by no means a comprehensive list.

UNCRC incorporation

As noted previously, there have been calls for some time (from the Children's and Young People's Commissioner for Scotland, Together – the Scottish Alliance for Children's Rights, and the Scottish Youth Parliament, and others) for the full incorporation of the UNCRC in Scots law[712] – and also into UK law.[713] Those in favour of incorporation argue (as noted in the previous section) that some of the protections available through the UNCRC are not currently available to children and young people in Scotland because it has not been fully incorporated into Scotland's domestic legislation.[714] They also say that incorporation will provide a number of benefits, including:

- A greater realisation of all children's rights and especially the right to be heard
- A clear channel of redress for breaches of children's rights
- A more consistent approach to developing policies that affect children and young people

[712] Children and Young People's Commissioner Scotland and Together (2019) *Briefing Paper. Incorporation in Context.* Available at: https://www.cypcs.org.uk/downloads/Incorporation_/Briefing_-_Scottish_Context.pdf – accessed May 2019.
[713] Rights of the Child UK (2012) *Why incorporate? Making rights a reality for every child.* See https://www.togetherscotland.org.uk/resources-and-networks/resources-library/2012/02/why-incorporate-making-rights-a-reality-for-every-child/ - accessed July 2019.
[714] Ibid.

- Increased knowledge and understanding of the UNCRC.

This group further believes that there is an urgency about this matter now that the UK is leaving the European Union, since (other) specific legal protections currently available to children and young people as a result of the UK's membership in the EU will be lost. At the time of writing this report, the Scottish Government is consulting on this issue with views invited in relation to the best model to use for incorporating the provisions / principles of the UNCRC into Scot's law.[715]

Concerns about the incorporation of the UNCRC into Scots law have previously been voiced, however. In particular, the Parliamentary debates and evidence submitted in relation to the drafting of the Children's Rights Bill (now the Children and Young People (Scotland) Act 2014 highlighted (i) political concerns about the possibility of increased litigation; (ii) the lack of an evidence base on the impact of children's rights on children's lives; and (iii) differences of opinion among legal experts about the value and feasibility of greater incorporation of the UNCRC.[716] Therefore, any attempt to fully incorporate the UNCRC in Scot law will likely need to address these concerns.

Developing rights-based services for children and young people

At a symposium organised by Unicef UK Childs Rights Partners in 2014 to explore the role of local authorities as child rights champions,[717] participants noted that the UN Convention on the Rights of the Child

[715] Scottish Government (2019) *Incorporating the UN Convention on the Right of the Child into Scots Law: consultation.* See https://www.gov.scot/publications/childrens-rights-consultation-incorporating-uncrc-rights-child-domestic-law-scotland/ - accessed July 2019.
[716] Tisdall EKM (2015) Children's wellbeing and children's rights in tension? *International Journal of Children's Rights, 23:* 769-789.
[717] Unicef UK Child Rights Partners (2014) *Local authorities as child rights champions. Transforming services, improving outcomes. Event report. Executive Summary.* See https://www.unicef.org.uk/child-rights-partners/wp-content/uploads/sites/3/2015/12/CRP_event_executive_summary_final.pdf - accessed July 2019.

provides local authorities with a practical framework for the design, development and delivery of all services affecting children and young people. However, realising and upholding children and young people's rights requires public services to move on from a theoretical knowledge of the UNCRC to a more detailed understanding of what the implementation of children's rights looks and feels like in practice. This is inherently challenging since it requires the balancing of child protection and child autonomy as well as competing priorities and an increasing scarcity of resources.

The seminar participants concluded that 'the benefits of rights-based practice far outweigh the inherent challenges, and it is widely accepted that practising children's rights should not been as a 'nice to do' but rather a 'get on with it'. The group highlighted that the development of rights-based services should involve:

- High-quality child rights training for all public sector practitioners and policy makers
- Political commitment, strategic buy-in and a culture of dialogue and co-production
- The participation of children and young people in the design and development of children's services
- Having mechanisms in place to enable ongoing, structured, systematic and meaningful engagement with children and young people
- Considering the impact of policy- and decision-making on the most disadvantaged groups of children and young people (for example through the use of a Child Rights Impact Assessment process)
- Putting in place consistent and co-ordinated action at all levels (national, local and at the level of individual services).

The Children and Young People's Commissioner Scotland echoed many of these points and provided further detail on the main elements of a rights-

based approach to corporate parenting.[718] The Commissioner stated that, to ensure that the rights of children and young people in care are respected, local authorities should:

- Consider the well-being of children and young people, and be alert to anything which might affect this
- Assess their need for services and support
- Promote their interests
- Make sure the voices and opinions of children and young people are heard
- Provide opportunities for children and young people to promote their wellbeing, and take action to help them access those opportunities
- Provide advice and assistance when they're needed
- Make sure services are easy for children and young people to access.

These elements would apply at both the strategic (planning) level and at the level of individual services. At a strategic level, the importance of local planning, service coordination, resourcing, appropriate information sharing, and the monitoring and evaluation of children and young people's services were all identified as key.

Things that looked after children say would help in realising their rights

The following themes have been consistently identified through consultation with children and young people as important components of rights-based services:

- **Better knowledge of their rights:** There is international evidence which shows that **knowing** about their rights, or even perceiving that adults respect their rights is associated with higher levels of

[718] Children and Young People's Commissioner Scotland, *Corporate parenting*. See https://www.cypcs.org.uk/policy/corporate-parenting - accessed July 2019.

well-being among children and young people.[719] Knowing about their rights has also been reported by children and young people to be helpful in resolving problems and concerns, such as having contact with families, during children's hearings, at looked after child review meetings and at school.[720]

- **Better information whilst in care:** Children say that they need to be given clear, age- and ability-appropriate information when they enter care and before leaving care.[721] Specifically, young people want more information on their rights and entitlements during periods of transition, information about where they are going (when they enter care) and the care standards and inspection results for the place they are living (whilst in care).[722] Some have said they want to be given an opportunity to meet their foster families first or have a trial stay beforehand when moving to a new placement. They also want information about when they will next see or speak to their birth family members.
- **Better listening:** Children say that they need to feel that their views have been heard in matters that concern them. This includes information relating to: contact with birth parents, contact with siblings and where they live.[723, 724]

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[719] Casas F, Gonzalez-Carrasco M and Luna X (2018) Children's rights and their subjective well-being from a multinational perspective. *European Journal of Education Research, Development and Policy.* https://doi.org/10.1111/ejed.12294.
[720] Elsley S, Tisdall EKM and Davidson E (2013), *Children and young people's experiences of, and views on, issues relating to the implementation of the United Nations Convention on the Rights of the Child.* Scottish Government. See https://www2.gov.scot/resource/0042/00427287.pdf - accessed July 2019.
[721] Children's Rights Alliance for England (2017) *Children speak out on living in care.* See http://www.crae.org.uk/publications-resources/children-speak-out-on-living-in-care/ - accessed July 2019.
[722] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015) *Children and young people's views on being in care. A literature review.* See https://coramvoice.org.uk/sites/default/files/Children%27s%20views%20lit%20review%20FINAL.pdf – accessed July 2019.
[723] Children's Rights Alliance for England (2017) *Children speak out on living in care.* See http://www.crae.org.uk/publications-resources/children-speak-out-on-living-in-care/ - accessed July 2019.
[724] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).

- **Having consistent and supportive adults in their lives whom they can trust**: Children and young people want supportive adults in their lives who listen to them and can bring about change. Trust, rapport, honesty and respect were all seen as essential in influencing children and young people experiences of participation.[725] Children living in residential homes say that having a member of staff that they are close to is important in providing support and motivation.[726] Young people suggest that more could be done to retain social workers by improving their working conditions. However, they also think that more could be done to support young people when there are staff changes, rather than the young person being informed haphazardly that they have a new social worker.[727]
- **Advocacy:** Young people emphasised that positive and respectful relationships are essential to helping them speak out, whether these were independent advocates, other professionals or family and friends.[728] Research in Scotland found that awareness and understanding of advocacy is generally poor among young people. However, almost all looked after children and young people who have accessed advocacy felt that it helped them.[729]

Educational resources

Finally, this review identified a range of resources available to give children and young people better information about their rights and the UNCRC, and to give professionals support in developing and delivering rights-based services for children and young people in care. These included:

[725] Van Bijleveld GG, Dedding CWM and Bunders-Aelen JFG (2015) Children's and young people's participation within child welfare and child protection services: a state-of-the-art review. *Child & Family Social Work, 20:* 129-138.
[726] Elsley *et al* (2013).
[727] Hadley Centre for Adoption and Foster Care Studies and Coram Voice (2015).
[728] Elsley S *et al* (2013).
[729] The research cited here was carried out by Who Cares? Scotland (2016). *Advocacy Matters; an analysis of young people's views,* http://bit.ly/2Bfr85V - accessed June 2019.

For children:

Children and Young People's Commissioner Scotland, *Your rights.*

SOS Children's Villages (2009) *Children and young people in care. Discover your rights!* Council of Europe.

For professionals:

CELCIS, Moving forward: Implementing the "Guidelines for the Alternative Care of Children"

SOS Children's Villages (2015) *Realising children's rights. A training manual for care professionals working with children in alternative care.*

Quality4Children (2007) *Standards for out-of-home child care in Europe (English language version).*

Jensdottir R (2015) The Council of Europe action in favour of children's rights: Helping professionals working with children make the best use of available standards. *Irish Journal of Applied Social Studies, 15(2):* 12-24.

9. Concluding thoughts

In summary, this review sought to address three questions:

1. What evidence is available about the extent to which current international legislation / guidance / frameworks on the rights of children are being upheld for children in care?
2. What do we know about the impacts / benefits of upholding / respecting the rights of children in care?
3. What do we know about (i) the challenges / barriers, and (ii) what helps to support / facilitate respecting the rights of children in care?

The review has presented evidence to indicate that efforts are being taken in Scotland to implement the UNCRC in Scottish legislation and national policy. However, there are areas where work is still required at a national level to ensure that children's rights are fully reflected in Scottish law and policy. In addition, these efforts need to be followed through consistently at a local level and within services to ensure that children and young people in care are truly able to experience the reality of their rights.

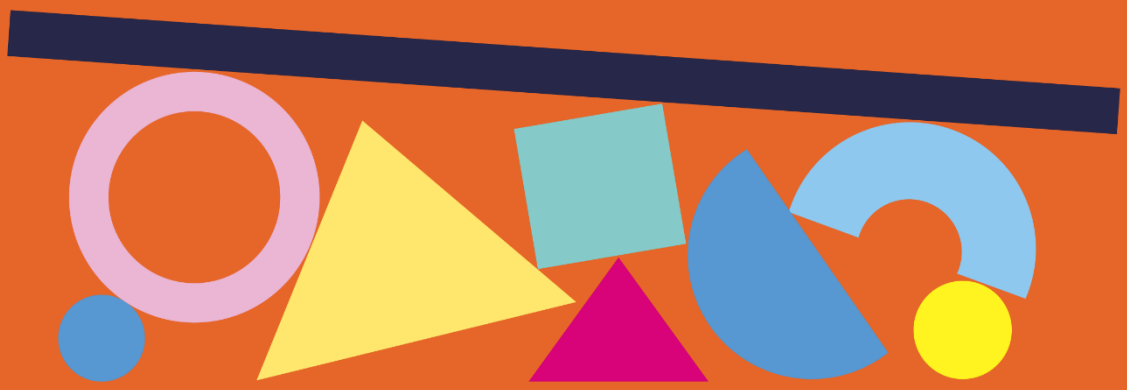
The impacts / benefits for children in care of having their rights upheld and respected (and particularly their right to be heard in matters that concern them) include: higher levels of well-being, increased self-esteem, feeling more in control and feeling valued. However, positive experiences of participating in decision-making processes are closely related to the quality of a young person's relationship with their social worker or other trusted adults.

There are many challenges to having their rights upheld for children and young people in care. Many of these are related to the complexity of the statutory processes that are part and parcel of being involved in the 'care system'. However, the evidence suggests that better implementation of

the UNCRC in law, the use of child rights-based approaches to service design and delivery, and the use of child rights impact assessment processes in policy development may lead to children's rights being more of a reality for children in care.

Stigma

The experience of stigma for children and young people in care



A review of the evidence on children's experiences and the effectiveness of approaches used to reduce stigma

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1. Introduction

Background

In May, June and July 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[730]

Stigma of children and young people in care

This report presents a review of the evidence in relation to the following questions:

- What evidence is available about the effectiveness of approaches which have been used to reduce stigma for marginalised groups (including, but not restricted to children in care, care leavers and those working with these groups)?

[730] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

- What do we know about (i) the points in the care system where children experience stigma and the characteristics of stigmatising practice? and (ii) the types of interventions which are successful in reducing stigma and changing attitudes towards stigmatised groups?

Scope of the evidence review

Some evidence has highlighted how the stigma associated with the 'care system' can affect carers (foster, kinship and residential), parents of children in care and the wider workforce (social workers and others) (Baker, 2017a). However, due to time constraints this review does not set out this evidence comprehensively and the focus here is primarily on stigma experienced by care experienced children and young people[731].

Structure of the report

The report is structured as follows:

- Section 2 reports relevant findings from the Discovery stage of the Care Review
- Section 3 set out the definitional issues which informs this evidence review
- Section 4 focuses on why challenging stigma is important
- Sections 5 and 6 looks at where care experienced people report stigma is located
- Section 7 assesses the evidence available on interventions to challenge stigma and discrimination
- Section 8 contains some concluding thoughts.

[731] Note that, in this context 'children and young people in care' is taken to **include** care leavers

2. Findings from the discovery stage of the ICR

In relation to the topic of the stigma associated with care experience the Discovery stage of the Care Review found:

- The theme of stigma, along with love and rights, permeated much of the evidence gathered. As a result, 'stigma' has been identified as cross-cutting and underpinning all of the Care Review work groups. (1000 Voices Discovery report)
- Children and care leavers identified stigma and societal prejudice as a significant concern in their lives. They shared how they often felt different due to their care experience. Negative views about care impacted on their relationships and inclusion in communities and school life. (1000 Voices Discovery report)
- Some children had experienced discrimination on the basis of their care status; they wanted this to be challenged and minimised as a matter of urgency. They felt there was a need to improve understanding, and raise awareness, about 'care' to challenge stereotypes. They thought both the general population and those looking after them should be included in this work. (1000 Voices Discovery report)
- Mainly children did not want to be treated differently from their peers. Despite this wish they highlighted attitudes, processes and practices often associated with the 'care system' that singled them out as different. (Baker literature review)
- Carers and parents of children in care also reported they had experienced stigma and discrimination. (Baker literature review)
- Children who were involved in the Discovery stage wanted the Care Review to focus on: raising awareness of care experience; what childhood and adulthood was like for a care experienced person and; to improve the knowledge and understanding of those not in caring

roles – especially the general public, but also employers, councillors and MSPs. (1000 Voices). These views echo those of others who have argued for measures to be taken to educate members of the public about care as a poor understanding can contribute to discriminatory attitudes (Baker, 2017).

- The government statistical outcomes for looked after children do not cover children's experiences of stigma or prevalence of discrimination. (CELCIS, statistical overview report, 2018)
- Care Review intention: There will be no stigma for care experienced children and young people in care because Scotland will understand why our children need care.

3. What is stigma?

This section provides a brief overview of how stigma, and the associated factors of discrimination including stereotypes and prejudice, are defined. It highlights the way these concepts are interlinked.

How is stigma defined?

The word 'stigma' is of Greek origin and historically was used to describe a cut or mark inflicted on a person, it was intended to act as a sign that something was 'different' or 'bad' about them (Rogers, 2017). This derivation is reflected in the definition contained within the Oxford English Dictionary which describes stigma as '*a mark of disgrace associated with a particular circumstance, quality or person*.' More recently, stigma has been more broadly defined as:

> *'a labelling process that triggers stereotyping followed by acts of discrimination that result in loss of status and reduced life options' (Holley et. al, 2012).*

Some definitions also refer to the following:

- *Stereotype:* A widely held but fixed and oversimplified image or idea of a particular type of person or thing.
- *Prejudice:* Preconceived opinion that is not based on reason or actual experience.
- *Discrimination:* The unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age or sex.

The Care Review's stigma working group defined stigma primarily as an individual experience that can set young people apart from others. It emphasises how the experience of stigma will differ for each person.

> *'Stigma is experienced on a personal level and means something different to everyone. It has underlying negativity that takes many forms i.e. prejudice, discrimination, stereotypes etc. and creates an "us vs. them" split.' (Care Review, April 2019)*

How and where stigma operates

Stigma is a dynamic multi-dimensional and multi-level phenomenon that occurs at three distinct but reinforcing levels of society: (1) individual or personal; (2) cultural and (3) structural (Thompson, 2017; NAT, 2016).

- *Personal level:* this is concerned with an individual's attitudes and behaviours; a prejudice against a certain group of people. It is related to the actions of individuals, but the individual's beliefs and ideas are supported through the two other levels ('cultural' and 'structural').
- *Cultural level:* this refers to stigma across society and is informed by cultural norms and attitudes. It relates to the 'shared values' or 'commonalties' and shared beliefs about what is right and wrong, good or bad which can form a consensus.
- *Structural level:* this relates to stigma within institutions and public policy; laws, regulations or policies. It highlights how oppression ('unjust treatment') can be 'sewn into the fabric' of society through institutions that support both cultural norms and personal beliefs. A number of institutions such as, media, religion and the government can cement the beliefs.

Work by Who Cares? Scotland[732] emphasises the need to pay attention to the *values*, *attitudes* and *behaviours* of individuals, cultures and structures or institutions. It is argued that the application of these towards people because of certain characteristic(s) or lived experience (in this case, 'care experience') can result in prejudice, stigma or discrimination:

[732] https://www.whocaresscotland.org/what-we-do/40-years-of-us/public-education-campaign-our-ask/

- *Values*: this is a measure of the worth or importance a person attaches to something or someone.
- *Attitudes*: this is the way a person expresses or applies their values and is expressed through words or behaviours.
- *Behaviours*: this is the action taken by a person to something or someone because of the values they hold or the attitudes they express.

Different ways stigma can be experienced

The different ways that stigma can be experienced are discussed by Earnshaw and colleagues (2012):

- *Experienced stigma* or 'enacted stigma': is the extent to which people perceive that they have experienced stereotyping, prejudice and discrimination directed at them by others.
- *Internalised stigma* or '*self-stigma':* is the extent to which people endorse negative beliefs and feelings associated with their stigmatised attribute and apply them to themselves. As a result, people (applying to the context of this briefing) with care experience may report feelings of embarrassment, shame, guilt, and have diminished self-worth because they are, or have been in care (Gronholm et al, 2017; National Academies of Sciences, 2016).
- *Anticipated stigma:* is the extent to which people expect to experience stereotyping, prejudice, and discrimination by others in the future. Evidence shows that people do not have to actually experience stigma to suffer negative outcomes associated with stigma. They merely have to believe that they may experience it in the future.

Stigmatisation of children in care is widely acknowledged; it is a long-standing and entrenched issue. There is a long history of children in care reporting their unhappiness with how they are treated by a variety of

processes both internal to the 'care system' and beyond it (Stein, 2011; Who Cares? 40 years[733]).

Over 20 years ago the term 'careism' was coined to describe the widespread discrimination faced by young people in care in society. 'Careism' was explained as:

> *'If a decision or action cannot be justified in relation to all young people, then it should not to be acceptable in relation to a young person in care. Treating those in care as a separate class with lesser rights than other children is discriminatory and can be termed careism.' (Lindsay, 1998[734])*

Whilst there is no national data on the prevalence of discrimination or experiences of stigma, research with children in care shows they are deeply concerned about stigma and prejudice, and worry about being treated 'differently' if people know about their 'care backgrounds' (Care and Prejudice, 2009; Dickson et al, 2009). Experience of stigma for each care experienced person will be different (as the Care Review definition acknowledges). The next section looks at why challenging stigma wherever and however it is experienced is important.

[733] https://www.whocaresscotland.org/what-we-do/40-years-of-us/public-education-campaign-voice-and-experience/
[734] http://www.policyreview.tv/document_stream.php?document_id=2868&conf_id=416

4. Why challenging stigma is important

This section sets out the arguments about why tackling stigma for care experienced young people matters. It argues that challenging stigma is important because (1) it is children's right to not experience discrimination, (2) it can affect acceptance of support to keep families together and (3) it impacts negatively on children's lives.

United Nations and Scottish Government emphasise the importance of challenging stigma

The importance of challenging and eradicating the stigmatisation of children in care has been acknowledged by international policy makers and the Scottish Government. The United Nations Convention on the Rights of the Child (UNCRC) is an international human rights treaty which provides the basis for children's rights everywhere in the world. The UK government ratified the UNCRC in December 1991 and it came into force in the UK, including Scotland, in 1992. UNCRC is legally binding for those countries that have ratified it.

Article 2 of the UNCRC relates directly to the issue of stigmatisation of children in care. It states that **all** children are entitled to the rights set out on the Convention regardless of their (or their parents' or guardians') race; colour; sex; language; religion; political or other opinion; national, ethnic or social origin; property; disability; birth or other status. Article 2 also says that governments must take steps to prevent discrimination against children on the basis of these characteristics.

Or as the child friendly version explains:

> *'You have the right to protection against discrimination. This means that nobody can treat you badly because of your colour, sex or*

> *religion, if you speak another language, have a disability, or are rich or poor' (Article 2).*

The 'Guidelines for the Alternative Care of Children'[735] offer a rights-based framework and a set of standards for providing services to children and young people who are unable to live with their families (and so, instead, live in 'alternative care'). These Guidelines emphasise the responsibility of agencies to avoid stigmatisation and overtly differentiating children in care.

> *'States, agencies and facilities, schools and other community services should take appropriate measures to ensure that children in alternative care are not stigmatized during or after their placement. This should include efforts to minimize the identification of children as being looked after in an alternative care setting' (UN, 2010).*

The importance of tackling stigma has also been acknowledged by the Scottish Government. In 2009, the Scottish Government published 'Do the Right Thing' in response to the 2008 concluding observations of the Committee on the Rights of the Child.[736, 737] This document set out the Scottish Government's plan for progressing children's rights in Scotland. As part of this work the government committed to developing a campaign to challenge stigma and reduce discrimination experienced by care experienced young people, as well as to gather evidence on the positive impact the care system' can have for children, young people and families.

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[735] *Guidelines for the Alternative Care of Children,* UN General Assembly 64th session, A/RES/64/142. Available from: https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf. A formal, printed version of the guidelines is available from SOS Children's Villages: https://www.sos-childrensvillages.org/getmedia/4972cb2e-62e1-4ae8-a0bc-b0e27fe3ea97/101203-UN-Guidelines-en-WEB.pdf

[736] Scottish Government (2019) *Do the Right Thing.* Available at https://www2.gov.scot/Resource/Doc/282927/0085645.pdf - accessed May 2019.

[737] UN Committee on the Rights of the Child (2008) *Consideration of reports submitted by States Parties under Article 44 of the Convention. Concluding observations: United Kingdom of Great Britain and Northern Ireland*, 20 October, CRC/C/GBR/CO/4.

This has led to the development of the '*Give me a Chance*' campaign (information on this work is detailed later in Section 7).

Stigma can impact on acceptance of support

The stigmatisation of the 'care system' may mean that some children and families who might benefit from state support avoid reaching out (Hannon et al, 2010). The devalued view of 'care', whereby it is primarily seen as 'last resort' and 'broken' can lead to a lack of confidence in its usefulness and its ability to provide a safe and nurturing experience for children. If care were seen as a less stigmatised source of family support and a more positive option for children and young adults then it may be accessed more as a form of short-term family support or early intervention help (Frameworks 2018a).

Care experienced people say stigma negatively affects their lives

Care experienced individuals reported that stigma affects their lives. Its impact is felt in terms of (i) their feelings about themselves, (ii) their well-being, (iii) their identity, (iv) their relationships and (v) how they are treated and the opportunities available to them. These effects can endure into early adulthood and beyond. These issues are discussed in more detail below:

Shame (feelings about themselves)

Stigmatisation of children in care can lead to feelings of shame and loneliness. It can contribute to the social isolation and marginalisation of care-experienced individuals (Frameworks 2018a). People who experience or anticipate stigma may be less likely to let others know about their care experience. Sometimes this means not talking about it and sometimes it means concealing it altogether (Dansey et al, 2019; Rogers 2017)

Well-being

Stigma associated with care experience can have a negative effect on well-being, confidence, self-esteem and future outcomes (Scotcen, 2018).

Identity

During adolescence and early adulthood many young people explore their identities. Care experienced young people are likely to explore and develop a 'care identity' as well as 'family' and 'cultural' identities. Developing a positive personal identity and a sense of personal history is associated with high self-esteem and emotional well-being (NICE, 2013). Children reported that their identity and personal history was, at times, intertwined and affected by the stigma associated with coming from a care background (Baker, 2017b).

Negative perceptions of care experience can impact on identity formation and how care experienced people view themselves. Care experience can be an integral part of identity but due to stigmatisation it can be viewed as something to be embarrassed about or ashamed of (Who Cares? Scotland[738]).

Relationships

Children say stigma associated with care experience can adversely affect their relationships with friends, their workers and others (1000 Voices Report)

How people are treated and opportunities

Work with children with a range of stigmatising experiences (e.g. children with disabilities, HIV, mental health illnesses, children of prisoners or migrant children)[739] has shown the commonalities between these groups and care experienced children. Children from 'marginalised' groups reported feeling isolated, being on the receiving end of prejudice or discrimination and not getting the same opportunities as peers who do not share their experiences.

As a consequence of the stigma associated with care experience some young adults saw 'leaving care' as an opportunity to put the past behind

[738] https://www.whocaresscotland.org/history/our-history/
[739] https://www.scottishinsight.ac.uk/Programmes/ViewProgramme/tabid/5828/articleid/96/programmepage/8176/rdid/5827/Default.aspx

them, and to distance themselves from the 'care system'. They wanted a chance to 'start again free from stigma' or 'not be tarnished with the brush of being in care'. Young people who felt like this may be more likely to leave care as soon as they can which may reduce opportunities for preparation and after care support available to them (Baker, 2017b).

Notably, if care experienced people don't tell people they are care experienced they may miss out on support they are entitled to. This help can include, but is not limited to, financial help from schools, colleges or universities, priority for social housing and council tax exemptions.

The impact of stigma can persist into adulthood and continue to have an effect throughout people's lifetime. For example, care experienced people report continuing discrimination in relation to employment or accommodation[740] (Frameworks 2018a):

> *"Some young people have been refused private tenancies because their previous address has been a children's home; some young people have been asked at job interviews if they are going to be any trouble because they are in foster care; and entire communities have united to prevent care experienced young people from living in their area" (Who Cares? Scotland[741]).*

[740] https://www.whocaresscotland.org/who-we-are/media-centre/press-releases/a-national-campaign-that-aims-to-end-the-discrimination-that-young-people-in-care-face/
[741] https://www.whocaresscotland.org/who-we-are/media-centre/press-releases/a-national-campaign-that-aims-to-end-the-discrimination-that-young-people-in-care-face/

5. How and where does stigma arise for children in care in Scotland

Introduction

This section examines the everyday experiences of children and young adults in care and exposes some of the factors associated with the 'care system' where, from their viewpoints, stigma can exist.

Stigmatising language

Much of the evidence examined for this review referred to the use of stigmatising language and terminology. Children reported the overuse of acronyms or too much jargon by social workers and other professionals involved in their care, which they found difficult to understand and did not like (Action for Children, 2017). Children and young adults said those supporting them sometimes used insensitive language when talking to or about them. They also found thoughtless language and terminology in the records and paperwork regarding them (Selwyn and Baker, 2018[742]). Children wanted what was recorded to give a balanced picture of their lives, to include information on what was going well as well as their strengths and achievements, not just the negative things that had happened to them (Baker, 2017a).

Children and young adults have been vocal about their dislike of the institutionalised language that can surround the 'care system'. For example:

- children say they do not live in 'placements'
- they do not go to 'contact' rather they have 'family time'
- 'respite' should be renamed as 'sleepover's
- they are not 'cases'

[742] https://www.celcis.org/knowledge-bank/search-bank/blog/2018/12/i-just-want-be-normal-looked-after-young-peoples-experiences-feeling-different/

- and, they report that they definitely do not want to be referred to as 'LAC' (shorthand for 'looked after child'), pronounced as 'lack', which implies to children that they lack some missing quality[743].

Lack of respect for children's privacy

Children and young people were concerned that they were not always able to control who knew intimate details about their personal lives (Selwyn and Baker, 2018[744]). They felt their personal information, such as details about their family and circumstances about why they were in care, were told to others who did not necessarily need to know this (Become, 2017). In the absence of clear information sharing protocols, carers and workers may feel they are under a professional obligation to share information that young people have confided in them with colleagues. The denial of privacy not only withholds a basic human right but may also deter young people in care from seeking the help that they need.

Unfair or different treatment

Children and young people in care wanted to be treated fairly and have parity with their peers. They wanted to feel 'normal' and not be made to feel othered because of their 'care status' (Dickson et al, 2009). But in reality, children sometimes felt they were not allowed to do similar things to their peers. They said there were 'too many rules' and sanctions; they felt those supporting them did not have enough discretion over decisions about how rules should be applied (Baker, 2017a). Processes and practices associated with the 'care system' identified as factors which singled them out as different from their friends included (Elsley, 2013; 1000 Voices):

- Delays in permission for things such as 'sleepovers', haircuts or school trips;

[743] See work by young people on language and the care system https://www.bbc.co.uk/news/av/uk-northern-ireland-48466031/kids-in-care-changing-the-language and https://www.youtube.com/watch?v=dIJDPEgNunA&feature=youtu.be
[744] https://www.celcis.org/knowledge-bank/search-bank/blog/2018/12/i-just-want-be-normal-looked-after-young-peoples-experiences-feeling-different/

- Needing a 'police check' before visiting friends' houses; bedrooms being locked; not being able to have friends over for sleepovers or meals;
- Waiting for 'health and safety' checks before taking part in activities.

Actions that unnecessarily identify children as 'looked after'

Children have described how the behaviours of social workers, teachers and other professionals who supported them could contribute to them feeling conspicuous and being seen as, and feeling, 'different'[745]. Including:

- holding meetings associated with being in care during school time which could result in them being taken out of lessons. This marked them out as different from their classmates. It could lead to unwelcome questions from their peers and disrupt their education (Wood and Selwyn, 2017; Mannay et al, 2017; Selwyn and Baker, 2018).
- Some workers were reported to wear their work ID badges when out in the community with children and young people (Coram Voice, 2015; Baker, 2017a).
- Activities that were only for children in care were often intended to be positive, for example, children in care awards ceremonies or allocation of a 'designated teacher' for children in care at school but things like this could sometimes inadvertently lead to the unwelcome identification of them as 'in care' (Selwyn and Baker, 2018; Become, 2017).

[745] Research evidence shows most young people (88%) did not experience adults as drawing negative attention to their care status. But about one in eight young people in care (12%) felt adults did things which made them *'feel embarrassed about being in care'* (Briheim-Crookall et. al, 2018). Consistent proportion of children in care report this:

- 12% of young people aged 11-18yrs from 17 local authorities in England in 2017-2018 (sample size n=1631)
- 14% of young people aged 11-18yrs from 6 local authorities in Wales in 2017-2018 (sample size n=378)
- 13% of young people aged 11-18yrs from 16 local authorities in England in 2016-2017 (sample size n=1,305)

NB: the proportion who reported 'embarrassing actions from adults' varied from 6% to 25% in different local authorities (Selwyn and Briheim-Crookall, 2017).

Across these experiences, children and young people reflected how these actions made their 'care identity' feel overly visible within their communities and among their friends. This could lead to feelings of anxiety, embarrassment, fears of rejection, exclusion and bullying (Selwyn and Baker, 2018; Rogers 2017). Within the reviewed research it was clear children and young people wanted their carers and workers to be mindful and sensitive over how their actions could (even when inadvertently) reinforce the stigma associated with care experience. They wanted people to take more concerted effort to avoid highlighting their care status.

6. Where else is stigma is found?

What do we know about the attitudes of the general population towards the 'care system' and care experienced people?

People's attitudes towards those with care experience matter because they can contribute to the stigmatisation of people in care. Negative attitudes can influence how people behave towards, or make decisions about, the care experienced population. Children and young people reported that others' could make unfair assumptions about people with care experience and as a result judgements could be made about them; by their friends, teachers, social workers and the general public (Dickson et al, 2009).

This section looks at this issue from two perspectives: (i) what do children and young people in care think others attitude toward the care system and children within it is and (ii) what do we know about what the general population thinks in reality?

What do children in care think the general public thinks about them?

Children and young people thought that the terms 'looked after child', 'in care' and 'care leaver' were not understood well by most of the general public. These were terms that could attract negative judgements from others (Baker, 2017a) and also arouse curiosity and pity – both of which were strongly disliked (Dickson et al, 2009; Baker, 2017b).

When asked what they thought about public understandings in relation to children in care, many felt the public held generally negative views. Children felt there was a perception that children in care and care leavers had family issues. They believed others' thought children in care were often uneducated, 'trouble' and had likely done something wrong or were likely to do something wrong in future (Become, 2017[746]). Those with care

[746] Based on result from an online survey (sample n=110) and focus groups (n=60 young people) in England and Wales

experience reported that in their view the general public seemed to think children and young people in care were emotionally unstable, had drug or alcohol addictions, or that it was their fault that they were in care. They also thought the public had negative views on their birth family (that they were 'bad', did not care about them or couldn't cope with raising them) or thought that they were unwanted (Become, 2017). Only a very small proportion thought the general public might think positively of children in care.

What are the views of the general public on the 'care system' and children in care?

Here we examine three sources of evidence on the way society sees the 'care system' and the children within it:

1. Coram: Results from national survey on public attitudes to children in care, UK wide[747]
2. Scotcen: A report from the Scottish Social Attitudes (SSA) survey focused on attitudes towards care experienced people[748]
3. Frameworks: This report had a broader remit to look at public understandings of childhood, parenting and the care system in Scotland.[749]

Coram (2018)

Coram asked the general public what three words they think of when they hear the term 'child in care'. The most common responses included: abused or abuse; lonely or loneliness; neglect or neglected; sad; vulnerable; foster or fostered; poverty or poor; and troubled.

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[747] https://www.coram.org.uk/sites/default/files/resource_files/Public%20Attitudes%20to%20Children%20in%20Care.pdf

[748] Based on survey: a random-probability online and telephone survey utilising a sample drawn from the high-quality Scottish Social Attitudes (SSA) survey. 1,031 adults aged 16 and over were interviewed between 19 April and 20 May 2018, with data weighted to take into account both non-response bias and the age and gender profile of the Scottish population.

[749] Work informed by 21 in-person, in-depth interviews with members of the public in the greater

Scotpol work

A Scotpol survey in Scotland looked at the attitudes of the general public towards people with care experience. It revealed that most people in Scotland *do not* have negative views of care experienced children and young people. Notably, 58% of those surveyed in this study knew someone in care.

However, a minority of respondents did hold discriminatory or stigmatising assumptions of this population. For example, over a third (35%) believed that children in care are more likely to get into trouble with the police and around a quarter (24%) believed that children in care are more badly behaved than other children. Four in ten (42%) thought a contributory factor as to why children are in care is 'because the parents can't cope with their child's behaviour' (Scotpol, 2018). Yet, overall, the survey suggested that people in Scotland had relatively positive views of children in care. Key findings included the following:

- *Attitudes towards care experienced people*: most respondents felt being in care made no difference to whether children behaved well or badly (72%); whether they were a good or bad influence on others (88%) or the likelihood they were involved with the police (64%). A large majority (83%) believed that being in care as a child makes no difference as to whether someone makes a good parent or not.
- *Opinions on forming relationships with care experienced people*: over two-thirds (68%) were happy for their children to be friends with a child in care, although there were slightly more negative views expressed towards those who were in residential care compared with foster care (Scotpol, 2018).

Frameworks[750]

The work focused on the 'cultural models' through which people interpret and engage with issues about 'care'. The aim was to understand 'broadly shared, deep and subconscious ways of thinking'.

The research (Frameworks, 2018a) revealed the public's dominant ways of thinking assume that:

- Only the family can provide children with what they need, and that the 'care system' is the opposite of family care.
- Individuals within the 'care system' have experienced significant trauma with irreparable long-term effects.
- Individuals with care experience are seen as dangerous 'others' with 'profound psychological scars and abnormal childhoods'.
- Selfish parents trapped in 'morally deficient communities' – neither of which are amenable to change.
- The importance of love and care in a child's development is recognised but the 'care system' is seen as unable to provide this.

These ways of thinking were identified by the researchers as *'unproductive cultural models'*. There was a belief that meaningful change was impossible, this way of thinking makes it challenging for the general public to support work to change the 'care system'.

This work also identified '*productive cultural models'*, which Frameworks asserts could have the potential to shift the general public's thinking about care experience in more positive directions. (See Section 7)

[750] This project is being led by the FrameWorks Institute, in partnership with The Robertson Trust, Life Changes Trust, and CELCIS (University of Strathclyde). The project is 'the first phase of a three-part programme to 'reframe' how children's social care (looked after children and care leavers) in Scotland is conceptualised and presented in public and political discourse, with the aim of facilitating improved public understanding of the issues affecting vulnerable children and families, and of the policy solutions available'

Representations in the media

The media plays a crucial role in how the 'care system' and care experienced people are portrayed. A common representation in the media is that the 'care system' is broken and chaotic (Hannon et al, 2010; Frameworks 2018b), and children and young people are ill-served by it (they are said to 'languish' there[751]). Care experienced people themselves are subject by the media to a range of negative and often, sensationalist stereotypes and 'distorted caricatures' (Who Cares? Scotland). This representation is problematic as media coverage is influential in shaping people's beliefs and attitudes and determining how the public understands the 'care system' and those growing up within it (Frameworks 2018b)[752].

Based on analysis of over 350 media and organisational materials about 'care experience' that appeared between 2015 and 2017, a report by Frameworks (2018b) concluded that:

- Media coverage focuses extensively on the care system's failure to effectively look after children and young people. News stories reinforce the public's belief that the 'care system' is dysfunctional
- It was rare to see descriptions of the collective benefits of improving the 'care system'.
- The media reinforce negative stereotypes of care-experienced individuals by focusing almost exclusively on the negative outcomes associated with care experience – such as criminal behaviour, mental illness, unemployment or dysfunctional personal relationships.

'Outcome Statistics'

The pervasive view is that the 'care system' fails children young people. This view fails to take account of the diversity of experiences, placements

[751] https://www.independent.co.uk/news/uk/home-news/david-cameron-urges-adoption-culture-change-6255132.html
[752] Based on analysis of a sample of 359 media and organisational materials that appeared between December 2015 and December 2017.

and outcomes (Forrester et al, 2009; see also ICR components paper, 2019; Care Review edges paper, 2019).

Reported official statistics often focus on the high proportion of care leavers in the prison system, suffering with mental ill-health or who are homeless. This narrow focus leads to a perception that looked after children and young people are destined for failure, when in reality many care experienced people live happy and successful lives (Duncalf, 2010; Hannon et al, 2010).

There was concern from children and young people about the over-use of negative statistics relating to care experienced people (Become, 2017) and how these could affect people's views especially when they were reported without context and without reference to a reputable evidence base (sample size or number of participants). More commonly there was concern that statistics often did not give a balanced view of children and young people in care as well as care leavers' lives. They tended to emphasise negative aspects rather than celebrate the positives. Even when positive statistics and research findings are available[753] there may be tendency for negative findings to be highlighted.

The issue is compounded by the limited amount of evidence available on 'outcomes'. There is not much information on how care experienced children and young people do over time and so statistics often do not capture the progression and long term change. There is a dearth of longitudinal information on what happens as care experienced people grow older; the focus tends to be on experiences whilst in care or the early years after leaving (up to the age of 20-25).

[753] E.g. surveys based on young people's views report many children in care feel their lives are improving (Briheim-Crookall and Selwyn, 2017). Research shows that the stability and well-being of some children in care is better than those who return home (Wade et al, 2010). Studies also reveal the beneficial influence on education for those who have been in care for some time (Sebba et al. 2015)

However, one recent piece of work took a 'longer lens'. Harrison (2017) looked at the experiences of people who had been in care and examined the proportion of those who were aged 14 or 15 in 2007-2008 who in the intervening 10 years entered higher education (young people aged up 23). This analysis showed 12% of care experienced people entered university compared to the 6% recorded within the UK Government figures which only cover ages 19-21.

Stigmatising experiences at school

A strong theme in the literature was school as a place where children and young people reported stigma or fear of stigmatisation. The main things mentioned related to bullying and attitudes or assumptions held by staff and policies related to admissions or exclusions. Information from England suggests that children in care can sometimes find it difficult to access school places[754]. Moreover, children and young people reported:

- they were subjected to teasing, bullying or rejection by other children for being in care (Children Rights Director, 2009).
- school staff lacked understanding about what being in care means (Become, 2017).
- being worried that school staff did not always hold high aspirations for them. Some children felt their teacher thought that children in care were not as clever as other children (Become, 2017). Stereotyping and stigma on the part of others, including teachers, was seen as a barrier to educational success and perceived as hampering the success of individuals (Dickson et al, 2009).
- they were subject to discrimination from adults, including teachers and other professionals. Children cited patronising attitudes, others' being more lenient or expecting children in care to need extra help (Frameworks, 2018a).

[754] https://bit.ly/2GlJeaN https://www.tes.com/news/exclusive-i-wont-accept-looked-after-children-unless-damian-hinds-oversees-their-safety-says

7. Approaches to challenging and reducing stigma

The Stigma Care Review working group explored: *What can be done to ensure that care experienced people can live without fear of discrimination and prejudice?* Therefore, this section looks at ways to challenge stigma.

It is based on evidence from a range of arenas (including but not limited to mental health, HIV, criminal justice) on what factors have been identified as helping transform public attitudes, knowledge and behaviours, and reduce stigma. As discussed earlier (Section 3), stigma and prejudice operate at three distinct levels (personal, cultural and structural), so tackling it will require action to effect change at all these levels (McBride 2015).

What kinds of interventions are used to challenge and reduce stigma?

Anti-stigma strategies broadly fall into the following groups:

- *Efforts to change the legislative framework:* the work of lobbying groups
- *Contact:* using interactions with people to challenge prejudice; theories of 'intergroup contact' – whereby association with other groups reduces negative attitudes and promotes inclusivity
    - Programs that facilitate social contact between people (contact-based programs)
    - Contact based education programs (combine contact with education content to raise public awareness or increase public knowledge)
- *Education:* replacing myths with accurate information; theories focus on how information about other groups can challenge and

alter the way people think about them (e.g. education initiatives or media campaigns) (McBride, 2015; Gronholm et al, 2017)
    - Media campaigns delivered over a range of platforms
    - Peer programs where people offer their experience and expertise (National Academies of Sciences, 2016)

Efforts to address stigma linked to care experience have generally involved four types of interventions all of which will be covered in this section: (1) ways to change the narrative about care, (2) public education campaigning, (3) working with communities and (4) lobbying for changes in law or policy. The section ends by emphasising the pivotal role the care experienced community have in taking forward this work.

Factors to consider in designing interventions

The selected evidence reviewed for this paper suggested that the following were important to take into account when designing anti-stigma approaches and campaigns:

- Consider the different causes of stigma and include interventions that are suitable for different elements (NAT, 2016). A range of different types of interventions is desirable (Gronholm et al, 2017).
- One-off activities have less impact, better results come from sustained activities over a period of time. Therefore, intervening to reduce stigma requires a long-term sustained commitment (Gronholm et al, 2017; McBride, 2015).
- It appears that many anti-stigma interventions are not rigorously evaluated. When conducting evaluations, it is important to have a long-term follow up plan to track changes over the longer term. So far there do not appear to be many studies that have this achieved this. Evaluation in this area is difficult. Evidencing a causal link between an intervention (such as change in policy or media campaign) and changes in stigma is likely to be difficult to establish (NAT, 2016). Yet, despite this difficulty future interventions need a

clear strategy and must be carefully monitored (McBride, 2015; Gronholm et al, 2017).

- Evidence appears to point towards anti-stigma interventions resulting in improved attitudes, at least in the short term. There is evidence for small to moderate positive impacts of both mass media campaigns and contact interventions. However, there is limited evidence from longitudinal follow-up studies so it is not clear whether short term contact interventions have a lasting impact (Gronholm et al, 2017).
- Contact-based interventions alone and contact-based educational programs have the strongest evidence base for reducing stigma (National Academies of Sciences, 2016; McBride, 2015). But again, evidence tends to report on short-term benefits (Gronholm et al, 2017).
- There is evidence that contact interventions result in improvements in knowledge amongst target groups and short-term benefits in improved attitudes, but there is less evidence that such interventions achieve change in behaviour (Gronholm et al, 2017).
- Educational programs alone may not be effective for adults but can be effective in changing young people's attitudes (National Academies of Sciences, 2016).
- The literature strongly supports the principle of peer engagement (such as, participants who previously took part in programmes) in helping to shape and facilitate future interventions (McBride, 2015).
- Lessons from work indicates that it is important to be as accurate as possible in the message that is put across to avoid reinforcing assumptions or stereotypes (McBride, 2015).

Altering the narrative about care

The evidence suggested that, to address issues of stigma, there was a need to create a new narrative about the experience of care. This would involve promoting a more balanced picture of the 'care system' and its outcomes

for children and young people. The literature also suggested better ways of telling the stories of people with experience of care.

Promote a more balanced picture of the 'care system' and outcomes

The evidence indicated that care experienced children young people wanted a more balanced picture of care and leaving care to be portrayed: one which celebrated their many achievements, challenged the stigma associated with care, and raised aspirations.

> *'The stories we tell about the children's 'care system' – about how it works, why it matters, and the solutions that can help improve it – have the potential to change public attitudes and discourse in powerful ways' (Frameworks, 2018a; Scotpol, 2018).*

In trying to shift this narrative children and young people themselves are already been at the forefront of work to challenge attitudes about care. They have used the creative arts including film and social media to promote positive messages[755] and have shared personal experiences through their creative writing[756].

Building on the work to understand 'cultural models' (presented in Section 6), key elements in a more balanced narrative could include work to (Frameworks, 2018a):

- Define the care system more widely to include all the services provided (kin carers, children looked after at home etc.)
- Broaden public understanding of the outcomes associated with care experience, show how they vary widely and emphasise that not all young people have poor outcomes
- Celebrate the many achievements of children in care and care leavers

[755] Examples include: https://theonepercent.uk/ and https://aspiretomore.wordpress.com/ and https://www.youtube.com/watch?v=OBo26NoEebc.
[756] https://www.celcis.org/news/campaigns/get-write/ and https://coramvoice.org.uk/voices-2019

- Increase understanding of the contribution care experienced people make to society
- Highlight what the care system can and does do to support care experienced children

The following 'productive cultural models' were identified as offering the potential to shift the general public's thinking in more positive directions:

- 'The power and potential of family-based care,
- The ability to see context as a cause of care involvement,
- The understanding that trauma has serious effects
- The unquestioned way that people hold government responsible for caring for children'

Ultimately the work by FrameWorks (2018) asserts that by understanding more about *how and why* people think the way that they do about care experience, it is possible to develop 'framing strategies with the power to change public discourse and thinking about these issues' (Frameworks 2018a).[757]

Ideas on *how* to tell the stories of care experienced people

In telling stories of lived experience there is a need to pay careful attention to the following:

- **'Avoid "othering" those with care-experience[758]:** focusing on those in 'extreme circumstances' to elicit empathy can reinforce an 'us' and 'them' thinking, positioning people as objects of pity, and obscuring common humanity and interdependence. Tell stories of 'us' making it clear that improving the lives of looked-after children and young people has implications for everyone, not just those who are directly affected.

[757] https://vimeo.com/229876826
[758] https://www.celcis.org/knowledge-bank/search-bank/blog/2018/12/how-do-you-solve-problem-stigma/

- **Explain the role of systems in shaping child and family outcomes:** Stories mostly focus on individuals; 'badly-behaved children, resilient adults, neglectful parents, and / or heroic care professionals'. The risk with these stories is that it makes it easy to vilify or champion individuals based on assessments of their strength of character or the wisdom of their choice. Therefore, more collective stories need to explain *why* children might need formal care and explain *how* social policies have contributed to this problem. There is a need to place stories in a social context.
- **Build a sense of efficacy:** Ensure stories have the right balance between documenting the problems with the 'care system' (the urgency of the situation) and the sense that these problems can be addressed (the efficacy of solutions). Stories that leave the public with the impression of an impending child welfare crisis lead to disengagement and apathy' (Frameworks, 2018a)

These authors, and others[759], argue that through 'disseminating a new, productive set of stories about the children's 'care system' it is possible to reshape how people understand those within it and reduce stigma by reminding us all of the ties that bind us to each other and to our society'(Frameworks, 2018a).

Public campaigns to reduce stigma

Media-based interventions are regularly used to promote anti-stigma messages. Such initiatives can include poster campaigns, advertising or storylines on television programmes. Campaigns tend to fall into three categories (i) general awareness raising, (ii) encouraging of reporting of discrimination or abuse and (iii) campaigns targeting certain groups.

The following provides a brief description and discussion of outcomes from several campaigns that have sought to address the issue of stigma among

[759] https://www.clinks.org/community/blog-posts/are-personal-stories-too-personal

different marginalised groups (only the first – 'Give me a chance' – was specifically intended to address stigma linked to care experience):

'Give me a chance'

The Scottish Government supported Who Cares? Scotland to roll out 'Give Me A Chance', Scotland's first national anti-stigma campaign specifically designed to address misconceptions and negative attitudes towards those who have experience of care. The campaign involved a series of posters; each featured a care experienced person in one of a range of roles (e.g. nurse or student) and a quote about a time when they had experienced stigma as a result of their care status. The aim was twofold: to challenge stigma related to care experience and at the same time to inspire other young people by showcasing a range of positive care experienced role models. Duncalf (2010) argues that positive care experienced role models can provide children in care with an alternative vision of their own futures (Duncalf, 2010).

To date, there appears to have been no evaluation of the impact of this work. However, earlier this year (February 2019) Who Cares? Scotland secured a Ministerial commitment for a public education campaign that is driven by children and young people with care experience. Further details of this work are not yet available.

SeeMe – challenging mental health stigma (Scotland)

Whilst evidence is sparse in relation to effective interventions for addressing stigma linked to 'care experience', there has been large scale targeted action in other areas. For example, mental ill-health stigma has been addressed through the SeeMe programme[760]. SeeMe is Scotland's Programme to tackle mental ill-health stigmatisation and discrimination. The latest report on the programme highlighted some of the impacts from

[760] https://www.seemescotland.org/

the varied work which includes community champions, media campaigns and face to face contacts[761].

Time to change – challenging mental health stigma (England)

In England the *Time to Change* programme[762] is a stream of work to challenge mental ill-health stigma. This campaign has involved a changing programme of activity since 2007. It has used television adverts and other social marketing mechanisms as well as a range of 'taglines' and social media messages. National surveys conducted over a 10-year period show the overall attitude trend changed positively with improved attitudes observed. There were also reported improvements in people's wiliness to live and work with someone with mental health problems. In addition, fewer people with mental health problems reported experiencing discrimination.

Like, SeeMe, the programme involves a range of activities, local events and personal contact along with a range of media activity. These different types of activities were both seen as critical to achieving sustained impact. *Time to Change* developed a network of campaign champions that would reinforce campaign messages. Social contact between people with and without personal experience of mental ill-health was shown to increase engagement from the public with the campaign.

Researchers found that greater awareness of the campaign was linked to greater improvements in knowledge and attitudes. Further activities may be needed to make a step from changing attitudes to changing behaviour.

> *'The campaign might have been better at disconfirming negative ideas around prejudice rather than enhancing positive attitudes and support' (cited in NAT, 2016)*

[761] https://www.seemescotland.org/media/7508/120216-final-pdf-seeme_annual-report.pdf
[762] https://www.time-to-change.org.uk/home/about-us/our-impact

Working with communities

Much of the focus in the evidence is on children and young people's experience of care – as distinct from their experience of everyday life – and their 'connectivity with wider environments'. Hicks and colleagues (2012) remind us of the important part that communities can play in the lives of children and young people in care.

'Community that Cares' project

Who Cares? Scotland have been working at a community level to educate people on what it's like to grow up in care (project based in Renfrewshire) and to connect communities with care experienced children and young people. A recent workshop on the work to date was held and planned to:

> *"This interactive and informal workshop will take you on a journey, giving you an insight into what life is really like for this group of young people who live in your community, in their own words. We want you to leave this workshop feeling empowered, having learned how you, your organisation, group, and community can help local young people and improve their life chances.*
>
> *Young people in care of the local authority are all of our children and will thrive with the acceptance and support of their local communities". (SIRCC conference programme)*

No evaluation of this work appears to be available yet.

Structural changes to law or policy

The law can be seen as a reflection of public attitudes and an influencing factor in societal concepts of right and wrong. It is a structural component of stigma (NAT, 2016). Altering laws that contribute to stigma or promoting laws that protect people from stigma can be an effective part of a stigma reduction strategy.

Discrimination based on care experience has been recognised at a statutory level in Scotland and corporate parents have a duty to proactively

tackle this discrimination (Who Cares? Scotland). Current legislation contains a duty to 'promote the interests' of children and young people in care (section 58(1c) of the Children and Young People (Scotland) Act 2014). The accompanying Guidance (2015) explicitly states that to meet this duty to promote interest could include 'taking action to tackle the discrimination faced by care experienced people'.

Call to amend existing legislation to introduce care experience as a 'protected characteristic'

On 1 March 2018 Who Cares? Scotland launched its #LifetimeOfEquality campaign asking everyone across the UK to do what they can to protect care experienced people from discrimination. Specifically, the campaign asked for the UK Parliament to amend the Equality Act 2010 and make 'care experience' a protected characteristic (Feb 2019[763]).

The Equality Act 2010 protects people against discrimination. Under the Act, there are nine protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. Under this legislation it is unlawful to discriminate, harass or victimise someone because they have or are perceived to have one of the characteristics protected under the Act, or if they are associated with someone who has a protected characteristic. It provides legal rights, reinforces anti-stigma and discrimination messaging and provides an accountability framework. Currently, the characteristic of 'care experience' is not protected under the Act.

The Equality Act 2010

Under the Equality Act you are protected from discrimination: when you are in the workplace; when you use public services (including but limited to health care services and in education institutions); when you use businesses and other organisations that provide services, goods and

[763] http://www.corporateparenting.org.uk/wp-content/uploads/2018/02/Protected-Characteristics-and-Care-Experience-final-draft-5-Feb-2018.pdf

facilities (e.g. shops, restaurants and cinemas); when you use transport; when you buy or rent a property; when you join a club or association and when you have contact with public bodies like your local council or government departments.

Protection under the law applies whether you experience direct discrimination, indirect discrimination, harassment, or victimisation.

- *Direct discrimination:* this is when you treat someone worse than you treat someone else and the reason is because of a protected characteristic.
- *Indirect discrimination*: this is when you treat everyone in the same way, but it has the effect of putting people who share a protected characteristic at a disadvantage.
- *Harassment*: when someone makes you feel humiliated, offended or degraded and this is related to a protected characteristic.
- *Victimisation*: This is when you are treated badly because you have made a complaint of discrimination under the Equality Act or supported someone else's claim.

Public bodies are also under a duty to pay due regard in the need to eliminate discrimination, advance equality of opportunity between people who share a protected characteristic and those who do not as well as promote good relations.

Making 'care experience' a protected characteristic

Who Cares? Scotland (echoing calls in the past, 2009[764]) is actively campaigning to make it unlawful to discriminate against a person on the grounds of their care status. The argument is that making care experience a protected characteristic would provide children and young people from a care background with the legislative protection from discrimination and

[764] https://www.cypnow.co.uk/cyp/news/1039002/children-in-care-face-exclusion

harassment on the basis of their care identity. Who Cares? Scotland contends this would:

- Ensure that any discrimination of someone with care experience is treated with the same seriousness as discrimination against people sharing any of the existing protected characteristics.
- Raise consciousness about the discrimination faced by care experienced children and young people, and the importance of providing support to this group.
- Allow corporate parenting and equality and diversity work to be more closely aligned.
- Ensure the protection and support would be life-long rather than stopping once a young person reaches their 26th birthday (when currently the right to aftercare support ends).

Who Cares? Scotland argues that whilst ultimately a change in the law would be needed, there are also actions that organisations can put in place now to embed tackling stigma within their wider equalities and diversity policies. For example, they could:

- Ensure internal policies have accurate and appropriate information about 'care experience'
- Incorporate 'care experience' as an example in anti-discrimination policy
- Make sure equality and impact assessments consider the potential impact on care experienced people
- Cover 'care experience' in equality and diversity training.

In September 2018 SCRA[765] (Scottish Children's Reporter Administration) backed the campaign to make care experience a protected characteristic.

[765] https://www.scra.gov.uk/2018/09/equality-for-care-experienced-children-young-people-and-adults/

Challenging problematic practices in the 'care system'

As detailed in Section 5, looked after children experienced a range of practices that reinforced the stigma associated with care experience. Thus, many want the procedures and practices in the 'care system' to be checked to make sure they did not unintentionally mark them out as different from their peers; they wanted everyone to model non-stigmatising language and behaviour (Baker, 2017).

To eradicate these phrases and change some of the language used to talk about them groups of children and young people in care have worked together and produced an 'alternative dictionary[766]' (TACT, 2019). Whilst another group have made a film explaining how the use of such language makes them feel[767]. Those with lived experience of care describe how particular words are depersonalising and disconnecting which can affect how they connect with their workers and service and also how the worker may relate to them[768].

Addressing 'self-stigma'

Much of what is described above has focused on care experienced individuals in their wider social context. Yet, in the case of self-stigma (NAT, 2016), the individual needs to be the primary focus of the 'intervention'. Self-stigma affects the way an individual feels about themselves as well as how they manage the experience of stigma and discrimination. Feelings of self-stigma may include blame or internalised shame.

One study explored how young people in foster care experience and manage stigma in their day to day lives (Rogers, 2017)[769]. Children and young people, it was found, coped with the challenge of stigma in two key

[766] http://www.tactcare.org.uk/content/uploads/2019/03/TACT-Language-that-cares-2019_online.pdf
[767] https://www.bbc.co.uk/news/av/uk-northern-ireland-48466031/kids-in-care-changing-the-language
[768] https://www.celcis.org/knowledge-bank/search-bank/blog/2018/11/i-couldnt-bring-myself-write-acronym-lac/
[769] Based on research with 10 children aged 12-14 all living in foster care

ways (i) by carefully managing 'disclosure' of their care status and (ii) by drawing support from their friendships. They particularly valued support from their peers who were also in care, as this group provided them with a valuable sense of belonging.

Some care experienced people have talked about the benefits of connecting with others who are or have been in care. Groups set up specifically for children and young people in care may offer opportunities to develop networks and relationships. They can also create opportunities to come together to raise awareness and understanding about the care system and challenge stigma (Hicks et al, 2012). For individuals it can provide an opportunity for peer support and a chance to learn from each other. It may create a sense of belonging and reduce isolation. Furthermore, it can create a sense of solidarity with others who are or have been in care. Identification with others in the care community can cut across boundaries of age, geography and ethnicity (Stein, 2011).

Summary of 'what works' in reducing stigma[770]

What is clear through a comprehensive review of what young people say regarding stigma, is that they want ownership of the narrative and they seek further opportunities to amplify their collective voice to educate and change the negative perception of care experienced people (1000 Voices). The challenge remains to find the most effective ways to do this.

[770] Adapted from NAT (2016)

Where?	**Personal: minimising the impact of self-stigma**
What?	• Feelings of shame, fear and blame among care experienced people • Poor knowledge of rights • Risk of poor well-being
How?	• Programmes that offer opportunities for peer support, acknowledge feelings and chance to discuss stigma and its effects • Promote opportunities for care experienced people to speak as a community in challenging stigma and discrimination
Where?	**Cultural: Reducing stigma between individuals in communities**
What?	• Poor knowledge of care experience • Pre-conceptions, stereotypes and 'othering' of care experienced people • Low awareness of care experience stigma and the effect on people • Discriminatory behaviour(s)
How?	• Increase access to accurate information on the 'care system' and care experienced people • Expose people to range of messages addressing different aspects of stigma • Challenge negative media messaging around care experience and use relationships with the media to maintain more accurate reporting • Link to opportunities for people to further engage with campaigns at a local or community level • Involve care experienced individuals in the design, delivery and facilitation of interventions • Provide information on care experience stigma and its effects within interventions • Provide opportunities to discuss stigma and the factors contributing to it with peers • Use mixed media to deliver a relatable narrative to encourage empathy with care experienced people

Where?	**Structural: Stigma at a public policy / structural level**
What?	• Lack of legal protection from discrimination for care experienced people • Where rights do exist, lack of awareness amongst care experienced people and others
How?	• Adjustment and challenge to discriminatory policies and practice • Provide information on rights to care experienced people • Increase activity to uphold rights of care experienced people
Where?	**Organisational: Reducing stigma in organisation settings**
What?	• Poor knowledge of care experience • Pre-conceptions, stereotypes and 'othering' of care experienced people • Inappropriate or absent policy and practices • Policies and practices which single care experienced children and young people as different • Tolerance of discriminatory (possibly subconscious) behaviour or attitudes in the organisational culture • Poor understanding of the impact of stigma on care experienced people
How?	• Involve care experienced people in the development, delivery and facilitation of programmes • Involve staff across organisations in the programmes • Secure championing of the anti-stigma message from leaders and individuals who have influence • Develop strong organisational policies that promote zero tolerance to discrimination • Promote a balanced narrative about the 'care system' and care experienced people

8. Concluding remarks

The Care Review wants to eradicate the stigma currently in the 'care system' and create a non-judgemental system with love rather than stigma at its heart.

The evidence reviewed here shows that:

- Stigma is a long-standing issue and continues to affect the lives of care experienced people both whilst in care and in their adult lives.
- Much of the focus here has been on the experience of care experienced children and young people either still living in care or recently left care. We know much less about the impact of the stigma associated with care experience over the life course.
- Stigma is a complex phenomenon. The impacts of stigma are wide ranging and vary greatly from one individual to another.
- There are strategies to combat stigma but the evidence base for their effectiveness is varied, especially over the longer term. A key challenge appears to be how to sustain impacts and profile from anti-stigma campaigns.
- There is limited evidence that focuses on what works in challenging stigma, specifically in relation to care experience.
- There appears to be no central national strategic plan for addressing the stigma associated with care experience. An action plan could synthesise work across Scotland to map *what* current work there is to reduce stigma for care experienced people; *who* this work is aimed at (whole population or targeted population); *how* interventions are delivered; *whether* there is a core message across Scotland and finally, increase understanding about *if* the work has an impact and makes a difference to the lives of care experienced people.

- It is unlikely that just one type of intervention will challenge stigma at all levels; a combination of approaches and a clear strategy are likely to be most effective.
- As explored earlier, there has been recent work looking at public attitudes to care experience. It will be important to use these findings as a benchmark and resurvey the public once further anti-stigma work has been undertaken to track impacts and (any) changes in attitudes and perceptions towards care experienced people.

9. References

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Workforce

Workforce development and support

A review of the evidence on what promotes the well-being of the workforce and facilitates relationship-based practice

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1. Introduction

Background

In May, June and July 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant to the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[771]

Workforce

This report presents a review of the evidence in relation to the following questions:

- What evidence is available on what helps the workforce to support and care for looked after children and young people; what do we know about:
    - What helps promote the well-being of the workforce?

[771] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

- What facilitates and what hinders relationship-based practice?

Structure of the report

The report is structured as follows:

- Section 2 reports relevant findings from the Discovery stage of the Care Review
- Sections 3 sets out the definitional issues which have informed this evidence review.
- Sections 4 looks briefly at what children and young people want from the 'workforce' around them.
- Section 5 examines what is known about the current state of well-being in the workforce
- Section 6 considers evidence in relation to factors that help support workforce well-being at both the organisational and individual level
- Section 7 discusses relationship-based practice, covering the core features of this approach and the barriers that can exist for the workforce in adopting such an approach.
- Section 8 contains some concluding thoughts.

2. Findings from the discovery stage of the Care Review

In relation to the topic of the workforce the Discovery stage of the Care Review found that:

- From the children and young people consulted the 'care system' should not be about processes, plans or reviews but should be all about the quality of relationships children and young people have with the 'workforce': their carers, workers and the people around them. The availability and quality of these relationships had the greatest impact on their experience of care (Baker, 2017)
- The views of children and young people as well as carers and professionals were sought in relation to the Care Review Discovery stage question: What would best care system look like? Commonly respondents reflected that a principle purpose of the 'care system' was to create opportunities for everyone to maintain or develop relationships (Baker, 2017)
- Across the evidence gathered in the Care Review the most common issue reported by children and young people with care experience was the importance and impact of the people they had available to them. As a result, the theme of relationships cuts across all of the Care Review workgroups (1000 Voices report, 2019)
- But everyone involved with the Discovery stage thought some of the processes and practices in the 'care system' made it harder or prevented them from having good relationships, including: changes of worker or carers; lack of time to get to know each other and the high number of children and young people each worker was responsible for were often raised as concerns (1000 Voices report, 2019)

- Children and young people in care as well as care leavers identified the qualities and attributes they sought from the adults who cared for them; they wanted those who supported them to be empathetic, and to have an understanding of (i) what it means to be care experienced and (ii) the complex emotions and behaviours that can result. Specifically, some wanted the people around them to understand more about the reasons behind their behaviours (1000 Voices Report, 2019)
- Consultation with the wider audience showed many professionals who work with children and young people in care would welcome increased training and focus on issues such as trauma, neglect and child development. (1000 Voices report) The children and young people consulted thought these skills were needed by their social workers and carers but were also needed by those who had 'supportive roles' in their lives such as teachers, police, children's hearing panel members and others who had a role in their lives. (1000 Voices report, 2019)
- The government statistical outcomes for looked after children do not cover the characteristics or experience of the workforce supporting looked after children (apart from information on the type of placement children live in, e.g. foster care, kinship care). (CELCIS, 2018, statistical overview report)
- Two of the twelve Care Review intentions are particularly relevant to the workforce workgroup:
    - All adults involved in the care of infants, children and young people are empowered, valued and equipped to deliver the best care system in the world
    - Scotland's care services will plan and work better together, sharing information more easily to ensure we understand the what and how of supporting infants, children and young people and their families from a local through to a national level.

3. Who are the 'workforce' for looked after children?

This section provides a brief overview of how the 'workforce' is defined in the context of Care Review.

How is 'workforce' defined?

The Care Review workforce group's working proposition was:

> *'To give full consideration to the entirety of the workforce, paid and unpaid, how they interact with each other in the interests of infants, children and young people, and how they are trained and supported to do this'*

The workgroup proposition contains a commitment to consider issues in relation to all the adults who work with looked after children and you people in care[772]. It is inclusive of everyone who comes into contact with care experienced children and young people regardless of the position they occupy. In doing so, it acknowledges that those in a less formal role such as, a school caretakers or child-minders can have a lot to offer individual people too. Several evidence sources reviewed to inform this paper also encouraged a broad conception of the looked after children and young people workforce (Rahilly and Hendry, 2014; Care inquiry, 2013a):

> *'Children in care are supported by a wide range of people. Alongside carers and social care staff, children and young people are helped by health staff, teachers, police, youth workers, mentors, advocates and a wide range of other professionals. All have important roles to play, so we need a wider conception of the children-in-care workforce that*

[772] A non-exhaustive list (in no particular order) from ICR Workforce: social workers, health staff, teachers, youth workers, mentors, advocates, police, managers, team leaders, senior leaders, aligned corporate parents (e.g. housing, DWP), children's hearing panel members, kinship carers, foster carers, residential workers, children's reporters, unpaid workforce e.g. friends, families, communities, etc.

includes all of these professionals and understands the role that they play.' (Rahilly and Hendry, 2014)

'There was a call for a broad understanding of the term 'workforce', so that everyone involved with children – foster carers, kinship carers, adoptive parents and residential staff – has attention paid to their training and support needs. Carers and workers are expected to deal with difficult, often complex, situations, and they do so in the context of insufficient support for promoting continuity of relationships for children. They are not going to get this right for children without the time and expertise to make it work. ...People not involved intensively in the child's plan, but who nevertheless saw themselves as a resource for the child, also wanted to be involved properly, so that children would know of their strong continuing sense of belonging and commitment.' (Care Inquiry, 2013a)

Defining *who* may be included in a broad conceptualisation of the looked after workforce in the context of Care Review is therefore a crucial first task:

'The children's workforce is varied and comprises multiple professions, employers and services, from teachers, sports coaches, social workers, family support workers and school nurses to police officers.' (ADCS, 2019)

People working in each of these roles will come into contact with children and young people at different stages of their 'care journey'. One way to think about the workforce is proposed by the ADCS (in England) below:

- The 'core' workforce, consisting of those who work directly with children and families, often holds statutory responsibilities and has a specific government focus due to the nature of this work. The core workforce comprises social workers, teachers and child and

adolescent mental health service (CAMHS) practitioners, amongst other professions

- The 'wider' children's workforce complements the core workforce, working with children, young people and families in a more universal capacity. People such as youth workers, school support staff and family support workers are included in this conceptualisation (ADCS, 2019).

However, the Care Review workforce working group further expands the notion of 'workforce' to include those in unpaid roles, and therefore includes people important to a child who may not occupy a 'formal role'. In an attempt to manage all the potential diversity within the Care Review workforce working group a model was proposed, which consists of three main 'layers'. This, in theory, could encompass the full range of roles (Care Review, May 2019):

1. First (inner) layer: Parental role group / 'family' carers[773] (e.g. parent / carer)
2. Middle layer: Decision-maker group (e.g. social worker, children's hearing panel)
3. Outer layer: Awareness-raising group i.e. wider audience / community (e.g. police, teacher)

A note on evidence

Due to time constraints and availability of evidence[774] much of the research cited in this paper is focused on only some sections of the workforce rather than all the possible workforce groups. In particular, evidence was more readily available in relation to the experiences of social

[773] The discussion notes from the ICR workforce group identify how they are working to shift how 'family' is conceptualised to create an environment in which looked after children would recognise their 'looked after placement' as close to 'family' as possible. 'Family carer' in this conceptualisation is therefore inclusive of anyone, personal and professional, involved in caring for a child. The aim emerging from the ICR workforce group is to change the identity of 'care experience' to 'just another type of family'.
[774] For example: annual statistics are available on some sections of the workforce but not on others – in particular the 'unpaid workforce' (e.g. friends, families and communities). https://data.sssc.uk.com/images/WDR/WDR2017.pdf

workers, foster carers and to some extent residential care workers. However, despite this narrow focus, many of the issues raised may well be applicable to those in the wider workforce whose involvement with looked after children and young people can have similar emotional demands and rewards. At the same time, it is acknowledged that the resources that can help the workforce manage work-related stress and build workforce are likely to vary considerably between different sections of the workforce (Kinman and Grant, 2016).

4. What do children want from their relationships with the 'workforce'?

Many children and young people viewed their social worker as the most important professional in their lives (Oliver, 2010). Lots of studies have highlighted that children and young people wanted positive relationships with their workers (Coram Voice, 2015).

Having these positive relationships promoted their well-being (McLeod, 2010). Children and young people saw their worker as a powerful ally when the relationship was good. When they felt their worker supported them, they felt well looked after (Minnis and Walker, 2012). Evidence further confirms the importance of positive relationships for looked after children and young people[775]:

- Relationships promote healing and recovery from trauma and adversity (Perry, 2006).
- Good relationships mean better lives for those in care, supporting better health and wellbeing (Griffiths, 2017)
- Resilience, the ability to adapt to change and cope with difficulty, is built through relationships (Stainton et al., 2018; Wade & Munro, 2008; Cashmore & Paxman, 2006)
- Giving the workforce the time and space to focus on relationships can help create a better environment to work in (Hayes, 2018) (this is further discussed in section 6)

From the evidence reviewed it seems that children and young people with care experience are clear on what they want and need from the workforce.

[775] References taken from Scottish Throughcare and Aftercare work – see https://www.staf.scot/blog/mapping-relationships-we-want-to-hear-from-you

Across studies children and young people identified that they valued relationships with people who:

- were always there for them;
- loved, accepted and respected them for who they were;
- were ambitious for them and helped them succeed;
- stuck with them through thick and thin;
- were willing to go the extra mile;
- treated them fairly and included them, as part of their family or setting;
- were part of their life, beyond childhood and into adulthood
- listened to what they felt and what they wanted;
- worked with them as an individual and did not judge them;
- were friendly, kind, not bossy and had a sense of humour;
- took time to understand what they'd been through;
- acknowledged positive changes they noticed in them; and
- kept them updated and fed back in an appropriate way about decisions.

(Care Inquiry, 2013b; Minnis and Walker, 2012; Berridge et al, 2012, Hiles et al, 2013, Action for Children, 2017)[776] *).*

The value of many of these attributes were echoed by carers (foster and kinship) who also appreciated workers who were reliable and available, kept them informed and included them in the plans and decisions that were being made (Brown, 2014; Dickson, 2009).

The main qualities that children valued appeared consistent across the different 'roles' that adults occupied in their lives. For example, 'stickabilty'

[776] These messages have been echoed in a recent article published in the Guardian newspaper: https://www.theguardian.com/social-care-network/social-life-blog/2016/jul/06/stand-up-for-me-and-be-brave-what-young-people-want-from-social-workers

or continuity were equally important to a child in relation to their foster carer, as it was to a child talking about their social worker.

In relation to the workforce who were responsible for the decisions taken about them, children and young people often emphasised additional important things: they wanted these people to be easily available, to keep them informed about what was happening and to be reliable (i.e. do what they said they would) (Baker, 2017).

5. What do we know about the state of well-being in the workforce?

The previous section discussed what children and young people say is important to them in terms of their relationships with workers, foster carers, residential staff, and other members of the workforce. However, relationships require time, space and effort to be able to develop, and one of the things that facilitates this is having a workforce that is stable, supported and motivated. The well-being of the workforce is therefore critical.

This section discusses the evidence on workforce well-being before going on (in Section 6) to consider the factors that help to support workforce well-being.

Working conditions and stress

Research, based on social workers accounts, has indicated the workforce find their role '*simultaneously emotionally exhausting and intrinsically rewarding*' (Kinman and Grant, 2016)[777].

The workforce supporting looked after children and their families can face a high risk of work-related stress which can impact negatively on their well-being. This has implications for sickness absence and retention, issues that have impacts at both the personal and organisational level[778].

[777] For examples nearly three quarters (73%) of children social workers reported high emotional exhaustion but in tandem, a majority, (91%), reported strong feelings of personal accomplishment from their work (Cunningham et. al., 2015)
[778] Workplace stress is the biggest cause of long-term sickness absence in the UK public sector (Ravalier, 2017)

Social Worker Working Conditions survey

The *Social Worker Working Conditions*[779,780] survey examines what working conditions are like for UK social workers and the influence these have on work-related stress. The findings from the last two surveys indicated that many social workers loved their job but the working conditions in which they practiced were often detrimental to their well-being and led some to consider leaving (and in some cases to leave) their role (Ravalier, 2017; Ravalier and Boichat, 2018). The findings and recommendations did not appear to differ significantly by country[781], and led the authors to conclude '*it is clear that for each of England, Scotland and Ireland working conditions are very poor*'. Other noteworthy findings included:

- UK social workers are working more than £600million of unpaid overtime[782](92% of social workers work more hours every week than they are contracted to).
- Over half of UK social workers in children's services intend to leave the profession within 15 months
- In both the 2017 and 2018 surveys, the analysis suggested the amount of work that social workers have to do (demands on their time) was the factor which had the biggest influence on stress. Other stressors were administrative loads and the lack of resources for the people they are working with.
- The reasons social workers gave for wanting to leave the profession included high, unmanageable workloads, a lack of professional and peer support, burdensome red-tape and bureaucracy. These issues

[779] https://www.basw.co.uk/resources/uk-social-workers-working-conditions-and-wellbeing-2017
[780] https://www.basw.co.uk/resources/uk-social-workers-working-conditions-and-wellbeing-august-2018
[781] Only the 2018 survey appears to give the number of respondents per country: the majority of responses came from social workers in England (2,642), compared to Wales (168), Scotland (301), and Northern Ireland (110).
[782] Another study also revealed a workforce facing high workloads in a context of staff shortage, as a result nearly two-thirds (62%) of respondents reported that they did additional work every week (IRISS, 2017).

came top of their list for negative aspects in their work for over 70% of the social workers surveyed.

- Poor working conditions were influencing outcomes, resulting in high levels of dissatisfaction in the role, high levels of presenteeism (i.e. attending work while ill enough that they should be taking sick leave), and high levels of turnover intentions
- Over time working conditions did not appear to be improving; in comparison to 2017 figures, the 2018 working conditions reported were worse.
    - According to respondents the right working conditions needed for excellent practice included:
    - access to professional supervision
    - a manageable workload
    - good leadership and management
    - fair pay
    - reduced unnecessary bureaucracy
    - time to spend with the individuals and families they work with
    - access to on-going professional development and wellbeing support.

Many of the social workers surveyed felt it was important for their organisation to combat low morale and the high risk of work-related stress. The survey respondents suggested a number of ways to improve working conditions, which the researchers used to recommend the following:

- *Caseload* - was the top source of workload-related stress. Social workers should have a 'maximum protected caseload' and where useful children and young people should be 'co-allocated' (supported by more than one worker).
- *Managerial pressures* - managers should only line manage a maximum number of employees at any one time and repetitive

administrative tasks should be removed and IT used to help reduce the administrative burden.

- *Reflective supervision* – various improvements were suggested in this area (see below for more discussion on this).
- *Work practices need improvement* – there is a need for a space away from the desk for non-work activities (such as lunch; reflection; peer groups).

Compassion fatigue

Compassion fatigue can be experienced by those working in the helping professions, as a response to being exposed to the trauma of people whom they are supporting. Compassion fatigue is widely understood to have three separate but related dimensions: (i) burnout, (ii) secondary traumatic stress (which impacts on the ability to maintain compassion for others) and (iii) compassion satisfaction (feelings of pleasure and success from helping others) (Stamm, 2010 cited in Ottaway and Selwyn, 2016).

- *Burnout* can be described as feelings of physical and emotional exhaustion. Symptoms include anger, frustration, hopelessness, depression and feeling inefficient in one's job
- *Secondary traumatic stress* develops when an individual hears about the trauma of others and is directly affected. Symptoms are similar to post traumatic stress disorder, and include experiencing intrusive images, sleep difficulties, problems with concentration, irritability and anger
- *Compassion satisfaction* is the pleasure people get from their work in terms of feeling satisfied with the job, and with simply having a role in helping someone else. Compassion satisfaction is believed to moderate the effects of burnout and secondary traumatic stress.

Compassion fatigue impacts negatively on workforce well-being, and there are consequences for employers, as compassion fatigue is associated with turnover and absenteeism, low motivation and morale, and employee

performance (including poor judgement, decision-making and quality of care). Moreover, compassion fatigue in the workforce can impact negatively on the relationships the workforce has with those they are supporting (Audin, 2018).

Evidence is available on the impacts and experience of compassion fatigue on the performance of the wider workforce - for example, the police, hospital staff, mental health professionals and social workers - but there appears to have been less attention paid to the effect of compassion fatigue on foster carers and residential care staff (Ottaway and Selwyn, 2016).

However, one study (based in England) looked at foster carers' experiences in relation to compassion fatigue and found:

- In comparison with people working in other stressful helping professions, foster carers had slightly higher levels of burn out, lower levels of compassion satisfaction and similar levels of secondary traumatic stress
- More than one in four foster carers had low well-being (Ottaway and Selwyn, 2016).[783]

Similarly, one study looking at the experience of the residential care staff[784] also found the workforce was at risk of developing compassion fatigue, including burnout and secondary traumatic stress but, like foster carers, there was also the opportunity to experience compassion satisfaction from the role.

[783] Sample size: 546 foster carers surveys. The survey asked about carer's well-being using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). The general population mean score is about 51 (Health Survey of England 2011). In this sample of foster carers the mean score was lower at 47.8. https://research-information.bristol.ac.uk/files/94738726/_No_one_told_us_it_was_going_to_be_like_this_Compassion_fatigue_and_foster_carers_final_report.pdf

[784] Based on 100 responses from England, Scotland and Wales https://www.celcis.org/files/8715/3719/1694/2018_Vol_17_No_3_Audin_K_Compassion_fatigue_compassion_satisfaction_and_work_engagement_in_residential_childcare.pdf

- Almost one-third (32%) scored high for burnout[785] and just over one-quarter (26%) scored high for secondary traumatic stress.
- One-quarter of participants scored low on compassion satisfaction[786] (Audin, 2018).

Although this evidence is drawn from single studies only (with relatively small sample sizes) it is concerning that between a third and a quarter of foster and residential carers were experiencing high levels of burnout and secondary traumatic stress.

> *'Heavy caseloads, burnout, poor pay and conditions, dysfunctional organisations, and low levels of training and support have all been found to explain this exodus… it is how these combine and interact… that result not only in the departure of weaker workers but also committed and excellent practitioners.' (Baginsky, 2013 cited in Bowyer and Roe, 2015)*

Monitoring well-being in the workplace

Ensuring organisations have systems in place to monitor, over time, the well-being of their workforce is very important. The UK Health and Safety Executive (HSE) developed a set of 'management standards' which identify working conditions which have the potential to negatively impact on workforce well-being (Bowyer and Roe, 2015). The HSE standards cover[787]:

1. Demands – workload and working hours
2. Control – how much say staff have in the way they do their work (autonomy over working methods, pacing and timing)
3. Support – encouragement and resources provided by the organisation, mangers and colleagues (including peer support)

[785] Compared to 26% in foster care study for burnout and 24% for secondary stress.
[786] Comparing scores on compassion satisfaction there appears to be similar proportions in residential study and foster care study (25% vs. 27%)
[787] The HSE have developed a free monitoring framework to accompany the standards http://www.hse.gov.uk/stress/standards/downloads.htm

4. Managerial support – supportive behaviours from line managers and the organisation, including encouragement and the availability of feedback
5. Relationships – the extent to which positive working is promoted to avoid conflict within the workplace, including: bullying behaviour, harassment and other kinds of unacceptable behaviour
6. Role – the extent to which people understand their role within the organisation, and how their work fits into the overall aims of the organisation
7. Change – how well organisational changes (large and small) are managed and communicated in the organisation[788].

Kinman and Grant (2016) suggest the HSE approach could be supplemented with measures of workforce burnout, compassion fatigue and satisfaction (as outlined earlier) to give a fuller picture of how the workforce are faring in relation to their well-being.

Summary

This section has considered the ways in which stress, working conditions and compassion fatigue can all have a negative impact on workforce well-being. Subsequently, the following section will consider what the evidence says about how to promote the well-being of the workforce.

[788] www.hse.gov.uk/stress

6. What promotes the well-being of the workforce?

The provision of high-quality services for looked after children, young people and their families relies upon a stable, supported and motivated workforce. An important aspect in this is ensuring the workforce have positive well-being. Even from the selected evidence presented in Section 5, the case appears compelling that strategies are needed to provide better support to the workforce to counteract the effects of stress and compassion fatigue.

This section sets out the evidence on the factors that help bolster emotional resilience and well-being among the workforce. It covers the features of organisations and individuals (namely, practitioners and managers) that protect the well-being of the workforce; in doing so it looks at:

- organisational factors (support and supervision)
- individual factors (personal competencies, history, training and coping style)
- access to training and learning (professional development opportunities)
- being empowered in the role (ability to take decisions and use professional discretion).

Research studies have suggested that 'emotional resilience' is an important aspect of helping to protect practitioners against 'burnout' and improve work-life balance. Emotional resilience has been defined as:

> *'Emotional resilience is the ability to maintain personal and professional well-being in the face of on-going work stress and adversity.' (Kinman and Grant, 2016)*

Previously work on developing resilience in the (social work) workforce tended to conceptualise resilience as an individual trait. Recently there has been a shift in understanding resilience as something which is supported by '*an array of possible resources both internal and external to the person*' (Admanson, 2012 cited in Earle 2017).

> *'Emotional resilience is not a personality trait and greater attention is now being paid to those factors that may predict emotional resilience. In child protection workers this includes organisational factors (such as workload, social support and supervision) and individual factors (such as personal history, training and coping style) … promoting emotional resilience ultimately demands a systemic approach – resilience organisations develop resilience staff.' (Earle, 2017)*

Thus, emotional resilience is not merely something that is intrinsic to individuals. It is something that organisations have a key role in developing.

Organisational factors which support workforce well-being

As discussed above, people who work in caring professions (including those working with looked after children) appear to be at high risk of work-related stress and compassion fatigue. This is a serious problem. The working conditions and organisational culture in which the workforce operates are crucial in addressing this problem (McFadden et al, 2015). Organisations need to be proactive in their attempts to promote and protect the well-being of their workforce.

Emotional resilience is associated with a number of work environment factors. These include:

- Workplace factors: caseloads, limited resources, organisational culture and social policies
- Social support: supportive work environment, social support from mangers and colleagues.

Supervision

> *'Direct work with children and families can be highly rewarding as well as complex, stressful and emotionally demanding. Organisations have a duty of care to their workforce and good-quality supervision can support practitioners' well-being and job satisfaction, and may support workforce retention' (Earle, 2017)*

A common definition used in social work describes supervision as having four main functions (i) management (i.e. ensuring competent practice and performance); (ii) continuous professional development; (iii) providing personal and emotional support to workers and (iv) mediation (i.e. engaging the individual with the organisation). In short, supervision is:

> *'A process by which one worker is given responsibility by the organisation to work with another in order to meet certain organisational professional and personal objectives which together promote the best outcomes for service users' (Morrison cited in Earle, 2017)*

Hughes (2010) expands on this definition, emphasising the relational aspect of supervision:

> *'Supervision is a safe, confidential relationship whereby an opportunity is provided to reflect, question and seek guidance on a regular basis.' (Hughes, 2010)*

Research[789] suggests supervision is associated with a variety of benefits (for both individuals and organisations). Those relevant to workforce well-being include:

- Supervision is associated with increased job satisfaction and a perception among staff that it improves their practice and helps them prioritise and manage their workload
- Supervision may affect the extent to which employees believe an organisation values their contribution and cares about their well-being
- Good supervision is associated with lower levels of practitioner stress, burn-out and role conflict and greater staff well-being
- Supervision is associated with practitioners' commitment to an organisation and intention to stay
- The quality of supervision and the supervisory relationship are often highlighted as important factors in promoting staff retention (Earle, 2017)

Furthermore, if the workforce feels supported, they can build relationships with families and use these relationships to facilitate change with families (a key feature of 'relationship-based practice' which is discussed in more detail in Section 7).

> *'Workers' state of mind and the quality of attention they can give to children is directly related to the quality of support, care and attention they themselves receive from supervision, managers and peers' (Ferguson, 2011 cited in Earle 2017)*

Despite its apparent importance, evidence (from England) suggests that both the quality and frequency of supervision can vary significantly.

[789] Supervision appears to be linked to a variety of benefits – however, there are some weaknesses in the evidence; a lack of detail on the nature, quality and regularity of supervision, and limited scope to say that supervision 'causes' certain outcomes. Furthermore, much of the evidence originates in the USA (Earle, 2017)

Supervision of foster carers

An international literature review examined the role of the 'supervising social worker' in providing support and supervision to foster carers (including kinship carers). In England, for example, the supervising social worker acts as '*a conduit between the fostering household and the fostering service, and is distinct from the role of the foster child's social worker*' (Cosis-Brown et al, 2014). Carers consistently report this relationship is very important to them. The retention of foster carers has been reported to be linked to the quality and quantity of the support received by the carer from the supervising social worker.

Evidence in relation to 'supervision' in other areas of the workforce such as residential care, teachers and others in the looked after workforce is not included here due to limited time available and seemingly less evidence available (though a systematic search for sources was not conducted).

Peer support

Carers (predominantly foster carers) and social workers stressed the value they placed on support from their peers. In the Social Worker conditions survey (reported earlier) the amount of support received from peers was one of the only positive highlights in relation to experiences of the working environment[790] (Ravalier and Boichat, 2018).

Research looking at the experiences of foster carers and their peers (i.e. other carers) found that peer support was a potential source of emotional support, practical help and on occasion, positive reassurance. Carers reported that this peer support could counteract the sense of isolation some of them could feel in their role. The opportunity to meet with other carers also provided an opportunity to learn from each other, share problems and spend time with people who had a deeper understanding of

[790] The only working condition which had not worsened since the previous year, and did not score poorly was peer support

what being a (foster or kinship) carer entailed (McDermid et al, 2016; Luke and Sebba 2013; Dickson et al, 2009).

In an international review on 'peer contact between foster carers', a small number of studies were identified that reported links between 'peer contact' and benefits for carers. They showed carers' perceptions of being supported were associated with a greater likelihood of continuing as a carer and a more positive attitude to fostering and in one study a lower likelihood of depression was found to be associated with greater peer contact (Luke and Sebba, 2013). In recent years, the Mockingbird Family Model (MFM), a support approach for foster carers and children, has been piloted in the UK[791]. One of the aims of the approach is improve peer support for foster carers and the evaluation reported positive impacts in this area from participating in MFM (McDermid et al, 2016).

Similarly, peer support from colleagues and a good sense of 'team' appeared to play a vital role in the well-being of social workers (Bowyer and Roe, 2015). The importance of making sure workers and managers were not isolated in their work and got the chance to learn from others was a common theme (Toombs, 2008: Dixon and Baker, 2016). Sometimes working conditions inhibited opportunities to spend time with other colleagues; hot desking and remote working as well as a heavy workload meant that time and space were limited.

The Working Conditions research (discussed earlier) highlighted pressures faced by social workers which were having an impact on attrition and job satisfaction. Social workers who took part in the research rated peer support highly as a protective strategy. Following on from these findings work in Scotland has been exploring 'communities of practice and social worker well-being'. Limited information is available in the public domain

[791] MFM is an approach to supporting foster carers and children and young people placed with them, which brings together clusters of between 6 and 10 'satellite homes' to form a 'constellation' (McDermid, 2016)

on this work. However, initial findings will be presented at an upcoming workshop.[792]

Other recent work relevant to peer support and well-being includes the piloting (in England) of *Schwartz Rounds*[793] in children's social care. Originating in health care, the concept is described as a '*unique forum in which people delivering healthcare can come together and reflect on their experiences. They have a simple aim: to support staff well-being, build empathy and compassion across organisations, and improve the quality of care*'.

Individual factors in building emotional resilience

This next section focuses on approaches that may support individuals in the workforce to develop greater resilience and to manage the emotional aspects of their work. However, individual focused interventions should not be offered in isolation. They need to be backed up by organisational support to promoted well-being (as discussed above) (McFadden et al, 2015).

Ideas on how to support an emotionally resilient workforce (all cited from Kinman and Grant, 2016) include:

- *Cognitive behavioural techniques (CBT)* - Provides tools to challenge negative thinking styles that can encourage too much self-criticism and lead to emotional exhaustion. After training, CBT can be used in reflective supervision to generate alternative strategies to manage emotional or behavioural concerns. These techniques can also help the workforce build coping flexibility and self-compassion and encourage a more open and creative approach to problem-solving in direct work with children and families (see Alexander et al in Kinman and Grant, 2016).

[792] https://www.basw.co.uk/basw-uk-conference-and-agm-2019
[793] https://s29720.pcdn.co/wp-content/uploads/Schwartz_Rounds_____evaluation_plan.pdf

- *Emotional writing* - Writing about emotions daily can be as effective as face-to-face discussions in gaining insight into complex emotional reactions and facilitating change. This technique requires little training and there is evidence that writing for only two minutes each day can have benefits for health (Burton and King, 2008). Research has found that writing about emotional reactions to practice (both positive and negative) improved empathy, reflective ability and emotional literacy in trainee social workers (Kinman and Grant, 2016).
- *Mindfulness* - Combines meditation, breathing techniques and non-judgemental conscious awareness to help people change the way they think, act and feel. Mindfulness can build the competencies underpinning emotional resilience and effective practice, such as emotional literacy, reflection and self-compassion. It can also help practitioners remain anchored in the present, rather than ruminating on past mistakes or worrying about the future. Mindfulness is also useful in building empathic connections with others while maintaining healthy emotional boundaries (see Parkes and Kelly, in Kinman and Grant, 2016).
- *Peer support and coaching* - The importance of supportive peers in protecting the wellbeing of the workforce was discussed earlier. Peer coaching is a more formalised type of support involving a reciprocal relationship between colleagues. It aims to support a more constructive, solution-focused approach to difficulties. This can not only facilitate change, but also improve reflective abilities, emotional literacy, resilience and wellbeing and encourage workers to celebrate success rather than dwell excessively on perceived failure. Some initial training is required, but the peer coaching relationship is self-managed. Sessions can be arranged during breaks or over the phone or Skype (see Baker and Jones, in Kinman and Grant, 2016).
- *Personal organisation and time management skills* - These can help the workforce cope more effectively with competing demands and help them schedule breaks between tasks. When introduced during

initial training, these techniques can be particularly useful in helping people set achievable and sustainable goals in subsequent practice. Knowledge of the behaviours that support or derail effective time management skills can also be gained (see Wray et al, in Kinman and Grant, 2016).

- *Reflective supervision* - Positive supervisory relationships based on authenticity, respect and positive regard can protect the wellbeing of the workforce (see earlier for further detail on supervision). To be truly effective, however, supervision should be reflective, developmental and supportive rather than focus primarily on administrative or managerial issues. Providing opportunities for reflective supervision is particularly important during the early stages of an individuals' career, as it can foster the emotional competencies that underpin resilience such as self-reflection, emotional literacy and bounded empathy. Supervision is also a valuable opportunity for organisations to model the type of relationship required to support families effectively and help them build their own emotional resilience (see Grant and Brewer, Kinman and Grant, 2016).
- *Self-knowledge/stress appraisal skills* - A series of easily-learned techniques can raise awareness of the aspects of the work that the workforce find most emotionally challenging. The workforce can also gain insight into how they respond to stress physically, psychologically and behaviourally, and the personal resources that can protect their well-being and emotional resilience. The important role of active coping styles (such as planning and positive reframing) and coping flexibility in building resilience should also be emphasised (see Kinman et al, in Kinman and Grant, 2016).

In addition, the evidence points to a number of competencies associated with emotional resilience including:

- Personality traits (e.g. hardiness, persistence and resourcefulness)

- Positive attitudes towards the self and others (e.g. self-efficacy, self-esteem and forgiveness)
- Positive explanatory styles (e.g. hope and optimism)
- Behavioural tendencies (e.g. appropriate coping and the ability to set boundaries)
- Social competencies (e.g. self-awareness and confidence)
- Well-developed critical thinking, problem solving and emotion management skills (Kinman and Grant, 2016)

Access to training and learning opportunities

Workforce training, learning and professional development opportunities have been found to be important to workforce well-being (Kinman and Grant, 2016). However, the coverage of topics in training and learning opportunities needs to be seen as important and relevant to the workforce (Dickson et al, 2009).

It is not within the scope of this evidence review to provide information on the very wide range of learning and development opportunities available to the workforce and how these may promote workforce development. However, it is worth highlighting here that many looked after children and young people have experienced some form of trauma in their lives, with on-going consequences for their emotional and mental health.

In the Discovery stage of the Care Review, one of the areas where the workforce wanted further training was in relation to trauma, neglect and children development (1000 Voices, 2019). There is an identified need for greater understanding across the paid and unpaid workforce of the challenges faced by looked after children, young people and their families. Consistency of understanding and a shared value base amongst those who support looked after children will contribute to the delivery of more consistent, joined up and effective services. At present, those who work with looked after children do not appear to share a common core of

training. Therefore, there is not necessarily a shared language and common ways of working across the entire sector.

The Scottish Government through their Programme for Government (2018-2019)[794] have already highlighted the need for an adversity and trauma-informed workforce and have committed to delivering this through:

- implementing national trauma training following NHS Education for Scotland development of a National Trauma Training Framework
- funding the development and testing of routine enquiry of Adverse Childhood Experiences (ACE)s in Scotland, where trained professionals ask adults in a sensitive way about adversity they experienced in childhood and how it impacts on them now
- continuing support from Education Scotland to schools in developing effective responses to ACES by embedding nurture and trauma-informed approaches
- improving experiences of the Children's Hearings system to respond compassionately to traumatised and neglected children and young people
- considering how the Barnahus795 concept for immediate trauma-informed support for child victims of serious and traumatic crimes can operate within the context of Scotland's healthcare and criminal justice system
- supporting work with adults affected by ACEs and trauma in health and justice settings, such as the Navigator Programme in hospitals and improvement fund for health and social care in prisons.

[794] https://www.gov.scot/publications/delivering-today-investing-tomorrow-governments-programme-scotland-2018-19/

[795] Healthcare Improvement Scotland and the Care Inspectorate have been asked by Scottish Government to develop a set of standards for a Barnahus response to children and young people who have been victims and witnesses of violence in Scotland. This work is in the early stages of development: http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/barnahus_standards.aspx

Being empowered in workforce role (decisions and discretion)

Some studies have found that many within the health and social care workforce felt their skills and knowledge are not being fully used, and that their levels of autonomy are diminishing (Christie Commission, 2011). Yet research shows that members of the workforce value respect for their knowledge and experience, involvement in designing and improving their own job. Staff also place a high premium on being valued for what they do as well as being trusted and empowered to do a good job. These factors, along with shared purpose and leadership, are all major drivers of job satisfaction and engagement (Christie Commission, 2011).

Some of the workforce (foster carers, kinship carers and residential staff) report they feel undervalued and believed their work had lower status in comparison to others who supported looked after children (such as social workers). Commentators have identified a tension in how carers (evidence usually focuses on foster carers and sometimes kinship carers) are viewed in the 'professional network' and whether they are seen as colleagues and part of the team (Brown et al, 2014).

Evidence from the Care Review Discovery stage and elsewhere showed some parts of the workforce were not always included in decisions or able to make decisions. Members of the workforce wanted an appropriate level of discretion in day-to-day decisions and to be empowered in their role supporting looked after children. Being empowered to take decisions and exercise professional discretion have also been found to be important contributors to staff well-being (Kinman and Grant, 2016).

Research with carers (foster and kinship) showed they wanted to have more discretion over managing day-to-day issues that were usually managed within families. Carers highlighted that their ability to make everyday decisions for children can be hampered and they are not always empowered to parent as they may wish (Baginsky, 2017). Children and young people often agreed that they wanted the people looking after

them to have more power to take decisions so that their lives were more 'everyday ordinary'. Examples given in research studies, where carers and young people reported they would like more day-to-day responsibility over permission, included things such as school trips, sleepovers and haircuts. Generally, it was important for those looking after children to feel empowered in their caring role. Currently, not all said this was happening. They thought there was potential for them to have better 'delegated authority'.

Some sections of the workforce also felt their views needed to be listened to and valued more. Children and young people placed high regard on 'respect'; this meant others' respecting their views and valuing their contribution (these issues are discussed in more detail in both the evidence reviews on Rights and Components). Much of what children and young people have said was echoed by their carers (foster, kinship and residential). They also wanted their views to be heard and valued but did not always feel this happened (Care Inquiry, 2013b; Brown et al, 2014). Similarly, workers fed back that they did not always feel listened to, and that senior staff and managers did not always acknowledge or respond to the concerns they raised (Cunningham, 2015).

Summary

This section has identified that factors such as high-quality supervision, opportunities for reflection, organisational and peer support, the ability to make a difference and feeling valued can all contribute to workforce well-being. Conversely a culture of blame, stress and burnout and overly bureaucratic systems can lead to poor well-being.

The research reviewed in this paper suggests a range of actions to promote workforce well-being and minimise burnout and compassion fatigue. These include:

- Regular high quality and reflexive supervision (both one to one and group supervision that enables the workforce to reflect on the emotional impact of their work)
- Opportunities for staff development and relevant training
- Space for peer support
- Providing manageable tasks and workloads
- Helping staff recognise the indicators of compassion fatigue in themselves so they can adopt good self-care and coping strategies
- Avoiding an organisational culture of blame; identifying systems failures rather than blaming individuals
- Ensuring staff feel valued and empowered in their roles
- Reducing the stigma of stress so that it is openly discussed in organisations to help build organisational cultures that support emotional resilience
- Supportive managers who model self-care to the workforce
- Good relationships between young people and families, managers and peers – this was one of the crucial aspects to feeling valued. But continuity of relationships is compromised by high staff turnover. Instability in relationships cuts through the core of 'relationship-based practice' and section 7 now looks at this in more detail.

(Audin, 2018; Bowyer, 2015, Bowyer and Roe, 2015)

7. Relationship-based practice

In the evidence presented so far in this review, children and young people in care as well as care leavers were unequivocally clear: relationships matter deeply (and scientific evidence and government policy on improving well-being among these groups appears to agree[796,797]).

From children and young people's perspectives, their relationships are very important to their quality of life and well-being (Baker, 2017; Hiles et al, 2014). Supportive and caring relationships helped them develop self-confidence, self-esteem and contributed to a strong sense of identity and belonging (Care Inquiry, 2013). If positive relationships were not available, or if they were constantly subject to change (as discussed in the Care Review Components' evidence review), there was a negative impact on children and young people's lives.

The workforce agreed that relationships were pivotal to their work with looked after children and young people. The relationships they had were multiple and diverse. They existed on many levels: (i) in relation to the children and families they were working with; (ii) in relation to colleagues within their own organisation and (iii) in different organisations and (iv) relationships also existed with 'the self' (Wilson, 2011).

[796] Healthy development depends on the quality and reliability of a young child's relationships with the important people in his or her life, both within and outside the family. Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development - intellectual, social, emotional, physical, behavioural, and moral (National Scientific Council on the Developing Child, 2004).

[797] Good social relationships and connections with people around us are vitally important to individual well-being. They are also important to national well-being because the strength of these relationships helps generate social values such as trust in others and social cooperation between people and institutions within our communities (Evans, Macrory and Randall, 2015).

Definitional issues: what is meant by 'relationship-based practice'?

It is clear that relationships are important to everyone. For those in the workforce, the relationship itself can be used in the work done to improve the lives of looked after children and young people. This concept is referred to as 'relationship-based practice'. Models of relationship-based practice suggest that the relationship *is* the 'intervention'; here the relationship is both an important source of information for the workforce to understand how best to help and, in tandem, the relationship is the means by which any help or intervention is offered (Ruch, 2005).

> *'Emphasis is placed on the professional relationship as the medium through which the practitioner can engage with the complexity of an individual's internal and external worlds and intervene' (Ruch, 2005)*

> *'Relationship-based social work is about creating relationships with families, which provide opportunities for them to change, and which are clear about the consequences if change cannot be achieved.'* [798]

Relationship-based practice is not a method per se but rather is at the heart of whatever approach or intervention might be adopted, so that 'relationships' are the practice tool. This shifts the narrative from simply 'building relationships' to working with the relationship as 'the vehicle for change' – underscored by the fact that learning, growth and healing can only take place within the context of a relationship (Mason, 2012).

> *There is no one theory; rather it describes a 'way of being' when communicating and resolving difficulties. Relational or Restorative practices enable those who work with children and families to focus upon building relationships that create change. When we work with and alongside people there is strong evidence to say that outcomes*

[798] https://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Pod%20structure_2.pdf

> *for children and their families are improved (Restorative Leeds 2016 cited in Glasgow[799])*

It is important to acknowledge that relationship-based practice is not new (Ruch cited in Wilson, 2011; Ingram, 2018). However, some commentators have signalled that there has been a resurgence in the prominence given to a relational way of working, following a period of time where a culture of managerialism and performance monitoring through data seemed to dominant (Ruch, 2012).

> *'Social work became technical / rational rather than an ethical and relational endeavour… Relationship-based practice collides with and poses a fundamental challenge to managerial approaches to social work, foregrounding relationships, in all their ambiguity and messiness, above the bureaucratic, instrumental and ostensibly rational foundations of contemporary practice.' (Ingram and Smith, 2018)*

Within a more managerial culture, one that rewards compliance and attention to process, there may be a tendency to see human behaviour as marked by predictability and rationality. This pays less attention to the emotional, irrational and unpredictable dimensions of human beings (Ruch, 2012). The antithesis of a relationship-based way of working would be one that was more didactic, authoritarian and transactional. In contrast, relationship-based practice recognises that human behaviour is complex and multi-faceted and each human encounter is unique. Complex situations require complex responses. There is no one way of 'doing' relationship-based practice.

[799] https://www.staf.scot/Handlers/Download.ashx?IDMF=c1f190c0-6408-4486-89d9-cfeb4c7c4058

Features of relationship-based practice

Given there appears to be no agreed common definition of relationship-based practice, it may be useful to look at what the literature seems to identify as the core elements in a model of relationship-based practice:

Emotional intelligence

Emotional intelligence is pivotal for relationship-based practice; it can help the workforce manage the emotional complexities involved in their role. Broadly it involves being aware of one's own emotions and being able to understand and manage these effectively within relationships while simultaneously understanding the emotions of others and communicating this within relationships. (Ingram and Smith, 2018)

Relationship-based practice means engaging with both the rational and emotional or irrational aspects of the behaviour of those with whom the workforce is supporting (Ruch, 2005). Ultimately, it recognises that relationships are complicated and require workers to understand and use themselves within their work (Ingram and Smith, 2018).

Using relationships to facilitate change

Much of what the workforce are engaged in is about promoting positive change in young people's and families' situations. Change comes about through relationships. Therefore, relationships are formed for a particular purpose – towards a young person and/or family achieving positive change. (Ingram and Smith, 2018)

Workers must see themselves as 'active change agents' not just assessing and reporting on children and family situations. The assessment process is conceived of as a relationship-based intervention that aims to promote change and development rather than just collate information[800].

[800] http://www.cfswp.org/blog-post-19-02-2015-relationship-based-practice-works-the-evidence.php

Balancing 'professionalism' with relationships

An emphasis on relationships can challenge assumptions of what it means to be 'professional'. Rule-bound professionalism can create a distance between workers and clients. The professional role can compromise the ability to form genuine relationships (Ingram and Smith, 2018).

Relationship-based practice shifts the concept of the relationship beyond the individual to incorporate an awareness of contextual factors – including issues relating to power, professional role, poverty, social exclusion. (Ingram, 2018)

Relationship-based approaches to practice seek to be participatory and empowering, acknowledging the expertise of the children and family as well as that of the worker (Ruch, 2005)

Use of self

'Self' is about an individual's values, emotions, beliefs and experiences that combine and contribute to making that individual who they are. The self evolves and is present in the dynamic nature of the relationship established with those the individual works with. The 'use of self' presents challenges for the workforce in managing the balance between the professional, personal and private. Developing relationships may require a degree of 'emotional exposure' to understand the feelings of others (Ingram and Smith, 2018)

Transference – individuals can unconsciously transfer past feelings into the present which can affect the dynamics within relationships that are formed. (Ingram, 2018)

Reflection – engaging in reflection helps the worker to understand the feelings, thoughts and actions present. *Reflexivity* involves a consideration of what the worker brings; their bias, assumptions or preconceptions. It encourages an examination of wider factors such as culture, power and social exclusion. It is a crucial element required for relationship-based practice. (Ingram and Smith, 2018; Wilson, 2011)

Effective communication

A cornerstone of relationship-based practice is effective communication but there is limited consensus on what exactly good communication is (Mason, 2012)

Research based on observations of many hundreds of encounters between social workers, parents and children has revealed an enormous amount of complexity in relationships. Analysis of these interactions showed much variation in the work with young people and families, some of the conversations were markedly more collaborative, more empathic and more helpful than others (Forrester et al, 2018).

Relationship-based organisations

As discussed in Section 6 of this report, the influence and importance of organisations in supporting the well-being of their staff is critical. However, organisations also have an important role supporting relationship-based practice. Relationship-based practice is not a skill that is taught, it is about a whole approach or 'way of being'. Therefore, organisations need to create cultural change to support relationship-based practice.

> *'Reflective and relationship-based management practice is facilitated by reflective organisational contexts that embrace diverse knowledge sources, promote relationship-based skills and are underpinned by reflective values.' (Ruch, 2012)*

> *'Creating the professional, social and political conditions for this kind of practice involve something of a cultural transformation. It is not just a question of developing a 'method', trialling it, producing the evidence, and replicating it. There are many social and cultural obstacles to the task of enabling ourselves to think of 'hard conversations' as ordinary, and necessary'* [801].

[801] http://www.cfswp.org/blog-post-19-02-2015-relationship-based-practice-works-the-evidence.php

One local authority (Brighton and Hove, England) described their journey (since 2015) in implementing relationship-based practice as a whole system change across children's social work services. To date, this had led to structural changes, the introduction of new practice processes and cultural changes in relationship-based management and leadership. Specifically, this has entailed:

- The Brighton and Hove model of practice (which has been evaluated) established a *'Team Around the Relationship'* which involved a move to small social work teams, or pods, which support children from the assessment stage through the whole of their journey across social work services.
- This model of practice incorporates group supervision, reflective practice groups and a new model of relationship-based assessment and recording as key processes to support whole system change.
- Relationship-based management and leadership is underscored by trust and openness. (Brighton and Hove, 2017)

In this local authority work to achieve cultural transformation towards becoming a 'relationship-based organisation' is supported by six principles:

1. Continuity of social work relationships with families – so families do not have to change social workers or re-tell their stories because of local authority processes
2. Consistency of social work relationships with families – so families have support from a team that knows them
3. Collaboration between practitioners – so workers share skills and specialisms to promote change for families
4. Social workers as change agents – so that support is purposeful, outcome-focused and builds on families own strengths
5. Creating a learning culture

6. Transformation of the organisational culture from a blame culture to a relationship-based one that inspires trust and confidence[802].

Early evaluation findings conclude that children, young people and families have a better experience of social work than they previously did; social workers feel more supported and more able to make a difference for families; relationship-based practice seems to be supporting safe and stable family lives for children; and the model of practice appears to have decreased demand for social work (during a time of increasing national demand) (Brighton and Hove, 2017).

Barriers to relationship-based practice: availability and consistency of relationships

As discussed above, certain organisational conditions are important in order for relationship-based practice to flourish. Conversely there are factors that can inhibit the workforce from practising in a relational way. One of the major issues that can undermine relationship-based work is consistency and capacity within the workforce. Instability in the workforce; too many changes of worker or carer can detrimentally undermine relationship-based practice[803].

Children and young people said it was upsetting and confusing to lose contact with people who supported them just because of 'administrative' reasons such as when they moved, or their worker had moved, from one team to another. They thought these kinds of changes should not necessarily mean they had to end the relationships they had built up (Care Inquiry, 2013a). At times relationships between the child and others were arbitrarily cut off (Sinclair, 2005). Those taking part in the Care Inquiry (2013b) agreed; and suggested there was a risk of an assumption that' old relationships must be broken for new ones to be made' (Winter, 2015).

[802] https://www.brightonandhovelscb.org.uk/how-do-you-do-relationship-based-practice/
[803] In a survey of 1631 looked after children aged 11-18yrs over a quarter (27%) reported they three or more social workers in the past year (Briheim-Crookall, 2018)

Some children and young people highlighted that they wanted to spend more time with their workers so that they could get to know each other more. Children and young people were acutely aware of the pressures faced by their social workers and the impact of their workload on their capacity to build relationships with them, and they often argued for a reduction in the amount of work their worker had (Rahilly and Hendry, 2014). The workforce expressed the same concerns and often felt work pressures inhibited the amount of quality time they spent with children and others building relationships.

Some of those in care thought professionals should develop a better balance in their work, between spending time directly with them and all their other tasks (Voice, 2005; Oliver, 2010). Across many studies young people reflected that their workers often seemed stressed and had many demands on their time. Overall, the message from care experienced children and young people was for the workforce to spend less time on paperwork and more time building relationships with them and getting to know them (Coram Voice, 2015; Rahilly and Hendry, 2014).

Momentum and emerging relationship-based work

The direction of Scottish public policy set out in the Christie Commission (2011) appears to resonate with relationship-based practice (Ingram and Smith, 2018). The Christie report emphasised the need to **move away** from an 'expert' top-down culture and **move towards** a culture that seeks the views and involvement of individuals and communities. Ingram and colleagues (2018) argue that relationship-based practice has the potential to become the cornerstone of social policy across not just individual relationships but in the ways workers across different services and wider communities interact and relate to each other. Young people appear to agree and also want cultural change in relation to how relationships are viewed and prioritised by the workforce. One recent project, looking at

embedding relationship-based practice[804] in Scottish throughcare and aftercare services, highlighted that:

> *'The looked after sector, Scottish Government, and individual local authorities need to work together to encourage a cultural change in attitudes towards relationships. This cultural change should be amongst practitioners, managers and foster carers and should push the boundaries of the relationships they build with young people' (Rohan and Smith, 2016).*

Summary

This section has discussed the importance of relationship-based practice, highlighting the concept of strong relationships being interventions in their own right. The characteristics of relationship-based practice, and of relationship-based organisations have been discussed, as have the barriers to relationship-based practice (in terms of workload and capacity).

[804] Ultimately the project will lead to the development of a practical benchmarking tool for relationship-based practice with care leavers. https://www.staf.scot/Blogs/blogs/Category/relationship-based-practice-benchmarking-toolkit

8. Concluding remarks

Maintaining a stable and motivated workforce is central to the delivery of effective high-quality services for children, young people and families. Pivotal to this is valuing and supporting the workforce and promoting their well-being.

In the absence of working environments that are supportive there is a risk that relationships, which are the foundation of practice, are not maintained or used to their full capacity. The evidence reviewed here shows that:

- Research is not easily available on the full range of the workforce; less is known about those in less formal roles who support looked after children and young people.
- From the evidence available there are serious concerns about the current state of workforce well-being.
- Supervision and support (particularly peer support) were identified as important factors when considering the resilience and well-being of staff
- A range of individual 'interventions' are also available to help bolster workforce well-being.
- To combat work-related stress and low morale a supportive organisational culture is needed, and strategies should not just focus on the individual but consider the wider context
- It appears that working towards a workforce with shared values, practices and language would be welcomed. One part of this might involve making sure everyone (including organisations) are trauma-informed and have good understandings of what is means to be looked after.

- Relationship-based practice equally needs a supportive organisational culture to flourish. Much of what is inherent in working in a relational way resonates with what children report they want from the care system.

Whatever the final recommendations from the Care Review, much of the implementation and success will fall within the remit of the workforce; as such, the workforce need to feel empowered, trusted and supported. Therefore, nurturing and supporting the workforce is a priority; so that they can make the changes asked of them and can prioritise nurturing and supporting looked after children.

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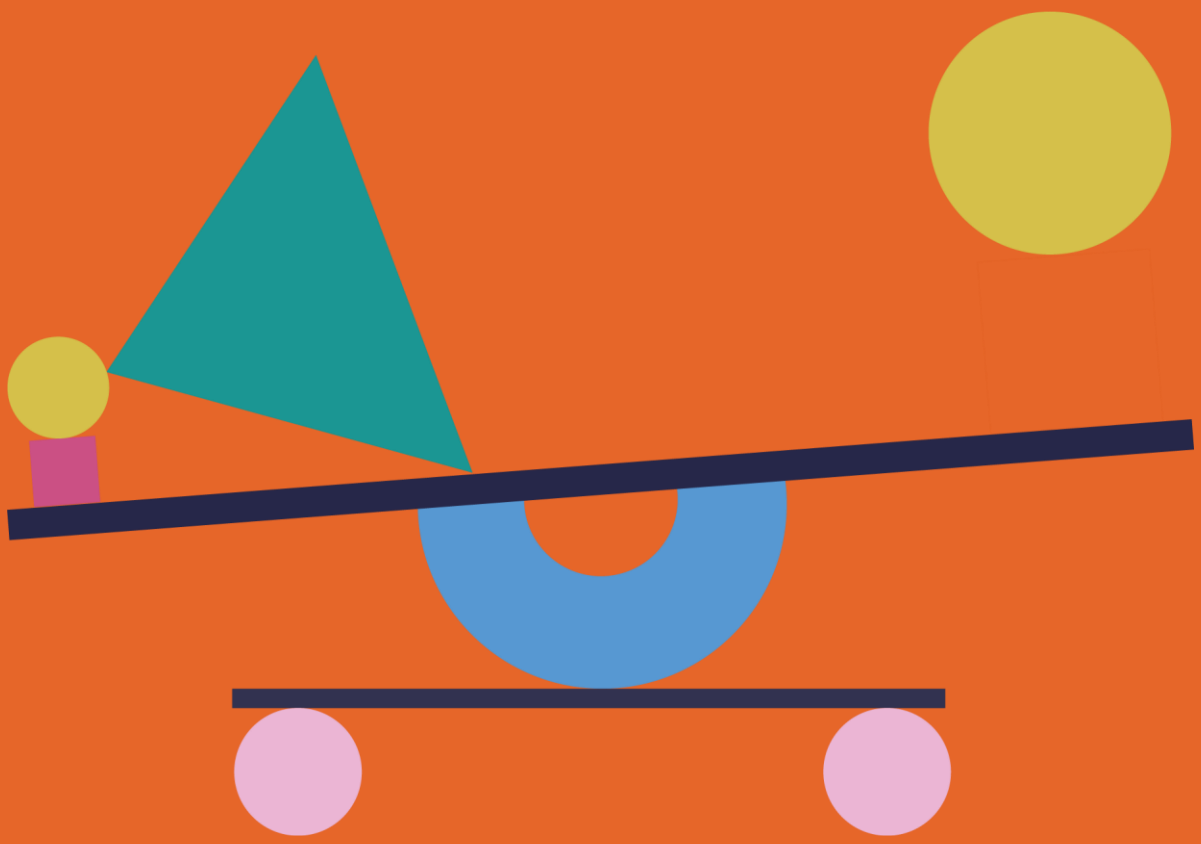
Data Use in Child Welfare

The Care Review: Use of data in 'care systems' internationally



Heather McCauley

November 2019

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Summary

Background – Development and uses of predictive risk modelling in child protection

Many jurisdictions are developing sophisticated predictive tools to ensure that risks of future maltreatment are accurately assessed, and children and families receive appropriate services, particularly at an earlier stage.

In child protection, this has been driven, particularly, by concerns about the accuracy and consistency of decision-making, and about rates of both over and under investigation.

Research has found that case decisions based on clinical judgement alone are "highly variable", leading most 'care systems' to adopt different types of "structured decision making" (SDM) tools. While these perform better than clinical/professional judgement alone in predicting child maltreatment, their predictive capacity is, nevertheless, "modest" at best, and they have a number of operational problems and limitations.

Predictive risk modelling (PRM) has potential to address these limitations and has been shown, at least in some cases, to have better accuracy than previous SDM tools. Traditional risk assessment focuses on assessing the recurrence of maltreatment rather than predicting a first occurrence, so proponents of PRM argue that it has the potential to support a shift towards preventative activities, and to do so in a targeted and cost-effective manner.

The two main applications of PRM have been to estimate the likelihood of:

1. A report or substantiation of maltreatment
2. Other child protection outcomes – such as fatalities, case failures and failed reunifications.

Increasingly, however, PRM is being developed to inform the level and type of service that children and families need, to support agency operational decisions (including caseworker dashboards, caseload

forecasting and performance tracking), to identify cross-system issues (including interactions between child welfare and the health, justice, education and other systems) and, in one case identified for this review, to assess the risk of future maltreatment referrals and substantiations relating to alleged perpetrators.

While most uses thus far have focused on risk, PRM can equally be used to identify the protective factors and strengths that support positive outcomes for children and families.

Annexes one-five of this report set out a selection of examples of PRM in child protection developed since 2012, chosen to illustrate these various applications.

Risks and issues

Key risks and issues with using PRM in child welfare include:

- methodological – including data quality and availability, type I and type II errors, and appropriate selection and reliability of outcomes
- ethical and legal – including concerns about privacy and consent, discrimination and bias, removal of human judgement and transparency
- practical/operational – including what and how PRM data should be given to practitioners, whether time and money spent on PRM would be better spent on designing effective interventions, how to involve communities, stakeholders and staff in the development and application of PRM, and what decisions should be informed by PRM – or not.

Many of these issues, however, are equally applicable to human-led tools, and any assessment of PRM needs to compare its use with the tools or methods that would otherwise be employed, rather than with some kind of theoretical ideal.

Findings from participatory design or similar work with families, frontline practitioners and specialists in the US have also found, amongst other things, that community perceptions of the use of algorithms in child protection are not somehow separate from perceptions of the wider operation of child protection 'systems'. Rather, the level of distrust in the existing 'system' has been found to be a significant contributor to a low level of comfort with algorithmic decision-making.

Principles and Recommended Approaches

There is a significant body of work considering what agencies should do to ensure good practice and accountability in the use of algorithms generally, and in child protection specifically. A number of examples are set out in the main report, with others referenced.

Conclusions

The potential benefits of PRM in child protection, particularly in improving the accuracy of assessment of the risk of maltreatment to enable earlier and more effective intervention, need to be weighted up against the methodological, ethical and legal, and practical issues and risks that they raise. Some researchers and jurisdictions have concluded that the risks outweigh the benefits. Most researchers and jurisdictions considered in this review believe that the risks can be safeguarded against for particular decision tasks (e.g. informing preventative spend) with appropriate design, accountability, and community and stakeholder participation, or that PRM is sufficiently promising to warrant further investigation.

A number of reviews are currently underway that could further inform the Care Review's consideration. These include a *What Works for Children's Social Care Centre* assessment of the technical feasibility of using PRM to predict risk of child harm, including an independent ethics review, and a UK Information Commissioner's Office consultation on AI and data use and sharing.

1. Introduction

Purpose

The Care Review commissioned this report to identify how countries use, or are intending to use, data in their child welfare systems. Since the use of data for monitoring, reporting and budgeting is commonplace across systems, this review has focused on the more recent and innovative use of predictive analytics to assist and support decision-making, improve operational efficiency and effectiveness, and support the targeting of early intervention and preventative spend within care and protection 'systems'.

Over the last twenty years, there have been a significant number of research studies assessing the statistical likelihood of different pathways and outcomes for individuals and groups within the health and other social sector systems. In the last ten years, particularly, child welfare systems have looked to use these to inform policy and practice. New Zealand (NZ) has been at the forefront of these initiatives and there has also been rapid expansion in the United States (US) and adoption by some United Kingdom (UK) local authorities, in particular.

Approach and Scope

Given the limited time available for this report, a rapid review approach was adopted. The author identified relevant review/overview papers and used 'snowballing' techniques from references cited in well peer-reviewed papers to identify further materials. She also drew on her own past experience in advising the NZ Prime Minister on the application of predictive analytics and other data-driven approaches in NZ public service policy and delivery.

This paper is not a systematic review but a summary of evidence from a range of sources, drawing out those aspects likely to be most relevant to the Care Review.

The review focuses on:

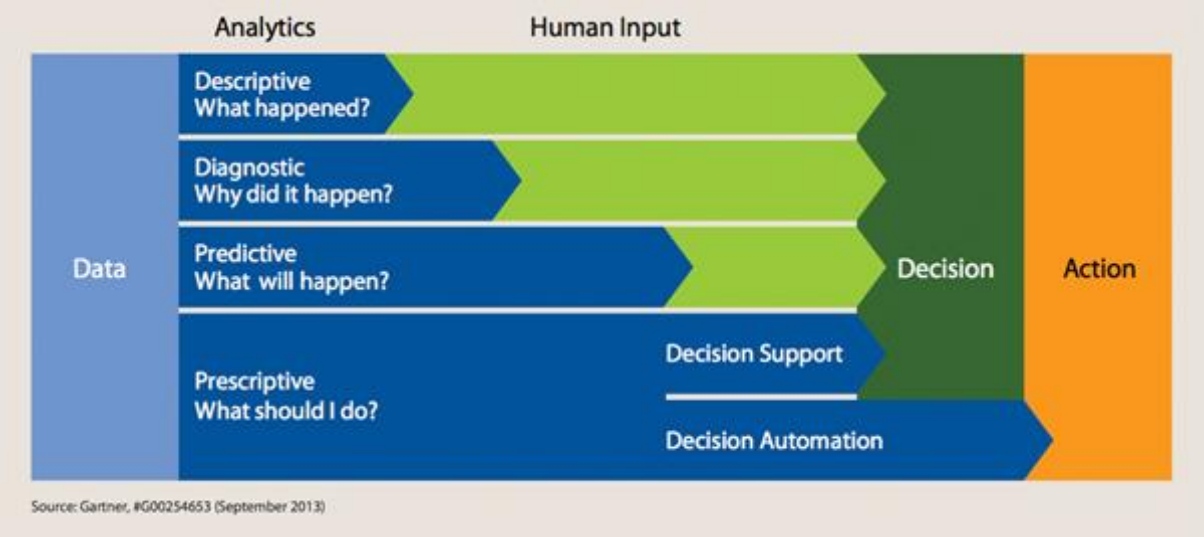
- jurisdictions or 'systems' rather than 'countries', to allow inclusion of regional or local authority level 'systems' where child protection is devolved
- developments during the last five-six years (2013-2019), rather than older examples, given that this is a fast-moving field
- the use or potential use of data within 'care systems', not academic studies of statistical probabilities or methods except where these have been developed specifically for application within a 'care system'.

While this review focuses on the use of data and predictive analytics in particular, these are usually applied within a wider system-wide transformation and context. These would also need to be considered and understood if the Care Review wanted to draw on these particular models in more detail.

2. Different types of data analysis and application - definition

Data analytics

At its simplest, analytics is the process of transforming data into insights for making better decisions.[805] The following diagram sets out a maturity model that includes the different types of data analytics – from "descriptive" to "diagnostic", through to "predictive" and "prescriptive." In the business context, it is usually argued that value increases as you move to greater levels of maturity.



Source: Gartner Inc, sourced from Puget, 2014.

The most significant distinctions between the different levels are the *purpose* of the analytics and the balance between analytics and human input in decision-making: at the earlier levels, the intelligence is left to the human; as the maturity increases towards predictive and prescriptive analytics, more of the intelligence is automated (Puget, 2013; Puget, 2014).

Predictive analytics and predictive risk modelling (PRM)

Russell sums up the potential uses of analytics as being to answer *why*, *when*, *who*, *who not* and *how* questions (Russell, 2015). Analytic models that associate risk factors with outcomes can be useful in answering the

[805] https://www.informs.org/Explore/Operations-Research-Analytics

why and *when* questions. Predictive analytics models are most useful in answering the *who* and *who not* questions. Predictive analytics can provide some insights to help answer the *how* question, but the evaluation of programmes usually requires different techniques.

In simple terms, predictive analytics uses relationships in existing data to estimate the likelihood of a future event. Developers mine vast amounts of administrative data to attempt to discover correlations, or tendencies for certain factors to occur together:

> *"Predictive analytics refers to the practice of extracting information from existing data sets and identifying patterns that may help to predict future outcomes. Predictive risk modeling (PRM) applies the outputs of these analyses by using models to generate algorithms, or sets of "if-then" statements, that can be used to calculate a level of risk for each new case based on similarity to previous cases. Predictive analytics uses routinely collected data (called "administrative data") to identify individuals at risk of an adverse event" (Chapin Hall and Chadwick Centre, 2018).*

Predictive analytics can include methods associated with big data, data mining, machine learning, classification and regression trees, and random forest modelling. A key feature is that PRM operates as 'learning models'; when implemented in live data systems, they continually adjust risk scores as data is updated, and models are regularly re-weighted and re-validated.

This is different to traditional data analysis. Predictive analytics does not start with a hypothesis or particular idea; rather, the analysis focuses only on any patterns that can be discovered in the data themselves. This implies a shift from a theory-driven to a data-driven approach, from hypothesis testing to empirically driven insights (Russell, 2015).

Predictive analytics contrasts with descriptive and diagnostic analysis. These typically provide information about the current state of an agency or of individual or groups of cases, enabling reactionary behaviour:

> *"... predictive analytics, on the other hand, can provide a forward-looking view into what might occur in the future, encouraging preventive behaviour before that probabilistic future becomes reality" (Teixeira and Boyas, 2017).*

On the other hand, predictive analytics identifies patterns and statistical probabilities; predictive analytics cannot answer the question of *why* something happens or is likely to happen. It is notable that, in subsequent work on the diagram above, Gartner separated the "Why did it happen?" question from predictive analytics (Puget, 2014).

In the context of child welfare, a review of five US states found that some agencies are currently involved in descriptive or diagnostic analytics projects, focused on providing data-driven snapshots of the child welfare system as it currently exists, while others are looking at predictive analytics "to help implement preventive interventions before a problem escalates" (Tiexeira and Boyas, 2017).

3. Development of PRM in child protection and welfare

Interest in applying risk-based approaches to social policy and delivery has been growing since the 1990s, particularly, and was given additional impetus by ideas around 'social investment' during the 2000s, often drawing on public health approaches to prevention.

In England under New Labour, for example, these approaches drew on knowledge of risk factors derived from longitudinal research to design early intervention programmes (Gilbert et al., 2011).

Interest in improving risk assessment in child protection specifically has also intensified. Most countries have experienced significant increases in service demand and notifications, and associated costs, leading to a need to ration scarce resources. Most have also been operating in contexts with high-profile cases and increased public and political scrutiny of child protection practices and decision making. Improved risk assessment has also been part of efforts to move towards more evidence-based practice.

Interest in risk-based approaches has been stimulated, particularly, by concern about the accuracy and consistency of decision making. Despite the wealth of literature on risk factors for child maltreatment, systems have found it difficult to accurately identify those referred children who are at greatest or most immediate risk of maltreatment. Most have seen high rates of re-referral among children with initially unfounded allegations, and child maltreatment deaths despite child protection agency involvement. Research has found case decisions based on clinical judgement alone to be "highly variable" between case workers and even between child welfare experts when tested, despite high levels of worker

confidence in their assessments (Russell, 2015).[806] Cuccaro-Alamin et al. describe this as "the enduring struggle to accurately assess children's current and future risk of abuse and neglect" (Cuccaro-Alamin et al., 2017).

A particularly strong theme in the US has been the need to reduce both over and under investigation. US child protection agencies received around 4.1 million allegations of abuse and neglect, involving 7.4 million children in 2016. Around 58% were "screened in" for further investigation while around 42% were "screened out." This meant that around one third of American children were investigated for abuse and neglect before they were 18 years old. Despite this, an estimated 1,750 children died from abuse and neglect and half of the children who were critically or fatally abused had never been investigated (Cuccaro-Alamin, et al., 2017; Casey Family Programs, 2018a; Vaithianathan, 2019 and 2019a).

In response to these issues, over the last twenty years, many child protection agencies have moved from clinical decision-making to more formalised and standardised 'structured decision-making' models (SDMs), either consensus-based or actuarial tools. The former are typically guided by a theoretical approach and examine child maltreatment risk factors identified by experts through clinical experience or research which are then 'processed' using professional judgement; the latter identify factors that are empirically related to future child maltreatment and are validated statistically, then construct these into a risk assessment tool that can be scored mechanically. Actuarial tools can also incorporate risk factors not theoretically related to abuse and neglect (Cuccaro-Alamin et al., 2017; Barber et al., 2007; Glaberson, 2019).

Both types of tool have been found to be more effective than clinical judgement alone in predicting the recurrence of child maltreatment, and there is strong evidence that actuarial SDMs have greater predictive validity and lead to more consistent decision-making in child welfare cases

[806] For a fuller discussion of the evidence on human decision making see Glaberson, 2019.

than consensus-based tools. Actuarial SDMs have, however, been shown to have a number of operational and statistical problems and limitations. These include subjectivity, a focus on static and negative risk factors, and inappropriate applications. While better than consensus-based tools, or human decision-making alone, their predictive capability has been found to be "modest" (Vaithlanathan et al., 2013; MSD, 2014a; Cuccaro-Alamin et al., 2017; Schwartz et al., 2017; Barber et al., 2007; Gillingham, 2019; Glaberson, 2019).

Over the last five-ten years, there has therefore been increased interest in using predictive analytics to inform important decision points in order to improve accuracy. While predictive analytics work had been undertaken since the 1980s, the scale of datasets now available, the ability to link these between different agencies (including health, education, police, income and housing) and new ways to mine such data using algorithms which can 'learn', has stimulated an increased interest in the use or potential use of PRM in child protection systems (Teixeira and Boyas, 2017; Munro, 2019; Gillingham, 2019).

PRM has a number of advantages relative to previous actuarial methods of risk assessment:

> *"First, because PRM uses vast amount of data, it can identify previously unobserved relationships between variables.... Second, PRM models are learning models that can continually adjust to new relationships present in the data. This flexibility allows the models to account for variants in different subpopulations and capture dynamic changes in risk over time. Third, PRM models use existing data on the population for which the tool is being used, whereas more common actuarial instruments are rarely validated with the population of interest.... Fourth, PRM as an approach is inherently more consistent than other risk assessment procedures....Fifth, unlike typical operator-driven assessments—in which effective implementation is dependent on worker training and compliance—*

> *PRM models operate independent of such factors" (Cuccaro-Alamin et al., 2017).*

They have also been demonstrated, at least in some cases, to have greater accuracy than previous SDMs. A 2014 New Zealand Government study found that the PRM tool developed in New Zealand (discussed at Annex One) would meet the criteria for a "good" predictor for child maltreatment" in contrast to an international scan that had found only one previously developed tool that would do so (MSD, 2014a). The performance of the PRM developed for Allegheny County (discussed at Annex Two), for example, was compared with an SDM that had been validated in California – i.e., the children followed-up and their outcomes compared to their original scores – and found that the PRM performed significantly better at predicting child removals (out-of-home placements) (Vaithlanathan et al., 2017).

PRM is also seen as a means of supporting effective preventative spend. Traditional risk assessment tools focus on assessing the recurrence of maltreatment, rather than predicting a first occurrence, and have therefore not been able to inform efforts to shift to preventative spend. Proponents of predictive analytics argue that PRM has the potential to support a shift towards preventative activities, and to do so in a targeted and cost-effective manner (Vaithlanathan et al., 2013).

4. Uses of PRM in child protection and child welfare

The two main applications of predictive analytics in child protection have been to estimate:

1. The likelihood of a report or substantiation of maltreatment
2. The likelihood of other child protection outcomes – such as fatalities, case failures and failed reunifications.

In either case, the goal is to increase the accuracy and reliability of the 'system', identify which families are more likely to experience future maltreatment and better match families with services, including preventative services, to improve outcomes (Russell, 2015; Cuccaro-Alamin et al., 2017; Teixeira and Boyas, 2017; Schwartz et al., 2019; similarly see Vaithlanathan et al., 2013; Chapin Hall and Chadwick Centre, 2018; Casey Family Programs, 2018; Gillingham, 2019).

Increasingly, however, predictive analytics is evolving from identifying the children at greatest risk of maltreatment to informing the level and type of services that children and families need to achieve safety and wellbeing:

> *"... the application of predictive risk models have expanded from answering the question "Who is at greatest risk?" to questions like* ***"Who first?" and "Who more?"*** *(Chapin Hall and Chadwick Centre, 2018).*

Beyond these main applications, agencies or wider jurisdictions have developed PRM in child protection in number of other ways. These include:

- using PRM to support agency operational decisions. This includes the development of dashboards and other technologies for case workers, identifying trends in cases and forecasting future caseloads to inform resource management decisions, and determining where

to deliver services to be most effective. There is also significant potential for child protection agencies to use predictive analytics to inform performance measurement and the tracking of key performance indicators including where functions/services are contracted out (Russell, 2015; Chapin Hall and Chadwick Centre, 2018).

- analysing system issues including interactions between the child welfare 'system' and other service systems, such as health, social welfare, education and justice systems, usually with the aim of informing proactive preventative measures. This usually requires linking of multiple datasets and resulting interventions often fall outside of the child welfare agency's remit (see, further, Teixeira and Boyas, 2017)
- to assess the risk of future maltreatment by current alleged perpetrators (as developed in Florida, see Annex Three).

A selection of examples developed since 2012, chosen to illustrate the various uses described above, are discussed in more detail in Annexes One-Five.[807] These include:

- New Zealand's (NZ's) development of a PRM to assess the risk of a 'substantiated' referral to the child protection agency. This achieved a 76% accuracy rate, similar to that found in digital mammography. The model has not, however, been implemented in the child protection agency (Annex One)
- Allegheny County, Pittsburgh (US)'s development and implementation of a PRM to provide a second option (or, more latterly, a first opinion) on whether calls to its child protection service hotline should be 'screened in' or 'screened out' for further investigation (Annex Two)

[807] For a summary of earlier examples from the noughties, see Cuccaro-Alamin et al., 2017.

- Hillsborough County, Florida (US)'s implementation of the Eckherd Rapid Safety Feedback tool to assess the likelihood of a child having a premature death as a support for case worker decision making and, especially, quality assessment and supervisor decision making. Florida also used this model to examine other risks such as re-referrals, failed reunifications, aging out of foster care, juvenile justice involvement, failure to complete high school and exposure to violence. The model is currently being investigated or applied in a number of other US states, although Illinois has subsequently ended its use (Annex Three)
- Broward County, Florida (US)'s development of a predictive model to estimate the likelihood of a child being re-referred to the child protection agency, and to determine the type and level of service most likely to prevent this. This has not, as yet, been implemented (Annex Three)
- Florida Department of Children and Families' predictive model to assess the risk of perpetrators having multiple maltreatment reports (Annex Three)
- Newcastle City Council's Family Insights Programme – a data-led redesign of children's social work services that included using data to segment and group the population of families by needs and characteristics (Annex Four).

In addition, Annex Five provides short summaries (but not any independent assessment) of a number of other examples:

- California (US) prototype tool - assessing the risk of a child being removed using child welfare data only
- London Councils' Children's Predictive Safeguarding Model (developed by Xantura) – early identification of children most at risk of harm before specific risk/crisis factors present to support early intervention services

- Hackney and Thurrock's Early Help Profiling System (developed by Xantura) - early identification of children most at risk of harm before specific risk/crisis factors present to support early intervention services – but subsequently ended in Hackney
- Bristol – using PRM to identify families and children at risk in order to target early intervention services
- Greater Manchester's integration of ten local authorities' data and use of predictive analytics to identify factors relating to referrals and evaluate the impact of interventions
- Amsterdam (The Netherlands) child health department's use of a predictive model drawing on unstructured (text notes) as well as structured data to flag cases of possible abuse to health professionals
- Behavioural Insights Team (UK) – predicting whether a "closed case" would be re-referred and escalated using unstructured (text notes) as well as structured data
- San Francisco (US) Family Resource Centre – informing decisions on the location of resource centres to focus on early intervention (i.e., the level of service to be offered in different locations)
- Casey Family Programs (US) Community Opportunity Map – interactive mapping of ecological indictors associated with child maltreatment
- NZ Treasury – system-wide analysis of the characteristics of children who are at risk of poor outcomes as young adults, their patterns of contact with selected government social service agencies, and the costs of service provision for different sub-groups by those agencies.

While most uses of predictive analytics have focused on risk, predictive analytics can also be used to examine the characteristics of children and families who have positive outcomes, to provide insights into how best to encourage and support protective factors, strengths and resilience (Cuccaro-Alamin et al., 2017; Chapin Hall and Chadwick Centre, 2018). One

impediment to doing so is that government administrative systems typically have more risk-associated data than strengths-based data, so such approaches may need to draw on broader data sources. This has been the focus of some recent studies (see, for example, Walsh et al., 2019). Such work may, over time, address one of the criticisms of PRM – that it is overly focused on risk factors and ignore protective factors and strengths.

Finally, while not the motivation for developing PRM, a number of jurisdictions and studies comment that a significant benefit of a predictive analytics project can be to improve the quality of child protection agencies' data, which has wider benefits. A study of PRM in child welfare agencies in the US, for example, found that:

> *"One of the largest, most significant benefits of a predictive analytics project in child welfare is that such a project forces an agency to examine and improve its data. A common theme is that child welfare data is messy and inconsistent, particularly the fields that are not part of nationally consistent federal reporting. In implementing predictive analytics, child welfare agencies are forced to clean up their databases, resolve duplicate entries, identify inconsistencies, and implement data quality assurance processes such that future data is much more reliable. This investment in data quality not only helps future predictive analytics projects, but also enables more advanced projects in all types of analytics. Additionally, work done to establish data warehouses and/or data sharing agreements across different agencies also helps improve data quality" (Teixiera and Boyas, 2017).*

5. Key risks and issues

Risks and issues with using predictive analytics in child welfare tend to fall into three broad categories: methodological, ethical/legal and practical/operational. Many of these are not specific to child protection but relate to the use of predictive analytics more generally.

Methodological issues

Methodological issues include (but are not limited to):

- data quality and availability
- type I and type II errors
- appropriate selection of outcomes
- reliability of selected outcomes.

These are discussed briefly below.

Data quality and availability

The quality of data used in PRM matters. If there are large amounts of missing data, incorrectly filled or poorly specified data fields, or other errors, these will introduce new flaws into the model:

> *"Algorithms are only as good as their data — simply put: "garbage in, garbage out"" (Glaberson, 2019; see also Cuccaro-Alamin et al., 2017).*

The quantity of data also matters: the statistical power of PRM improves as the amount of data increases. In addition to data held by the child protection 'systems', data may also be needed from other sources likely to include useful predictors for child safety such as social security, education, health, mental health, employment, housing and criminal justice.

There is, however, wide variability in the types and quality of data available across jurisdictions, and in the extent to which child welfare and other

services data is included in integrated databases. If it is not, the development of PRM requires multiple data use agreements and data linkages. Three of the five US states studied by Tiexeira and Boyas (2017), for example, were only using their own data for PRM, although they planned to incorporate more as data agreements were finalised.

There is also an issue about the currency of data. "Real-time", or at least frequently updated, data, is needed if models are to inform case practice (Ibid.).

Type I and type II errors (false positives and false negatives) and levels of accuracy

Despite the increased accuracy of PRM when compared to traditional risk assessment tools or professional judgement, no predictive model can be 100% accurate. Depending on the level of risk threshold set, a model will either identify too many children (false positives) or too few (false negatives) as being at risk.

Both types of errors in child protection have a potentially high cost. Those wrongly identified as high risk may be subject to unnecessary involvement with social services and interventions including, in the most extreme case, removal of the child from the family. At the very least, it may result in stigmatisation of the family, regardless of the outcome of any investigation. Conversely, children and families wrongly identified as low risk may not receive necessary services and could go on to experience maltreatment (Cuccaro-Alamin et al., 2017; Munro, 2019).

There is debate about what level of accuracy is acceptable for predictive models in the child protection context. Gillingham, for example, has argued that while 70% may be an acceptable level of accuracy in clinical decision making in health contexts, for example, it is not sufficient in child protection work given the consequences of an incorrect decision (Gillingham, 2019).

It is important to note, however, that these kinds of misclassification errors are not unique to PRM but are also possible with clinical judgement and other risk assessment tools. Proponents of PRM argue that the greater accuracy and transparency of predictive risk modelling enables these models to serve as a check, albeit imperfect, against alternative approaches to risk assessment with their well-understood flaws. This means that both clinicians and statisticians need to be involved in model design and application:

> *"The expertise of both clinicians who understand the practice implications of false positives and false negatives, as well as statisticians who can quantify trade-offs, is required to set initial risk thresholds. The ongoing involvement of both clinicians and statisticians is also required to analyze the performance of PRM models and appropriately re-weight covariate predictors and adjust thresholds to reflect changes in the client population and the local decision making context" (Cuccaro-Alamin et al., 2017).*

A more radical view is that of Gillingham, who argues that the "key challenge" of improving the performance of these algorithms will only be met if agencies move away from using existing datasets entirely and use datasets that are "custom made" for this purpose. These would include the factors that research has shown are antecedents of maltreatment, not just those for which data happens to be available in administrative or other ready-made datasets. Gillingham argues that this would require changes in the way that practitioners collect, record and use data, which means that:

> *"Starting again in terms of collecting data means that future development of DSS will not only be a costly exercise but also a long-term endeavour" (Gillingham, 2019).*

Selection of outcome

The selection of an appropriate outcome that the analytics model is seeking to predict is critical.

The more frequently an outcome occurs, the easier it is to predict; the less frequently an outcome occurs, the harder it is to develop a model with a useful level of accuracy because the available data may not contain a sufficient number of cases. PRM can be highly effective in predicting events that occur with reasonable frequency, but does not perform well when predicting more rare events.

Outcomes such as child fatalities occur relatively infrequently, so it is difficult to develop a high accuracy rate in predicting these rare events (Chapin Hall and Chadwick Centre, 2018; Munro, 2019), although some studies suggest this is possible (see discussion in Russell, 2015). Cuccaro-Alamin et al. (2017) argue that it is critical that agencies recognise these statistical limitations and should be cautious in employing PRM to help prevent rare outcomes such as fatalities.

Reliability of selected outcomes

The reliability of the outcome chosen, and data associated with it, is also critical. It is notoriously difficult to define 'child maltreatment' or 'neglect' in a consistent way. Even if this can be agreed, there is no single piece of data that will accurately reflect it.

Given this, the developers of PRM usually try to identify proxies for child maltreatment. These, however, have their own problems.

One outcome that has been used, for example in the NZ PRM (Annex One), is "substantiated abuse". Critics point out that a lot of child abuse goes unreported, however, so will not be picked up by a substantiation outcome. They also argue that an outcome of 'substantiation' is not independent of the 'system' itself, so is not measuring the actual occurrence of abuse but just the 'system' response. Unlike outcome variables in the health sector, which can generally be empirically observed

and relatively objectively diagnosed, substantiation of child maltreatment depends on multiple subjective factors:

> *"Research about child protection practice has repeatedly shown how… the outcomes of investigations into maltreatment are reliant on and constituted of situated, temporal and cultural understandings of socially constructed phenomena, such as abuse, neglect, identity and responsibility" (Gillingham, 2015).*

Similarly, other 'within 'care system'' outcomes such of out-of-home placements, used in the Allegheny PRM (Annex Two),for example, have been criticised as reflecting the 'system's' response rather than the occurrence of abuse itself, and as likely to be particularly prone to bias (Ibid.; Glaberson, 2019).

In response to these concerns, the developers of the NZ, Allegheny and California Prototype tools have undertaken external validations of their models, typically using medical and 'critical events' data that may be better proxies for maltreatment. These have found significant positive correlations between risk scores and the rate of hospital events and/or fatalities, suggesting that "within 'system'" outcomes may be reasonable proxies for maltreatment and harm in these cases (see Annexes One, Two and Five).

One suggested alternative to a "substantiation" outcome has been to use more formal decision points, such as decisions to remove children from the care of their parents or where courts grant orders for children to be removed (Gillingham, 2015). At the other extreme, some jurisdictions such as Florida have focused on reports to child protection agencies rather than the results of investigations, as they have found that both unsubstantiated and substantiated investigations are risk factors for "chronic" maltreatment by the perpetrators concerned (Florida, 2016). Consistent with this, the US Federal Commission to Eliminate Child Abuse and Neglect Fatalities found that a prior report to a child protection agency,

even if it wasn't substantiated, was the single strongest predictor of a child's injury death before the age of five (Casey Family Programs, 2018a).

6. Legal and ethical issues

Legal and ethical issues include (but are not limited to):

- privacy and consent
- bias and discrimination
- removal of human judgement
- transparency.

It has been strongly argued, however, that these need to be considered relative to the counter factual, rather than in relation to some "ideal" state or principle.

These are discussed briefly below.

Privacy and consent

There are two key consent issues: one is the question of whether consent must be obtained before an individual's data is used for the drawing of inferences in data analytics – i.e. the predictive analysis; the second is whether consent must be obtained for the *use* of inferred data. Underpinning both is the question of how to balance the right to privacy and due process against care agencies' duty to ensure the safety of children (Gavaghan et al., 2019; Cuccaro-Alamin et al., 2017).

Concerns about privacy and consent also affect views on when the PRM is applied and whose data it is ethical to use.

A US scan of five states found that some of the states and stakeholders argued that including data from birth means that information is less subjective and avoids the racial bias that can be created by focusing on the subset of the population actively involved in the child welfare 'system'. Other states and stakeholders considered running large scale predictive models on every child or family to be problematic if families did not voluntarily participate (Teixeira and Boyas, 2017). Similarly, the ethical

review of the Allegheny County project (Annex Two) argued that applying the PRM at the point at which a call is made to the child protection hotline was preferable to applying it at the birth of every child, because a call provides "at least some grounds to think that further inquiry is warranted in a particular case" (Dare and Gambrill, 2017).

The US report noted, however, that the implication of the latter view is that:

> *"... such interventions would be reactive instead of proactive and could reduce the overall impact of predictive analytics" (Teixeira and Boyas, 2017).*

While these issues need to be considered, it has been argued that PRM and other models are simply a new way to use existing agency data for risk assessment, as is the case in the Allegheny model, for example. The ethical review of Allegheny's PRM makes this point:

> *"Finally, if (the department) were already entitled to access the data gathered by the tool in response to a call, then it seems legitimate to regard the use of the tool at that point as a new and more effective way of doing something already permitted. The force of this point depends, we think, on the extent to which the (PRM)... delivers information that would have been available, in principle, to a diligent call screener" (Dare and Gambrill, 2017).*

Bias and Discrimination

One of the most frequently raised concerns about PRM is that it will reflect and then exacerbate existing systemic biases, particularly racial disparities, in child protection 'systems':

> *"The capacity of predictive modeling to contain hidden biases is a major concern in child protection because of the nature of the datasets used" (Munro, 2019).*

> *"Predictive algorithms may be infected by, and may even magnify, the same faulty assumptions and biases that created and perpetuate a system that disproportionally affects poor families of color" (Glaberson, 2019).*

This can arise from the incompleteness of datasets (which are incomplete in non-random ways) and over-representation of low income and ethnic minority families. PRM often draws on other data in which minority groups are over-represented. In the US, for example, black children are nearly three times as likely as white children to have some interaction with the child protection 'system'. They are also more likely than white children to be "screened in" and placed in out-of-home care; if screened out, black children are more likely than white children to be re-referred and placed (Dare and Gambrill, 2017). Without careful attention to the details of tool development and training, algorithms using already-biased data sets are likely to rate individuals coming from poor or ethnic-minority communities as higher risk, while systematically discounting the risk of wealthier, white families (Glaberson, 2019).

Proponents of PRM recognise this risk but argue that the solution is to diversify the datasets that the models use; they also argue that PRM provides an opportunity to openly track disparities and then correct for them (Gavaghan et al., 2019; Dare and Gambrill, 2017).

There is some evidence that PRM can *reduce* the effects of disparities in the child protection data and *enhance* equity in decision making compared to clinical judgement, which may also be biased and influenced by preconceptions, particularly if they provide a common threshold for initial action (Vaithianathan et al., 2013; Dare and Gambrill, 2017). The developers of the California Prototype tool (Annex Five), for example, argue that it has the potential to reduce over-investigation due to racial bias.

A further consideration is the nature of the action that will be taken in response to a PRM's findings. The ethical review of Allegheny's model,

which informs initial "screening" decisions, for example, argued that if the PRM does overstate the actual risk status of a child or family, the resulting intervention is designed to identify the child's *actual* risk status through more detailed home visits or professional judgement, and provide positive interventions to address any risk factors that exist, rather than punitive responses (Dare and Gambrill, 2017). Others, however, have strongly disagreed with this view, citing the negative consequences that even brief interactions with the child welfare 'system' can have for children and families (e.g. Glaberson, 2019).

Given these concerns, Chapin Hall and Chadwick Centre (2018) recommend that PRM should:

> *"avoid predictor variables that signify potentially biased system responses to children and families, and engage ethics review committee with diverse representation. Demographic predictors should be incorporated and interpreted cautiously."*

Removal of human judgement

Another frequent concern is that predictive algorithms could be used instead of human judgement to make child protection decisions.

All of the studies supporting the use of PRM considered in this review argue that guidance from predictive algorithms should support, supplement and enhance, not replace, expertise and clinical judgement that takes account of strengths, needs, and contextual factors. The developers of the Allegheny model, for example, comment that:

> *"In health and human services, there are potentially two uses of predictive screening tools. One is to replace clinical decisions (e.g., through automatically screening in children based on their score) and the other is to augment and standardize clinical decisions (e.g., through a "risk score" or a summary statistic weighting information from the administrative data). Allegheny County was interested in developing the latter type of tool – one in which an empirically*

> *derived score could be used in conjunction with clinical judgement (and other sources of data that are not available to the PRM tool) to generate a hotline screening decision (screen in or out)" (Vaithianathan et al., 2017).*

Panel members at a 2016 conference hosted by the American Enterprise Institute that included representatives from Florida, Connecticut and Texas, as well as the Chair of the US *Commission to Eliminate Child Abuse Neglect Fatalities,* agreed that tools such as the Eckard Rapid Safety Feedback Tool in Florida (Annex Three) can be important but cannot replace human judgment:

> *"rather it is a tool to help workers make judgments. And to determine high risk and high priorities" (CWLA, 2016).*

Similarly, Chapin Hall and Chadwick Centre (2018), argue that systems should always allow for human overriding of a predictive analytics-identified response.

The NZ Law Commission has, however, pointed out that while solutions such as requiring a "human in the loop" may have appeal, such blanket guarantees could, in some cases, have a detrimental effect on accuracy. Instead, they argue that having a human in the loop should be seen as being useful in specific circumstances rather than in general:

> *"where automated systems are not reliable enough to be left to operate independently; where factors need to be considered that are not readily automatable; or in situations where a measure of discretion is for whatever reason desirable" (Gavaghan et al., 2019)*

Transparency and accountability

Lack of transparency and accountability has been a significant concern in relation to PRM, particularly if algorithmic tools could be perpetuating discrimination or having unintended consequences. In an interim report

earlier this year, for example, the UK Information Commissioner's Office (ICO) concluded that:

> *"While there are undoubtedly benefits to this use of AI, there are also risks. Increasingly, governments and regulators are considering how to mitigate these risks. One such risk is the lack of transparency around how AI decisions are made" (quoted in https://www.theguardian.com/society/2019/nov/18/child-protection-ai-predict-prevent-risks)*

Child welfare agencies often lack staff with the appropriate skills and background to develop, test and implement PRM, and some have drawn on external private contracting and consulting agencies for PRM development. This has been highly controversial in the US, not least because it means that there is typically much less (if any) information about the methodology used in, or assessment of, resulting models in the public domain. This makes it difficult to assess these models' validity, compare their accuracy, and understand how trade-offs between false positive and false negatives are being made (Russell, 2015).

Concern has also been expressed in the UK about the role of profit-making companies including, for example, by the National Director of the British Association of Social Workers England. *The Guardian* has reported that most councils in England that are trialing predictive analytics are using commercial organisations, such as Xantura, who has been working with Thurrock Council and Barking and Dagenham Council in east London, amongst others (https://www.theguardian.com/society/2019/nov/18/child-protection-ai-predict-prevent-risks) (see Annex Five).

Given the potentially very significant consequences of decisions made in child protection, most researchers argue that agencies should ensure that their model and process are as transparent as possible. Recommendations usually include that agencies publicly release the details of models, including descriptions in plain language, have oversight committees that

review the process, and ensure that models are regularly reviewed by experts (for example, Chapin Hall and Chadwick Centre, 2018).

While transparency is often seen as a solution to concerns about bias and discrimination, however, some studies argue that even if an algorithm is transparent, it may not be understandable to those impacted by resulting decisions or even to case workers who are applying or drawing on it. The article by Gillingham included in this review, for example, explicitly sets out to provide social workers with an insight into the "black box" of algorithms "in order that they might engage in debates about the efficacy of PRM…" (Gillingham, 2015).

The NZ Law Commission has recommended that algorithms in government should be "publicly inspectable" and, where affected individuals have a right to an explanation, this should include a "meaningful" explanation of predictive tools used (Gavaghan, 2019). In the UK, the ICO has set up Project ExplAIn with the Alan Turing Institute, which specialises in data science, to open public discussions on how such data should be shared and used across both public and commercial sectors. It plans to issue further guidance on the use of machine learning following a public consultation currently underway.[808]

Counterfactual

While a range of legal and ethical questions arise in relation to using PRM to identify the risk of abuse and neglect, many of the criticisms made of PRM tools, including concerns about false positive and false negatives, biases and stigmatisation, are equally applicable to human-led tools. Consideration of the ethics of a PRM needs to weigh up, not only the ethics of the use of the PRM in question, but also how this compares with the ethics of other models that are, or are likely to be, used, rather than some kind of theoretical ideal:

[808] https://ico.org.uk/about-the-ico/ico-and-stakeholder-consultations/ico-and-the-turing-consultation-on-explaining-ai-decisions-guidance/

> *"When considering the significance of these ineliminable errors for the (Allegheny model) it is essential to keep in mind that decisions informed by predictive risk modeling tools will in almost every case have been made by some other means prior to the use of the tool and will continue to be made if such tools are not adopted. Consequently, ethical questions about predictive risk modeling tools are essentially and unavoidably comparative: they are questions not simply about the costs and benefits of a particular predictive risk modeling tool, but also about how those costs and benefits compare from an ethical perspective with the costs and benefits of plausible alternatives. They must be considered in light of alternatives that carry costs of their own.*
>
> *And, while it is true that all predictive risk modeling tools will make errors at any threshold, is also true that they are both more accurate than any alternative.... The greater accuracy and transparency of predictive risk modeling tools also allows them to serve as (inevitably imperfect) checks against well-understood flaws in alternative approaches to risk assessment" (Dare and Gambrill, 2017; similarly Dare, 2013).*

Dare and Gambrill make the same argument with regard to potential stigmatisation of families that are wrongly identified as high risk (false positives):

> *"These are matters for significant ethical concern. Again, however, it must be remembered that that they are not distinctive of predictive risk models. It would be naive to suppose, for instance, that negative conclusions were not already drawn from correlations between child maltreatment and socio-economic position, that existing approaches to child protection did not carry risks of confirmation bias, of unwarranted intrusion on families who were not at risk, of appropriating and reinforcing existing stigma" (Ibid).*

Their reviews recommend a range of actions to reduce these risks.

7. Practical/operational issues

Many jurisdictions have found that the biggest challenge with PRM in child protection lies in its integration into day-to-day social work and case worker practice in a way that appropriately balances the "digital world" of PRM with the "analogue world" of professional judgment, experience and interpretation (for example, Teixiera and Boyas, 2017; RNZ, 2015).

A key issue is how risk-based data is used by practitioners. Research has shown that users may overestimate the accuracy of PRM or use the results in ways for which they were not intended (Gillingham, 2015; Glaberson, 2019). Indeed, given this, some researchers argue that predictive models need to be tested in "real world" settings before any conclusions can be drawn about their accuracy or effectiveness (Russell, 2015).

There is also debate about what information generated by PRM should be given to practitioners. Some agencies give detailed risk scores, others display them as a "thermometer", which gives a general risk but not the detailed prediction, given that models are never perfect. Some agencies give, or plan to give, all caseworkers access to the scores; others to restrict their use to screening purposes in call centres. Some require screeners to make an assessment first, before gaining access to the risk score; others to consider the risk score before deciding whether to 'override' it. There is not yet sufficient research to assess which of these approaches might represent "best practice" (Teixiera and Boyas, 2017).

Moreover, simply identifying children at risk is not sufficient in itself – frontline social workers and other support services want to know what the risk or protective factors are in order to inform their response (Walsh et al., 2019).

A key question is what type of intervention should be informed by PRM. Given the risks and issues discussed above, many researchers argue that predictive models should be used to inform the level and type of service, but that they should "not drive legal decisions, such as the termination of parental rights" (Chapin Hall and Chadwick Centre, 2018). Others argue that predictive tools should only be used at the population, not individual, level, and to guide preventative activities rather than triage or crisis interventions (e.g. Glaberson, 2019). This raises resource allocation issues, particularly the question of how much of agencies' resources can be spent on children who have an elevated risk but may not experience maltreatment in the future.

Some also question whether the time and money spent on developing PRM would be better spent on designing effective interventions. Others argue that this is not an either/or, and that a lack of evidence-based responses is something that better predictive tools can help to highlight, rather than detract from (Gillingham, 2019; Dare and Gambrill, 2017). The developers of the NZ, Allegheny and California Prototype models suggest that, far from being an 'either/or', PRM can improve the impact of services by targeting them more effectively:

> *"Emily Putnam-Hornstein, of the University of Southern California, and Rhema Vaithianathan, now a professor at the Auckland University of Technology in New Zealand began asking a different question: Which families are most at risk and in need of help? "People like me are saying, 'You know what, the quality of the services you provide might be just fine — it could be that you are providing them to the wrong families', Vaithianathan told me"" (NY Times, 2018).*

Much depends on the cost of the preventative spend that PRM may facilitate. If a service is inexpensive, it may be cost effective to provide it to all children, regardless of their 'risk'. If more expensive services can only be

provided to some children and families, however, then a predictive risk model allows the threshold for access to be based on a child's risk (Vaithianathan et al., 2013). The main value of PRM, therefore, may be in identifying children and families who would most benefit from preventative spend, where the cost of those services or interventions mean they cannot be provided universally.

One criticism of predictive models in child welfare has been that they tend to measure long-term and probabilistic risk (such as the risk of re-referral within two years), but most of the day-to-day decisions that child welfare authorities and courts need to make are about "imminent" risk (Glaberson, 2019). This, in itself, doesn't mean that PRM might not be useful in child welfare 'systems'; rather it highlights that those 'systems' are often focused on reactive and immediate rather than long-term preventative interventions.

Regulation and Oversight

It is beyond the scope of this report to consider the issues and options in relation to regulation and oversight of predictive algorithms in or by government. Glaberson, however, argues that the risk of "mission creep or a change in leadership" means that legislatures should put in place clear, and enforceable legal rules to limit how such tools are used (Glaberson, 2019). A useful summary of the actual and potential regulatory responses to the use of predictive algorithms by government, looking particularly at New Zealand but also scanning other jurisdictions, can be found at Gavaghan et al.(2019).

8. Principles and recommended approaches

There is a significant body of work considering what agencies should do to ensure good practice and accountability in the use of algorithms generally, and in child protection specifically. Most of the studies considered in this report set out principles or approaches for algorithms in child protection to follow. A few examples are given below.

Citing previous studies, Russell (2015) sets out four "well-established" standards against which predictive models in child protection should be judged. These are summarised by Schwartz et al. (2017) as follows:

1. Validity: Well-functioning models ought to produce a distribution across categories (such as high, moderate, low, or any other scale of categories) that corresponds to actual outcome rates;
2. Equity: Equity is the degree to which a model classifies outcomes the same way across subgroups and is an essential measure of instrument validity;
3. Reliability: Reliability represents how often different users of a predictive model come to the same conclusions from the same information. This speaks to case worker reliability in judgments about a child's safety; and finally
4. Usefulness: A useful predictive model has to provide useful information and practicable guidance for workers making decisions in the field. It also must be easily understood and not overly burdensome for workers to use."

The US National Council on Crime and Delinquency (NCCD) Children's Research Centre recommends the following principles:

1. Be clear if a predictive model is the right tool to answer the question, rather than existing tools.

2. Use the model to drive supportive not punitive or net- widening interventions.
3. Consider how to mitigate racial bias in the data and use the results positively.
4. Be transparent about the research, model, implications, and limitations.
5. Support appropriate use and implementation of the tool with initial and ongoing testing and evaluation.
6. Make sure the sample is appropriate.
7. Examine model performance for validity and equity.
8. Build in continuous quality improvement effort.
9. Evaluate a model's use and fidelity to implementation (Scharenbroch et al., 2017).

The developers of the NZ, Allegheny and California Prototype tools (Annexes One, Two and Five) propose six elements as needed for the ethical use of data in child protection:

1. Agency leadership – agencies are trying to keep children safe and should talk to the community about why data analytics might help do this.
2. A multidisciplinary team.
3. Transparency and fairness – a full methodology report and openness about what they get wrong.
4. An independent ethics review.
5. Participatory design/community engagement.
6. Independent evaluation (Vaithianathan, 2019 and 2019a).

Finally, a key principle recommended by a number of researchers, including those at the US NCCD Children's Research Centre, is that predictive models should only be used if they "offer a demonstrable improvement" on current 'system' responses for children, families, and staff (Scharenbroch et al., 2017).

Other recent work has used participatory design or similar approaches to understand the concerns of families, frontline practitioners and specialists about the use of data-driven algorithmic tools in child protection, in order to inform their future development and application (see, for example, Brown et al., 2019, looking at a mid-sized US county).

Such studies find, amongst other things, that communities and stakeholders believe that algorithms should weigh positive as well as negative data, to avoid focusing on deficits and not strengths. They also need to explain and share evidence on how algorithmic systems would produce better child outcomes than traditional decision-making approaches. Gillingham (2015) notes that, within agencies, "demystify(ing) the PRM black box and the data fields it requires" will promote buy-in from frontline data-entry staff and ultimately improve data quality and model performance as well.

A number of researchers also note the importance of engagement with stakeholders and the public as part of obtaining a social license for the use of algorithms and PRM in child protection in addition to individual consent. Brown et al. comment that:

> *"Algorithmic systems that are deployed in full compliance with the existing regulation may nevertheless fail to have so-called "license to operate", also known as "social license".... without such licence from the public, the promise of algorithmic systems for promoting positive social change may fail to be fully realized" (Brown et al., 2019; similarly, Vaithianathan, 2019).*

Importantly, these studies find that community perceptions of the use of algorithms in child protection are not somehow separate from perceptions of the wider operation of child protection 'systems'. One conclusion of Brown et al. (2019)'s study of a US state, for example, was that:

> *"Our findings indicate that general distrust in the existing system contributes significantly to low comfort in algorithmic decision-making."*

Agencies therefore need to address the problem of a lack of trust in child welfare 'systems' more widely, "otherwise these will be projected onto algorithmic tools" (Brown et al., 2019).

For other examples of recommended principles and approaches see, particularly, Brown et al. (2019) and Gavaghan et al. (2019). In addition to the overview of five US states cited above (Teixeira and Boyas, 2017), the US Department of Health and Human Services has produced an introduction for administrators and policymakers using predictive analytics in child welfare, which includes recommended questions to consider[809] and guidance for agencies that are contracting with external providers for the development and/or implementation of PRM in child welfare.[810]

[809] https://aspe.hhs.gov/predictive-analytics-child-welfare-decision-tool
[810] https://aspe.hhs.gov/system/files/pdf/259236/PACWConsiderationsContractingVendorsPredictiveAnalytics.pdf

9. Conclusions

The potential benefits of PRM in child protection, particularly in improving the accuracy of assessment of the risk of maltreatment to enable earlier and more effective intervention, need to be weighed up against the methodological, legal and ethical, and practical issues and risks they raise.

Researchers, commentators and child protection jurisdictions themselves, have reached different conclusions from the evidence about the use of PRM in child protection. Some researchers have concluded that the risks outweigh the benefits. Criticism of algorithmic tools has led to their cancelation in a number of jurisdictions – including by the Illinois Department of Children and Family Services and the County of Los Angeles Office of Child Protection, both in 2017. Others, such as the New Zealand PRM, have not been implemented in case work practice (Munro, 2019).

Others consider that the challenges can be overcome and risks safeguarded against for particular decision tasks and with appropriate design, accountability and community and stakeholder participation, or that further investigation is worthwhile (e.g. Cuccaro-Alamin et al., 2017; Vaithianathan 2019; Gillingham, 2019; Brown et al., 2019; and the five US states studied in Teixiera and Boyas, 2017).

Schwartz et al., for example, conclude that:

> *"The limited amount of research using predictive analytics and machine learning in child welfare suggests that these methods can help improve the level of predictive power of risk assessment instruments.... (although) more research is needed before any definitive conclusions can be drawn" (Schwartz et al., 2017).*

Chapin Hall and Chadwick Centre (2018) conclude that:

> *"Predictive analytics can be applied with transparency, integrity, and responsibility to improve outcomes for children and families. It can be a powerful tool to target resources and attention to families who may require more intensive interventions, while also identifying children and families who are succeeding, so we can learn from their experiences. Intentional efforts can reduce the risks of misapplication so that the full potential of predictive analytics can be achieved."*

Despite his reservations, Gillingham concludes that PRM has potential, but requires, amongst other things, a complete redesign of data systems to realise this:

> *"Predictive risk modelling has the potential to be a useful tool to assist with the targeting of resources to prevent child maltreatment, particularly when it is combined with early intervention programmes that have demonstrated success.... It may also have potential to predict and therefore assist with the prevention of adverse outcomes for those considered vulnerable in other fields of social work. The key challenge in developing predictive models, though, is selecting reliable and valid outcome variables, and ensuring that they are recorded consistently within carefully designed information systems" (Gillingham, 2015).*

While some jurisdictions have cancelled predictive models, others are using them, including Allegheny County's Family Screening Tool (Annex Two), Florida's Rapid Safety Feedback tool (Annex Three), and London Councils Children's Predictive Safeguarding Model (Annex Five). Glaberson found that, as at 2018, there was publicly available evidence that child protective authorities in more than a dozen US states were using or developing such tools" (Glaberson, 2019). Many, however, are careful to stress that PRM is only one part of the picture:

> *"Predictive analytics alone will not provide a panacea for all challenges child welfare agencies face but can be an important tool to support processes, practices, policies, and other systemic changes and improvements" (Teixiera and Boyas, 2017).*

The *What Works for Children's Social Care Centre* (UK) is currently undertaking a project to assess the technical feasibility of using predictive analytics to predict child outcomes such as whether a child is at sufficient risk of significant harm to justify a child protection conference, with a final report due to be published in the Spring, 2020.[811] Alongside this, an independent ethics review will assess the applicability of existing ethical frameworks to current 'machine learning' practices in the children's social care sector.[812]

[811] See https://whatworks-csc.org.uk/research-project/predictive-analytics/
[812] See https://whatworks-csc.org.uk/blog/what-works-centre-for-childrens-social-care-announces-the-rees-centre-department-of-education-university-of-oxford-and-the-alan-turing-institute-as-research-partners-in-ethics-review-of-ma/

10. Appendices

Annex one: New Zealand – A PRM to identify children at risk of needing statutory care and protection services

Background

In 2012, a New Zealand Government White Paper on Vulnerable Children identified predictive risk modelling (PRM) as a possible and promising mechanism for early intervention in relation to vulnerable children. It noted that, at that time, the use of PRM for early identification of child maltreatment was untried in NZ and overseas, carried ethical risks and warranted "careful, staged, feasibility study and trialing." The proposal was part of wide-ranging reform of child protection services in NZ that included new legislation, the formation of specialist teams and the linking-up of databases across public service systems (MSD, 2012a and 2012b; MSD, 2014a; Gillingham, 2015).

Prior to this, decision making in child protection in NZ had generally relied on consensus-based risk screening models and clinical judgement, with some use of standardised actuarial tools that obtained a risk score from a checklist or questionnaire.

The White Paper proposed that Children's Teams would target children whose level of risk was just below that which would require a statutory care and protection response, to prevent these children needing statutory services later on. PRM tools would be one source of referrals, but referrals would also be made by front line professionals (MSD, 2012b).

These developments were part of a wider shift in New Zealand's provision of social services from around 2011 to a "social investment approach" which included using information and technology to identify people for whom additional early "preventative" interventions would improve longer-term outcomes. Central to the approach was the prediction of outcomes for groups and "segmentation" of the population into groups with specific needs that policy could respond to (Scott et al., 2017; Gavaghan, 2019).

Predictive model

The PRM considered in the White Paper had been developed by the University of Auckland. The following section is summarised from Vaithianathan et al. (2013).

The model took data from the welfare and child protection administrative databases, with linked data including 103,397 public benefit spells, reflecting 57,986 unique children. The "outcome" or "dependent variable" was a substantiated finding of neglect or emotional, physical, or sexual abuse by the age of five. A total of 224 "predictor variables" were used, with 132 being retained in the final model as sufficiently correlated to the outcome variable.

The model's predictions of maltreatment risk were estimated to be accurate in 76% of cases, similar to the predictive strength of digital mammography in detecting breast cancer. The researchers found that children in the highest-risk decile when the PRM was applied were 25 times more likely to be substantiated for maltreatment than those in the lowest-risk decile. Although the model only included children whose parents had entered the public benefit system, the researchers found that this data captured a significant proportion (83%) of NZ children substantiated for maltreatment by age five years.

The researchers argued that this level of accuracy was sufficient for PRM using integrated data to be used to identify young children at high risk of maltreatment but that this should complement rather than replace human decision-making; they also proposed its use for targeting early intervention rather than later removal decisions:

> *"Although a PRM cannot replace more comprehensive clinical assessments of abuse and neglect risk, this approach provides a simple and cost-effective method of targeting early prevention services."*

The researchers acknowledged that the study was limited by the fact that it drew on administrative data associated with benefit receipt so could only pick up children whose families had had a spell on benefit, not children from the wider population who were maltreated and who could benefit from preventative interventions.

Feasibility and Ethics Reviews

Following the White Paper, the NZ Government commissioned a Feasibility Study (MSD, 2014a) and Ethical Review (Dare, 2013), which were in turn subjected to international and domestic peer review and discussed at various fora within NZ over a two-year period. The studies and peer reviews are all available on the NZ Government's website and provide a rich source of detailed analysis and assessment.[813]

Feasibility

The Government reported that the overall conclusion of the Feasibility Study was that:

> *"... while the application of Predictive Modelling to child maltreatment raises some significant ethical concerns, those concerns can either be significantly mitigated by appropriate implementation strategies or are plausibly outweighed by the potential benefits of such modelling" (https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/predicitve-modelling/).*

The Feasibility Study observed that it was not possible to assess the "true predictive accuracy" of the PRM models developed because much abuse and neglect goes undetected and therefore doesn't lead to a substantiated finding of maltreatment. But it did find that the models performed well, compared to other tools reviewed in the international

[813] See https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/predicitve-modelling/

literature, in predicting "administratively recorded substantiations of maltreatment" both overall, and for Māori children specifically.

It therefore concluded that PRM tools based on linked administrative data could be used to identify early some, but not all, of the new-born children at high risk of maltreatment. Since not all children who go on to experience substantiated maltreatment would be able to be identified early using this approach, the Study recommended that:

> *"... if taken to trial, PRM tools should not be the sole mechanism for identification and referral of children at high risk, and should be used in combination with professional judgement" (MSD, 2014a).*

It also recommended that a wider set of data be included (such as births and deaths) so that risk could be considered across the whole population. Finally, it recommended that "careful thought" be given to how PRM risk scores be used in social work practice:

> *"It would be important that any front-line professionals who were to have access to risk score information received training in how to interpret and apply that information, and on the circumstances in which it should be over-ridden" (MSD, 2014a).*

Ethics

The Ethical Review, which was also peer reviewed by international experts, considered a range of issues including:

- over and under identification
- stigmatisation
- the ethical risks associated with mandatory vs voluntary engagement
- ethical constraints on screening
- resource allocation issues
- privacy and confidentiality
- effects on social services staff.

It concluded that:

> *"The application of predictive risk modelling to child maltreatment does raise significant ethical concerns. Many of these concerns can be significantly mitigated or ameliorated. Remaining concerns may plausibly be regarded as outweighed by the very considerable potential benefits of the Vulnerable Children PRM. In sum, the application of predictive risk modelling to child maltreatment is ethically justified provided the recommendations below are addressed" (Dare, 2013).*

Perhaps most importantly, the review argued that ethical issues in the application of PRM need to be considered alongside the counterfactual:

> *"It is important to bear in mind that the Vulnerable Children PRM addresses issues that have been and are being managed by way of a variety of alternative methods and approaches. Consequently, ethical questions about the model are often comparative, asking how costs and benefits associated with the model compare with those of plausible alternatives" (Dare, 2013).*

As one peer reviewer of the Ethical Review noted, "the ethical analysis must be comparative" (Downie, 2013).

A separate review of ethical issues for Māori was also undertaken, and again peer reviewed by international and domestic experts, together with a Privacy Impact Assessment for the research.

Other concerns

Despite the conclusions of the Feasibility Study and Ethics Reviews, a number of methodological and ethical concerns were raised by academics and commentators about NZ's PRM model. The use of "substantiated maltreatment" as the outcome that the model aims to predict was criticised, concerns were raised about the appropriate level of accuracy of a

PRM for child protection purposes, and the model was criticised on various ethical grounds.

Substantiated maltreatment

While still considering that PRM is a promising approach, Gillingham and some others (for example, Keddell, 2015) criticised the NZ model for using "substantiation" as the outcome it sought to predict. They cited a range of studies showing that data on substantiation is often unreliable and misleading as a signifier of actual maltreatment (see above, pp. 13-14). In the NZ context specifically, Gillingham argued that a finding of substantiation did not necessarily mean that maltreatment had been proven to have occurred, only that further intervention by welfare services was warranted.

Gillingham acknowledged that predicting "substantiation" may still be useful as it could identify children and families with a high likelihood of raising concern within child protection services, but argued that, as well as picking up more children than are likely to suffer ill treatment, the potential negative consequences of labelling individuals in this way also needed to be considered (Gillingham, 2015).

More recent research by the developers of the NZ PRM has, however, found significant correlations between a child's risk at birth of a substantiated finding of maltreatment by child protective services and mortality rates in NZ. The researchers found that children in the top ten% and 20% of risk scores for maltreatment using the PRM had four point eight times and four point two times higher mortality rates than other children by the age of three years old and two times and one point eight times greater risk of hospitalisation, respectively. They argued that this suggests that PRM built around substantiated maltreatment outcomes does appear to target those children at risk of the most serious forms of maltreatment (Vaithianathan et al., 2018). These researchers have also 'externally validated' their Allegheny (Annex Two) and California (Annex

Five) models, again finding that these algorithms are also sensitive to adverse medical events and/or maltreatment deaths.

Accuracy

While the NZ PRM was found to have achieved a good level of accuracy (76%), Gillingham has argued that this is insufficient as a basis for making decisions about which cases to investigate, or to make removal decisions. He argues that a 76% accuracy rate means that the PRM would be wrong in a quarter of cases; it also assumes that the humans making the decisions about substantiation in the first place were always correct (100%) (Gillingham, 2019).

It is important to note, however, that the researchers did not develop the NZ model for these purposes; rather, they explicitly recommended it for identifying which families to help with early intervention and preventative services, and that it be used to complement, not replace, professional decision making. The question of what level of accuracy is acceptable may depend, critically, on the use to which the model is being put.

Ethics

While the Ethics and international peer reviews commissioned by the NZ Government were generally positive, others have been more critical on a range of ethical grounds (see, for example, Keddell, 2015).

Further developments

Following the Feasibility and Ethics reports, NZ Government officials indicated that they would carefully test predictive modelling as a tool to "enhance" and "support", not replace, professional judgement in relation to children who were reported to the child protection agency because of concerns about abuse or neglect. Amid media, public and political concerns about ethics and legality, testing was to be based on anonymised historical case histories in the first instance; and the question of how the information produced by the model would be used by social

work practitioners and cases workers was to be further worked through (RNZ, 2015).

Politicians subsequently cancelled the testing of the model primarily in response to proposals to include an observational study of newborn children. The Minister was widely reported as having commented that undertaking such a study, without intervening when the risk of abuse was detected, was akin to treating children as "lab rats" (for the original comments, see MSD, 2014b).

The general focus, following the election of a Labour Government in 2017, shifted from a social investment to "social wellbeing" approach which had less emphasis on big data and fiscal management (Gavaghan, 2019). A 2018 Stocktake of the use of algorithms by the New Zealand Government stated that the child protection agency "does not currently deploy any operational algorithms for use in operational decision-making" although it does "conduct research to guide forecasting and to support policymaking, as well as using data in performance reporting" (Statistics New Zealand, 2018).

The researchers who developed the PRM have criticised its lack of application by the NZ Government. They agree that there are ethical challenges in using the tool but, echoing the conclusion of the Ethical Review and its peer reviews, argue that there are also ethnical challenges *not* using it (RNZ, 2015).

Predicting protective factors

The university department that developed the PRM has, more recently, looked at whether it is possible to build a predictive risk model for "protective", as well as "risk" factors.

Their study used a much wider dataset than the original PRM, the Growing Up in New Zealand (GUiNZ) study. It also assessed the risk of Adversities of Childhood Experiences (ACEs), rather than maltreatment or abuse specifically, and sought to identify protective factors that were observable

at birth or pre-nataly for children who are highest risk of being exposed to ACEs but “beat the odds” and do not experience a single ACE by age 54 months.

The study identified several factors that appeared to be protective in children at high risk of ACEs. Specific factors under the broad categories of mother-partner factors, parental health/wellness and family finances were all found to be important, with parental relationship factors particularly important. The authors recommended further investigation of the impact of programmes to improve the quality of the mother-partner relationship, as a possible addition to existing public sector interventions (Walsh et al., 2019).

Annex two: Allegheny County (Pittsburgh, US) – A PRM to support screening decisions at the point of a call to the hotline

The following is taken from the Allegheny County's website[814] and Allegheny (2019 and 2019a) unless otherwise stated. The website contains links to all of the County's published research and partner evaluations. A detailed summary of the methodology, external validation and implementation, and subsequent enhancements to increase accuracy, is set out in Vaithianathan et al. (2017 and 2019).

Background

The Allegheny Family Screening Tool (AFST) is a predictive risk model that was implemented in August 2016, making Allegheny County, which includes the City of Pittsburgh, the first jurisdiction to use a PRM in child protection. It was the result of a two-year process looking at how existing data could be used more effectively to improve the County's handling of maltreatment allegations. A feature article in the *New York Times* noted that this followed a series of tragedies in which children died after their family had been "screened out" for investigation by the child protection agency (NY Times, 2018).

Allegheny had a problem common to US child protection 'systems': high rates of both over and under investigation (see above, p 7). Initial research found that 27% of the highest-risk cases were being screened out with no investigation while 48 percent of the lowest-risk cases were screened in for further investigation (Casey Family Programs, 2018a). The question, therefore, was how to safely reduce the number of investigations and

[814] https://www.alleghenycountyanalytics.us/index.php/2019/05/01/developing-predictive-risk-models-support-child-maltreatment-hotline-screening-decisions/. Accessed 12 November, 2019.

more effectively identify which families were most at risk and in need of help.

Uniquely in the US, Allegheny County's Department of Human Services had an integrated client service record and data management system. This meant that hotline staff could access historical and cross-sector administrative data (including child protection, mental health, drug and alcohol and homelessness services) related to individuals. It was, however, challenging for staff to access and assess all available records (Vaithianathan et al., 2017).

Allegheny sought proposals that would improve the accuracy and consistency of decisions made about referrals to the child protection hotline, and ensure resources were being directed to the most vulnerable clients. The researchers who had designed the NZ model undertook development of the AFST.

Predictive Model

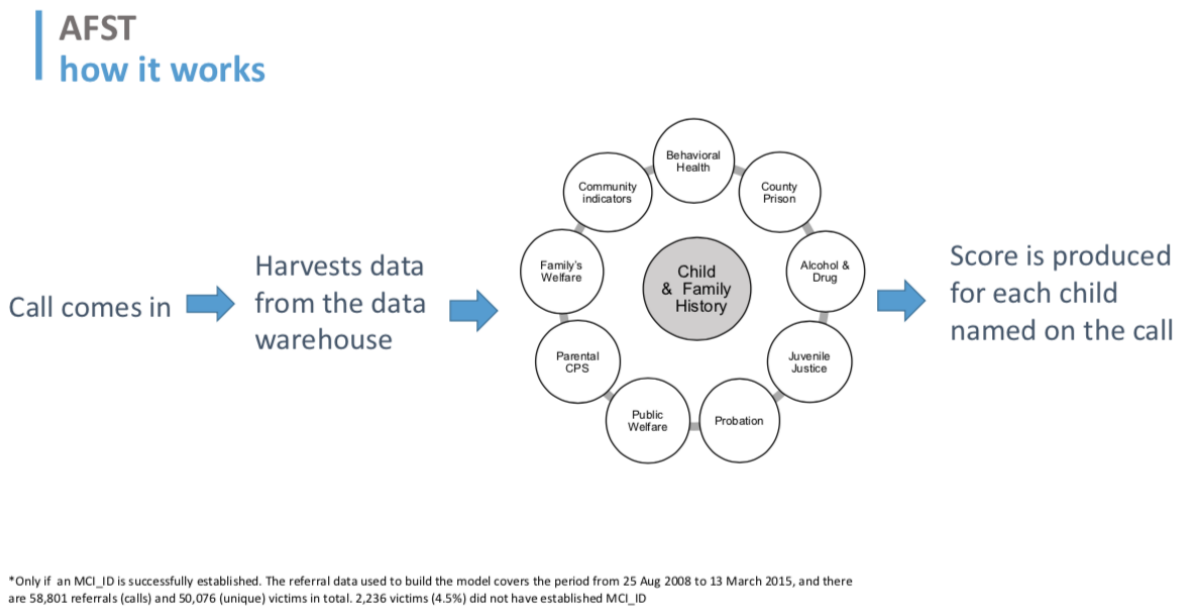
The AFST was designed to improve decision making in the 'system' by providing a second opinion on every incoming call to its child protection service hotline. The aim was to help hotline screeners decide whether referrals of alleged child maltreatment were of sufficient concern to warrant an in-person investigation (i.e. should be screened in or out).

The AFST uses data about the child and his/her family from the county's data warehouse to calculate the likelihood that a child referred for abuse or neglect will later experience a safety incident so significant that they are removed from their home and placed in out-of-home care within two years.[815] A second model predicted whether a child who was initially referred and screened out would be re-referred within the same period.

Whichever score was the highest from either model across all children on the referral was shared with the call screener in the form of a risk rating

[815] Note that this is a different "outcome variable" than that used in the NZ model, of "substantiation."

ranging from one (lowest risk) to 20 (highest risk). The original model was based on a statistical analysis of four years of prior calls, using more than 100 criteria.



Source: Vaithianathan, 2019a.

The AFST was incorporated into the county's process at the screening stage, when the call screener was given re-referral and placement risk scores that they, and the supervisor, reviewed when deciding if the referral should be investigated. The risk scores did not impact the process beyond this.

All of the databases used in the PRM were already accessible to case workers, but would have taken many days to search and weigh relevant factors. The tool, which could do this in a few seconds, was designed to speed up the identification and weighing of risk factors, and to inform but not replace human judgement:

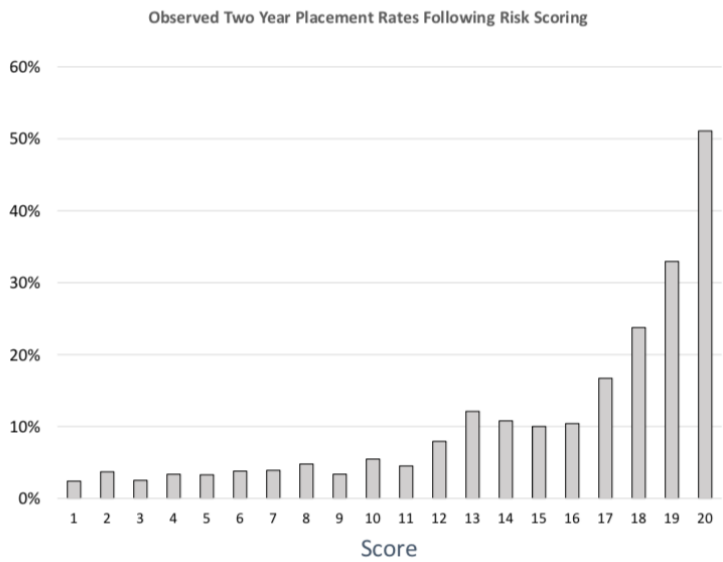
> *"It should be noted that while in some settings machines have been used to replace decisions that were previously made by humans, this is not the case for the Allegheny Family Screening Tool. It was never intended or suggested that the algorithm would replace human decision-making. Rather, that the model should help to inform, train*

and improve the decisions made by the child protection staff "(Vaithianathan et al., 2017; also Allegheny, 2019a).

Results

At the point of implementation, the AFST's predications of whether a child would be placed in care within two years after being referred and screened-in for investigation were accurate in 70% of cases. Around half of children in families with a risk score of 20 were removed within two years, whereas only around one% of children in families with a risk score of one were removed within two years.

AFST
how well it predicts



Source: Vaithianathan, 2019a.

The researchers argued that the AFST had the potential to reduce both under and over investigation. Around one third of children who scored 20 had been "screened out" previously, while 25% of children who scored one had been investigated (Vaithianathan, 2019).

Input and Reviews – Ethical, Process, Impact

Independent ethnical, process and impact reviews were commissioned, and the developers of the model undertook external validation. Allegheny also maintained a high degree of community input and transparency throughout the process.

Ethical Review

The ethical review was carried out prior to implementation. It concluded:

> *"In our assessment, subject to the recommendations in this report, the implementation of the AFST is ethically appropriate. Indeed, we believe that there are significant ethical issues in not using the most accurate risk prediction measure.*
>
> *Instruments that are more accurate will result in fewer false positives and false negatives, thus reducing stigmatization (false positives) and more lost opportunities to protect children. It is hard to conceive of an ethical argument against use of the most accurate predictive instrument" (Dare and Gambrill, 2017; see also response from Allegheny at Allegheny, 2017).*

The ethical review provided guidelines that guided the development of the tool and its implementation (Vaithianathan et al., 2017).

Process Evaluation

The process evaluation included stakeholder interviews and surveys as well as document review. It found that stakeholders "overwhelmingly applauded" the County's efforts to be transparent and keep them informed throughout implementation. Findings for staff were less positive, with less than half of call screeners seeing the AFST as benefitting screening practice. The evaluators recommended that Allegheny County continue its stakeholder involvement and improve engagement with staff (Hornby Zeller, 2018).

Impact Evaluation - Results

The impact evaluation covered implementation of the AFST through to May 2018; the evaluation itself was also independently peer reviewed during its development (GoldHaber-Fiebert and Prince, 2019; see also Allegheny's summary at Allegheny, 2019).

The evaluation found that AFST and related policy changes had made "moderate improvements" in accuracy of "screen ins" and may have slightly decreased the accuracy of "screen outs". The overall rate of referred children being "screened in" for investigation did not increase, but a *different pool* of children were being screened in as a result of the AFST, and those children that were screened in were more likely to be found in need of services. When interviewed in the *New York Times,* the researchers commented that, in using AFST, Allegheny "appear to be screening in the kids who are at real risk" (NY Times, 2018).

Racial bias also appeared to have reduced as a result of the AFST. The evaluation found that the AFST led to reductions in disparities between black and white children in case opening rates compared to the period prior to the introduction of the AFST – i.e., the AFST was better at weighing biases than human screeners alone. Consistent with this, the *New York Times* reported that the Allegheny County officials saw the AFST as a way of limiting the effects of bias (NY Times, 2018).

The authors acknowledged, however, that underlying rates of neglect and maltreatment for each group is unknown, so it is difficult to assess whether increases or decreases in 'system' outcomes such as "screen ins" reflect a widening or narrowing of disparity in actual rates of maltreatment.

The evaluation did not find any evidence that the AFST had improved consistency in decision making between call screeners, although only very large shifts in consistency would have been able to be identified. It had, however, been evaluated during its initial period, when implementation challenges had arisen, which may have reduced its impacts.

External validation

The researchers undertook external validation using a range of healthcare data. This found, for example, a positive correlation between risk scores at the point of a hotline call and the rate of hospital events – those who

scored 20 had a rate of hospital events from physical assault that was 17 times higher than those who scored one (Vaithianathan et al., 2017).

Input and Transparency

Pittsburgh responded to potential ethical concerns by maintaining a high degree of transparency, engaging with stakeholders and the public about the tool, and by only applying the algorithm in limited ways.

The original model was developed over two years and input was sought throughout from community groups and stakeholders. Parents, children and civil rights organisations interviewed by the *New York Times* in 2018 "all applauded how carefully C.Y.F. has implemented the program", particularly the fact that Allegheny was only using it to inform decisions about which calls to investigate, not decisions about removal of children from families. The *New York Times* contrasted this with algorithms that have been developed for the justice sector in the US:

> *"The Allegheny Family Screening Tool… is different: It is owned by the county. Its workings are public. Its criteria are described in academic publications and picked apart by local officials. At public meetings held in downtown Pittsburgh before the 'system's' adoption, lawyers, child advocates, parents and even former foster children asked hard questions not only of the academics but also of the county administrators who invited them" (NY Times, 2018).*

Criticisms

Despite the largely positive process review, the AFST has been criticised on a number of grounds, including by the National Coalition for Child Protection Reform (NCCPR) in the US. They have argued that the AFST is overly reliant on variables that are direct measures of poverty or that measure interaction with the child welfare or juvenile justice 'systems', and therefore "confuses parenting while poor with poor parenting." They argue that middle class families with less of a profile on public sector administrative databases will tend to have lower risk scores, and are

therefore less likely to be investigated (NCCPR, 2019, quoting Virginia Eubanks, *Automating Inequality: How High-Tech Tools Profile, Police, and Punish the Poor,* St Martin's Press, 2018).

The NCCPR has also expressed concern that the limitations and safeguards put in place in the Allegheny model may not be maintained in future. They are concerned that predictive tools will eventually lead to monitoring and racial profiling, with families investigated before any abuse occurs, even though they agree that this is not the intent of those currently involved (Rivlin-Nadler 2016; NCCPR, 2018).

Allegheny has refuted these criticisms saying, amongst other things, that:

> *"The tool simply augments the human decision whether to investigate a call alleging abuse or neglect by quickly distilling information already available to the call screener. It does not supplant the decision. It does not predict child abuse, and it certainly does not confound poverty with neglect" (Pittsburgh Post Gazette, 18 February, 2019: https://perma.cc/D7R8-36WK).*

Further Developments

Following the initial implementation (August 2016-November 2018) and process and impact evaluations, Allegheny implemented an improved model, Vtwo, in December 2018. This included changes to the target outcome, data sources and visualisation of the tool which are set out in Vaithianathan et al. (2019b).

Of the two models and outcomes used, the re-referral model was found to be less strongly linked to the outcome of concern, serious abuse and neglect than the out-of-home placement model. The re-referral model was also inclined to over-represent black children relative to white, and calls scoring highly on this model resonated less strongly with call screeners as appropriate for investigation. An external validation also suggested that the re-referral model did not add value over and above the placement model in predicting medical encounters for injuries. For all these reasons,

Vtwo restricted the model to predicting only the most serious outcome of a court-ordered out-of-home placement.

A range of changes were made to predictor variables, due to changes in availability of data in the County's data warehouse. Some new predictor variables were added such as the nature of the allegation, which call screeners had traditionally relied heavily on as a determinant of screening decisions. These and other methodological changes improved the model's accuracy to 76% (Allegheny, 2019a).

New data visualisations were developed for call screening staff that included "nudges" – for example, to default the highest-risk cases to be screened in unless supervisors explicitly override that decision with written justification. A similar "nudge" was later added to the lowest risk cases.

External validation of the Vtwo model using medical records and critical events data, replicating those that had been undertaken for the original model, have found positive correlations, for example, between the Vtwo risk scores and medical encounters for injury, abusive injuries and suicide.

Further work is reported to be underway to explore models that might be deployed at earlier points, to help prioritize families for various early intervention and family support programs (Cuccaro-Alamin et al., 2017).

Annex three: Florida – Eckerd Rapid Safety Feedback Tool; Broward PRM to identify the most appropriate intervention; and FDCF PRM to assess the risk of perpetrators having multiple maltreatment reports.

Background

Like Allegheny, Florida has been concerned about the level of over and under investigation in its child protection 'system' and the desirability of directing its resources towards those most likely to suffer maltreatment. Predictive models have been developed, and in some cases applied, in a range of ways. This annex sets out examples of PRM to assess:

- the risk of fatalities (Hillsborough County – Eckerd Rapid Safety Feedback Tool)
- the most appropriate intervention (Broward County)
- the risk of perpetrators being the subject of multiple maltreatment reports (Florida Department of Children and Families (FDCF)).

Florida has a unique 'system' for child welfare whereby the FDCF contracts with 20 community-based care lead agencies that manage the child welfare 'system' in each of the 20 judicial circuits. The FDCF retains overall responsibility for child welfare services, providing oversight and ensuring accountability.

Child welfare in Florida has been described as having shifted in recent years from a focus on parental punishment and child removal to focusing primarily on providing families with voluntary services to prevent a child from coming into the child welfare 'system' and reduce the number of removals and out-of-home placements (Schwartz et al., 2019).

PRM for the risk of fatalities and other outcomes - Eckerd Rapid Safety Feedback Tool

In 2012, following an unprecedented nine child homicides in less than three years in Hillsborough County, Florida, the FDCF replaced the lead child protection agency with Eckerd Connect, a non-profit service provider. They directed Eckerd to:

- identify cases with highest probability of a poor outcome before they occur, and
- change the directory of these cases through focused review (Eckerd, 2016).

The "Eckerd Rapid Safety Feedback" tool, with software developed by a private sector firm, Mindshare Technology, used state historical data about maltreatment to quantify the likelihood that a particular child would experience premature death:

> *"The analysis identified 14 risk factors associated with increased risk of child death, including age (children aged zero–two were most at risk), prior removal for physical or sexual abuse, removal for parental substance abuse, and presence of a physical or intellectual disability. Receipt of in-home services was shown to have a protective effect" (Cuccaro-Alamin, et al., 2017).*

Once the model was fine-tuned, it was updated daily with data about new investigations and cases and used to provide real time data and agency performance dashboards to enable workers to monitor risk factors and intervene when warranted (CECANF, 2016; Eckerd, 2016; https://eckerd.org/family-children-services/ersf/; Cuccaro-Alamin, et al., 2017; an example of guidance to case workers using the tool can be found at Florida, 2019).

The model also supported a change to quality management (supervision). After getting case notices, quality management staff review each case, guided by a list of critical practice questions. If any answers raise concerns, they call a meeting with the supervisor and worker for the family on the same day and, together, the teams address the issues through a range of interventions. These may include immediate and more focused visits to the home, improvements to safety plans and/or access to specific services (CECANF, 2016).

Like Allegheny, the Eckerd model and practice is intended to assist caseworkers with decision making, not replace human decision makers; unlike Allegheny, it has a particular focus on assisting supervisors – providing a "second set of eyes" – who can then provide an independent view of the case (CWLA, 2016). This is a shift from traditional quality assurance (QA) that focuses on a random selection of cases, to QA of cases that have been identified by the PRM as involving children at greatest risk of severe maltreatment.

Results

The author of this report has not been able to source any independent evaluation of the Eckerd tool. This is particularly concerning since a number of researchers have argued that jurisdictions should be very cautious about developing PRM for child fatalities, as it is very difficult to develop accurate tools for such rare events (see p 13, above).

Eckerd reported in 2016 that there had been quantified improvements across various case practices (including in sharing critical case information, Supervisor Case Reviews, safety planning with the family and frequency of visits with the child) during the first three years of implementation. The tool had also been recognised by a number of organisations for its "promising results," including the US Federal *Commission to Eliminate Child Abuse and Neglect Fatalities* (CECANF, 2016).

It is unclear from material available on Eckerd's webpage, however, what impact the tool has had on child welfare *outcomes*, as opposed to case worker practice. Eckerd noted in 2016 that, since implementation, there had been no abuse-related child deaths in Hillsborough (https://eckerd.org/family-children-services/ersf/; Eckerd, 2016). Similarly, in the same year, the company that developed the software claimed it had generated benefits from improved child safety outcomes to "significant" savings in "man-hours" (sic.) but did not reference details of methodology, impact assessments or independent evaluations of the model (Mindshare Technology, 2016, 2016a).

At a conference in 2016, Eckerd noted that further evaluation was needed, and said that they were working with four grant states and Casey Family Programs on this (Eckerd, 2016).

Further developments

As at early 2017, there were at least ten US states at some stage of development with Eckerd's RSF, including Florida, Alaska, Connecticut, Indiana, Maine, Oklahoma, Louisiana, Tennessee, Ohio, and Illinois

(Glaberson, 2019). Mindshare Technology said that predictive analytic applications had also been developed for other child welfare outcomes…

> *"… including applications to determine which children are most likely to experience repeat maltreatment, prolonged stays in the foster care system and "age out", and the likelihood of re-entry into foster care after a reunification with family" (Mindshare Technology, 2016).*

Its use was, however, subsequently ended by Illinois's Department of Children and Family Services due to its unreliability: press articles (no longer available on-line) reported that the tool had overwhelmed case workers with thousands of children being rated as needing urgent protection, while two young children died, neither of whom had rated as "high risk" by the model (cited in Glaberson, 2019; similarly Gillingham, 2019).

The Florida Institute for Child Welfare has announced that it is currently working in partnership with the FDCF and Florida State University on an evaluation of predictive analytics in child welfare including formative, process, impact and outcome evaluations of a model that was rolled out in March 2019, with data being collected for 12 months. Its website does not specify the location or details of the model being assessed (see https://ficw.fsu.edu/research-evaluation/predictive-analytics).

PRM for the level and type of service – Broward County

Broward County provides an example of a predictive analytics approach that been developed, but not yet applied, to determine risk but also the level and type of service that could best ameliorate this.

Background

As with many other jurisdictions, Broward County experienced increases in the numbers of children being notified, investigated, substantiated and, especially, returning to the child protection 'system'. Between 2013 and 2015, the number of out-of-home placements increased from 1348 to 2406, with Broward having higher than average removal rates within Florida

more widely. Combined with budget cuts, this led to large caseloads, well above the FDCF's recommended levels, and increasing staff turnover (Schwartz et al., 2017).

Predictive models

Broward developed *predictive* models to determine the likelihood of a child being notified again and compared the results with the existing child welfare decision-making process which was based on a Structured Decision-making tool; they also developed *prescriptive* models to determine the type and level of service that were most likely to prevent the child entering the child protection 'system' again.

The following is taken from the description of methodology and research methods set out in Schwartz et al. (2017).

The researchers used a large database (of over 78,000 children) with complete case histories between 2010 and 2015, which they merged with datasets from the Broward County Sheriff's Office, ChildNet (the local agency contracted to provide foster care and in-home services) and the Children's Services Council (CLC), which represents community based agencies serving lower-risk cases.

Cases were grouped at different stages of the reporting, investigation, substantiation, service and outcome process, according to their characteristics. Techniques such as propensity score matching were used to control for differences between members of each group that might affect their outcomes. For each group of similar children, the researchers compared those who received different interventions, in order to see whether otherwise similar groups experienced different outcomes.

The outcome that was tested was re-referral within a year of leaving the child protection 'system'. The researchers noted the problems associated with the use of a subsequent referral as the outcome or dependent variable, including that reports are often inaccurate, most are not substantiated, and substantiation rates differ widely between jurisdictions.

On the other hand, they noted that "substantiation" is also unreliable (as discussed above, pp 13-14). In Broward County itself, researchers found significant variations between case workers as to whether a case ended up being substantiated. While recognising that "re-referral" was an imperfect metric, they therefore decided to use it as more consistent across child welfare 'systems' than substantiation.

The researchers found that their predictive model had "quite good" accuracy in predicting the likelihood that a report would be substantiated through the investigation process and considered that it could be used "to help make more informed predictive decisions."

On level and type of service, the authors concluded that many families were receiving services that were too intensive for their needs:

> *"... at least 40% of the cases that were referred to the court did not contain hot line or investigative data that warranted the referral. Moreover, these inappropriate referrals to the court were 30% more likely to return to the 'system'. Clearly, referring cases to the court for judicial action is a critical decision."*

A similar conclusion was drawn about "inappropriate referrals" to ChildNet, which had a 175% chance of returning to the 'system'.

The authors concluded that "inappropriate" assignment of lower-risk cases to more intensive services was associated with worse outcomes and more out-of-home care placements, so could actually "be causing more harm than good." They described this finding as "troubling" and warranting careful further research. They concluded:

> *"In short, the overwhelming majority of referrals to CSC-funded agencies are very low risk cases. And, in 90% of these cases there appears to be no significant difference to be gained by making these referrals. If anything, these cases might just need such light-touch services as a periodic phone call, a monthly visit by an agency staff*

> *member to inquire about the family situation and whether any services might be needed and wanted, transportation assistance, childcare, etc."*

The authors also developed a "prescriptive" model to identify which services were most likely to prevent a case from having another report of abuse and/or neglect within one year. The authors claimed that an effective substantiation and referral-to-services process, using the two models discussed above, would reduce "inappropriate referrals" to court and ChildNet and improve child and family outcomes "by as much as 30%", with outcomes being defined as being referred to the appropriate level of service.

Issues and criticisms

The Broward model has been described as a "pioneering effort" to apply predictive analytics to recommend the appropriate services for each child, and as "innovative and exciting" but also, by the same authors, as having "serious flaws." As a result, the Child Welfare Monitor argues that its preliminary results "should initiate a conversation but should not be used to support policy recommendations" (Child Welfare Monitor, 2017).

Specific criticisms include the use of one-year re-referral rates to assess intervention success, given that maltreatment may not be seen or reported for months or years; the likelihood of unmeasured differences between groups, given the study drew entirely on hotline and investigative data on family history and characteristics, not other factors; the use of the child rather than family as the unit of analysis; and the fact that the researchers reported the proportions of children that had too-intensive services such as foster care but not the proportion that had insufficiently intensive services.

The Executive Director of the US National Coalition for Child Protection Reform criticised the use of a subsequent report of maltreatment as exacerbating the potential biases in a system:

> *"If your system confuses poverty with neglect then more poor children will be reported," said Wexler, whose organization advocates for greater emphasis on family preservation by child welfare 'systems'. "And if the family stays poor, they are more likely to be reported a second time"" (quoted in Kelly, 2017a).*

PRM for risk of perpetrator re-referral and substantiation – FDC

The following is taken from Florida (2016 and 2017) unless otherwise stated.

While most PRM in child protection focus on risk factors for children or families, usually at the point of first referral or occurrence, Florida has also developed PRM to assess the risk of repeated maltreatment by *perpetrators*, at the point of initial but also subsequent reports to the child protection agency. The aim is to support agencies in their decisions for screening, assessment, service planning and placements.

Background

Work on perpetrators was sparked by a 2015 study that had found a "critical link between maltreatment fatalities and the number of prior reports in the extended family networks" (Florida, 2015).

Predictive Model

In light of the 2015 finding, Florida built and tested models to predict perpetrators with high likelihood of "chronic" maltreatment. "Chronicity" was defined as five or more maltreatment reports. The focus was to examine re-reporting and re-maltreatment, with or without substantiation, to identify perpetrators with high likelihood of chronic maltreatment. Separate models were built for each additional report received by the child welfare 'system' prior to the fifth, chronic, report.

Florida saw these models as helping fulfil the mandate that they have, to prevent future maltreatment, particularly repeated abuse. Initial analysis found that:

> *"At the first report, the most powerful risk factors are whether the perpetrator or caregiver (subject) was a parent, subject age, and gender, the minimum age of the victim, the number of intergenerational maltreatment reports for the subject, the total number of reports in all levels in the last 20 years and the county of residence. For subsequent reports, the time interval between the current and previous as well as initial reports became the dominant risk factor, in addition to the covariates from the initial report" (Florida, 2016).*

Using these and other factors in a PRM, the FDCF found that between ten% and 33% of chronic perpetrators could be identified using the initial report, around five point four years before they reached "chronicity":

> *"The adjusted true discovery rate for these individuals ranged from 73.5% to 85.3%, meaning only a quarter or less of individuals with high risk scores had no additional interactions with the child welfare system."*

Subsequent reports enhanced the prediction, so half of all "chronic" individuals could be identified within 28 months from the initial report, and 80% within 55 months. This compared to a median time to "chronicity", without intervention, of 64 months.

The researchers also found a consistent relationship between chronicity and substantiation. By the fifth report, almost two-thirds of perpetrators had at least one substantiated report and over nine out of ten had a report with either verified or some indicator of maltreatment. This suggested that the likelihood of substantiation also increased significantly over time.

Implications for policy and practice

Given these results, the researchers recommended that effective prevention of child maltreatment should shift from being "child-centric" to "perpetrator-centric." This would have potentially transformational

implications for child welfare, some of which are set out in more detail in their reports.

In terms of screening and case work practice, the researchers recommended that PRM be implemented to...

> *"... "screen out" perpetrators with low risk or a low likelihood of recurrence of maltreatment... (and) to target the most intensive and costly child protection services to families at highest risk of future maltreatment."*

They also suggested that risk scores could be used to direct high-risk cases to specialist caseworkers with more experience with complex cases or lower caseloads, and to set minimum contact guidelines between a family and caseworkers.

As in other areas of social policy, the research found that a relatively small number of perpetrators out of the total coming to the attention of the child protection agency in any one year may be responsible for a significant portion of child maltreatment:

> *"If a cohort is tracked, this and former study showed that approximately one out of ten perpetrators are reported five or more times over eight to ten years period. However, in a given year, perpetrators with their first report coming that year (those in the first years of their cohort periods) make about half of all perpetrators reported in that year" (Florida, 2017).*

Identifying alleged perpetrators who are at greatest risk of being the subject of further reports, including over a long period, may therefore assist decision-makers to prioritise calls for investigation and intervene earlier to prevent future child maltreatment, where this is substantiated.

The findings also have implications of the time horizon for policy and practice. The researchers found that "chronic" perpetrators re-perpetrate over a long period of time, and many were themselves a victim of child

maltreatment. This suggested that "breaking the cycle of maltreatment" requires a much longer timeframe than current initiatives typically allow and should include consideration of practice changes that may prevent current child victims from becoming future perpetrators.

The researchers noted that there is a lack of evaluation and evidence on the effectiveness of prevention strategies and there is therefore "*no clear evidence-based method for preventing the recurrence of maltreatment*." They found that the evidence "is still sparser from the perpetrator-centric perspective." Some of the associations highlighted in their research, however, such as the finding that chronic perpetrators disproportionately required substance abuse and mental health services, could help inform prevention efforts and prioritisation of resources.

Annex four: Newcastle City Council's Family Insights Programme – Increasing the use of data by care workers

The following summary is taken from the Newcastle City Council (NCC) Family Insights webpage[816], Symons 2016 and Beninger et al., 2017, unless otherwise stated.

Background

The Family Insights Programme (FIP) was a data-led redesign of Newcastle's children's social work services that was launched in May 2015. It was prompted by concerns about Newcastle's relatively high re-referral and looked-after-children rates; fiscal pressures, with child social work services being a significant portion of Newcastle's budget which was being cut; and concern that bureaucracy and paperwork were giving social workers little time for direct work with families.

Data-Led Service redesign

Newcastle used data as the basis for restructuring its social services. A major feature was the segmentation and grouping of the population of families by needs and characteristics identified by the 'system' using historical "concern factor" data. This required strengthened analytics.

Specialist social work units were established according to these groups, to address the needs and circumstances of different segments of the client population. The intention was that social workers would become more specialised, improving the quality of support they could provide, and children and families would be assigned to the most appropriate specialists rather than the closest unit.

Each social work unit had an "embedded" data analyst who worked alongside social workers. They maintained data dashboards (ChildStat),

[816] See: https://innovationcsc.co.uk/projects/family-insights-programme/, accessed on 14 October 2019.

which were updated nightly, to make it quicker and easier for social workers to manage their caseloads. They drew on information from a data warehouse that brought together information on families including data from social care, education and the Common Assessment Framework.[817]

The data analysts also reviewed team performance and undertook research and analysis including identifying patterns, undertaking deep-dive or case-study analysis, providing insight into how social workers could best help children and families, testing 'what works', and measuring the success of externally commissioned services.

The approach was inspired, amongst other things, by:

- the Hackney model, which had grouped social workers into units (see, further, Annex five), and
- evidence from the US on integrated care pathways based on the segmentation of children and families by their care needs and tailoring of interventions by 'segment' or group. This literature found that successful integrated 'care systems' focused on the 'segments' likely to have high spending, adapted delivery to support multidisciplinary teams, and put in place necessary components to support integrated delivery.[818]

The programme aimed to achieve a range of short to medium term outcomes, along with longer-term impacts that included reduction in demand on child protection services, reduction in the rate of re-referrals,

[817] Newcastle describe the Common Assessment Framework as a process that "aims to identify, at the earliest opportunity, children's additional needs that are not being met by the universal services they are receiving, and provide timely and co-ordinated support to meet those needs" and give "a holistic view that considers strengths as well as needs." See: https://www.nscb.org.uk/staff-and-volunteers/procedures/common-assessment-framework

[818] NCC webpage, citing Carter, K. Chalouhi, E. McKenna, S. Richardson, B. (2011). *What it takes to make integrated care work.* Available at: https://www.mckinsey.com/~/media/mckinsey/dotcom/client_service/healthcare%20systems%20and%20services/health%20international/issue%2011%20new%20pdfs/hi11_48%20integratedcare_noprint.ashx

re-assessments and repeat plans, and reduction in children's social care costs.

Results and Evaluation

An independent evaluation published in July 2017 (Beringer et al., 2017) assessed the implementation of the FIP and early impacts on children, families, staff and wider community partnerships. Along with interviews and surveys, it included a comparison of FIP cases with a selection of cases with similar characteristics from the periods prior to and following the implementation of FIP. The evaluation focused on implementation because it was undertaken while implementation was still in train and limited impact evidence was available. It acknowledged that many of the desired outcomes would require longer timescales to assess.

Key findings from this early evaluation that did relate to child outcomes, however, included:

- a reduction in the proportion of cases that were de-escalated: 12% of cases compared to 21% of cases under the preceding model of social care
- a smaller proportion of cases being closed: 22% of FIP cases had closed compared to 41% in the baseline
- fewer re-referrals: two% compared to four% in the baseline. The evaluation noted, however, that it was too early to assess whether this was an attributable or sustainable outcome
- an increase in the proportion of Looked After Children who were returned to their families (50% compared to 25% under the preceding model). Although this was based on only 87 cases, it was regarded as an indication that long-term outcomes were better under the FIP.

The evaluation also found evidence of:

- financial benefits. The financial viability of the programme was confirmed as sound, but more time was needed to determine cost savings
- increased systemic practice by social workers
- increasing satisfaction from families and reductions in complaints.

The evaluation recognised that it was too early to assess with confidence whether the segmenting of children and families into groups with similar needs and characteristics would achieve the anticipated outcomes for children and families.

Alongside the other changes, it was expected that a greater use of analytical insights would enable staff to take a more outcome-focused and evidence-based approach to social work and decision making. The evaluation found that "data was increasingly seen as 'a tool and an asset' among staff, encouraging 'curiosity' – a key aim of Family Insights…" It found that evidence and insights provided by the Unit Analysts had directly fed into initiatives that had led, or were expected to lead, to improved service quality.

A report by NESTA in 2016 gave an example of how analysis within Newcastle social work teams could change the approach of these units:

> *"Data insights can uncover the need to work in a different way. For instance, one social work unit works with children at risk of physical abuse. Case file analysis of the mental health histories of the parents found that 20 per cent of children had parents with a personality disorder, and 60-70 per cent of the children had a parent who had experience of sexual or physical abuse as children. Traditional social work methods may not have uncovered this insight, it led Newcastle to look for new responses to working with these types of families" (Symons, 2016).*

Nesta also found that *embedding* analysts with social work teams was critical to success:

> *"Before Newcastle's data-led changes to children's social care, there was a deep distrust of data among social workers… (but) since the introduction of embedded data analysts, there is a lot more affinity between different disciplines about the use of data. The proximity of data analysts to frontline social workers was an important factor in this as it meant the data analysts could 'live and breathe' the cases" (Symons, 2016).*

The evaluation also found, however, some frustration amongst senior practitioners that the Unit Analyst roles had been a missed opportunity, with a lack of clarity and structure in their roles, and the Analysts often diverted to work elsewhere. The creation of the data warehouse was viewed by analysts and strategic staff as a potential opportunity for exploring trends across a range of topics, but it was too early to assess its impact. The evaluation noted that the quality of datasets outside children's social care presented a challenge.

Further developments

In 2016, Nesta reported that:

> *"following the success of the Family Insights Programme, senior decision-makers have committed to expanding it across all of children's social care" (Symons, 2016).*

The NCC has also committed to assessing whether the FIP has a lasting positive impact on children and families.

Annex five: Other examples

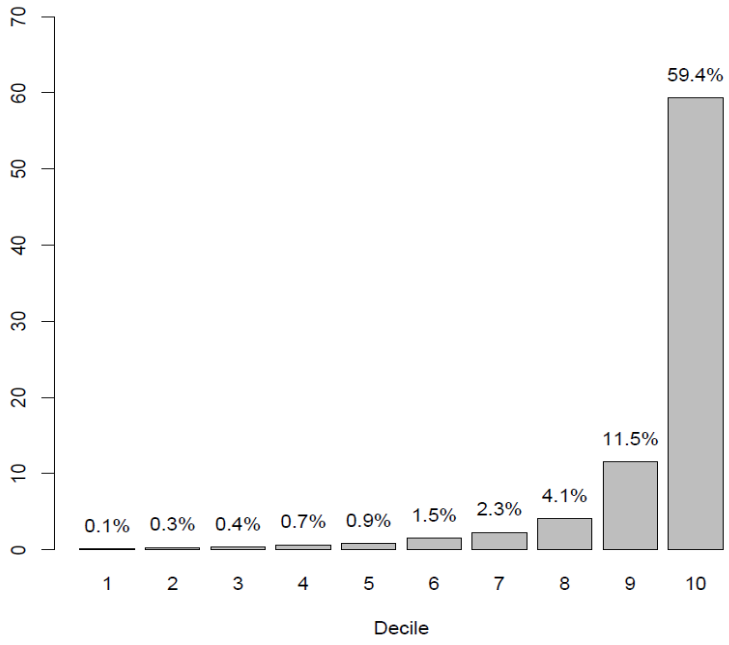
The short examples in this Annex are summarised or directly quoted from the one or two sources cited in each case, usually the researchers or jurisdiction that have developed or implemented the PRM. It has not been possible, in the time available for this report, to draw on a wider range of material or assessments of these models. They are included, however, to provide a starting point for the Care Review should it wish to do so.

California prototype tool – using a child welfare dataset to predict risk of removal and child fatality

Source: Vaithianathan, 2019 and 2019a.

The researchers who developed the NZ and Allegheny PRM investigated whether it was possible to develop such a tool with data from one source, in this case, the California child welfare 'system'. Despite the limited data, the researchers reported that their PRM achieved a high degree of accuracy. Of those children with a risk score of ten, around 59% were removed from their families, while less than one% of children with a risk score of one were removed.

California prototype
how well it predicts



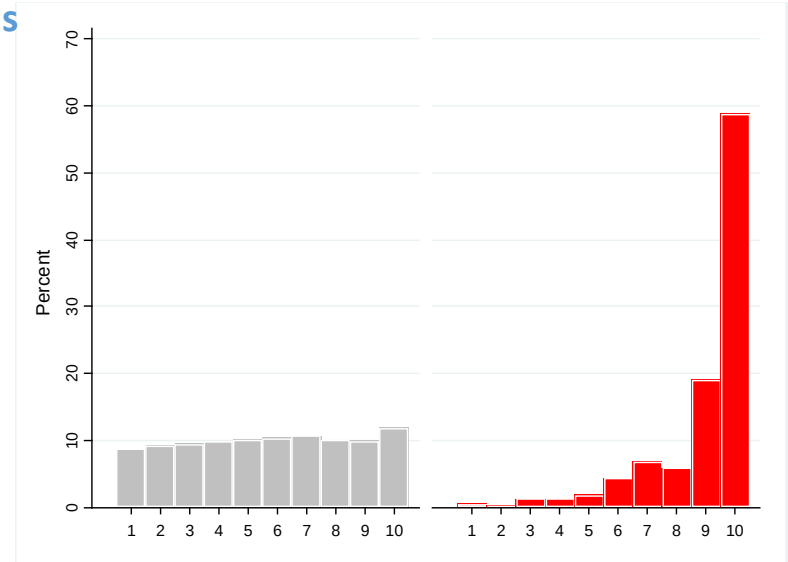
Source: Vaithianathan, 2019a.

The researchers surmised that, in this case, the limitations of a single dataset were offset by the size of the dataset, which contained millions of observations.

The researchers argued that this PRM has the potential to reduce over-investigation, including due to racial bias. Over 50% of the children that were found to have a low score were being investigated, with black and Hispanic children with a low score more likely to be investigated than white children with a low score.

They also reported that the algorithm was also sensitive to maltreatment deaths: almost 75% of child deaths were children who would have been scored at nine or ten. While the "outcome" used for the algorithm was removal/out-of-home placement, they therefore argued that this was also a good proxy for actual maltreatment, and that the algorithm could pick up both.

California prototype maltreatment deaths



Source: Vaithianathan, 2019a.

According to Professor Vaithianathan's webpage, the California Department of Social Services has commissioned these researchers to conduct a preliminary analysis for the state; and they are also working with Douglas County, Colorado to implement a predictive-analytics program

there (https://www.aut.ac.nz/research/professors-listing/rhema-vaithianathan).

London Councils Children's Predictive Safeguarding Model (Xantura) – identifying families that may need additional support.

A predictive 'safeguarding' model is in use in London Councils. The following is quoted directly from the London Councils webpage: https://www.londoncouncils.gov.uk/our-key-themes/our-projects/london-ventures/current-projects/childrens-safeguarding

"Xantura's capability, primarily a data sharing platform, brings together data from multiple council services and partners to create a 'single view' of a household and individuals. It uses advanced analytical modelling to identify people who are most at risk of harm six to nine months before specific risk and crisis factors present. This gives service professionals a full picture of an individual or household and enables them to intervene early, preventing escalation to crisis point and improving outcomes for the most vulnerable residents in our society.

The capability is used to support professional judgement and improve decision making, not to override it. The effectiveness of the model is enhanced with increased data input.

Xantura's capability is being implemented across children's services, troubled families, homelessness services and adults' social care. In children's services for example, the information collated from multiple data sources is used to analyse risk factors and generate alerts for cases that are showing a high risk of escalating into Children In Need, Child Protection and Looked After Children....

Benefits

To date, over 80% of the alerts generated by Xantura's predictive models developed within children's services have been accurate in identifying needs earlier than would have otherwise been possible.

Some key benefits of the Xantura capability are:

- Improved access to multi-agency data, leading to increased efficiency in safeguarding teams – equating to c.£148k
- Reduction in the number of safeguarding cases due to earlier identification of people most at risk and more targeted, effective interventions – could amount to cost avoidance of over £700k
- Increased identification of individuals / households at risk – one local authority has identified almost 400 additional families to receive support through their Troubled Families programme

Improved commissioning insight supporting more targeted allocation of reducing budgets – individuals' outcomes can be tracked over time, allowing the effectiveness of interventions to be assessed."

Hackney and Thurrock (Xantura) – identifying families that may need additional support.

The following is taken from media reports in:

- *The Guardian,* 16 September 2018: https://www.theguardian.com/society/2018/sep/16/councils-use-377000-peoples-data-in-efforts-to-predict-child-abuse
- *Hackney Citizen Newspaper,* 18 October, 2018: https://www.hackneycitizen.co.uk/2018/10/18/council-360k-xantura-software-profiles-troubled-families/
- *The Guardian,* 18 November, 2019: https://www.theguardian.com/society/2019/nov/18/child-protection-ai-predict-prevent-risks

In 2018, *The Guardian* reported that Hackney and Thurrock both contracted Xantura to develop a predictive model for their children's service teams (the Early Help Profiling System). The model was run at the household level in response to "warning signs, such as a child being expelled from school or a report of domestic violence."

This followed a reorganisation of social work services in Hackney, "Reclaiming Social Work", which included a focus on families and wider systems rather than individuals, the organisation of the workforce into multi-disciplinary teams with specialists led by a social worker and cases held collectively by each team.[819]

The model's prediction was passed to a social worker to alert them to families who may need extra support, but with the social worker making the decision about whether any further action was warranted.

The Guardian reported in 2018 that the systems had generated 350 risk alerts for families in Hackney and 300 in Thurrock. It cited a Thurrock Council memo as saying that all of its referrals to the UK Government's *Troubled Families* scheme were now identified by their PRM.

The Guardian reported in 2019 that Hackney Council had recently abandoned its initiative because of difficulties matching information across databases. The process had, however, also been criticised for its lack of transparency and Hackney's refusal to release details about the system, reportedly at the request of Xantura on commercially sensitivity grounds. The director of the campaign group Unlock Democracy was quoted as saying:

> *"Commercial sensitivity should not override democratic accountability.... (and that) "Hackney Council's failure to consult on the project, and now its refusal to share information on targeting, could undermine public trust. "If people's data is being used then they have a right to know how and why...."*

Bristol – using PRM to identify families and children at risk

The following is quoted directly from:

[819] For a short summary of Reclaiming Social Work see http://springconsortium.com/wp-content/uploads/2014/07/Case-Studies1.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/611991/Supporting_disadvantaged_families.pdf

> *"By using predictive analytics tools alongside their comprehensive 'Think Family' database, Bristol is able to identify families who are at risk from a range of problems, and are therefore most likely to experience difficulties if early intervention is not provided. The local authority used its Troubled Families Service Transformation Grant to successfully launch a number of predictive models, for example, to help them identify children at risk of sexual exploitation."*

Greater Manchester – "whole 'system'" approach to reviewing children's services.

The following is summarised from Greater Manchester (2017) and Childhub (2018).

Background

In 2017, Greater Manchester designed a "whole 'system' approach" to reviewing children's services across ten local authorities. This was in response to a number of challenges:

- increasing looked-after-children (LAC) numbers, due to demographics and the rate of inflows vs. outflows
- increasing cost of services for children
- difficulties in retaining quality social workers.

The local authorities needed to work out how to combine, standardise, and improve Children's Social Care Services. The intended outcomes of the project were a more efficient identification of families in need of additional support and to transform social services from reactive to proactive, through quicker access to better quality information about families at the point of assessment and testing whether the existing services were achieving the stated objectives. Their objectives included "a target of 20% reduction in looked after children."

Use of data

Along with changes to the approach to leadership and accountability, commitment to early intervention and delivery via place-based teams that utilise local assets, Greater Manchester concluded that their new delivery model needed to be "intelligence led and able to target high risk CYP and families."

A key "enabler" was the Greater Manchester Data Infrastructure and Data Sharing Capacity, an integrated data warehouse that combined information from sixteen services across the city. This enabled social workers to look through cases faster, without needing to request information from other agencies or old case files.

Greater Manchester also aggregated this data, identifying individuals and linking them to all existing information such as multiple addresses, families, or agency-related events. They have used predictive analysis, cluster analysis and decision trees to try to isolate the factors relating to referrals, and to forecast and evaluate the impact of interventions and policies.

Amsterdam

The following is taken from Amrit et al. (2017) unless otherwise stated.

Background

The researchers developed the model in response to the problem that, despite a large number of referrals for alleged child maltreatment in various countries, only a portion of child victims appear to come to the attention of children's services or Police. They observed that most predictive analysis only used "structured data" (i.e., data entered into a specific field, such as age or weight) which do not take account of the knowledge of the paediatrician. The researchers sought to develop a predictive model that incorporated the "free-text" data (the notes made by health care professionals), which comprises a significant portion of the medical data held about children.

The aim was to increase the number of correctly identified child abuse cases and improve their registration with child protection agencies.

PRM model

The data consisted of the medical files of 13,170 children born in 2010 in the Amsterdam region, all reaching age four in 2015, when the research was undertaken. With an average of just under 15 contacts with the child health department per child, this resulted in 195,188 individual data entries. The researchers claimed that, unlike previous studies, their prediction model was based on a large data set that was "complete both in terms of quantity (all the children of the Amsterdam region over a four year time period) and quality (detailed information about every child included)."

The outcome the model sought to predict was a correct classification of an "abuse presumption". The child health department had labelled 657 of the 13,170 children as "presumably abused," but estimated that these children accounted for only 25-30% of the children that should have been labelled as such.

The methodology and types of approaches and models tested are set out in detail in Amrit et al. (2017). The researchers involved end users from the start of the development of the model, including generating data visualisations of specific anonymised cases to provide end users with more insights into its "inner workings."

Results

The researchers found that their model performed better than previous models, achieving a 90% accuracy rate using their particular data. Both the structured and unstructured data produced meaningful patterns, but these were outperformed by a model that combined both, suggesting that the addition of unstructured data can improve accuracy in PRM.

Application

The model was welcomed by the research director at Amsterdam's public health organisation:

> *"This research shows that machine learning techniques perform well in predicting suspected child abuse. In practice we can benefit from using this model through implementation in a decision support tool, supporting our paediatricians in their judgment of a situation" (quoted in Amrit et al., 2017).*

It was subsequently implemented as a "decision support system", with results made available at the point at which the child health agency was closing a child's file, when cases of possible abuse would be flagged, based on the data from the entire file. This is intended to prompt the professional to take action and register the case, if needed. There is an option for the professional to provide the model with feedback which is then used in the next cycle to improve its performance over time.

Evaluation

The model does not appear to have been independently formally evaluated, although Amrit et al. report anecdotal positive feedback from subsequent research using the model at three more public health organisations in The Netherlands. They also report positive results from a comparison of the model's predictions with assessments by the liaison officer at the child health agency. The researchers stated that they intended to begin with same research in five more public health organisations in The Netherlands later in 2017.

Gillingham reported in 2019 that the health authority was open to researchers evaluating the impact of the model on health professionals' decision-making, citing a personal communication to this effect (Gillingham, 2019).

Behavioural Insights Team (UK) – predicting whether a "closed case" would be re-referred

The following is summarised from Behavioural Insights Team (2017).

In 2017, building on earlier work in Crewe, the Behavioural Insights Team investigated whether it could predict which cases that had been closed by

social workers would return within three months and be escalated – i.e., result either in a child protection plan or a child being taken into care.

Like the Amsterdam example (above), the Behavioural Insights Unit analysed data from case workers' free-form case notes (unstructured data) as well as structured data. The methods (such as Topic modelling for the unstructured data) and data used are set out in Behavioural Insights Team (2017). This involved analysis of 11,000 children's cases that were referred into the system over a two-year period, of which 5,117 were immediately closed, with no further action.

The aim was to enable interventions to be more precisely targeted to the children and families most in need.

Results

The algorithm was able to identify a small (six percent) group of cases that were closed as "high risk," within which were nearly half of the cases that would later return and be escalated, with very few (zero point six percent) 'false positives' (i.e. high-risk cases that did not return and escalate). Analysis using both text and structured data predicted eight point three times better than chance which cases were likely to be referred back into the 'system'.

The text that was most useful in identifying cases that were likely to return seemed to correspond to case notes where the social worker felt that it was necessary to spend time justifying why they were closing a case, often due to insufficient evidence or lack of consent from the family. These may be cases where there is not enough evidence to substantiate issues that the social worker suspects may be present, or the evidence is not clear cut, or the families may be hiding the extent of the issues.

A second type of text that was predictive was language used by social workers when they believed that a family might benefit from their help but the family refused to cooperate or accept help from social care.

Next steps

The 2017 report stated that the Behavioural Insights Team was working with social workers to build a digital tool to enable social workers to see the algorithm's estimated risk for a particular case. Given the findings above, they considered that the best use of this algorithm might be in providing an evidence base to justify spending more time on potentially risky cases, when the decision is not clear cut, but the social worker typically wouldn't have sufficient grounds for keeping a case open.

San Francisco Family Resource Center - using data to decide where resource centres should be located to focus on early intervention

The following is quoted directly from https://www.casey.org/hope/

"San Francisco's Family Resource Center Initiative provides parents with a range of support services, including child care, counseling, parent education, mentoring, case management and other activities that strengthen families and improve child well-being. The multisector effort brings together government, community, nonprofits, business and philanthropy to share resources and use data to track their progress.

Each of the city's 26 resource centers offers a different level of service based on its community's needs. Some provide basic support services, while others provide more intensive or comprehensive services, including evidence-based parenting classes, hands-on interaction with children, and referrals to other resources with case management support.

They focus on prevention and collaborating among agencies, using data to help them decide where a resource center should go to focus on early intervention, helping families before they enter the child welfare 'system'.

The family resource centers are a critical part of the city's strategy to keep more children safe from harm and with their families. The results have been impressive. **Since 2008, the city has safely reduced the rate of children in foster care by 52 percent. Perhaps even more promising, the substantiated rate of child abuse has dropped by 60 percent."**

Community Opportunity Map, Casey Family Programs (US) – geographic mapping of ecological indicators associated with child maltreatment

Source: Casey Family Programs, 2018.

The Community Opportunity Map (COM) was developed by Community Attributes Inc. for Casey Family Programs.

The COM is an interactive mapping platform that displays publicly available community data in user-specified geographic areas across the United States. It is free to the public and aims to increase access to available information about communities.

The COM specifically draws attention **to "ecological indicators commonly associated with child maltreatment."** Casey note that:

> *"Broadly speaking, community characteristics have an impact on child abuse and neglect rates in communities, separate from the influence of individual family characteristics. Ecological factors can pose risks to families (or act as benefits and protective factors) through such mechanisms as social support, economic distress, residential stability, lack of formal and informal community resources, and community norms related to parenting."*

The choice of indicators included in the COM is supported by research studies and other material referenced on Casey's website. They include:

- vacant housing
- housing cost burden
- resident turnover
- single mother families
- child to adult ratio
- people aged 65 and over
- unemployment rate

- adults with HS diploma/GED (i.e. educational attainment, used as a proxy for access to quality employment and wages and social support networks for parenting)
- poverty rate.

Casey stresses that the information displayed in the COM is not exhaustive and does not contain all of the information necessary to make critical decisions that impact communities. Instead, it is designed to be one of many tools that can be used "to inform decision making, strategic intervention, calls to action, and stakeholder engagement to promote community health and well-being."

NZ Treasury – characteristics of, and costs associated with, children who are at risk of poor outcomes as adults.

The following is summarised from NZ Treasury (2016).

In 2016, the NZ Treasury produced an analysis of the characteristics of children who are at risk of poor outcomes as young adults, their patterns of contact with selected government social service agencies, and some of the costs of service provision by those agencies. This included the costs of provision of care and protection, as well as welfare benefits, youth justice, prisons, health and education.

The analysis found that a small number of key characteristics (or indicators) of children and their families, observable in government administrative data, sets were highly correlated with poorer outcomes as young adults:

- having a finding of abuse or neglect, or having spent time in care of child protection services
- having spent most of their lifetime supported by benefits
- having a parent who has received a community or custodial sentence
- having a mother who has no formal qualifications.

The Treasury quantified the extent to which children with some or all of these characteristics were more likely to have poorer outcomes as young adults compared to children with none of these indicators. For example, it found that children aged zero-five with two or more of the four indicators were:

- eight times more likely to have contact with Youth Justice services before age 18
- three times more likely to leave school with no qualifications
- six times more likely to receive welfare benefits for more than two years before age 21, and
- ten times more likely to spend time in jail before age 21.

The analysis estimated the costs of these future outcomes for the provision of services by selected government social services agencies. It therefore demonstrated and quantified in fiscal terms the potential financial and human costs of "failure" in relation to vulnerable children, particularly those in care or with experience of the 'care system'.

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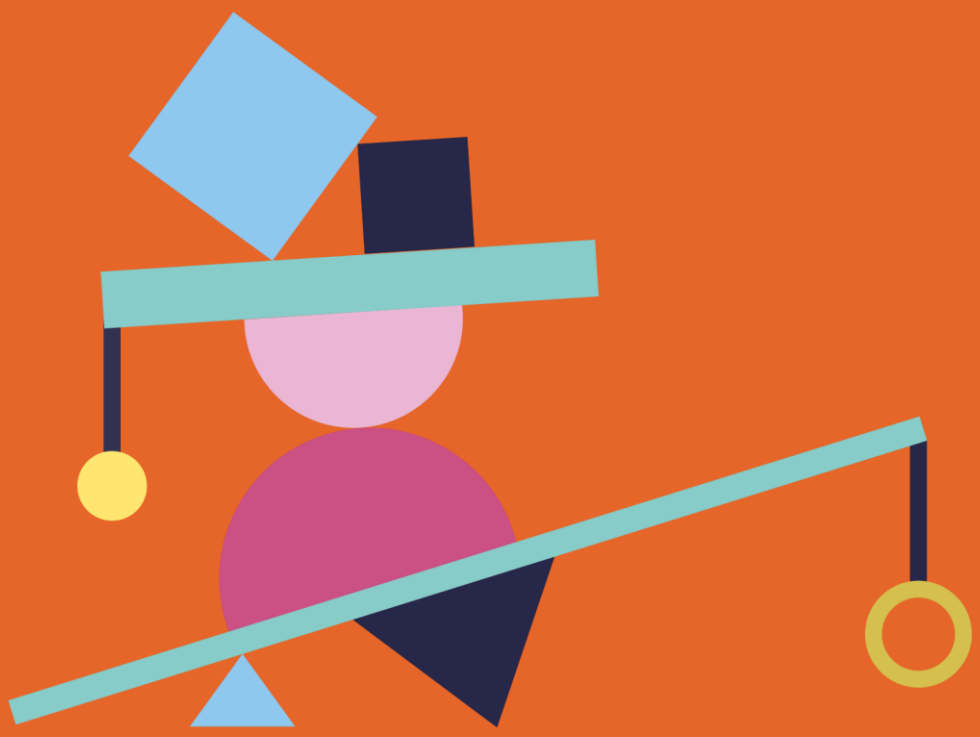
International Models of Care

The Care Review: International models of care



Heather McCauley

October 2019

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1. Summary

The Care Review commissioned this report to "map international models of care, evidencing their relevance for consideration by the Care Review." The aim is to help to inform and shape the conclusions and recommendations of the Care Review by providing evidence about 'care systems' in other countries for its consideration.

What can we learn from other countries' 'systems'?

There are widely recognised difficulties in comparing 'systems' or models across different languages and cultural terms, definitions, meanings and measures. Comparing individual components of 'systems' often leads to normative and quite rigid judgements about what good practice looks like.

Given these considerations, this report has focused on cross-country studies that take account of the context for different 'care systems' and try to understand the strengths and limitations of different models, rather than identify 'best practice.' It recognises that the wider environment is likely to have the greatest influence on care outcomes, but argues that the design and operation of 'care systems' can also have an impact.

Broad models of child protection internationally

All 'systems' balance protective and supportive elements. Many of the differences between countries come down to differences in views about, and the balance between, parents' and children's rights, and between the responsibilities of the state and the family.

The most commonly used typology identifies four approaches or 'orientations' of 'care systems' across countries:

- child protection – which tends to focus on protection and managing risks of abuse and neglect
- family service – which tend to focus on responding to family needs, early intervention and support
- child development or child-centric – which has the state playing a paternalistic role in supporting equal developmental outcomes for children
- community care – which focus on developing responses in partnership with communities.

Another, provisional, typology developed for UNICEF and Save the Children UK characterises 'systems' according to whether they have an individual or collective focus, and whether they are more or less regulated by authorities. This is better able to accommodate 'systems' with a mix of characteristics and may be a useful framework for the Care Review to use in assessing areas of strength or weakness in Scotland's current 'system', or in the proposed future 'system'.

English-speaking jurisdictions such as the US, Canada, England, Australia and New Zealand are generally classified as having a 'child protection' or forensic orientation. Continental European and Nordic countries are usually categorised as having 'family service' models. Most countries have, in recent years, been influenced by child development approaches.

'Community care' models have been associated particularly with indigenous communities and have also emerged in response to emergency contexts. They have not been considered in detail in this review due to a lack of effective systematic evaluation.

These 'types' are not absolutes. There is a lot of variation within each approach and, in some cases, within countries with the same high-level approach, particularly where responsibility for administration and practice sits at sub-national levels.

Commonalities and differences in approaches and responses

Despite their different models, most countries have expanded their child protection or child welfare 'systems', experienced significant increases in service demand and notifications, seen increased rates of out-of-home care (OOHC), and faced escalating costs in recent decades. Most have been operating in highly volatile contexts, with high-profile cases and increased scrutiny of child protection practices and workers. Many have been concerned about inconsistency in decision-making, case work and services provided within countries. Most have become more bureaucratic and placed increased emphasis on legalistic and systemic approaches.

At the same time, countries with different 'orientations' have developed differently in some respects. For example:

- thresholds for intervention have tended to be high in the Anglophone countries and lower in the Nordic countries. In child protection-oriented countries, assessments were more focused on safety, whereas family service-oriented countries focused more on child and family need
- family service-oriented countries often had a much higher rate of voluntary notifications, including from parents and children themselves, than was typical in child protection-oriented countries
- in child protection-oriented countries, services were usually targeted and time-bound, and could be unevenly available; in family service-oriented 'systems', service delivery usually occurred within the context of wider universal services, and may include intensive family support, counselling and economic support, focusing on family preservation
- residential care has been more readily considered as a first choice, and been used more extensively, in European countries; kinship and relative care has tended to be more common in Anglophone countries, as has adoption

- child welfare teams in family service-oriented countries have tended to have a wider range of professional disciplines than those in some child protection-oriented countries
- some family-service-oriented countries have tended to be more inclusive of children's and parent's voices than some child protection-oriented countries, although there has been a trend towards greater participation in a number of countries in recent years.

Outcomes

While there have been significant differences between and within country 'types', a common theme across international studies is the lack of robust evidence about the impact of interventions or services, or the outcomes achieved. This makes it very hard to draw conclusions about the success or otherwise of different 'systems'.

In many countries where studies have been undertaken, however, evidence has shown that children who received child welfare services did not have the same opportunities to lead healthy and successful lives that other children had – this has been true in both the child protection and family service-oriented countries.

OOHC rates might be considered a possible indicator of 'care system' performance but, despite the emphasis on prevention and provision of significant universal and in-home child services in some family service-oriented 'systems', these countries have not necessarily had lower OOHC rates than child protection-oriented countries.

It is, however, difficult to draw conclusions from OOHC rates because of differences in the scope of OOHC services in different countries, the greater rate of voluntary arrangements in the Nordic and some other family service-oriented countries, and the very different age profile of OOHC placements in family service-oriented countries where OOHC is mainly a teenage phenomenon.

It is clear from cross-country studies that no country has a 'system' that is able to ensure the present or future wellbeing of children at risk. A number of researchers suggest that, rather than looking for a single model that is 'successful', countries can use similarities and differences between countries as an opportunity to learn from others, and reflect and draw on *elements* of 'care systems' in other countries, adapting the best innovations and developments to fit the local context.

Recent trends – learning from other model 'types'

Whereas previously, countries tended to compare their 'systems' with others of the same broad orientation, countries have increasingly looked to learn from different model 'types' in recent years in response to the increasing strain that many 'systems' have come under.

This has resulted in moves towards family support elements in Anglophone countries, particularly the adoption of differentiated responses to risk of harm and more supportive family services when referrals are made; and many family service-oriented countries have incorporated policies and practices more typically found in child protection-oriented countries, including greater 'legalism', more punitive sanctions and compulsory measures, or more investigatory risk control and surveillance.

Reforms to increase collaboration between sectors across the prevention spectrum and attempts to focus 'systems' on outcomes rather than process or output measures have also been seen across both 'types' of countries.

Many countries have also been influenced by the emerging child development or child centric approaches influenced by 'social investment' ideologies and/or an increased emphasis on children's rights. In some countries, this has included an increasing emphasis on holding parents responsible for the wellbeing, and not just safety, of their child. Most countries have incorporated more 'risk' or 'needs-based' assessment and

related, often data-driven, tools and technologies. These aim to improve accountability, increase evidence-based practice and improve outcomes for children.

Child centric approaches have led to some tensions in family service-oriented countries between the traditional emphasis on addressing the family as an entity and addressing the needs of the individual child directly, not just through the family.

A second concern has been a tendency for a child centric approach, particularly when influenced by social investment ideologies, to lead to more regulations, intervention and surveillance of families, particularly poorer families.

Recent trends – 'systems' approaches

While there is a broad consensus within the international child protection sector about the value of 'systems' approaches to preventing and responding to child maltreatment, this has not led to implementation of the structural reforms required to support more holistic and integrated approaches. Some governments, such as Australian Governments, are currently doing work to understand how 'system'-design approaches to transforming child protection could be undertaken, with ongoing 'system' "stewardship" being seen as critical.

2. Introduction

Purpose

The Care Review commissioned this report to "map international models of care, evidencing their relevance for consideration by the Care Review." The aim is to help to inform and shape the conclusions and recommendations of the Care Review by providing evidence about 'care systems' in other countries for its consideration.

This report will sit alongside a number of Evidence Reviews on more specific aspects of, or issues related to, 'care systems' that were completed for the Care Review in July 2019.

Approach

Given the limited time available for this report, a rapid review approach was adopted. This included:

- identifying relevant review/overview papers and using 'snowballing' techniques from references cited in well peer-reviewed papers to identify further materials
- drawing on advice from the Care Review and the authors of the Care Review's Evidence Reviews
- *combined with* researcher judgement to limit the scope of the material and focus the task on material likely to be most relevant to the Care Review. For example, the review includes more information about 'care systems' in 'family service-oriented' countries than those in Anglophone countries that are likely to be more familiar to the Care Review.

This paper is not a systematic review but a summary of evidence from a range of sources, drawing out those aspects of frameworks and evidence most relevant to the Care Review.

Scope and Focus

To get the greatest potential value from the time available, this review has focused on:

- reviews and assessments undertaken during the last five years, where possible. Some older material has been included where important – a ten country review undertaken in 2011, for example, remains the most comprehensive relevant study (Gilbert et al., 2011 and individual chapters)
- reviews spanning more than one country, not individual country studies or comparisons of 'care systems' within countries
- reviews spanning 'care systems', rather than those focusing on individual aspects of 'systems' (such as assessment and decision-making), types of care (such as foster care, residential care, the 'edges' of care) or particular groups (such as adolescents, immigrant children). Each of these, and other, areas have very substantial bodies of research in their own right.

To make the task manageable within the time available, the review has also excluded:

- cross-country incidence and performance data, with the exception of out-of-home care (OOHC) rates. Incidence data tends to be a poor proxy for prevalence; 'system' outputs tell us little about outcomes for children and families. These issues are being considered elsewhere in the Care Review
- reviews of therapies, intensive programmes and specific interventions, given the scale of this literature and the difficulty of comparing across programmes. Some useful lists and summaries of "successful" interventions can, however, be found in Bowyer and Wilkinson (2013), Expert Panel (2015a) and in the sources set out in Annex E, should the Care Review wish to consider these further

- reviews of child welfare approaches for non-western countries and for indigenous communities (especially from Australia, New Zealand, US and Canada) due to the specific contexts of these approaches. These may, however, offer insights worth considering in the Scottish context.

Finally, the Care Review also agreed that the researcher should include or reference conclusions or case studies from existing analyses rather than constructing new cross-country comparisons or case studies from primary sources.

Definitions

Given the international focus of this report, definitions are, unless otherwise stated, taken from those used in work for international bodies such as by UNICEF (see Annex A) and from those set out in the Care Review 'Care Journeys' Evidence Review paper, section three (Baker, Griesbach and Waterton, 2019).

Relevant work already undertaken by the Care Review

A number of reports and Evidence Reviews have been undertaken as part of the Journey Stage of the Care Review, or recent Scottish Government reviews, focused on specific issues relevant to the 'care system' in Scotland. Some included aspects of the international context and/or models for 'care systems'.

The draft Joining the Policy Dots document (provided by the Care Review as at 12/9/19) sets out international and national goals and objectives relevant to 'care systems' for looked after children. This has identified the following *international* goals as most relevant to the Care Review:

UN Sustainable Development Goals							
No poverty	**Zero hunger**	**Good health and wellbeing**	**Quality education**	**Gender equality**	**Reduced inequalities**	**Clean water and sanitation**	**Affordable clean energy**

UNCRC (guiding principles)				
Definition of the child	**Non-discrimination**	**Best interests of the child**	**Right to life, survival and development**	**Respect for the views of the child**
The Convention defines a 'child' as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger.	The Convention applies to all children, whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from.	The best interests of children must be the primary concern in making decisions that may affect them.	Children have the right to live. Governments should ensure that children survive and develop healthily.	When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.

The Care Review 'Best Place' Evidence Review paper includes data comparing Scotland to 41 countries on five indicators of child well-being. It also provides details of legislation and policies affecting children and families in Finland, the Netherlands and Sweden, including child welfare policies (Griesbach, Waterton and Baker, 2019).

The Care Review 'Edges of Care' Evidence Review paper includes a summary of international findings on the effectiveness of interventions to support children and families on the 'edge' of care (Waterton, J., Baker, C. and Griesbach, D., 2019).

In addition to work commissioned by the Care Review, the Centre for Child Wellbeing and Protection at the University of Stirling recently did a rapid review of the literature for the Scottish Government in relation to programmes, approaches and interventions with children who may be experiencing neglect. This included articles from North America, Canada, the UK, Europe, Australia and New Zealand. The review identified some common core principles as to how Scotland might have greater impact with children, young people and families living with neglect and summarised a wide range of approaches, interventions and programmes

for which there is available evidence, across a range of countries (Scott and Daniel, 2018).

This report has endeavoured to contextualise or extend, rather than replicate, the work already undertaken above.

3. What can we learn from other countries (or not)?

System dimensions

Attributes or characteristics that are typically used to group and classify child protection 'systems' include the scope (particularly legal scope), structures, actors and functions of countries' 'systems'. The European Union Agency for Fundamental Rights' comparison of EU member states' child protection 'systems' (EUFRA, 2015) is fairly typical in including summary maps and tables on various aspects of each country's:

1. national legislative and regulatory framework, including child protection policies
2. national authorities responsible for child protection and service providers
3. human and financial resources, focusing on qualification and training of personnel
4. identification and reporting procedures for children in need of protection and procedures for placing children in alternative care
5. accountability and monitoring 'systems', focusing on the monitoring and development of common quality indicators.

More analytical comparative studies, such as recent work for the Australian Government, try to assess the *approach* taken by countries on a number of dimensions, for example:

- principles and 'system' goals
- the level of service integration and shared responsibility for children (single or multi-agency responsibility for children)
- emphasis on early intervention and prevention vs response measures
- focus of protection efforts – families, institutions, or community
- degree to which interventions are established or sanctioned by the government

- overall approach of the 'system' to the child in his/her family and community (e.g., from punitive to a rights-based 'system')
- the context within which the child protection 'system' operates
- the performance of the 'system' (Wise, 2017).

There are, however, widely recognised difficulties in comparing models or 'systems' across different languages and cultural terms, definitions, meanings and measures.

Some practical challenges noted by the Care Review 'Best Place' Review paper (Griesbach, Waterton and Baker, 2019) are that:

- international studies and comparisons are often out-of-date by the time they are published, particularly large-scale international comparison studies which often refer to data that is between four and five years old
- international comparisons often include the United Kingdom but do not usually present findings for each of the countries of the UK separately; and in some cases, the UK findings do not include data from Scotland at all.

Studies of other countries' 'care systems' also run into definitional challenges. Definitions of child abuse and neglect have been found to vary in time and space, between cultures, between professional disciplines and even within professional disciplines (Desair and Adriaenssens, 2011). Terms such as "child protection", "child welfare" or "residential settings" also vary in their meaning between countries, as can the scope of what is included in a "care system." Nordic countries' 'care systems', for example, combine universal services for children and families in general, and targeted child protection services for 'at risk' families in particular, but the latter are predominantly given on a voluntary basis, and are in many respects similar to general welfare services. This makes it particularly difficult to differentiate the child welfare and child protection parts of their 'systems' for comparative purposes (Pösö et al., 2013).

A further difficulty is that many mappings and studies look at, and compare, components of 'systems' individually. To understand the functioning of a 'system', it is critical to understand how the components *interact*, not just what components are in place. The UNICEF framework used by many countries, for example, encourages assessments of compliance with international models, standards and conventions, but the resulting descriptions of the 'system's' constituent parts and indexing of information has been described as tending to be "one dimensional" (ECPAT, 2014).

These types of comparisons also, implicitly or explicitly, make normative and often quite rigid judgements about what good practice looks like. While studies can outline specific principles and/or functions that 'systems' should strive towards, some researchers argue that these should not be automatically accepted as the correct or most appropriate approach for implementation across diverse contexts (ECPAT 2014).

Finally, many child protection 'system' mapping reports do not address or analyse the historical, cultural and socio-economic context in a country that will have driven the functioning of its 'care system' and which the 'care system' will continue to respond to. These will affect not only the structures and broad approaches of the 'system', but how child welfare workers perceive risk, assess need and respond to social problems within these and more widely.

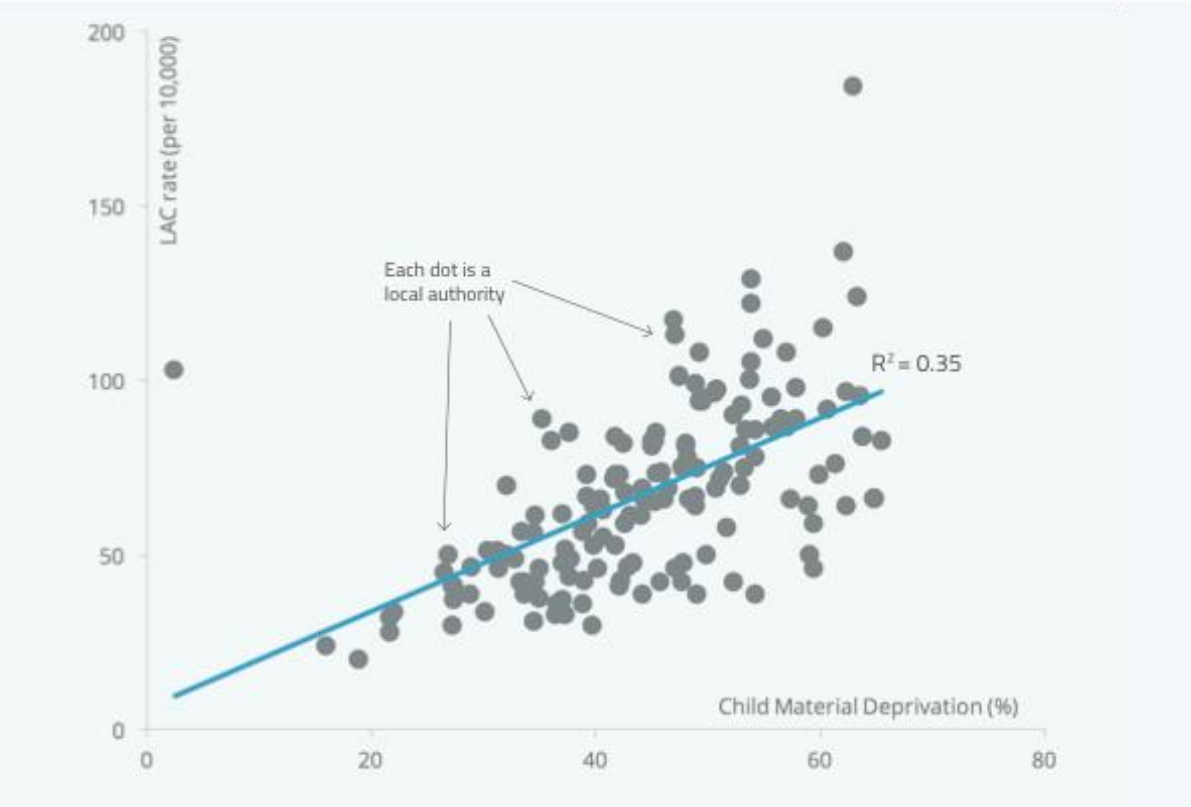
Despite this, the approach of comparing individual features of 'care systems' continues to be used in many mappings of international 'care systems'.

The role of 'systems'

There is also debate about the significance of the design and functioning of 'care systems' relative to other factors in contributing to outcomes for children. Some researchers point to the correlation between poverty and deprivation, on the one hand, and notifications to child protection services,

on the other, to argue that care services will have a limited effect on outcomes. They argue that countries should focus, instead, on poverty reduction and improving community economic and social cohesion. This has prompted Bywaters et al., for example, to argue that contact with the child protection agencies should be seen as an *expression* of inequalities, with researchers asking whether child welfare interventions "reveal, reinforce, or redress these inequalities?" rather than determine outcomes themselves (cited in Keddell, 2017, my emphasis).

Others argue that models and 'systems' still have an important impact on outcomes. The Dartington Service Design Lab has shown that, for some English local authorities at least, the number of children in care is not solely determined by need. While there is a higher rate of children in care in local authority areas with higher levels of child material deprivation, there is also a varying rate of children taken into care regardless of the level of economic disadvantage. Indeed, there Dartington found more variability for authorities with higher levels of need (see following chart).



Source: Dartington Service Design Lab, 2019, citing Office of National Statistics (Looked After Child rates, 2017), Department of Work and Pensions (Child Material Deprivation %, 2016).

Dartington conclude that the structure and behaviour of the care and protection 'system' – "from the organisation of the local services to the ingrained behaviours exhibited by staff (senior, managers and practitioners), to the thresholds for risk applied" – is likely to be the largest factor influencing this variability (Dartington, 2019). Notwithstanding the importance of wider socio-economic factors, the care model, 'system' and/or practice also influences outcomes.

Approach taken in this review

Given the considerations above, this review has not drawn on mappings of international care models that compare across individual 'system' characteristics, that apply normative judgements or that seek to identify 'best practice'. Instead, it has focused on cross-country studies that take account of the historical, cultural and socio-economic context for different 'care system' models, and that try to understand the commonalities and differences in different jurisdictions, or the strengths and limitations of each model.[820] While other, wider, influences may be more significant contributors to outcomes, it is clear that the design and operation of the 'care system' also has an impact and is therefore worth considering in addition to those wider factors.

[820] Studies comparing across single components may, however, provide a useful starting point if the Care Review wishes to further examine international practice in relation to specific aspects of 'care systems' or programmes. For this reason, references identified in the course of this review are included at Annex B.

4. Broad models of child protection internationally

All countries need the 'basics' of underpinning legislation, and human and financial resources and services, but these and other characteristics of child protection or welfare 'systems' evolve in response to the different circumstances and challenges countries face, as well as their cultural, social and economic context:

> *Around the world, child protection systems face the challenge of preventing and responding to child maltreatment and doing so fairly and equitably without intruding on parents' rights, and while containing costs. Systems in different jurisdictions have developed to negotiate these dilemmas in different ways. Child welfare systems are embedded in welfare systems with specific legal and historical bases, and there is significant variation in structure, function and capacity, both across and within countries (Katz et al., 2016).*

Many of the differences between countries come down to differences in views about, and the balance between, parents' and children's rights, and between the responsibilities of the state and the family. Clustering countries according to their broad characteristics can facilitate discussion about the objectives and performance of 'systems'. It can also inform choices about how a 'system' will develop, provided it is aware of the values and beliefs that underpin different models, the context and specific challenges they are responding to, and the fact that these 'systems' will be in a continuous process of change (Connolly, Katz and Shlonsky, 2014; Katz et al., 2016).

Types of 'care systems' – typologies

The most commonly used typology was developed by Gilbert in 1997. This identified two broad types of 'systems' – "child protection" and "family support' 'systems' – by their position on:

- the way the problem was framed (individualistic/social)
- the response mechanism (legalistic/therapeutic)
- the state/parent relationship and how professionals functioned (adversarial/partnership), and
- OOHC placements (the rate of voluntary/involuntary arrangements with the family).

Subsequent work expanded these two categories to four, adding in the 'child-focused' and 'community care' approaches (see Gilbert et al., 2011; Connolly, Katz and Shlonsky, 2014; Katz et al., 2016, Wise, 2017).

The characteristics of these four types are set out in more detail below.

Child protection

'Systems' with a child protection approach tend to frame parents as culpable – abuse is due to the harmful behaviour of malevolent parents – and focus on surveillance of families and child removal. They tend to be marked by adversarial relationships between parents and the state (usually in the form of social workers). Most OOHC placements are compelled through the coercive powers of the state, usually via court orders.

These 'systems' are underpinned by a general belief that welfare services should only be used when absolutely necessary – 'care' is primarily viewed as a response to allegations of abuse and tends to be seen as distinct from the wider continuum of services for children with lower levels of need (Gilbert et al, 2011; Bowyer and Wilkinson, 2013; Baker, Griesbach and Waterton, 2019).

Some commentators see the child protection approach as reflecting a neo-liberal and individualistic philosophy that focuses on individual responsibility and where the identification of risks dominates the aims of intervention (for example, Hyslop, 2018; Keddell, 2015).

Family Service

The family service approach identifies abuse as a problem of family dysfunction that arises from social and psychological difficulties and that is best addressed by a service-oriented, often therapeutic, response, focusing on family needs and keeping families together. It tends to be marked by a spirit of partnership with the family and particularly the parents. There is often a high rate of voluntary OOHC arrangements agreed with parents.

Care is seen as having a positive role to play and as part of a continuum of child and family services – in the Nordic countries, particularly, it complements generous universal services for children and families in general (Gilbert et al., 2011; Noble, 2011; Bowyer and Wilkinson, 2013; Pösö et al., 2013; Baker, Griesbach and Waterton, 2019).

Some commentators characterise the family service approach as focusing mainly on systemic social and economic inequalities, while not eschewing concerns about risk in relation to individual parents or families (for example, Hyslop, 2018).

Child Development or Child-centric

The child development or child-centric approach orients the 'system' towards child development, with the state playing a paternalistic role in supporting equal developmental outcomes. Rather than focusing on narrow forensic concerns about harm and abuse, the object of concern is the child's overall development and wellbeing. The approach looks at 'care system' processes from the point of view of children and is concerned with how care workers' work with children, including children's rights to participate in decision-making about their own affairs (Skivenes, 2011).

The child development approach has been shaped by two influences. The first is ideas about the 'social investment state' (particularly as promoted by the OECD and EU). These see investment in children as desirable in order to create healthy, educated workers, to equip citizens to adapt to global economic change, and to enhance individual and national competitiveness; the state should invest in children for the sake of society and the economy. From this perspective, children are treated as future workers.

The second influence is that of 'child rights' perspectives: a growing recognition that children are individuals who should be allotted their own rights. This sees ensuring children are treated with respect and love and aiming to give children in the child welfare 'system' the same opportunities as other children as a social justice issue. Children are seen less as future workers and more as current citizens, with many countries having made efforts to secure national legislation, and child protection and wider practice, that is in accordance with the UN Convention of Children's Rights 1989.

Both lines of influence see children as important in their own right and as having an existence independent of their family. The child development or child centric approach puts children's rights above parents' rights, and emphasizes parents' obligations, including in return for the services provided to promote children's well-being.

The rationale for seeing the children as future workers or as current citizens can lead to different emphases in policy and practice in different countries. Gilbert et al. argue that these perspectives particularly influence how much priority and influence is given to the views of children, for example, discussed further below (Gilbert et al., 2011).

Community care

Community care approaches are particularly associated with indigenous and minority communities and have also emerged as a key response in

emergency, transitional and developmental contexts. They recognise that child protection 'systems' are embedded in broader family and community services, and retain children in, and develop services in partnership with, families and communities. Effective systematic evaluations of such programmes have, however, been rare, making it difficult to determine their effectiveness as an approach (Katz et al., 2016, Wise, 2017). For these reasons, community care approaches are not considered in any detail in this review.

Summary of 'care system' 'types'

The table below summarises the key characteristics of each of the four approaches. This shows how problems are defined in each approach, along with the mode of intervention and the role of the state. A more detailed summary is appended at Annex B.

Table: Child Protection, Family Service, Child Development and Community Care typologies

	Child protection	Family service	Child development	Community Care
Problem frame	Deviant behaviour and dysfunctional parenting	Social/ psychological stress and family problems	Child's developmental needs and unequal outcomes	Discriminatory, culturally inappropriate child welfare policies
Mode of intervention	Legalistic/ investigative	Therapeutic /needs assessment	Early intervention and assessment of needs	Partnership with Aboriginal and other community-based organisations
State-parent relationship	Adversarial state sanctioning parental misbehaviour and using coercive powers for involuntary out-of-home placement	Partnership between parents and the state to strengthen family relations. Voluntary out-of-home placement	Substitutive/ paternalistic, whereby state assumes family responsibilities for support and care	Embedded in broader family and community preservation services. State respects Aboriginal culture and parenting values

Source: Katz et al., 2016, citing Gilbert, N. (2012). 'A comparative study of child welfare systems: Abstract orientations and concrete results,' in *Children and Youth Services Review*, 34: 532-536.

It is important to stress that these categories represent broad types and are, inevitably, an over-simplification. The approaches are not necessarily mutually exclusive and most legislative and policy frameworks will comprise elements from more than one type (Price-Robertson et al., 2014). Rather, they reflect what is given emphasis in a 'system'.

There is also a lot of variation within each approach and, in some cases, significant variation within countries with the same high-level approach, particularly where responsibility for administration and practice sits at a sub-national level, or in responses to different situations. For these reasons, many researchers prefer to talk about 'orientations' rather than models or approaches, to place countries somewhere along the line of a continuum rather than in one category (for example, Gilbert et al., 2011).

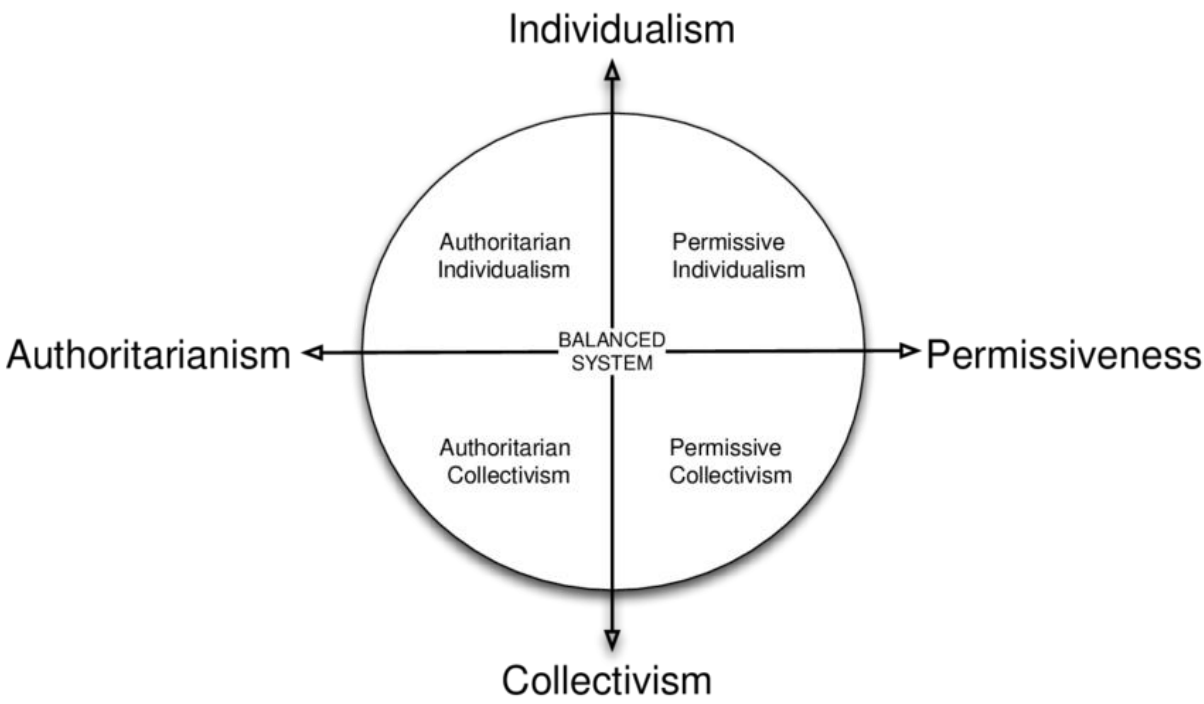
Another way of categorising 'care systems' and their characteristics

The typology discussed above is the one most commonly used or referenced in international studies.

One variant on this approach developed for UNICEF and Save the Children UK, however, may be more useful for the Care Review's work as it is better able to accommodate 'systems' with a mix of characteristic 'types' (Connolly, Katz and Shlonsky, 2014). This provisional typology characterises 'systems' along two spectrums: whether they have an individual or collective focus (individualism and collectivism), and whether they are more or less regulated by authorities, both formal and informal (authoritarianism and permissiveness).

This produces a "values and beliefs-based provisional typology" along four prototypical 'system' dimensions: *Authoritarian Individualism, Permissive Individualism, Authoritarian Collectivism, and Permissive Collectivism,* as illustrated below:

Provisional Theoretical Typology of Child Protection 'Systems'



Connolly, Katz and Shlonsky, 2014.

The table attached at Annex C provides a fuller summary of the characteristics associated with each of these 'dimensions' or 'orientations.'

As before, each country or jurisdiction may share elements of each of the four dimensions, but some will be more dominant than others for each broad 'type.' Rather than taking a normative view, each type is seen as having its own strengths and weaknesses – indeed, the context may determine not only where a 'system' is located, but what location is *desirable* at any point in time.

The authors argue, however, that if a 'system' moves too far in one or other direction (i.e. outside the circle), to an extreme expression of these underlying values/beliefs, it will become out of balance. For example, a 'system' that is excessively authoritarian may become so highly regulated and heavily procedural that it is no longer responsive to children and their families; conversely, a 'system' that is excessively permissive may allow the continuation of harmful traditions by a dominant group.

It may be useful for the Care Review to assess whether Scotland's current 'system', and proposed future 'system', would sit on this provisional typology as one way of shining a light on areas of strength or weakness that warrant further consideration.

Where do countries sit?

Looking at the most commonly used typology, Anglophone jurisdictions such as the US, Canada, England, Australia and New Zealand are generally classified as having a 'child protection' or forensic approach. Gilbert et al.'s 2011 mapping of ten countries classified Sweden, Denmark, Finland, Belgium, The Netherlands and Germany as having a 'family service' approach; subsequent work added the other Nordic countries to this list (Gilbert et al., 2011; Parton, 2010; Pösö et al., 2013).

One point of difference between countries that did not map onto this categorisation, however, has been whether they have mandatory child abuse reporting laws. Five of the countries studied to develop the original 1997 typology (US, Canada, Denmark, Sweden, Finland) required doctors, nurses, social workers and some other designated groups by law to inform welfare authorities if they suspected abuse, for example, whereas four did not (England, Belgium, The Netherlands, Germany) (Gilbert et al., 2011). Similarly, the law in Norway required all public (and many private) employees to report any suspicions of maltreatment toward children (Skivenes, 2011).

Commonalities in issues and responses

Notwithstanding the many differences between countries' 'care systems', most studies find significant commonalities in the issues and challenges they have faced in recent decades, and in some of their responses.

The 2011 ten-country study found that child protection 'systems' in all countries had been impacted by wider social, political, and economic trends in recent decades, particularly the growing influence of neo-liberal ideas, the influence of globalisation, and increased awareness of risk and

insecurity. All ten countries had been influenced by neo-liberal attitudes to some degree, with ideas around individual self-reliance having more influence, and those of the collective welfare state less.

More specifically, all countries had expanded the responsibilities and services provided by their child welfare 'systems', and most had experienced significant increases in service demands and higher rates of notifications. In most countries, more children were placed in OOHC than previously, more workers were usually employed by the 'system', 'systems' had come under significant cost pressures and there were issues with caseworker morale (Gilbert et al., 2011). Subsequent work has shown that these trends have continued over the last decade in both child protection and family service-oriented 'systems' (for example, Cortish et al., 2019).

It is not clear, and research hasn't provided firm answers, whether this expansion of 'care systems' reflects more incidents of child maltreatment, broader definitions of abuse, lower thresholds for interventions, greater reporting requirements, more awareness of child abuse and children's rights, or some mix of these. Some argue that this expansion can be seen as reflecting more serious attempts to improve prevention and early intervention for children in need; others see it as part of a broadening of 'systems' of social surveillance toward families (Gilbert et al., 2011; Katz et al. 2016; Australian Productivity Commission, 2019). Nevertheless, all 'systems' are under pressure from governments to both improve outcomes for children and reduce costs.

Gilbert et al also found that most 'systems' had been operating in highly volatile contexts. Almost all countries in the 2011 ten-country study had dealt with cases that provoked media and public outcry, often leading to scrutiny of child protection practices and workers, and had generated new or refined child protection laws in response. This critical context has been one factor leading to difficulties in recruiting and retaining social workers in many countries (Gilbert et al., 2011).

Another theme in many country studies, particularly where administration and practice are devolved to local or municipal authorities, has been concern about a lack of consistency in decision-making, case work and services. Each of the 430 Norwegian municipalities is required by law to have a child welfare administration, for example, but there is a large degree of variation between the various municipalities (Skivenes, 2011). In many countries, there has also been a growing recognition of the issues for child protection and wider child welfare 'systems' of racial and ethnic disparities (for example, Gilbert et al., 2011).

In response, many countries have placed increased emphasis on legalistic and systemic approaches to their child protection 'systems'. There is more bureaucratisation than previously, more standardised tools and procedural manuals, and increasing focus on the evidence base for interventions (Gilbert et al., 2011)

More recently, a report commissioned for the New Zealand Government (Katz et al., 2016) found that common issues or themes across countries included:

- strategies to reduce the numbers of children in OOHC and the associated escalation of costs, including through promoting kinship care, legal guardianship, adoption and adoption subsidies, and/or restoration and prevention through targeted services
- pressure to expand OOHC past the age of 18 to increase support into young adulthood, with some jurisdictions having done so
- new approaches to protecting indigenous and ethnic minority populations
- tensions between bureaucratic and professional approaches to practice, and other workforce issues
- collaboration between multiple government agencies
- the distribution of responsibility between government and non-government sectors

- an increasing role for data systems in improving policy and practice and supporting evidence-informed practice
- measures taken to monitor and improve effectiveness and cost effectiveness
- more effective services with much more attention paid to the implementation infrastructure used to support these.

A fuller summary of the issues and themes across countries identified by the New Zealand review is attached at Annex D.

Differences in approaches and practice

While there are commonalities across countries, countries with different 'orientations' have also developed differently in other respects. Some examples are set out below. Annex F provides further details of studies considered in this review that also provide analysis of the countries compared individually, which may provide a useful starting point if the Care Review wants to look at particular countries in more detail.

Thresholds for intervention

Thresholds for intervention are largely culturally determined across countries and, in some cases, between sub-national jurisdictions within countries such as Switzerland (Nett and Spratt, 2012). Moreover, these do not appear to be related to the prevalence of child mistreatment in a country:

> *A recent analysis of data from New Zealand, the U.S., and four other developed nations suggested wide variations in the degree to which (child protection services) intervened with children and families, despite small differences in the rates of violent death or maltreatment-related injuries, two indicators of the successful protection of children (Vaithlanathan et al, 2013).*

There are, however, broad contrasts between Anglophone child protection-oriented countries and the continental European and Nordic

family service-oriented countries in their approach. Thresholds for intervention were high in the US, for example, and a child must be at serious risk of harm before the state will intervene; in contrast, the goal of the Norwegian child welfare 'system' was to prioritize children's "best interest" and give each child the same basic opportunities, which meant that the state intervened at a lower threshold; a low threshold also aimed to reduce risk and avoid maltreatment by providing services at an early stage (Berrick et al., 2015).

Similarly, a comparison of Australia and Norway found that the recorded reasons for intervention in Australia were narrowly prescribed – the type of abuse and neglect recorded as part of the investigation and substantiation process – whereas the causes reported in Norway's data were broader (Kojan and Lonne, 2012). The threshold for intervention was also low in Finland, where intervention responded to a wide array of childhood and family problems (Pösö et al., 2013; Pösö, 2015).

The purpose of assessments also differed. In Norway and Finland, for example, staff were assessing for child wellbeing and child and family *need*; in child protection-oriented countries like the US, the issue was *safety*, not need, and staff were trained to assess for imminent harm or risk of harm to the child (Berrick et al., 2017). Indeed, the 2011 ten-country study found that, in Finland, the terms "child abuse" and "child neglect" barely existed in the child welfare vocabulary (Gilbert et al., 2011).

Similarly in Belgium, the child was found to play a leading role in the assessment, with diagnostic work and assessment considered as supportive rather than leading – the aim was to analyse the strengths and vulnerabilities of the child, the parents, and the family, in order to lay the foundation for care and assistance:

> *... early detection is encouraged, not from a judicial standpoint, but from the view that it is important for the victim's recovery (Desair and Adriaenssens, 2011).*

This 'system' did, however, sit alongside judicial authorities, to which reports of child abuse and neglect could also be made, and most cases of extrafamilial child abuse were referred to the judicial authorities (Ibid).

The nature of the threshold has also been found to be associated with approaches to decision-making. High thresholds for intervention in countries such as the US and England tend to lead to urgency in decision-making and vertical processes to confirm decisions via supervisors, managers and/or lawyers. These 'systems' were found to be highly regulated with narrow discretionary space, relying on agency policy, state regulations and evidence-based decision-making tools. These rights-oriented and legalistic 'systems' ensure all parties have legal representation; they also tend to have layers of procedure or risk-assessment tools in order to divert cases from court action. Berrick et al comment that:

> *... this may be appropriate; (in such 'systems') time for deliberative team-based decisions may place children at even greater risk of harm" (Berrick et al., 2015).*

In contrast, when making decisions, particularly removal to care, family service-oriented countries were more inclined to have decentralised and de-regulated 'systems' with wide discretionary space, relying on individual practitioner judgement. In Norway and Finland, for example, the state imposed few directives or research-based models to dictate local agency practices. Again, Berrick et al comment that, in family service 'systems' that are concerned with children's wider "wellbeing" and where thresholds for intervention are low:

> *... reliance on horizontal structures to assess and authorize decisions may be an appropriate, though time-consuming, strategy... (Berrick et al., 2015).*

As always, there are also differences between countries who sit within the same broad 'orientation'. While high threshold child protection-oriented 'systems' are generally found to be more legalistic than lower threshold family service-oriented 'systems', this is not always the case. In Norway, for example, all serious interventions, such as care orders and involuntary intervention, were ordered by the court (Skivenes, 2011).

Sources of notifications

There are often differences in the sources of notifications between child protection and family service countries. A comparison between Norway and Australia for 2009/10, for example, found that the main source of notifications in Australia was the Police (26.5% compared to 11.8% in Norway) whereas the main source of notifications in Norway was parents (15.8% compared to five point six% in Australia). Norwegian children were also more likely to be the source of a notification than in Australia, while NGOs, relatives and neighbours were more likely to notify authorities in Australia than they were in Norway (Kojan and Lonne, 2012).

Family service-oriented countries also tended to have a relatively high rate of *voluntary* arrangements. A 2013 study found that 70–85% of OOHC placements in Denmark and Finland, for example, were based on the consent of the custodians and the children themselves where aged over 15 or 12 years, respectively. The same study found that around 25% of placements in Norway were made with parental consent and without a care order (Pösö, et al., 2013). An earlier study had found that 30% of referrals in Belgium were self-referred by parents or families (cited in Price-Robertson et al., 2014).

Range of interventions

Interventions offered prior to, or in addition to, child removal also varied between child protection and family service-oriented 'systems'.

Most Anglophone countries had a stand-alone child protection service or services. In contrast, intake services into child welfare in Sweden, for

example, were provided through general child welfare services whereby referrals to universal, secondary and tertiary services could be made (Price-Robertson et al., 2014). In Belgium, pathways into child welfare services were predominantly identified through the health sector, with centres located in hospital settings to ensure anonymity (Desair and Adriaenssens, 2011; Price-Robertson et al., 2014).

In child protection-oriented models, once eligibility was established, studies find that targeted services were provided but were usually time bound and could be unevenly available. In contrast, in Belgium, for example, centres based in hospitals offered a highly therapeutic and multi-disciplinary approach to child protection (Desair and Adriaenssens, 2011; Price-Robertson et al., 2014). In the Nordic countries, services might include intensive family support, counselling and economic support in addition to universal services available to all. Nordic countries focused on the aim of family preservation and addressing the family as the "recipient unit," and efforts to maintain the family could be extensive and long lasting. Pösö noted that the increasing numbers of children and family receiving in-home services in these countries in recent years was seen as a form of preventative spend (Berrick et al., 2017; Pösö et al., 2013).

Consistent with this, one comparative study of the Australian (child protection-oriented) and Norwegian (family service-oriented) 'systems' concluded that the most crucial difference between these two 'systems' was their emphasis, or not, on providing supportive services. Under the supportive and welfare-oriented Norwegian 'system', approximately 80% of children in the child welfare 'system' received supportive services of some kind in 2009; these were usually provided before children could be removed from their parents. The forensic risk-focused approach in Australia meant that the services offered were 'core' child protection services, with an emphasis on protective orders and OOHC to protect children from 'dangerous' parents; some supportive service were offered

but usually provided by Non-Government Organisations (NGOs) (Kojan and Lonne, 2012).

There are also differences *between* countries of the same broad 'type'. Berrick et al found in 2011, for example, that while England was most similar to the US, many of England's interventions were incorporated into community prevention programmes. The English 'system' also contained more central guidance, directives and managerial oversight for child welfare workers than those in the US. As such, they characterised England's 'system' as containing aspects of the procedurally oriented US 'systems' and the more practitioner-based, intimately focused Nordic 'systems' (Berrick et al., 2015).

From an Anglophone country perspective, the family service-oriented models may appear better able to prevent child maltreatment – Boyer and Wilkson, for example, argue that where (adolescent) care is seen as part of a continuum of services, and not as a last resort, early support is likely to be available with the potential to avert the escalation of problems and entry to care as a result of a crisis incident (Bowyer and Wilkson, 2013). Studies have not, however, found significantly different rates of OOHC between at least some child protection and some family service-oriented models, as discussed further below.

Moreover, very little is known about the impact of in-home child and family services. With regard to the Nordic countries, for example, Pösö et al. concluded that:

> *Despite the growing interest in providing services that are based on a high level of evidence or research-based knowledge, by far, the most services in child protection are still provided without any strong research evidence. Local politics, professional culture, anecdotal evidence and traditions in the municipalities may have more influence on service provision than research (Pösö et al., 2013).*

Types of OOHC placements

Once removal of a child from their family is considered, there are differences between child protection and family service-oriented countries in the types of OOHC placements made. In most European countries, residential care is more readily considered as a first choice and used more extensively, although foster care is still the preferred option where available. In these countries, a graduated range of residential care is seen as appropriate for those with complex and challenging needs and who need greater professional expertise. In England, by contrast, residential care is seen more as a last resort than a positive therapeutic intervention (Bowyer and Wilkinson, 2013).

Similarly, a comparison of Australia and Norway found that while foster care was the most common type of OOHC, and the proportions of children in foster care was similar in both countries (at 47.1 and 51.5% for OOHC placements, respectively), Australia had much more relative and kinship care (45.4% compared to 21.3% of placements for Norway in 2008/09), while residential care and independent living was more common in Norway (23.5% compared to five point three% of placements in Australia for 2008/09) (Kojan and Lonne, 2012). A study of Finland similarly found that most children who had been placed in OOHC were in institutional care: 8,095 were in residential care compared to 5,526 in foster homes in 2007 (Pösö, 2011).

This may reflect the older age profile of children in OOHC in many family service-oriented countries, discussed further below.

There are also differences *between* countries of the same broad 'type'.

A study of 'care systems' in the mid 2000s, for example, found that Australia placed the largest proportion of children in kinship care followed by New Zealand and Italy. It has been suggested that increases in kinship care in Australia may have been a result of greater demand for OOHC generally coupled with an insufficient supply of foster carers; the

Aboriginal Child Placement Principle also facilitated culturally appropriate placements for aborigine children. In New Zealand, the high proportion of children in kinship care may have been a consequence of the widespread use of the family group conference (FGC) process developed out of traditional Maori restorative justice practices, where professionals and families work together to address concerns and agree a plan for the child (Bowyer and Wilkinson, 2013).

Among the Nordic countries, Denmark and Finland placed many more children into residential institutions than Norway, where foster care was the dominant type of placement. There is, however, very little research on the connection between type of placement, quality of care and aftercare services, and outcomes, across Nordic countries, although some studies show adopted children doing better than children in foster homes, and others suggest foster care is better for children than residential care, particularly if the foster care is stable and starts before the teenage years (Pösö et al., 2013).

There are also significant differences between countries in the use of adoption. As at 2013, Bowyer and Wilkinson found that England, the US and Canada were the only countries of that that actively supported adoption, particularly for younger children, as a route out of care. Indeed, these countries had clear policies stating that adoption is the next-best option if reunification with biological parents was not possible. By contrast, adoption was either not allowed in Nordic countries, or only used rarely (Bowyer and Wilkinson, 2013; Gilbert et al., 2011).

This was, however, starting to change in some family service-oriented countries. From the late 2000s, various policy initiatives aimed to prioritise foster care, including kinship care, with residential care taking on a secondary role. The need to contain costs was also a key argument in a number of these countries (Bowyer and Wilkinson, 2013; Gilbert, et al., 2011; Pösö, 2011; Pösö et al., 2013).

Adoption was also being considered, or starting to be considered, from the early 2010s in some of the countries that had previously used it only rarely, or not at all, where in the best interests of the child. Denmark, Norway and Finland, for example, were introducing changes to their child protection policies to support more adoption in order to achieve greater permanency for children (Bowyer and Wilkinson, 2013; Gilbert, et al., 2011; Pösö et al., 2013).

The 2011 ten country review pointed out that, despite these variations, the common objective underlying OOHC placements across countries is to establish a stable and permanent family base for the child, with kinship care, foster homes, guardianship, and adoptions being different paths to achieving this objective (Gilbert et al., 2011).

Workforce professionalisation

The level of professional qualifications within the workforce tends to differ between child protection and family service-oriented countries. Bowyer and Wilkinson found a lower level of qualifications within the residential care workforce in England compared to European countries, for example, despite the fact that many children in these homes have very challenging behaviour and complex needs; they also found a wider range of professional disciplines in child welfare teams in Denmark, France and Germany, with psychologists and social pedagogues routinely employed within social work practice, and most pedagogues training for three to four years at first degree level (Bowyer and Wilkinson, 2013).

Despite these differences, a common theme across 'systems' has been the increasing demands and pressures on 'care system' workers, and the need for greater education and training, including to increase worker satisfaction and reduce turnover (Katz et al., 2016). A 2011 study of Norway, for example, found that topics related to practitioner knowledge had been consistent issues within the Norwegian 'care system' in the previous 20 years, including the need for evidence-based practice, greater knowledge

about different types of issues, and increased competencies and skills amongst child welfare workers (Skivenes, 2011).

Children's and parents' voices

The extent to which children's and parents' voices are included in decision-making was found to be "one of the most dramatic differences" between 'care systems' in England, Finland, Norway and the US in a 2015 comparison (Berrick at al., 2015). Norway was found to be the most inclusive of the four, with parents and affected children entitled to participate in decisions affecting them according to their ability, while the US had relatively little parent and/or child involvement in decision-making. In England, however, the inclusion of child and parent perspectives were mandatory in higher threshold cases, and there has been a trend towards greater participation in a number of countries, influenced by child rights' perspectives, discussed further below.

5. Outcomes

A common theme across studies of both child protection and family service-oriented 'systems' is the lack of robust evidence around the impact of models and the outcomes achieved. Together with the difficulties in comparing 'system'-level data, and the significant historical, cultural and socio-economic contextual factors influencing 'systems' and outcomes, this makes it very hard to draw conclusions about the 'success' or otherwise of different 'systems'.

In many countries where studies have been undertaken, the evidence shows that children who receive child welfare services do not have the same opportunities to lead healthy and successful lives as other children – this has been found in both child protection and family service-oriented countries (see, for example, Skivenes, 2011). Looking at Finland, Norway and Denmark, for example, Pösö finds that there are few studies that compare outcomes of children in the child protection 'system' with those who have not been in the 'system', controlling for socio-economic factors. There are, however, a number of studies comparing outcomes for children in the child protection 'system' with those for the general population, and these show "overwhelmingly problematic and negative outcomes" later in adolescence and adult life (Pösö et al., 2013).

OOHC rates

Taking a narrower perspective, the rates of OOHC placements in countries might be considered to be an indicator of success or otherwise of a country's 'care system'. It might be expected that Nordic countries, with the "least intrusive" principle, focus on parental and family responsibility and emphasis on preventative and in-home services, for example, would

have lower rate of OOHC placements than child protection-oriented countries.

Despite the many differences in models, however, Gilbert's seminal 1997 study found no link between the child protection and family service orientations and OOHC placement rates:

> *The United States, with a child protection orientation, and Denmark, with a family service orientation, had the highest out-of-home placement rates in 1992–93, whereas the lowest placement rates were in family service–oriented Netherlands and child protection–oriented England (Gilbert et al., 2011).*

Similarly, the 2011 ten-country study found that the Nordic countries had higher OOHC numbers than England and the US, with the highest figures for Denmark and Finland, and Norway among the highest half. Indeed, the Finnish rate was twice that of England (Gilbert et al., 2011). More recently, Berrick et al. found prevalence rates for OOHC in England, Finland, Norway and the US to be similar (Berrick et al., 2015). Despite the focus on prevention and provision of significant universal and in-home child protection services, often on a voluntary basis, the Nordic countries still have a relatively high number of children in care (Pösö et al., 2013).

It is, however, difficult to draw conclusions from countries' OOHC placement rates for a number of reasons:

Definitions and Application of OOHC.

There are significant differences in definitions and in the application of OOHC across (and even within) countries. In Finland and Sweden, for example, OOHC placements include cases in which children engaged in criminal acts and substance abuse, and because of juvenile delinquency and mental illness, respectively, whereas these types of cases would have been counted under the administrative jurisdiction of the criminal justice and health systems in the UK and US.

'Systems' differ in the types of OOHC offered, as discussed above, and many of the family service countries offer care on a short-term basis, when parents need help (because of sickness or hospitalisation, for example), often through self-referral. The high OOHC rates may also reflect less use of adoption in Nordic countries (Bowyer and Wilkinson, 2013; Berrick et al., 2016; Skivenes, 2011; Pösö, 2011).

Much of the difference in rates may therefore be due to the broader scope and different application of care services in Nordic and some other family service-oriented countries.

Voluntary vs involuntary.

OOHC placements in family-service oriented 'systems' have often been more likely to involve voluntary arrangements with parents than in child protection 'systems'. In the 2011 ten country study, Finland and Denmark had the highest OOHC rates, but 80%–90% of these were arranged with the voluntary consent of both parents and often the children. In contrast, the US and England had some of the lowest OOHC rates, but these were mostly involuntary, brought about through "the coercive powers of the state" (Gilbert et al., 2011; Pösö, 2013; Gilbert, 2012).

Similarly, a comparison of Australia and Norway found that the OOHC rate was higher in Norway (zero-22 years) than in Australia (zero-17 years), but many children in Norway were placed on a voluntary basis (Kojan and Lonne, 2012).

Age differences.

There were significant differences between many family service and child protection-oriented countries in the age profile of OOHC. In 2009, 50-60% of OOHC placements in Nordic countries were for young people aged 13-17 whereas a large proportion of such placements in the US were for children under the age of five (Pösö et al., 2013; Berrick, 2011).

Similarly, Bowyer and Wilkinson found that around 50% of care entrants in Norway and Sweden in 2004-2005 were over 15 years of age, whereas the

Anglophone countries had a much higher proportion of care entrants under the age of five (Boywer and Wilkinson, 2013). In Denmark, also, OOHC has mainly been a teenage phenomenon: only ten-12% of children and young persons in Danish OOHC placements were aged zero-six years old in 2007, whereas 13 to 17 year olds made up 63% children in OOHC in 2006 (Hestbæk, 2011). Similarly, a majority of children taken into care in Finland in 2007 were teenagers (55%) (Pösö, 2011).

Studies have found that OOHC was, therefore, being used for different groups of children and young people, as well as in different ways, in child protection and family service-oriented countries. In addition, the 'care system' has covered a higher age group in countries such as in France, Norway, Sweden and Denmark (up to 21 or 22) than in many child protection-oriented countries such as Australia, where the age was 18 years in 2012 (Boywer and Wilkinson, 2013; Kojan and Lonne, 2012).

This age difference may also explain differences in types of OOHC between countries, such as the higher rates of residential care and independent living in Norway, with a higher proportion of teenagers and young adults in OOHC, compared to Australia and other child protection-oriented systems, with a younger profile in OOHC and greater use of adoption.

Rates of OOHC and wellbeing

For all these reasons, while OOHC rates might be considered to be a possible indicator of how a 'care system' is performing, is difficult to draw conclusions from them. From an Anglophone country perspective, higher rates of OOHC could be seen as a negative outcome, but one study has found that there was a positive correlation between OOHC rates and child wellbeing indicators: the countries that scored best on a child wellbeing index also tended to have higher rates of OOHC placements (Gilbert, 2012). This may have reflected the family service-oriented countries' view of care as having a positive part to play within the wider 'system' (Bowyer and Wilkinson, 2013).

On the other hand, some researchers argue that the different age profile and application of OOHC in some family service-oriented countries may be a negative indicator of 'system' effectiveness – that the older demographic profile of OOHC placements may be a reflection of these 'systems' leaving children for too long before considering removal, and that children might as a result experience continuing abuse while agencies seek to work with families. Some suggest that the focus on the family preservation principle, which is based on the biological nuclear family model, may be an obstacle for alternative family models that might provide better support for the child, and thereby be harming disadvantaged children (Price- Robertson, 2014; Skivenes, 2011; Pösö et al., 2013).

It is therefore difficult to draw a conclusion from rates of OOHC in different countries. As one study of Denmark, which has the second highest rates of OOHC among the Nordic countries, and predominantly for teenagers, put it:

> *It is subject to discussion whether this figure reflects a tight and efficient social security net, or a poor ability to implement prevention effectively (Hestbæk, 2011).*

While cross-country comparisons are problematic, however, the 2011 ten-country study did find that rates of OOHC placements had been increasing *within* all countries, apart from the US (Gilbert et al., 2011). A greater emphasis on involving relatives in providing OOHC in the US during this period may explain US exceptionalism in his regard (Gilbert, 2012).

Implications for the Care Review

It is clear from cross-country studies, such as the 2011 ten-country study, that no country has a 'system' that is able to ensure the present or future well-being of children at risk (Gilbert et al., 2011).

One conclusion may be that, rather than looking for a single model that is 'successful', countries can reflect and draw on *elements* of 'care systems' in other countries.

In reflecting on the different 'care system' approaches and rates of OOHC for different age groups in Australia and Norway, for example, Kojan and Lonne speculate that the Norwegian family services approach may be better at keeping children in their homes in the early years of their lives, but be less successful for younger adults – services may be providing too many chances to parents in the form of services, rather than the protection that children are later found to need (Kojan and Lonne, 2012). Similarly, Berrick et al. suggest that 'systems' closer to the US and English model may find value in closely examining the ways that parents and children are offered voice in the Nordic 'systems', while the more diffuse Nordic 'systems', which rely on individual practitioner judgment, could consider the possibilities associated with research-based tools for decision making (Berrick et al., 2015).

6. Recent trends – learning from other model 'types'

Whereas countries previously tended to compare their 'systems' with others of the same broad 'type', in response to the increasing strain that many 'systems' have come under in recent years, and to improve efficiency, accountability and outcomes, countries have increasingly looked beyond jurisdictions with similar model 'types' to learn from those with different approaches.

Many researchers argue that the original two typologies are converging to some degree, with moves towards 'family support' elements in child protection-oriented countries and more legalistic approaches in some family service countries. Some argue that this is appropriate, since an optimal child protection 'system' needs to include both support for families to prevent poor outcomes for children at risk and legally mandated interventions for those needing immediate protection (Nett and Spratt, 2012).

Changes in child protection-oriented countries

Countries previously identified with the child protection orientation have taken on some of the elements of the family service orientation. During the 2000s, most Anglophone 'systems', such as England and the US, adopted differentiated responses to risk of harm and a wider range of more supportive family services when referrals were made (Cortis et al., 2019; Katz et al., 2016). For example:

- official policy in England during the 2000s attempted to 'refocus' practice towards supporting families with children in need, with an emphasis on partnership, participation and prevention rather than focusing on investigation of allegations of abuse. Gilbert et al.

describe this as "a serious attempt to shift practice from a child protection orientation, to one which was organized according to principles sympathetic to a family service orientation." These and wider changes to combat social exclusion were described by some researchers as "the most significant change in the philosophy and delivery of children's services in England since 1948" (Gilbert et al., 2011; Parton, 2010).

- a number of US states developed 'differential response' 'systems' so that not every report was responded to as a potential case of child abuse, and responses differed depending on the level and nature of risk to the child. There was significant investment in services that attempted to "offer early support, work in partnership with parents, and maximise cultural and community continuity" (Ibid).
- the national framework announced by Australian Governments in 2009 included a strong early intervention and prevention emphasis, and a less forensically-oriented and more supportive approach for families (COAG, 2009).
- during the 2000s and early 2010s, New Zealand made a range of attempts to increase services to prevent abuse and neglect and reduce the need for statutory care (Expert Panel, 2015b).

In some countries, this has been associated with, or drawn from, a 'public health' approach that emphasises universal preventative initiatives and early intervention, with the placement of children in OOHC being seen as a last resort:

> *Under the public health approach, priority is placed on universal (primary) support for all families (for example, maternal child health services or positive parenting media campaigns), with more intensive (secondary) prevention targeted to vulnerable or higher-risk families, often with a focus on early intervention (for example, parenting programs that build skills and address mental health problems).... Tertiary (statutory) child protection services (for example, care and*

> *protection orders and out-of-home care) are seen as a last resort when abuse or neglect has occurred and use of alternative non-statutory approaches (for example, family support services) is not possible (Australian Productivity Commission, 2019).*

Consistent with this, a recent review for the Scottish Government suggested that:

> *It may be that society needs intervention at different levels: primary (or universal) prevention or public health approaches are designed to prevent behaviours before they occur. Such approaches focus on reducing risk factors and enhancing protective factors; secondary (or selected) prevention focus on the early detection and treatment of existing problems, often targeting groups or individuals identified as at-risk; and tertiary (or indicated) prevention approaches are designed to reduce the impact of existing problems (i.e., the re-occurrence of abusive behaviours). Thus, tertiary prevention programs focus on families in which abuse has already been identified (Scott and Daniel, 2018).*

Most Anglophone jurisdictions have instituted reforms to increase collaboration between sectors across the prevention spectrum, including health, education, justice, police and non-government organisations (Katz et al., 2016). This has also been a trend in some family-oriented countries: reforms in Denmark in the mid-2000s, for example, required investigations and action plans to include "the child's school performance, behaviour and development, family relations, health issues, leisure time activities, friendships, and other relevant factors", to encourage cooperation and coordination across sectors (Hestbæk, 2011). Also in the mid-2000s, the Flemish Parliament in Belgium legislated for 'Integrated Youth Assistance' to improve collaboration and information exchange between organisations for young people (Desair and Adriaenssens, 2011).

A further trend has been for 'systems' to attempt to focus on outcomes rather than process or outputs measures, although most countries have found reliably measuring changes in wellbeing to be challenging. The review for the New Zealand Government also found a substantial trend across jurisdictions to fund services that have been rigorously evaluated for effectiveness, with some linking payment to the provision of such services (Katz et al., 2016).

Limitations and issues raised

These attempts to reform policy and practice have had some limitations. In England, for example, reviews of reform efforts from the mid-1990s onwards found that it had been very difficult for local authorities to reorient their services in the manner intended (Parton and Berridge, 2011). Similarly, despite Australian governments' commitment to prevention and early intervention agreed in 2009, there has been growing concern efforts are still too crisis oriented (Australian Productivity Commission, 2019).

The merging of family service-oriented approaches with existing child protection approaches has often created a tension between high level supervisory models and structured decision-making tools of the latter, and practitioners' capacity for face-to-face relationship-building with children and families. It has been found that while managerial models of practice can set standards and promote quality improvement, they can also divert practitioners from critical face-to-face therapeutic work that is required as part of these broader approaches (Cortis et al., 2019).

There are also questions about whether these new approaches have necessarily improved outcomes within child protection-oriented 'systems'. The review commissioned for the New Zealand Government, for example, found that no one differential response model emerged as optimal and that the empirical evidence was conflicting about whether differential responses did reduce costs and improve outcomes. It speculated that the lack of strong positive findings, however, may have resulted from setting

the 'differential' or 'alternative' too far down the services pathway, perhaps suggesting that the focus should be shifted further towards primary prevention rather than intervention with families once difficulties for children occur. This review also reported that there was little evidence to date that efforts to increase collaboration had resulted in improved outcomes for children in the mostly child protection-oriented countries studied (Katz et al., 2016).

At the same time as attempting to institute more preventative and supportive family services, some countries have simultaneously expanded or strengthened elements of their child protection orientation. The COAG initiatives in Australia, for example, were accompanied by the expansion of mandatory reporting and linkage of federal income support systems with state-level child protection 'systems' for some communities (Kojan and Lonne, 2012). In England, "significant harm" still provided the key threshold for compulsory state intervention to protect children, and the Baby Peter case in 2008 moved concerns about child protection back to centre stage (Parton and Berridge, 2011). Substantial cuts to funding after 2008 led to a significant decrease in the availability of early intervention and family support services, along with other policy changes introducing greater conditionality in welfare provision that placed families under increasing pressure (Baldwin & Biehal, 2016).

Similarly, a 2011 review found that although policies and services in Canadian states and provinces had shifted towards family support to some degree at times, the overall trend had been towards intensified attention on risk and security. This had been reinforced by changes in federal law on corporal punishment and an increasing use of risk assessment and auditing tools, often in response to high profile media stories about child deaths and resulting reviews. Most Canadian jurisdictions continued to have a residual child welfare 'system', with a focus on protection rather than support (Swift, 2011).

While child protection-oriented countries have adopted elements of family service models, therefore, some have reverted to 'type' on occasion as they came under pressure. This possibility was recognised by Gilbert et al. in 2011:

> *As a final observation, we should keep in mind the volatile character of child welfare systems. In any of the countries studied, the focus and orientation of these systems might quickly change, particularly in times of crisis. Any system, when placed under severe pressure resulting from financial constraints, increased demand, or political and media opprobrium, might revert "to type" and adopt a default position that carries many of the hallmarks of its previous orientation.... Therefore, while having identified some clear developments and the emergence of new approaches, we should never underestimate the fragile and uncertain nature of this area of policy and practice (Gilbert et al., 2011).*

Changes in family service-oriented countries

Countries previously identified with the family service orientation have incorporated policies and practices more typically found in 'child protection' oriented models. The 2011 ten-country study found that this was the case in all the Nordic and Northern European countries studied, with the possible exception of Sweden (Gilbert et al., 2011). Examples include:

- moves towards greater 'legalism' in the Finnish 'System' (Spratt et al., 2015)
- more stringent intervention with legislation that increased the use of punitive sanctions and compulsory measures in Denmark (Hestbæk, 2011)
- the introduction of mandatory reporting in Germany, with more investigatory risk control, reactive interventions and surveillance of "deviant populations" (Gilbert et al., 2011; Gilbert, 2012).

While Norway has largely retained its family service-oriented model, it has also adopted some elements more commonly associated with child protection models. A major critique of the Norwegian 'system' has been that it had too great a scope for professional discretion, which may potentially be unjust, and not enough emphasis on evidence-based knowledge and systematically collected information; in response, some municipalities implemented programmes for systematic investigations based on risk assessment research and practice from the US, for example (Skivenes, 2011).

Incorporation of child protection-oriented policies and practices in these countries has often been closely intertwined with child development or child centric approaches, discussed below.

Influence of child development or child centric approach

In addition to some mixing of elements previously associated with the child protection and family service orientations, many countries have been influenced by the emerging 'child development' or 'child centric' approach. This concentrates on the child as an individual, who has an independent relationship to the state, and is concerned with the child's overall development and wellbeing, not just harm and abuse.

While also drawing on family service-oriented models, the more comprehensive child-focused policy programs in the US and England during the 2000s are seen as examples of this, influenced by 'social investment' approaches (Gilbert et al., 2011; Parton, 2010). More recent reforms to the child protection 'system' in New Zealand have also been heavily influenced by social investment approaches (Expert Panel, 2015a).

Some Anglophone countries have also drawn from the social pedagogy model that is widely used in a number of family service-oriented countries, in residential care and in childcare and education more widely. Social pedagogy builds on an understanding of children's rights, takes a holistic view of the child, supports the child's overall development and emphasises

working with the child and young person. While grounded in a child rights perspective, a key principle is to offer choice to the family and involve them in decision making. Evaluation of pilots of this approach in some local authorities in England in the early 2010s did not find significant differences in outcomes for children, but the limitations of these pilots meant that researchers nevertheless concluded that social pedagogy was a promising approach (Bowyer and Wilkson, 2013).

Similarly, aims for a child-friendly society in Finland and Norway are seen as influenced by child development approaches. These have, however, resulted in quite different policy approaches.

In Finland, from the mid 1990s and particularly with the 2007 Child Welfare Act, the child welfare 'system' moved from the family service-oriented model that had been in evidence since the 1980s to a more child-centred orientation. The scope of child welfare expanded, and the number of children taken into in-home or OOHC increased significantly. These changes reflected an increased emphasis on children's rights, a social investment ideology, and a more control-focused family and childhood ideology (Pösö, 2011).

Similarly, during the 2000s Denmark was moving from a family service-oriented model, emphasising voluntary partnership and preventative family-based interventions, to a more interventionist and legalistic child protection 'system', with a stronger focus on the responsibility of the individual citizen, on punitive sanctions and compulsory measures (Hestbæk, 2011).

While generally characterised as a family service-oriented country, Norway has seen a trend towards a child-centric perspective but, in their case, influenced by 'child rights' rather than 'social investment' approaches. This included the strong standing of children's rights in legislation, including a legal requirement that child welfare workers hear and 'weigh' children's views, the view of care workers' that the child is central to child welfare

cases, an emphasis on child participation in decisions, and a focus on the child's point of view in weighing up conflicting principles such as the need for permanent care vs the biological principle (Skivenes, 2011).

More generally, Nordic 'systems' have seen an increasing emphasis on holding parents responsible for the wellbeing of their child – not just to avoid harm but to actively support children's needs and wellbeing (Knijn and Nijnatten, 2011).

The degree to which states have held parents responsible for children's wellbeing varies. In Denmark and Germany, for example, parents could lose economic support if they did not comply with standards set by the state. This required parents not only to prevent harm but to promote their children's best interest, and develop skills and competencies (Gilbert et al., 2011). Legislation in Denmark stressed the responsibility of parents, wider family and the family's own networks for solving the problems of children, as part of reforms promoting kinship or 'network'[821] care (Hestbæk, 2011).

Most countries, across both child protection and family service-orientations, and further influenced by child development approaches, have incorporated more 'risk' or 'needs-based' assessment' and related, often data-driven, tools and technologies. These are designed to make 'care system' workers more formally accountable for what they do and how they do it, and to support an increase in evidenced-based practice rather than tradition or discretionary judgements; as such, Gilbert et al. noted that they were often closely associated with the growth in managerial approaches (Gilbert et al., 2011).

New Zealand has been at the forefront of governments' attempts to use 'big data' to understand outcomes, including for children at risk of poor outcomes generally, and maltreatment in particular. A review for the NZ Government observed that:

[821] In which the child is placed with a teacher or friends of the parents to whom the child is not biologically related.

> *There is recognition of the scope to increase the use of 'big data' to go beyond simply providing performance indicators to better understand trajectories through the system and system outcomes. Data linkage provides opportunities to track individuals through multiple systems, health, education, welfare and justice, and to underpin approaches to predictive risk modelling already underway in New Zealand. The collection of such data, as part of the course of normal service provision, offers the opportunity for service providers to use this information to individually monitor outcomes and use the data they collect to work toward these outcomes (Katz et al., 2016).*

Gilbert et al. also argue that the increasing focus on children's rights is particularly evident in increasing rights for children to participate, provide input and be involved in decisions that affect their lives in most countries, even if most have not gone as far as Norway. These rights usually imply that decision makers should hear and 'weigh' children's views, according to age and maturity, and therefore that they should have an impact of care worker practice (Gilbert et al., 2011).

Tensions and critiques

Child-centric approaches have led to some tensions in family service-oriented countries between the emphasis on addressing the family as an entity, which is strongly embedded in current 'systems', and addressing the needs of the individual child directly, not only indirectly through their parents. A study of Norway, for example, observed that the "strong trend" towards a child-centric approach:

> *... challenges the biological presumption of the traditional family-centred approach that has dominated Norwegian child welfare thinking for a long time.*

The author observed that, without a political decision on how these two approaches should be balanced, or which should prevail, child welfare workers and the courts were being left to interpret and prioritise (Skivenes,

2011). Similarly, in Denmark there has been concern that while the child development approach might increase consideration of the best interests of the child, it may also result in further exclusion of biological parents, depending how it is implemented (Hestbæk, 2011).

There has therefore been debate in a number of family service-oriented countries about to be truly child-centric without losing sight of family and other social relations of the child (Pösö et al., 2013; Pösö, 2015; Price-Robertson, 2014). Others argue, however, that a child perspective is not necessarily in conflict with a family-orientation approach, if both focus on the wellbeing of children (Kojan and Lonne, 2012).

A second concern has been a tendency for a child-centric approach, particularly when influenced by social investment ideologies, to lead to more regulations, intervention and surveillance of families. Social investment-motivated approaches have tended to support state-sponsored processes of surveillance and behaviour management, particularly focused on poor families, rather than social rights and economic redistribution. There has been an increased emphasis on regulating the behaviour of both professionals and also the parents and children themselves, to ensure that the 'investment' pays off and parents, particularly, fulfil their responsibilities (Knijn and Nijnatten, 2011; Gilbert et al., 2011; Hyslop, 2018).

As noted above, some family-service countries have placed an increasing emphasis on holding parents responsible for the wellbeing of their child, not just avoiding harm. In some cases, interventions have gone further than setting standards – in Denmark, for example, parents can lose child welfare benefits if they do not comply with standards set by the authorities for a specific child (Pösö et al., 2013). In The Netherlands, the definition of child maltreatment has broadened to include humiliation and a parental duty to stimulate child development; at the same time, the number of children and young people in foster care doubled between 2000 and 2011.

Risk-focused approaches, and increasingly intensive investigation and surveillance, have been criticised as out of proportion to the scale of the problem. Swift notes that research findings for Canada show low and consistent numbers of children have been killed or seriously harmed by their parents, yet there is increasing surveillance and investigation of many families, most of them poor:

> *It would seem that as the social safety net shrinks, the focus on scrutiny and control of child welfare populations intensifies (Swift, 2011).*

Increasing numbers of children in OOHC in most countries could be argued to reflect an increasingly effective child protection 'system' that is more responsive to children at risk, but could also be argued to reflect a trend towards more repressive interventions rather than services to support families. This is particularly pertinent since these repressive measures affect some types of families more than others, particularly those in unemployed, low-income families (Knijn and Nijnatten, 2011).

7. Recent trends – Interest in 'systems' approaches

Finally, a further development worth consideration by the Care Review is the emerging consensus within the international child protection sector, including organisations such as UNICEF, Save the Children and the United Nations High Commissioner for Refugees (UNHCR) on the value of a 'systems' approach' to preventing and responding to child maltreatment.

This usually envisages a move away from a traditional focus on single issues, which often results in a fragmented response, to a more holistic and integrated approach to child welfare and protection, with organisational arrangements and structures to support this (Wulczyn et al., 2010; ECPAT, 2014).

While the potential value of 'systems' approaches to child protection and welfare has been recognised in a number of countries since the early 2000s, this has not led to implementation of the structural reforms that would support a more holistic and integrated approach to child welfare and protection (ECPAT, 2014).

Some recent or current government reviews, however, have recognised that 'system'-design approaches may be needed to bring about the kinds of child protection or welfare 'system' transformation that are needed. The Australian Productivity Commission, for example, has argued that a number of challenges in implementing a public health approach need a 'system'-design approach. These include how to ensure:

- norms and values consistent with prevention of child abuse and neglect are present throughout the 'system' — for example, norms at the community level to support parents seeking 'help' are reinforced

by norms at the service (organisation and workforce) level to facilitate this
- 'at-risk' families who are most likely to benefit from early intervention programs, but least likely to engage, are attracted to and retained in programmes
- services are matched to the needs of particular families — for example, different services for lower risk families and higher risk families
- governance and funding arrangements provide incentives to focus on prevention and early intervention, rather than reinforcing a tertiary response
- organisations in different settings facilitate families easily accessing services, and coordinate their efforts (Australian Productivity Commission, 2019).

The Commission stresses that shifting the design of a child protection 'system' will require change at multiple levels – local, regional and national – and with approaches ranging from bottom-up (focusing on directly changing families' experiences and outcomes) to top-down (building the capacity and conditions of the 'system' to ensure the bottom-up approaches are successful, such as through supportive rules, regulations and funding arrangements) (Australian Productivity Commission, 2019). An earlier Australian review stressed the need for ongoing "stewardship" to achieve this:

> *… we do know that system strengthening is not a singular "event". The complex problem of child maltreatment and child removal will need to be managed through a continuous process of adaptation. System stewardship as an improvement model is a promising way forward. This requires leaders and decision-makers who understand how systems behave, who can foster shared learning and shift the collective focus from reactive problem-solving to co-creating future action.… The rudiments of a system learning approach are evident in*

> *developments in policy-making that connect feedback loops, strategic research, evaluation and data to decision-making and which engage policy people with diverse stakeholders through collaborative forms of governance and co-design. To produce real and lasting change for children and families, the principle of collective responsibility for protecting children must extend to system stewardship (Wise, 2017).*

Given the Australian Productivity Commission work is currently underway, it could be useful for the Care Review to connect with, and draw from, their research.

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9. Appendices

Annex A: Glossary of terms

Term	Definition	Source
Child protection 'system'	Child protection 'systems' comprise certain structures, functions and capacities that have been assembled to prevent and respond to violence, abuse, neglect and exploitation of children	UNICEF, UNHCR, Save the Children, and World Vision (2013)
Social Protection	Social protection is the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation. Social protection is essential to … the realization of the rights of children, women and families to an adequate standard of living and essential services.	UNICEF (2012)
Typology	The study of classes with common characteristics; classification, esp. of human products, behaviour, characteristics, etc., according to type; the comparative analysis of structural or other characteristics; a classification or analysis of this kind.	Oxford English Dictionary
Child Protection Orientation	The basic implicit or explicit underpinning philosophy which guides policy and practice within a child protection 'system' or a group of similar child protection 'systems'	
Child Protection 'System' Dimensions	Attributes or characteristics of child protection 'systems' that are used to group and classify child protection 'systems'.	

Source: Connolly, Katz and Shlonsky, 2014.

Annex B: The Orientation of Child Protection 'Systems'

	Child Protection	Family Service	Child Focus	Community Care
Main driver for intervention	Parents being neglectful and abusive towards children (maltreatment)	The family unit needs assistance	The individual child's needs in a present and future perspective;	Reaction of aboriginal populations to the negative impacts of discriminatory and culturally inappropriate child welfare policies
Relationship of child protection and family support services	Child protection services separate from family support services	Child protection services embedded in broader family support programmes	Child protection services located in broader welfare services for all children-in-need	Child protection services embedded in broader family and community preservation services.
Role of the state	Sanctioning: the state functions as "watchdog" to ensure child's safety	Parental support: the state seeks to strengthen family relations	Duty bearer - the state has obligations to promote and protect children's rights to protection	Partnership with aboriginal communities that are afforded a degree of self-determination in child welfare matters within a defined mandate.
Problem frame	Individual/moralistic	Social/psychological and systemic e.g. poverty, racism, etc	Violations of child rights to protection and unequal outcomes for children	Relationship between the dominant child welfare system and minorities cultural system
Mode of intervention	Legalistic/investigative with a focus on families identified as high risk or requiring immediate intervention	Therapeutic/needs assessment looking for a voluntary, collaborative solution	Best interests determination and early intervention	Consultation with parents, extended family and local community in accord with aboriginal values and culture.
Aim of intervention	Protection/harm reduction	Prevention/social bonding	Harm reduction and overall child well-being	Harm reduction while retaining children within their families and aboriginal society
State-parent relationship	Right to family privacy but adversarial/coercive if action required	Partnership with, and offer of help to, families	State supports parental responsibility but has a independent relationship with the child	State respects traditional values on parenting

Source: Connolly, Katz and Shlonsky, 2014.

Annex C: Dimensions and Descriptions of the Provisional Typology (Connolly, Katz and Shlonsky)

	Dimensions			
Description	Authoritarian Individualism	Permissive Individualism	Authoritarian Collectivism	Permissive Collectivism
"Ideal" type (balance between dimensions)	Regulated Independence	Supportive Independence	Regulated Cooperation	Supportive Cooperation
Primary focus	Protecting Individual children at risk	Supporting Vulnerable children and families	Protecting and regulating communities or populations at risk	Supporting vulnerable communities and populations
Dominant intervention modes	Investigation, Assessment, removal	Support, restorative justice, dialogue	Regulation/ inspection, law enforcement	Community development; public health approaches (primary and secondary prevention at the population level)
Main focus of prevention	Targeting high risk children	Targeting vulnerable families	Legal and institutional reform	Media campaigns/culture change
View of children	Victims	Vulnerable	Community members	Participants
Role of the state	State or state sanctioned organisations act to protect children	State acts to mediate or support change	State regulates communities and organisations	Role of the state downplayed – communities are the major protective bodies.
Balance of rights	Children's right to protection prioritised	Balance of child and parental rights	Communal rights prioritised over individual rights	Communal rights prioritised over individual rights

Source: Connolly, Katz and Shlonsky, 2014.

Annex D: Summary of Issues Across Jurisdictions (Katz et al).

Issue	Driver
Rising costs	Multiple drivers, including expanding scope of child protection (recognition of impact of emotional abuse, neglect, domestic violence); rising numbers in out-of-home care; increased length of time in out-of-home care; mandatory reporting or culture of reporting.
Reduce children in out-of-home care	Pressure due to funding restraints and evidence that outcomes can be poor. Increasing emphasis on permanence and need to provide supports into young adulthood will increase costs.
Over-representation of indigenous and ethnic minority children	Ongoing issue which has yet to be resolved in any jurisdiction and is becoming worse in some. Where progress has been made for indigenous children it has been insufficient for narrowing disparity with non-indigenous children. Unaccompanied asylum seekers covered by system in some jurisdictions (Norway, England) but not others (Australia).
Shifting emphasis and resources to prevention by providing a differential response	Prevention is less costly and potentially more cost effective than statutory intervention. Early and decisive statutory intervention for those children who have ongoing need for care is prevention. Recognition that increasing resources to tertiary services is expensive and unproductive. However no *differential response* model has emerged as optimal, and there is conflicting empirical evidence to date about whether differential response actually does reduce costs.
Multi-agency response	Recognition that the child protection system itself cannot protect children without health, education, justice, police and non-government organisations. However there are significant barriers including information sharing, resources and agency cultures.
Role of government, non-government organisation and private sector provision	No optimal approach. Trade-offs between cost, quality, accountability. Non-government organisations can provide a more flexible service and are less bound by bureaucracy, but are less accountable than statutory services and there are significant transaction costs in contracting out services.
Focus on outcomes rather than outputs or processes	Particularly significant for out-of-home care where the state has a responsibility, but also for whole system. Realisation that outputs do not equate to impacts. However, outcomes-based monitoring can cause unintended consequences. Challenges in reliably measuring changes in wellbeing are significant.
Workforce issues; reduce administrative burden, better training for front line workers, worker satisfaction and churn	Includes resource, quality and larger systemic issues. High turnover of workers creates significant problems for the system. Flawed practice models and social workers' negative experience in applying them, poor training and low morale have been demonstrated to lead to poor results. There is a clear need to develop adequate and effective training models for a career that involves a significant amount of secondary trauma. In addition professionals are expensive to train and employ. Increased professionalisation of foster carers is also an issue. Bureaucratic burden has been shown to reduce productivity and effectiveness.

Issue	Driver
Big data and predictive analytics	Increasingly sophisticated tools to assess risk. But depends on quality and appropriateness of data captured from frontline workers. It would be useful to extend beyond routine, administrative child data collection to also cover specialised developmental and wellbeing assessment. Accurate assessment is not a substitute for effective intervention. Systems are moving towards direct measurement of outcomes rather than reliance on proxies.
Population impact	All prevalence studies show that the majority of maltreatment is never investigated and the majority of reports are not substantiated. This means that however overwhelmed the system is, there are many children in the population who could be reported but are not. Many systems are therefore looking at ways of reducing the prevalence of abuse through population-wide measures including greater awareness of and early intervention in domestic violence, alcohol and drugs, improved support for vulnerable new parents etc.
Implementation	Effective implementation increases the chances that programmes or reforms will yield intended outcomes, but many barriers to fidelity, including short-term costs and preoccupation with urgent issues.

Katz et al., 2016.

Annex E: Further sources of basic information on international child protection and welfare 'systems'

European Union Agency for Fundamental Rights comparison of 28 EU member states' child protection systems (UNFRA, 2015). This includes summary maps and tables on various aspects of each country's:

1. National legislative and regulatory framework, including child protection policies
2. National authorities responsible for child protection and service providers
3. Human and financial resources, focusing on qualification and training of personnel
4. Identification and reporting procedures for children in need of protection and procedures for placing children in alternative care
5. Accountability and monitoring systems.

Protection Project Model Law, John Hopkins School of Advanced International Studies (Protection Project 2013a). Sets out a draft 'Model Law, developed in consultation with experts globally, with each article based on the Project's identification of 'best practice' examples from international instruments and specific countries' legislation. It cites articles from 130 domestic laws from 68 countries as good examples for child protection legislation including policy, agency arrangements, workforce, licensing and training for service providers, the formal response system, reporting obligations, intervention obligations, orders of removal and supervision, rights to accommodation and alternative care and associated principles, administration and monitoring, and adoption.

This is intended as a guide for countries that are in the process of drafting a child protection law and those that are looking to amend existing laws.

Protection Project Best Practices Guide (Protection Project, 2013b). Provides examples of approaches, programmes and/or legislative provisions from civil organisations, individuals and government agencies

internationally, in the same areas as the Model Law, above, that the Project has assessed to be 'best practice' but without significant additional commentary or explanation as to why these examples were chosen.

The **UK What Works for Children's Social Care Centre** has a dashboard of specific UK interventions it has reviewed, including at-a-glance ratings for overall effectiveness and strength of evidence, as well as detail on how the intervention works, who it is for and where it has been studied. See: https://whatworks-csc.org.uk/evidence-store/

The **UK Department of Education**, the **UK Institute of Public Care** and **Research in Practice,** amongst others, have published numerous studies and case studies of specific areas of models and practice, interventions and/or programmes in the UK. See: https://ipc.brookes.ac.uk/publications.html

Annex F: Sources considered in this review that also provide further details of individual countries' 'care systems'

The Care Review 'Best Place' Evidence Review paper provides details of legislation and policies affecting children and families in Finland, the Netherlands and Sweden, including child welfare policies (Griesbach, Waterton and Baker, 2019).

Katz et al., 2016, provides a detailed discussion of the issues and responses in New Zealand, England, the US, Ontario (Canada), Norway and New South Wales (Australia).

A review for the Australian Government provides detailed discussions of 'care systems' in Manitoba (Canada), Sweden, Belgium and the Gaza Strip (as an example of a community-based model) (Price-Robertson et al., 2014). These focus particularly on where responsibility for legislation, policy and service delivery lies in these different 'systems'.

The HESTIA project includes individual policy case studies for England, Germany and The Netherlands, but no comparative analysis (http://www.projecthestia.com/en/home-2)

Kojan and Lonne, 2012, provide detailed discussion of the context and specific aspects of the Australian and Norwegian 'systems'.

Nett and Spratt, 2012, provides detailed case studies of 'care systems' in Finland, the UK, Sweden, Germany and Australia, along with comment about Switzerland.

Berrick et al., 2015, provide a summary of child protection decision-making in England, Finland, Norway and the US.

Berrick et al., 2017, compares how frontline staff in four national child welfare 'systems' and policy contexts – Finland, Norway, England and the US (specifically, California) – respond to questions about a scenario of possible harm to children.

Gilbert et al, 2011, includes individual chapters on the US (Berrick, 2011), Canada (Swift, 2011), England (Parton and Berridge, 2011), Sweden (Cocozza and Hort, 2011), Finland (Pösö, 2011), Denmark (Hestbæk, 2011), Norway (Skivenes, 2011), Germany (Wolff et al., 2011), Belgium (Desair and Adriaenssens, 2011) and The Netherlands (Knijn and van Nijnatten, 2011). These are separately listed in the bibliography.

Poverty, child abuse and neglect

An exploration of the links between poverty, child abuse and neglect and the care experience in Scotland

Ilona Haslewood

3 December 2019

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Main definitions

Poverty

'When someone's resources, mainly material resources, are well below those required to meet their minimum needs, including participating in society.'

- 'Well below' means 'where the lack of resources is associated with much higher risks of harmful effects on people such as problem debt or deprivation'.
- 'Participating in society' means 'being able to have and do the things that people regard as necessary to be part of contemporary society, ranging from going on a school trip to communicating by phone'.[822]

Deprivation

"Deprived' does not just mean 'poor' or 'low income'. It can also mean people have fewer resources and opportunities, for example in health and education.'[823] The seven domains in the Scottish Index of Multiple Deprivation are: income, employment, education, health, access to services, crime, housing.

Child abuse and neglect

'Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm to the child.'

Some of the ways in which children may be abused:

- 'Physical abuse is the causing of physical harm to a child or young person. ...'

[822] Joseph Rowntree Foundation (2016) UK poverty: causes, costs and solutions, https://www.jrf.org.uk/report/uk-poverty-causes-costs-and-solutions. [accessed 31 August 2019]. Poverty is not the same as income inequality.
[823] Scottish Government (2016) Introducing the Scottish Index of Multiple Deprivation 2016, https://www2.gov.scot/Resource/0050/00504809.pdf [accessed 4 November 2019]

- 'Emotional abuse is persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child's emotional development. …'
- 'Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. …'
- 'Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child's basic emotional needs. Neglect may also result in the child being diagnosed as suffering from "non-organic failure to thrive", where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.'[824]

Care experience

'A child or young person has 'care experience' when the state has or had a formal role in bringing them up. … there are a wide variety of care experiences, including but not limited to living at home (subject to

[824] Scottish Government (2014) National Guidance for Child Protection in Scotland, https://www.gov.scot/publications/national-guidance-child-protection-scotland/ [accessed 8 August 2019]. The Guidance provides examples for the definitions of various forms of child maltreatment. Here only the examples of neglect are quoted given that this category is more broadly defined than the others.

compulsory monitoring by a social worker), kinship care, foster care, residential care or education, and care provided in a secure unit.'[825] The term is not used in legislation or statutory guidance.

[825] Gerstein Pineau, M, Kendall-Taylor, N, L'Hote, E & Busso, D (2018) Seeing and Shifting the Roots of Opinion. Mapping the Gaps between Expert and Public Understandings of Care Experience and the Care Systems in Scotland. FrameWorks Institute, https://www.frameworksinstitute.org/assets/files/scotland/robertson-map-the-gaps-final-2018.pdf [accessed 10 October 2019]

Introduction

The Care Review for Scotland, launched in 2017, 'is a once in a lifetime opportunity to make real and lasting change happen for Scotland's infants, children and young people who experience care'[826].

It is a root and branch review to understand what works, what doesn't and why in all the parts of the 'system' that determines the care journeys of individuals. Crucially, people with care experience are at the heart of the Care Review, steering and undertaking the work and sharing their experience.

This paper is part of the Journey stage of the Care Review, where the detailed work happens on both immediate improvements and the long-term, frequently intertwined and often gnarly issues that surround and impact upon various parts of the 'care system' in Scotland. Looking for answers to the seemingly simple questions of who is being looked after by the state and why, soon leads the enquirer to some of the 'gnarliest' issues, such as whether poverty and disadvantage plays a role in child abuse and neglect and in the likelihood of children ending up in state care. Looking at every root and branch means exploring these issues too, all the more so as the majority of children are deemed to enter care because of neglect and abuse.

The paper has been commissioned as part of a number of evidence reviews and the engagement work with care experienced people. It is an exploration rather than a systematic review of the evidence, focusing on already existing evidence reviews, key pieces of research and recent publications. The evidence review undertaken by Paul Bywaters and his

[826] The Care Review for Scotland (2018) A journey imagined with care, https://www.carereview.scot/wp-content/uploads/2018/11/Care-Review-Report_Web.pdf

colleagues on the links between poverty and child abuse and neglect[827] was a particularly helpful source, together with their research on inequalities in child welfare intervention rates in Scotland[828]. Wherever possible, the evidence is specific to Scotland. Wider evidence (mostly from other parts of the UK and other English-speaking countries) is used in making comparisons and highlighting particularly relevant findings, especially where they fill gaps in knowledge.

Having to investigate several topics and the links between them within a short period of time inevitably results in a broad, rather than a deep, review. All along, wherever possible, it has been a priority to foreground the views and experiences of people whose lives have been touched directly by the 'care system'.

- The first section focuses on poverty, inequality and disadvantage in Scotland, particularly in children, and spells out the different ways in which poverty affects lives and why this matters.
- Section two brings together the reasons why children enter care in Scotland, the places where more children are subject to care and child protection interventions and the ways in which child neglect and abuse are related to poverty and deprivation.
- The third section focuses on the perspectives of those with direct experience of care, child protection and poverty and of professionals working with them. It also discusses the importance of relationships in children's welfare services.
- Section four is an overview of some of the emerging initiatives and solutions in policy and practice. Some of these are universal solutions

[827] Bywaters, P Bunting, L, Davidson, G, Hanratty, J, Mason, W, McCartan, C & Steils, N (2016) The relationship between poverty, child abuse and neglect. Joseph Rowntree Foundation. https://www.jrf.org.uk/report/relationship-between-poverty-child-abuse-and-neglect-evidence-review [accessed 3 September 2019]
[828] Bywaters, P, Brady, G, Bunting, L, Daniel, B *et al* (2017) Identifying and Understanding Inequalities in Child Welfare Intervention Rates: comparative studies in four UK countries. Briefing Paper 4: Scotland. Child Welfare Inequalities Project, Coventry University, https://www.coventry.ac.uk/globalassets/media/global/08-new-research-section/bp_scotland_0617.pdf [accessed 22 August 2019]

to reduce poverty whilst others are targeted at families and children in need of further support.

- The fifth section is a short summary of trans-generational patterns of care.
- The conclusions discuss what is known about the links between poverty, child abuse and neglect and care, where the gaps are and what the implications might be for the future.

1. Poverty, inequality and disadvantage in Scotland

Poverty and inequality in Scotland among adults and children – the figures

Analysis from the Scottish Government[829] suggests that in 2018 *a fifth of Scotland's population* (20 per cent), 1.03m people, lived in relative poverty after housing costs have been taken into account[830]. After a decade of decrease from the late 1990s, it has been climbing back again, including a one per cent rise on the previous year in 2018. It is now three percentage points below the rate it was in the mid-late 1990s.

The comparable poverty rate for the whole of the UK in 2017/18 was somewhat higher, 22 per cent, 14.1m people.[831] The Scotland rate was two percentage points higher than in Northern Ireland but four per cent lower than in Wales. Compared with English regions, it was marginally higher than in the South of England, but lower than in the north of England and the Midlands.

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[829] Scottish Government (2019a) Poverty and inequality in Scotland 2015-2018, https://www.gov.scot/publications/poverty-income-inequality-scotland-2015-18/ and associated tables, https://www2.gov.scot/Topics/Statistics/Browse/Social-Welfare/IncomePoverty/povertytable [accessed 26 August 2019].

[830] There are various ways in which poverty is currently measured, with each measure highlighting a different aspect. It is worth noting that *'relative'* poverty only means that it is a year-on-year measure (thus it's focused more on change in median incomes), compared with *'absolute'* poverty, which compares poverty rates with those in the year 2010/11 (highlighting changes in inflation rates). In both cases, the poverty rate shows the proportion of the population whose income fell below 60 per cent of the median household income. Absolute and relative rates can be produced *before and after housing costs* have been deducted (BHC and AHC), which shows the contribution of housing costs to poverty rates – the BHC rate compared with the 20 per cent figure above is 17 per cent. Persistent poverty means that someone has lived in poverty for three out of the past four years.

[831] Recent analysis shows that a key reason for lower poverty rates after housing costs have been taken into account is generally lower housing costs in Scotland, and the fact that more people in poverty live in social rented, than in more expensive private rented, housing. See Congreve, E (2019) Poverty in Scotland 2019. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/poverty-scotland-2019 [accessed 2 November 2019]

Looking at persistent poverty, the Scotland rate was 11 per cent between 2013 to 2017, compared with 13 per cent in the UK as a whole.[832]

Child poverty rates are higher than levels of overall poverty everywhere in the UK. *Nearly a quarter of children* in Scotland (24 per cent, about 240,000) were in poverty in 2017/18. This is lower than the current UK average of 30 per cent,[833] and considerably lower than what it was at the turn of the century in Scotland.[834] However, as the Social Mobility Commission recently noted, despite the stated ambitions of the Scottish Government, relative child poverty has risen in recent years, partly due to UK-wide benefit changes.[835]

Moreover, both overall poverty rates and child poverty rates are projected to increase further in Scotland and in other parts of the UK. Projections may differ on the detail, but the direction of travel is similar. According to one projection[836] overall rates of relative poverty in the three years 2019-2021 will see a modest increase (under two per cent) in Scotland, one of the lowest in the UK. Relative child poverty rates are expected to increase more, by approximately seven per cent. A significant factor in this is the extent to which families' income relies on earnings or benefits – given the effect of recent UK working-age benefit reforms (such as the still-ongoing benefits freeze), where household incomes draw more on state benefits, poverty will increase more steeply. This is less so the case in Scotland, hence the projected lower increase.

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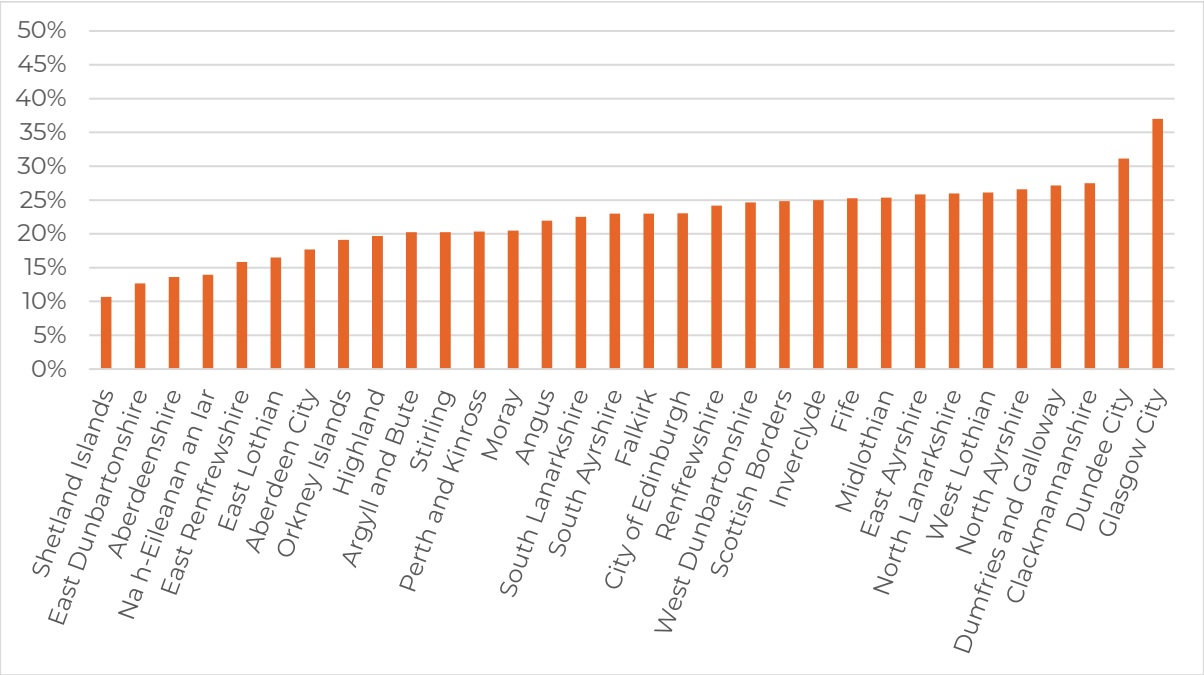
[832] House of Commons Library (2019) Poverty in the UK: statistics, https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN07096#fullreport [accessed 26 August 2019]
[833] Ibid; after housing costs, based on three-year averages 2015/16 – 2017/18; and Scottish Government (2019a)
[834] Congreve, E & McCormick, J (2018) Poverty in Scotland 2018. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/poverty-scotland-2018 [accessed 26 August 2019]. At that time about a third of children were in relative poverty.
[835] Social Mobility Commission (2019) State of the Nation 2018-19: Social Mobility in Great Britain, https://www.gov.uk/government/publications/social-mobility-in-great-britain-state-of-the-nation-2018-to-2019 [accessed 26 August 2019]
[836] Hood A & Waters T (2017) Living standards, poverty and inequality in the UK: 2016–17 to 2021–22. Institute for Fiscal Studies, https://www.ifs.org.uk/publications/10028 [accessed: 29 August 2019]

The distribution of children in poverty in Scotland is uneven. As with the whole population, children in larger urban areas, particularly in Glasgow, have a much greater chance of living in poverty (Figure One).

Figure 1. The proportion of children living in poverty in Scottish local authorities in 2017/18 (based on figures from the End Child Poverty Coalition 2019[837])



The Scottish Government, unlike the UK Government, has targets for child poverty reduction, enacted in the Child Poverty (Scotland) Act 2017, to ten per cent (relative poverty rate) by 2030/31, with an interim target of 18 per cent by 2023/24. Given the projected increase, however, there is a high risk of missing the interim target.[838] This is likely to happen despite the new Scottish Child Payment, the new benefit for low-income families with children (initially with children aged under six) who receive qualifying UK-wide benefits, such as Universal Credit. It is due to begin to be paid sometime in 2020 and is expected to have sizeable and tangible benefits,

[837] End Child Poverty Coalition May 2019 estimates of the level of child poverty in each local authority in Britain http://www.endchildpoverty.org.uk/wp-content/uploads/2019/05/Regional-Estimates-LAD-Scotland-with-summary.xlsx [accessed 29 August 201] Note that Na h-Eileanan Siar is not on the chart as the proportion of children living in poverty was shown as 0 – it is not known whether this was for reasons of data reliability.

[838] Congreve, E (2019) Poverty in Scotland 2019

reaching about 400,000 children in total and lifting 30,000 children out of poverty once it is fully rolled out by the end of 2022. It has been estimated, however, that although doubling the payment would double its impact, it would only bring child poverty levels down to 2017/18 levels, not to the interim target.[839]

From the many intersections between low income and other life circumstances, work, disability, gender and housing are highlighted below because these mean that children in families among such circumstances are more likely to grow up in poverty (severe and multiple disadvantages will be discussed separately).

Similar to other parts of the UK, in Scotland the majority (60 per cent) of working age adults in poverty live in households where someone is in paid work, either full-time or part-time. Among children in poverty, the proportion of those who live in working households is even greater, nearly two-thirds (65 per cent).[840] This trend has been on the increase continuously since 2011-14, following the rise of a labour market with low pay, limited working hours and insecure work, coupled with rising prices, and a decrease in the value of in-work benefits.

Poverty is higher in families in Scotland where someone is disabled: 24 per cent, or 440,000 people, compared with those with no disability (17 per cent, or 600,000 people).[841] As JRF analysis also points out, over 40 per cent of children in poverty (about 90,000) live in families where someone is disabled. The extra costs of disability, not all of which is covered by social security support, can mean the difference between families experiencing poverty or not.[842] However, it is not known how many children with

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[839] Congreve, E, Hay, D, McCormick, J, Gunson, R & Statham, R (2019) Briefing: making the most of the Scottish Child Payment. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/making-most-scottish-child-payment [accessed 2 November 2019]

[840] Scottish Government (2019a), Poverty in Scotland 2018

[841] Ibid. The proportion of people living in a household with disability is higher still (30 per cent, approximately 550,000 people) if certain disability-related benefits (DLA, PiP, AA) are excluded from incomes.

[842] Congreve & McCormick (2018) Poverty in Scotland 2018

disability live in households in poverty in Scotland; in the UK there are more than 300,000 such children.[843]

Nearly 40 per cent of single mothers lived in poverty in 2015-18, roughly ten per cent more than single women without children. A considerable proportion of single mothers in poverty are not in paid work – the proportion of children in these families in poverty has increased over the past few years (since 2011/12). It is also notable that the proportion (and number) of children in poverty in single working families has also increased during the same time, to the point where the gap between children growing up in working and not working single-mother families in poverty is at its narrowest.[844]

At UK level, women are more likely to live in poverty and rely on means-tested benefits and on the social security system than men. According to one calculation, the cumulative impact of changes to the tax and benefits system between 2010/11 and 2020/21 is largest for women in the bottom third of the income distribution, and particularly black and Asian women. Lone mothers are hardest hit among all these groups.[845]

In Scotland, as elsewhere in the UK, rates of poverty are highest in the social rented sector: 40 per cent of those living in socially rented housing live in poverty (the same figure is also high, 34 per cent, for those who rent privately). Social renters are also more likely to be in persistent poverty than those living in other housing tenures. This is despite the fact that Scotland has proportionally the largest social housing stock and lowest

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[843] Tinson, A, Aldridge, H, Born, T B & Hughes, C (2016) Disability and poverty. New Policy Institute, https://www.npi.org.uk/files/3414/7087/2429/Disability_and_poverty_MAIN_REPORT_FINAL.pdf [accessed 3 September 2019]

[844] Scottish Government (2019a) Poverty and inequality in Scotland 2015-2018 and Congreve & McCormick (2018) Poverty in Scotland 2018. The gap between single women and men without children was much lower, two percentage points.

[845] Women's Budget Group (2016) New research shows poverty, ethnicity & gender magnify the impact of austerity on BME women, https://wbg.org.uk/media/new-research-shows-poverty-ethnicity-gender-magnify-impact-austerity-bme-women/ [accessed 2 September 2019]

social rents compared with other parts of the UK, and despite the Scottish Government making efforts to mitigate the impact of UK policies such as the benefits cap and the 'bedroom tax'.[846]

The Scottish Index of Multiple Deprivation (SIMD) is a ranking of small neighbourhood areas (data zones) by income and access to other resources and opportunities (such as employment, education, housing, health as well as crime). It focuses on *areas*, not individuals – which matters, because not everyone in poverty lives in a deprived area and not everyone who lives in a deprived area is in poverty. It is perhaps worth noting here too that the areas that show income deprivation also show health deprivation.[847]

The existence of a social gradient in health is supported by other analysis of health inequalities based on the SIMD.[848] For example:

- healthy life expectancy[849] at birth for women in the ten per cent most deprived areas in 2015/16 was 49.9 years, whereas in the ten per cent least deprived areas it was 72 years, a 22-year gap. For men the gap was even larger, 26 years (43.9 years vs 69.8 years)
- people in the most deprived areas were three point seven times more likely to die before age 75 than in the least deprived areas
- the first admission rate to hospital for a heart attack under age 75 was two point six times higher
- cancer mortality rates (between the ages of 45-74) were two point four times higher

[846] Scottish Government (2019b) Rent affordability in the affordable housing sector. A literature review, https://www.gov.scot/publications/rent-affordability-affordable-housing-sector-literature-review/ [accessed 26 August 2019]
[847] Scottish Government (2016) Introducing the Scottish Index of Multiple Deprivation 2016
[848] Scottish Government (2017) Long-term Monitoring of Health Inequalities https://www.gov.scot/publications/long-term-monitoring-health-inequalities-december-2017/pages/1/ [accessed 31 August 2019]. The social gradient means that the lower a person's socio-economic status is, the worse their (health) outcomes are likely to be.
[849] This is the number of years a person can expect to live in good health.

- strikingly, the rate of first hospital admissions for alcohol-related conditions was six times higher (even though the gap between the ten per cent most and least deprived areas had reduced by a quarter since the mid-1990s).

Income inequality has been rising in Scotland in the past few years. The 'Palma ratio', comparing the total income of the top ten per cent of the population with that of the bottom 40 per cent, shows that the former had 27 per cent more than the latter in 2015-2018, an increase of seven per cent compared with 2012-15. Another measure, the 'Gini coefficient' also shows some increase since then (from 31 to 33).[850]

Severe and multiple disadvantage (SMD) and poverty

Although less than a fifth of people in poverty in Scotland live with severe or multiple disadvantage (approximately 191,000 people live with at least one of the three core SMDs: homelessness, substance abuse or offending), the recent Hard Edges Scotland report has found a *very strong association* between poverty and simple, as well as multiple, forms of disadvantage. The more concentrated the SMDs, the stronger the link[851]:

- The rate of poverty among those with a current substance misuse problem is nearly double to that in the general population, and triple among those who are homeless.
- For people with specific combinations of SMDs (offending and homelessness or offending and substance misuse), the rate goes above 70 per cent.

[850] Scottish Government (2019a) Poverty and inequality in Scotland 2015-2018. The Gini coefficient shows relative income distribution where 0 = everyone has the same income (total equality) and 1 = one person has all of it (total inequality).
[851] Bramley, G, Fitzpatrick, S, Wood, J, Sosenko, F *et al* (2019) Hard Edges Scotland. Heriot-Watt University, I-SPHERE, Lankelly Chase & The Robertson Trust, https://lankellychase.org.uk/wp-content/uploads/2019/06/Hard-Edges-Scotland-full-report-June-2019.pdf [accessed 23 August 2019]

- Among people with three or more disadvantages, financial stress and debt levels are also very high (79 per cent, compared with 22 per cent in the wider population).

One of the additional dimensions of SMD, mental ill-health, is currently experienced by just over 200,000 people in Scotland, and over 400,000 have experienced it either currently or in the past. Having ever experienced a mental health problem, even without other disadvantages, increases the likelihood of poverty, to about 50 per cent. On the other hand, the experience of domestic violence and abuse (at any point in someone's life) has a weaker connection with low income: the risk is a few percentage points higher than for the general population.

There is also a clear connection between living in a deprived area (the most deprived ten-15 per cent of the Scottish Index of Multiple Deprivation) and a person experiencing severe or multiple disadvantage. If someone has ever experienced one such disadvantage, their likelihood of living in a deprived area doubles, and with three or more it increases about fourfold (to around 40 per cent).

The nature of the associations between poverty and some forms of SMD is clearly a key question, if difficult to evidence. The Hard Edges analysis concludes that causality is likely to run in *both directions*. Poverty itself may increase the risk of SMD (e.g. homelessness, or mental ill-health through stress) and various forms of SMD, e.g. substance misuse, incarceration, a criminal record or mental ill-health are likely to increase the risk of entering and remaining in poverty, either directly, or through mediators such as relationship breakdown.

As for living in deprived areas with severe or multiple disadvantage, there is likely to be both an 'area effect', a higher risk of young people starting to use drugs or commit offences through local associates, but also a 'selection effect', whereby people who experience SMD and low income

are more likely to end up in areas of high deprivation through housing allocation processes.

In addition, the Hard Edges Scotland report notes that there is emerging qualitative and quantitative evidence that people with experience of SMD had difficult early lives and childhood trauma. Most people interviewed by the authors had difficult early lives, including physical and/or sexual abuse, disrupted schooling, and some of them had also experienced local authority care.

The presence of violence and the psychological role it plays in the lives of people with SMD is a key observation from the qualitative part of this work; namely the ever-present threat of violence, which means living constantly in 'survival mode' and bearing its impacts, such as substance dependence and mental ill-health.

Why does all this matter?

Poverty does not simply equal to low income, it has a large impact in many ways on the people who live in it - a fifth of the total Scottish population, including a quarter of Scottish children.

Poverty is costly for all of us

Financial costings cannot tell the full story of the damage poverty causes, but they can perhaps give an indication of the enormity of such additional costs to society. The *additional* public spending due to poverty is estimated to be £69bn per annum, about 20 per cent of the total spending of relevant service areas. Identifiable long-term *knock-on effects* of earlier poverty add another £9bn per annum, for example in lost tax revenues and various payments such as Employment Support Allowance and Pension Credit.[852]

[852] Bramley, G, Hirsch, D, Littlewood, M & Watkins, D (2016) Counting the cost of UK poverty. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/counting-cost-uk-poverty [accessed 3 November 2019]

The largest additional cost is within the health service (for example due to more common early onset of various conditions among working-age people on a low income), this represents about 40 per cent of the £69bn UK-wide[853]. Scotland data is available on health spending from the study: the total cost of poverty-related health services was estimated to be about £2.66bn in Scotland in 2014/15, about 25 per cent of total health spending that year.

About £10bn of the additional costs fall to schools, spent for example on efforts to close the attainment gap between children from low and higher income backgrounds. Other service areas counted here include police and criminal justice, adult social care, housing and children's services (plus a few other, smaller areas).

As regards children's services, about £7.5bn is spent UK-wide annually on additional services due to poverty: about 40 per cent of early years services and 60 per cent of family services (including children's social care) that are attributed to poverty. No specific Scotland figure was available on this from the study.

Not being able to afford the essentials

A low income can also mean having to make hard decisions and going without the essentials. Everyday examples of 'going without' from research on living on a low income[854] included mothers who would eat cereal for dinner until an unexpected bill was paid off, or rely on wearing 'hand-me-downs' from friends to save money. A father was talking about having to 'swallow his pride' and borrow money for essentials from family.

Other households, who usually get by, can still find themselves in a precarious position if a sudden expenditure (such as a major household

[853] Ibid. p 17.
[854] Padley, M, Valadez, L M & Hirsch, D (2017) Households Below a Minimum Income Standard: 2008/09-2015/16. Joseph Rowntree Foundation. https://www.jrf.org.uk/report/households-below-minimum-income-standard-200809-201516 [accessed 30 August 2019]

gadget breaking down), or an unexpected reduction in income occurs (for example through illness or redundancy). Families with children also spoke about the effort that had to go into finding free activities to fill out summer holidays, or only being able to afford activities and clubs for the children if grandparents paid for them.

Living on a low income affects families directly in other ways too, for example having to live with uncertainty doing low-paid, insecure work; having to make trade-offs between spending time with the family or taking on more hours of work for extra income; but also, having to rely on informal networks of family and friends to get by.

A qualitative study[855] found a number of factors that influenced a family's ability to get by on a low income:

- family instability – in case of family separation, help (or the absence of it) from a non-resident parent made a lot of difference. Reconstituted families, i.e. families formed by parents with children from previous relationships, also faced extra financial pressures and overcrowding due to the increased size of the family.
- health issues for parents or children, which affected the ability to work and the choice of work, and/or meant increased costs for the family. (As discussed previously, in a high proportion of households in poverty one person has a disability.)
- the availability (or lack of) family help and informal support – to help with childcare and in other ways, as discussed above.
- the debt situation of the family – unaffordable credit may lead to a cycle of debt, and a bad credit history could also mean higher borrowing rates.

[855] Hill, K, Davis, A, Hirsch, D & Marshall, L (2016) Falling short: the experiences of families below the Minimum Income Standard. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/falling-short-experiences-families-below-minimum-income-standard [accessed 31 August 2019]

It was clear from families' experience that managing on a low budget involved a lot of time and organisation and it could introduce much tension into relationships. It was also clear that families prioritised their children. Alongside the basics of life, ensuring that children 'fitted in' (and didn't feel different or bullied) was one of the spending priorities; this applied especially to clothing, even though families often could not afford everything their children would have liked. It was also important to have the occasional treat, particularly for the children, but sometimes also for the parents, such as a pizza or a beer, which was seen as some relief from the stresses of daily life.

Living on a low income and in disadvantaged neighbourhoods is stressful

In addition to stress, as discussed earlier, there is evidence of a much increased risk of poverty associated with an episode of mental ill-health.[856] But is it poverty that causes mental ill-health or the other way round? There is evidence to suggest that the relationship runs both ways, at least as far as poverty, stress, low level anxiety and depression are concerned.[857,858] However, the linkage happens via a large number of mediating and moderating factors that can increase or decrease risks for the individual (Figure Two). Cumulative exposure to disadvantage and risk factors increases the risk of anxiety and depression, and cumulative exposure to protective factors points to better wellbeing.

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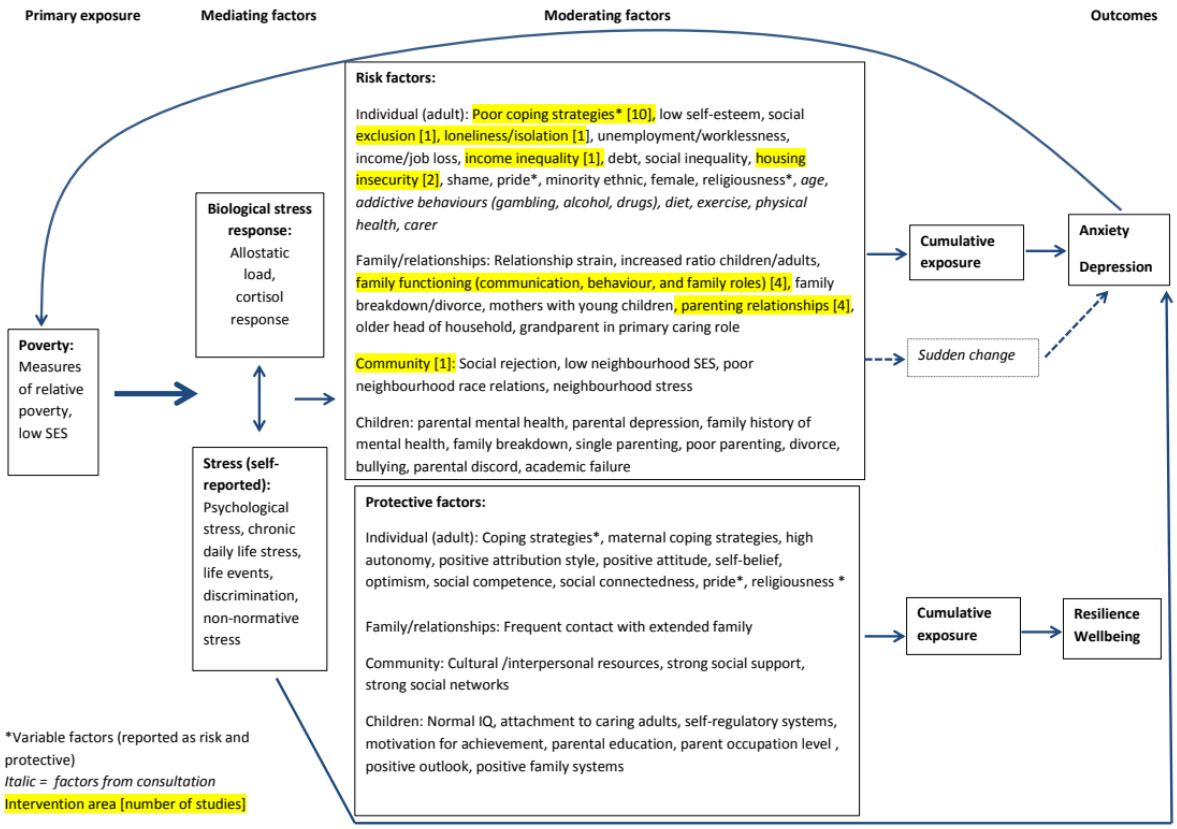
[856] Bramley *et al* (2019) Hard Edges Scotland

[857] Blank, L, Baxter, S, Buckley Woods, H, Fairbrother, H, Bissell, P, Goyder, E & Salway, S (2016) Multidisciplinary systematic review of the relationships between poverty and stress, low level anxiety and depression across the life course. University of Sheffield, https://figshare.shef.ac.uk/articles/Multidisciplinary_systematic_review_of_the_relationships_between_poverty_and_stress_low_level_anxiety_and_depression_across_the_life_course_/4148199/2 [accessed 31 August 2019]

[858] There is also evidence of a higher *prevalence* of schizophrenia among people with a low socio-economic status. See Fell, B & Hewstone, M (2015) Psychological perspectives on poverty. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/psychological-perspectives-poverty [accessed 1 September 2019]

Figure 2. The links between poverty, stress, low level anxiety and depression



(Source: Blank *et al* (2016), Figure Seven)

In Figure Two above, one of the mediating factors between poverty and anxiety/depression is the 'biological stress response'. One form of this is a heightened level of cortisol (stress hormone), consistently found in children from low socio-economic-status[859] backgrounds. There is also evidence that chronic, long-term stressors are more damaging to mental health than isolated episodes of stress. Chronic stress, interspersed with multiple occurrences of acute stress, can quickly deplete a person's ability to deal with any of it.

Social support is found to be helpful in preventing stress from developing into depression, but there are indications that it is less effective in low

[859] Low socio-economic status is broader than poverty, it includes income as well as other attributes such as level of education and occupation.

socio-economic-status neighbourhoods. It is not known exactly why, one possible explanation is that other members of the same neighbourhood are also stressed.[860]

A biological impact of poverty and disadvantage

Poverty has an important role in explaining long-term negative life outcomes, including the social gradient in health discussed earlier. An emerging body of evidence suggests that over time, exposures to the social environment (which can be, for example, external materials such as air pollution, or stressors like financial difficulties or violence) lead to modifications in individuals' biological processes.[861] The process of adaptation to environmental exposures in the nervous, endocrine and immune systems is the allostasis. If the exposures are chronic (e.g. due to environmental stressors), they cause prolonged activation in these systems which then lead to strain on the body (e.g. elevated blood pressure and cortisol (stress hormone) levels) – the impact, or in other words, the price the body pays, is called the 'allostatic load'. There is evidence to show that socioeconomic disadvantage and stressful life conditions are associated with higher allostatic load, which in turn is associated with multiple chronic diseases. Health behaviour, psychosocial responses, education and material deprivation are all pathways through which this process operates.

Interestingly, there is also some evidence to suggest that people who had experienced a disadvantaged childhood and were able to use a 'shift and persist' strategy in adulthood had a lower allostatic load than those from a similar background who were not able to. 'Shift' consisted of 'adjusting oneself to stressors through cognitive reappraisals and emotion regulation' whereas 'persist' was 'enduring life with strength by holding onto hopes for the future'. It was suggested this strategy worked through counteracting the 'inflammatory stimuli' (cigarette smoke, air pollution,

[860] Fell and Hewstone ibid.
[861] Kelly-Irving, M (2019) Allostatic load: how stress in childhood affects life-course health outcomes. The Health Foundation, https://www.health.org.uk/publications/allostatic-load [accessed 1 September 2019]

high-fat diets) present in many low socio-economic-position environments.[862]

Young people's future chances are impacted by poverty across key areas of life

The impacted areas include education, employment, housing and health (as discussed above). According to the Social Mobility Commission, social mobility has increased over the past few years in Scotland (as has in Wales, but not in England), in that the gap between individuals' likelihood of working in a professional or managerial job depending on their background has decreased by five percentage points in the four years to 2018. It is still the case, however, that a person's socio-economic background at birth is likely to determine the type of occupation they will work in.[863]

Attainment gaps between the most and least deprived pupils remain high. By the age of 11-12 there is approximately a 20 per cent gap for reading, writing and numeracy between children living in the most and least deprived areas. Despite an increase in university attendance by young people from disadvantaged backgrounds, there is a 29 per cent gap between the most and least advantaged. Care leavers are one particular group at a greater risk of poor outcomes than others, including homelessness, unemployment, worse mental health, incarceration, sexual exploitation and early death.[864]

Whilst there is substantial evidence of worse social, emotional and behavioural outcomes for children on a persistently low income that last into adulthood, not all children growing up in poverty will have poorer outcomes. For example, quantitative analysis of data from the Growing Up

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[862] Chen, E, Miller, G, Lachman, M, Gruenewald, T & Seeman, T (2012) 'Protective Factors for Adults From Low-Childhood Socioeconomic Circumstances', *Psychosomatic Medicine* vol. 74, pp. 178-86. 10.1097/PSY.0b013e31824206fd, quoted in Kelly-Irving, ibid.
[863] Social Mobility Commission (2019) State of the Nation 2018-019
[864] Waterton, J, Baker, C & Griesbach, D (2019) Edges of care: entering and leaving the 'care system'. The Care Review. Unpublished report.

in Scotland longitudinal birth and cohort study[865] (initiated in 2003), found that the presence of social assets can make a difference. The strength and quality of closeness and support by family and friends (described in the study as social assets) were generally higher for higher-income mothers and these social assets were highly significantly associated with their children's social, emotional and behavioural wellbeing. Nevertheless, it is remarkable that among mothers in the lowest income quintile (but only in this quintile), having high social assets was positively associated with significantly higher social, emotional and behavioural wellbeing in their children. Association is not causation, but as the author argues, both the analytical model and corroborative evidence from elsewhere supports the direction of the relationship from social assets to child wellbeing.

Although the study did not investigate the particular pathways through which this effect worked, other studies[866] suggest that one of these pathways is family and friends helping to decrease financial strain on the low-income family and thus increasing material wellbeing and reducing financial stress; the crucial importance of this help has been discussed before. Another pathway enabling a positive parent-child relationship is through maternal wellbeing and good mental health that good social support helps to create. The third pathway is the extension of the support and closeness of family and friends to the child too.

It is also notable from the study that factors such as parental separation and the mother's ethnicity became insignificant in children's wellbeing once both low income and social assets were in the model of analysis, meaning that those were accounted for by the latter two. Although there is more to explore, the findings are both encouraging and significant, because they show that maternal and child wellbeing is sensitive to

[865] Treanor, M (2016) Social assets, low income and child social and emotional and behavioural wellbeing. Manuscript draft for *Families, Relationships and Societies*, https://researchportal.hw.ac.uk/en/publications/social-assets-low-income-and-child-social-emotional-and-behaviour [accessed 1 November 2019]
[866] Quoted in Treanor's study, ibid.

income, and that close and supportive family and friends can improve child wellbeing on a low income in Scotland, even though with the caveat (as discussed below) that social support can be less effective in low income neighbourhoods.

Living in poverty can affect the decisions people make and the way they see the social world

Everyone, regardless of socio-economic status, can make less than optimal decisions, because humans have limited mental processing capacity (or 'bandwidth') to weigh up every single decision they make in a day[867]. The families in research discussed earlier spent much of their 'bandwidth' on making decisions about family finances; but seemingly small decisions take up mental resources the same way as big ones, and the consequences of making a mistake once the processing capacity is spent can be serious for the family budget. Poverty is a context that places constraints on decision-making also because it alters the psychological, social and cultural factors that influence the decision-making process, and the way people view the world around them.[868] Some issues to note are:

- The scarcity-effect – the scarcity of resources (e.g. money, time, support) induces a psychological state where attention is focused on solving the immediate tasks, at the expense of longer-term or more peripheral tasks. This is not unique to people in poverty, but it is certainly a relevant issue. The 'tunnel vision' that scarcity induces comes with reduced cognitive capacity and at a cost of potentially missing other important things such as following medical prescriptions or buying insurance.

[867] Gandy, K, King, K, Streeter Hurle, P, Bustin, C & Glazebrook, K (2016) Poverty and decision-making: how behavioural science can improve opportunity in the UK. Behavioural Insights Team, https://www.bi.team/wp-content/uploads/2017/02/JRF-poverty-and-decision-making.pdf [accessed 31 August 2019]
[868] Sheehy-Skeffington, J & Rea, J (2017) How poverty affects people's decision-making process. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/how-poverty-affects-peoples-decision-making-processes [accessed 1 September 2019]

- Preference for the 'here and now' - linked with the above, many of the seemingly sub-optimal decisions associated with people from low socio-economic status groups have a 'proximal' focus: on the 'here', 'now', the actual (tangible) and on the people who are socially close. One example might be eating comforting but unhealthy food, even if it has negative health consequences in the longer term, or buying clothes that are expensive for the family budget, as in the example above. These decisions, however, often only seem 'irrational' viewed from an outsider perspective. They serve a purpose (e.g. temporary comfort, social status), even if they may come at a cost later down the line. Relying on those socially close also makes sense in the context of immediate need or pressing threat. However, it also comes with both a greater commitment to one's peer group and greater mistrust towards others outside one's social group (and this may include strangers as well as authorities).
- The role of social norms – patterns of behaviour in our social circle – is important because we model our behaviour on others' and teach these behaviours to others. The relationship between poverty and the role of social norms is not yet fully understood. It seems clear though that, because the context of poverty triggers a focus on the 'here and now', this includes placing a greater importance on doing what people closest to us would like us to do, and modelling our behaving to fit with their norms.
- In the context of meeting material needs and participating in society, bringing the prevailing social norms to the surface can be an illuminating and practically useful exercise. The Minimum Income Standard research does this by bringing together groups of people living in similar household types from across the income spectrum to agree what goods and services are necessary, for example, for pre-school children, to achieve a socially acceptable minimum standard of living. Norms are slow to change, but they do move on in some respects, including on necessary child care arrangements that

enhances early development (nursery, not only child minder), or the necessity for a family with children to own a car, which makes it possible for children to attend out-of-school activities.[869]

- Greater risk-aversion: perhaps contrary to expectations, the evidence suggests that people who grew up in poverty are more risk-averse than those who did not (for example in choosing an occupation, or sexual behaviour). The exception from this is a situation of acute need that can only be satisfied by taking a risk.
- Self-efficacy and response efficacy – these have been consistently positively linked with socio-economic status (higher status - higher efficacy). They determine both the extent to which one feels able to learn new skills and perform the actions required by a task, and the extent to which one feels that their actions matter to how their life turns out. But the evidence suggests that it is the experience of living in a low socio-economic status that leads to re-appraising one's ability to influence life-outcomes downwards, rather than not having aspirations or motivation in the first place.
- Stereotype threat – evidence suggests that people's performance can be worse when they internalise a negative stereotype about their social status (e.g. class or minority status). For example, when questions were asked about their parents' income and occupation before a test, low-income students did worse in the test than similar students who were not asked these questions. Concerns about identity in this case overload cognitive capacity and working memory. This clearly matters for children who feel stigmatised as a result of care experience too.
- Feelings of exclusion – there is some evidence to suggest an association between poverty and a sense of social exclusion. In

[869] See e.g. Davis, A, Hirsch, D, Padley, M & Shepherd, C (2018) A Minimum Income Standard for the UK 2008-2018: continuity and change https://www.jrf.org.uk/report/minimum-income-standard-uk-2018 [accessed 2 September 2019]

children, this can manifest in a lower sense of belonging to their (primary or secondary) school, much of which is mediated by a lower sense of acceptance by peers and higher incidence of bullying and harassment. Later in life, people in a low socio-economic status have been reported to have weaker attachment to their wider community and society at large (including institutions), but a stronger sense of attachment to those in similar circumstances.

- Parenting styles and aggression in children - *"children from poorer socioeconomic backgrounds report a lower sense of belonging at school and greater exposure to negative incidents such as bullying or sexual harassment. These findings might explain the robust association between living in poverty and demonstrating more aggressive, and less co-operative, behaviour at primary and secondary school. Parents living in worse economic conditions have harsher parenting styles, a pattern also connected to greater levels of child aggression, which endures later in life. Growing up in poverty is also linked to lower general trust of others, perhaps because of a lower sense of inclusion in society at large."*[870]

What people in poverty say about poverty

A new participatory research study (including participants from Scotland)[871] identifies six key dimensions of poverty, incorporating much of what has been discussed in this section so far. The number of dimensions underline the view that poverty is not just about lack of money, even if it is an important dimension (together with financial insecurity and debt). Disempowering *systems, structures and policies* are just as important, because the very services that are meant to support people in difficulty can be the ones that control and disempower them (the benefits system and social services were highlighted as particular examples). Damaged

[870] Sheehy-Skeffington and Rea, ibid, p. 3.
[871] ATD Fourth World (2019b) Understanding poverty in all its forms. A participatory research study into poverty in the UK. https://atd-uk.org/2019/10/12/understanding-poverty-and-social-rights-through-lived-experience/ [accessed 15 October 2019]

health, shorter lives and lower wellbeing, as well as stigma, blame and judgement are further dimensions, produced by the first two dimensions. They in turn shape the others, including lack of control over choices and unrecognised struggles, skills, and contributions. Research contributors see all these dimensions coming together in a web, entangling those caught in it. They also make a distinction between agency and control, arguing that people living in poverty 'do have agency within their lives, but this does not mean they have control'[872].

Other groups of people with direct experience of poverty[873] confirm and add detail to many of the findings from the literature. Among these are the impossible choices to be made between 'gas and electricity or food or new shoes for kids'; being an 'easy target to wreak austerity havoc on'; and being discriminated against by employers:

> *'I've seen me fill in application forms and I'll put down I live in Govan. But I'm then told "No, you don't put down Govan. Write Glasgow, because if you say Govan, no-one is going to employ you." They are even saying that at the Job Centre.'*[874]

One particular aspect of the stigma reported by people in poverty is not being treated with empathy and respect by public services.[875] In the words of one person with experience of poverty, 'They [services such as banks or Job Centres] don't understand your needs and they don't listen to you. They don't try to understand where you are coming from. They make you lose hope. … It's threat after threat, and stress after stress'.[876] Some

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[872] Ibid, p. 29.
[873] See e.g. the Poverty Truth Commission Scotland (2014) Turning up the volume on poverty https://www.faithincommunityscotland.org/wp-content/uploads/2014/06/REPORT.pdf [accessed 2 September 2019]
[874] Ibid, p. 15.
[875] For example: West Cheshire Poverty Truth Commission 2017/18 (2018) Final Report, https://www.edgehill.ac.uk/i4p/files/2018/07/4392-PTC-final-report.pdf [accessed 2 September 2019]
[876] In a speech entitled 'Let me tell you about social discrimination', marking World Day for Overcoming Poverty in October 2018 ATD Fourth World (2019a) https://atd-uk.org/2019/09/30/let-me-tell-you-about-social-discrimination/ [accessed 7 October 2019]

people with experience of poverty saw the humiliating treatment of individuals as a systems-issue, a consequence of the prevailing policies and practices (including lack of funding for services), while others thought that frontline workers should still treat people in adverse circumstances in a more understanding and humane way.[877]

Naomi Eisenstadt, the Scottish Government Independent Advisor on Poverty and Inequality pointed out that, although universal services are generally thought to be less stigmatising, the stigma that is often associated with targeted services sometimes results from the way service recipients are treated. It doesn't have to be so: she highlights SureStart as a positive example of a targeted service that 'everybody wanted'.[878]

In summary

Poverty matters hugely in Scotland for the families, individuals and children who experience it and for society as a whole. It affects a fifth of the population and disproportionately affects children (particularly in large urban areas), disabled people, women (particularly single mothers), people living in social housing and those experiencing severe and multiple deprivation, including many care leavers. It is expected to rise in the next few years.

It is important to emphasise that poverty is a systemic issue and the solutions are primarily systemic too[879] – 'willpower', resourcefulness or other individual characteristics will not, on their own, make a difference at a mass level. As participatory research[880] points out, the necessity to cope with living in poverty may be interpreted as 'resilience', but it is problematic in the context of hardship.

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[877] ATD Fourth World (2019b) ibid.
[878] Independent Advisor on Poverty and Inequality (2016) Shifting the curve: A report to the First Minister https://www.gov.scot/publications/independent-advisor-poverty-inequality-shifting-curve-report-first-minister/pages/8/ [accessed 2 September 2019]
[879] Joseph Rowntree Foundation (2016) UK poverty: causes, costs and solutions
[880] ATD Fourth World (2019b) ibid.

Poverty brings with it not only low material resources, but also a complex and intricate web of other disadvantages and psychosocial processes that have impacts ranging from the immediate to the distant, on family life, health and wellbeing, education, employment, housing and many other areas of life. About this same web of associated factors similar narratives have been told from many perspectives, including from public health[881] and housing[882].

This also means that when looking at links between poverty and other social problems such as child abuse and neglect, there are many factors that are part of the picture alongside material circumstances. The evidence makes it clear that poverty affects these factors as well (including social connections, decision making processes, feelings of exclusion and stigma), often through the mediation of stress. It is important to appreciate in policy and practice how poverty may affect people, but just as important to avoid pathologising and stigmatising accounts of the effects (a practical example is to avoid situations where stereotype-threat can reduce performance in children and young people).

The high number of variables in the picture also means that individuals and families from similar social contexts will have different risk and protective factors. This explains (admittedly in a general way), why people living on a low income who may share some social circumstances will have different life outcomes. This question comes into particular focus when trying to understand why neglect and abuse occur in some families in poverty, but not in the majority. The complexity of poverty may also help to explain how lower material resources to meet children's needs may get

[881] See e.g. Bibby, J & Lovell, N What makes us healthy? An introduction to the social determinants of health https://www.health.org.uk/publications/what-makes-us-healthy [accessed 1 September 2019].
[882] Scottish Government (2019b) Rent affordability in the affordable housing sector. A literature review https://www.gov.scot/publications/rent-affordability-affordable-housing-sector-literature-review/ [accessed 26 August 2019]. This review found that poor housing conditions may have a negative impact on people's health, well-being and life chances, especially for children, including an increased risk of mental health and behavioural issues and a risk of low educational attainment, unemployment and poverty.

translated into neglect through the filter of interpreting resources and behaviour according to different sets of social standards.

2. Poverty, child neglect and abuse and entering care

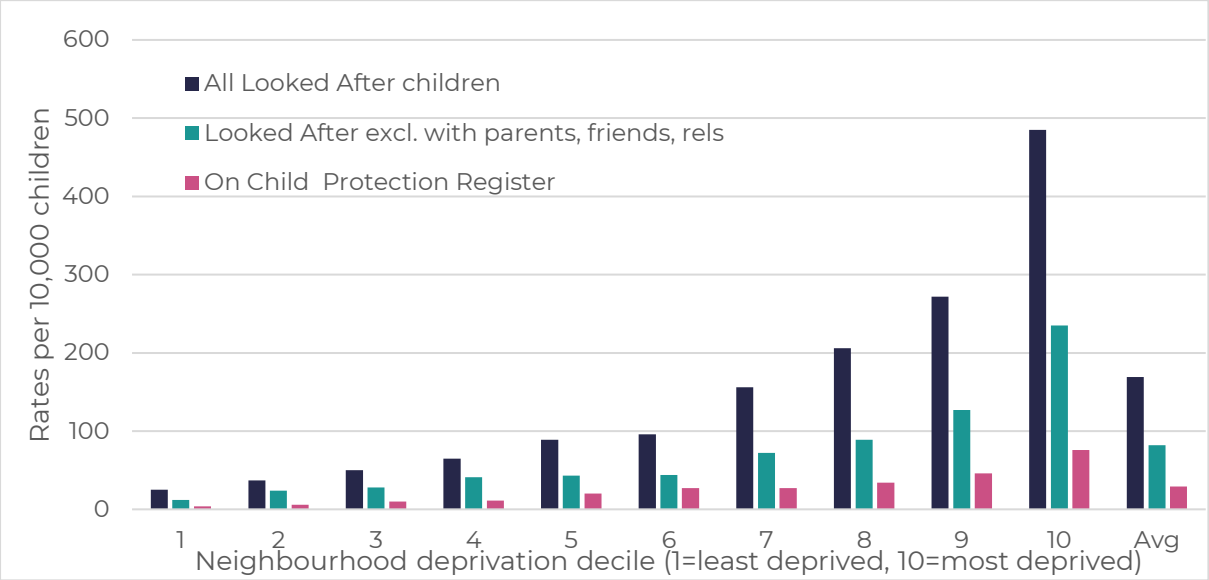
A social gradient in care experience

There is evidence to suggest that children living in deprived areas of Scotland have a far greater likelihood of entering care both away from home, or when living with parents, relatives or friends. This is also true of the likelihood of being on the child protection register (Figure Three).[883] The magnitude of the difference is startling:

> *"In Scotland, children in the most deprived 10% of small neighbourhoods were around 20 times more likely to be looked after or on the child protection register than children in the least deprived 10%. … Deprivation was the largest contributory factor in children's chances of being looked after and the most powerful factor in variations between LAs. This was seen for children of different age groups, boys as well as girls, and children on CPR [Child Protection Register] as well as LAC [Looked After Child]."*[884]

[883] Bywaters *et al* (2017) Identifying and Understanding Inequalities in Child Welfare Intervention Rates
[884] Ibid, p 1.

Figure 3. Looked after and child protection rates per 10,000 children, Scotland 2015 (constructed from data in Bywaters et al 2017[885])



In the absence of systematic data collection on the social and economic circumstances of children and their families who are subject to a child welfare intervention, the evidence has been generated by research in ten Scottish Local authorities, covering just over half of all children in Scotland. The research matched children's postcodes to data zones (small neighbourhood areas) in the Scottish Index of Multiple Deprivation. As discussed before, the data is therefore not specific to children's actual family circumstances, but to the neighbourhood where they live.

The same study found that the '*inverse intervention law*' also applied in Scotland (and elsewhere in the UK). This 'law' is contrary to expectations. It means that although in local authorities with a higher rate of deprivation there were higher rates of intervention overall, when comparing areas with similar levels of deprivation across high and low deprivation local authorities, there were more interventions in low-deprivation local authorities. Thus a child living in a low-deprivation local authority in a similar area to another child in a high-deprivation local authority had a higher chance of a child welfare intervention. This was thought to have a

[885] Ibid.

relationship with the higher level of resources available relative to demand in low-deprivation local authorities. It also means that the social gradient of child welfare interventions could be even greater but for this 'law'.

What is known about the reasons why children become looked after in Scotland?

From the currently available statistics it is not known why all children who are in care in Scotland became looked after. Data on why children are referred to the Children's Reporter suggests that in 2018/19 for a third of children (33 per cent) this was because of lack of parental care. There has been a 25 per cent decrease in recent years: more than 1,400 fewer children were referred on these grounds than in 2016/17[886]. The number of children referred for offending and for close connection with a person who has carried out domestic abuse remained unchanged (each account for about a fifth of referrals). Children who were referred on grounds of lack of parental care and in connection with domestic abuse tended to be young: on average six years old, but they were more often referred in their first year of life than later on.[887]

As the statistical overview for the Care Review notes[888], the grounds for referral to the Reporter is a useful but limited guide, since not all children become looked after via this route. Data from England suggests that the primary reason for nearly two-thirds (63 per cent) of all children looked after in 2018 was abuse or neglect, followed by family dysfunction (fifteen

[886] No analysis was available on the reasons for this particular fall in numbers, but as the CELCIS statistical overview for the Care Review (CELCIS 2018a) pointed out, the number of children referred to the Children's Reporter both for offence and non-offence reasons had been falling dramatically since their 2007 peak. (But this also means that a higher proportion of those who *are* referred are given a legal order and end up in care.)
[887] See Scottish Children's Reporter Administration Statistical analysis 2018/19 and 2016/17 and the Care Review Edges of care review paper for more data and longer trends.
[888] CELCIS (2018a) Statistical overview for the Care Review, updated October 2018. Unpublished report.

per cent) and family in acute stress (eight per cent).[889] In the majority of assessments there is more than one reason identified, which may help explain why low income as the *primary* reason for being looked after was stated in the case of only 110 children, a tiny fraction. Nevertheless, the dominance of abuse and neglect in reasons why children are in care is in line with trends in other European countries[890], and it is reasonable to expect that the same holds true for Scotland.

Only a small proportion (about four per cent) of children who are looked after in Scotland are on the child protection register concurrently. But as the register's primary purpose is to protect children from abuse and neglect, it is useful to see what the concerns were that led to children being registered. Nearly 2,700 children were placed on the register at 31 July 2018, for whom case conferences identified over 6,800 concerns. The most frequent concern was emotional abuse, closely followed by neglect (both for nearly 40 per cent of children), and domestic abuse (37 per cent). A non-engaging family was a concern for more than 600 children (nearly a quarter) - this is more than concerns of physical abuse and considerably more than of sexual abuse.[891]

There is no further statistical information on the specifics of neglect, but as the definition in the statutory guidance is broad and focuses on the outcome for the child (the child's basic physical and/or psychological needs not being met, which is likely to result in the serious impairment of the child's health or development), it could include a range of ways that

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[889] Department for Education (2018) Children looked after in England (including adoption) year ending 31 March 2018, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757922/Children_looked_after_in_England_2018_Text_revised.pdf [accessed 20 June 2019]. Guidance on data submissions advises that if there is a difficulty in choosing the primary code between two or more codes, a hierarchy of choices should be followed, with abuse and neglect on top of the hierarchy. This also means that the other codes are only used if abuse or neglect were not among the reasons. 'Abuse or neglect' is one code, with no further breakdown to distinguish between them.
[890] CELCIS (2018a) ibid.
[891] Scottish Government (2019c) Children's social work statistics, https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/pages/4/ [accessed 3 September 2019]

neglect results from. Also, as the categories of concern in the available child protection statistics are non-exclusive, the neglect may at least be partially the result of another noted concern (e.g. parental substance misuse).

For the sake of a fuller picture, it is worth noting that offences of cruelty and neglect recorded by the police in Scotland had seen a sharp decline between 2009/10 and 2016/17 (the latest available data), from 20.4 to eight point six per 10,000 children (792 offences). This is in line with the decline in referrals to the Children's Reporter. It is, however, not clear what role public reporting and change in police practice play in these figures, so caution should be exercised when drawing conclusions about the real extent of, and trends in, cruelty and neglect.[892] As the true extent of child abuse and neglect is mostly hidden, it is not known how many children are maltreated in Scotland. According to an NSPCC estimate, for every child subject to a child protection plan or register, another eight have suffered maltreatment.[893]

The link between poverty and child abuse and neglect

The most comprehensive recent UK evidence review on the relationship between poverty and child abuse and neglect[894] highlights the lack of even basic official data in all UK administrations. For example, there is no knowing what proportion of children in poverty have been abused or neglected, or have been placed on the child protection register at some point. Linking of different existing administrative databases is also under-used. More broadly, the review notes, 'the policy and research worlds of poverty and CAN [child abuse and neglect], while sometimes nodding in

[892] NSPCC (2018) How safe are our children? https://thecpsu.org.uk/resource-library/research/how-safe-are-our-children-2018/ [accessed 9 August 2019].
[893] NSPCC (2015) Spotlight on preventing child neglect. An overview of learning from NSPCC services and research. https://learning.nspcc.org.uk/media/1069/spotlight-preventing-child-neglect-report.pdf [accessed 11 October 2019]
[894] Bywaters *et al* (2016) The relationship between poverty, child abuse and neglect

each other's direction, engage directly with one another surprisingly rarely in the UK.'[895]

As to why this is, the reviewers conclude that there is a *cultural gap* 'embedded in all dimensions of current policy, practice, education and research'[896], which exists for various and varied reasons, including a lack of acknowledgement by some that poverty plays a role in a child's chance of experiencing abuse and neglect. Others are concerned that if a link is made, it would further stigmatise families, yet others feel that children experiencing neglect and abuse cannot wait until a long-term issue like poverty is solved. Further concerns point to the limited power that practitioners have to resolve families' socio-economic problems. Finally, even when a connection is acknowledged, it can be seen as a deep but distant background issue, rather than something that families live with every day. (Some of these arguments will be discussed in more detail later.)

What is known from research (self-report studies, cohort studies and specific pieces of research), mostly from abroad, led the review authors to conclude that there is *a strong association* between families' socio-economic circumstances and children's likelihood of suffering abuse and neglect.

For example, one of the few UK studies, a relatively recent large longitudinal study from Avon, England, followed up a cohort of approximately 14,000 children born in 1991-92. It found that the strongest risk factors for both an investigation and being placed on the child protection register were proxy measures for poverty, such as paternal unemployment, (lack of) car ownership, overcrowding, and (lack of) home ownership. "Parental background factors – being young, poorly educated and from a background in poverty – increased the chances of children

[895] Ibid, p. 10. This point also seems to be borne out in the 2018 NSPCC overview of child protection (ibid). One sentence refers to a piece of research that found social and economic factors influencing the risk of child suicide.
[896] Ibid, p. 48.

being vulnerable to CAN, while stronger social support for mothers reduced the risk."[897]

In Scotland, a study undertaken in 22 localities of Glasgow looked at referrals and registered cases of abuse between 1991-93, using area or neighbourhood-level deprivation measures such as unemployment rates, free school meals and clothing grants. It found strong correlations between neighbourhood deprivation, male unemployment and registered child physical abuse, but a less strong one with sexual abuse or neglect. However, this study also highlights the huge change in patterns of registered abuse since the study was undertaken (physical and sexual abuse decreasing, neglect increasing, emotional abuse included as a category).[898]

Whereas *poverty is found to be 'neither a necessary nor a sufficient factor'* in child abuse and neglect (given that this happens in only a small minority of families living in poverty, and not all children who suffered abuse and neglect are from disadvantaged backgrounds), it is suggested that poverty is a '*contributory causal factor'*. This is based on emerging experimental evidence on the efficacy of financial assistance to families on reducing child abuse and neglect (this will be discussed in more detail further on).[899]

Not only that, but there is a *social gradient* to socio-economic circumstances and child abuse and neglect, similar to other outcomes such as health and education (as discussed earlier in the paper). The authors of the review argue that the wide ranging evidence spanning over time, countries, demographic groups, definitions and research methods

[897] Sidebotham, P, Heron, J & Golding, J (2003) 'Child maltreatment in the "Children of the Nineties:" deprivation, class, and social networks in a UK sample'. *Child Abuse & Neglect*, vol. 26 no. twelve, pp. 1243–59, quoted in Bywaters et al (2016) ibid, p. 22.

[898] Gillham, B, Tanner, G, Cheyne, B, Freeman, I, Rooney, M & Lambie, A (1998) 'Unemployment rates, single parent density and indices of child poverty: their relationship to different categories of child abuse and neglect'. *Child Abuse & Neglect*, vol. 22 no. 2, pp. 79–90, quoted in Bywaters *et al* (2016) ibid.

[899] Bywaters *et al* (2016), ibid.

make the case for the existence of such a gradient more, rather than less, convincing.

A few other important points from this study[900]:

- differences according to certain characteristics, such as disability: the review quotes international literature demonstrating much higher rates of maltreatment of disabled than non-disabled children, and authors arguing that abuse of disabled children remain under the radar in the UK and should be understood better. Better understanding is also needed with regard to Black and Asian children, who appear to be on the child protection register in lower proportions, once neighbourhood deprivation has been controlled for.
- There is not enough robust evidence to suggest if any specific form of abuse is more or less closely linked with family poverty.
- Additional sudden or negative effects with financial consequences can increase the risk of investigations for child abuse and neglect – such as moving house, the arrival of a new child, a child's exclusion from school, unexpected expenses, non-arrival of welfare payments or sanctions (this is based on qualitative evidence from the US).
- On the question of bias, namely whether the differential rates of child abuse and neglect are due to socio-economic circumstances, or to various forms of bias in the child welfare system, the evidence seems to point to substantive differences according to socio-economic background. Forms of such bias can be differences in service allocation, greater visibility of families in poverty, and biased views on their capability to look after their children, or class bias. Changes in policy and practice, such as changing rates of referrals and registrations (see the example from Glasgow above), and the 'inverse law of interventions' certainly suggest that there are 'system

[900] Ibid.

effects', in which bias may well play a part, but this in itself does not explain all the differential rates of abuse and neglect according to socio-economic background.

- Inequality, not only poverty, was independently linked with child abuse and neglect – the evidence for this comes mainly from international comparisons, suggesting that more equal countries such as Sweden, or more equal counties within the US, see lower rates of child abuse and neglect. Although more evidence is needed, it is of some concern that, as discussed earlier, inequality has grown somewhat in Scotland in the past few years. As to why inequality (and not only poverty) also matters, a clue might be in some of the literature discussed earlier on psychological, social and cultural factors that points to feelings of exclusion being a stressor.
- Poverty is often closely inter-linked with other factors of disadvantage and deprivation which can be difficult to disentangle from one another. A related issue is the difficulty of distinguishing the *direct* effects of neighbourhood deprivation and material hardship from the *indirect* effects of family stress on child abuse and neglect. As a result, poverty can unhelpfully recede into the background in policy and practice considerations and not viewed as a risk factor of its own right, or the link between poverty and other issues can be lost altogether.

In a different paper, the last point was developed further and described as two different but interactive perspectives that explain variations in demand (for services) between families; these perspectives are also well known from sociological discourses on poverty[901]. One perspective emphasises *structural* pressures on parents' ability to look after children well, either directly linked to poverty (e.g. low income, low parental educational level, unemployment, low quality or insecure housing,

[901] See e.g. Shildrick, T & Rucell, J (2015) Sociological perspectives on poverty. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/sociological-perspectives-poverty [accessed 4 September 2019]

parental and child health and disability) or mediated through stress, that then affects parents' ability to function (e.g. through poor mental health, domestic violence or substance misuse). The picture also includes the personal and emotional impact of poverty. In contrast, those emphasising the *individual*, behavioural, aspects of parenting tend to detach the socio-economic context of the family from parenting styles. Even if they acknowledge that the context is in the background, it not seen as something that can drive practice.[902]

A fresh (2019) systematic review of the evidence originating from a diverse variety of countries (including the US, Australia, Brazil, the Netherlands, Switzerland, Israel and England) further confirms the conclusion of the Bywaters *et al* (2016) study on the existence of a clear relationship between a child's socio-economic position and their risk of both maltreatment and adverse childhood experiences (ACEs). The study also echoes concerns about the decontextualised manner in which ACEs and maltreatment are discussed, despite ACEs being a policy focus now in many countries.[903]

Another new study looking at ACEs and socio-economic background specifically in Scotland[904] (drawing on the Growing Up in Scotland cohort study) found that children in the lowest income quintile had odds of about eight times higher of having one or more ACEs by the age of eight than the most affluent children (only eight per cent of children in the lowest quintile had no ACEs, compared with nearly 53 per cent of those in the highest quintile). The most frequent ACEs were parental mental ill-health and parental separation (each concerning about a third of children), but

[902] Bywaters, P, Brady, G, Sparks, T, Bos, E *et al* (2015) Exploring inequalities in child welfare and child protection services: Explaining the inverse intervention law. *Children and Youth Services Review* vol. 57, pp. 98-105, https://doi.org/10.1016/j.childyouth.2015.07.017
[903] Walsh, D, McCartney, G, Smith, M & Armour, G (2019) 'Relationship between childhood economic position and adverse childhood experiences (ACEs): a systematic review'. *Journal of Epidemiology and Community Health* [Epub ahead of print 14 November 2019] doi:10.1136/jech- 2019-212738
[904] Marryat, L & Frank, J (2019) 'Factors associated with adverse childhood experiences in Scottish children: a prospective cohort study'. *BMJ Paediatrics Open* 2019;3:e000340. doi: 10.1136/bmjpo-2018-000340

about a fifth of children had been subjected to corporal punishment (used as proxy for physical abuse) and the same proportion had not been loved and supported (proxy for emotional neglect).[905]

Recent analysis of a large-scale survey of children's health in the US[906] further supports the idea that *parenting stress* has a mediating role in adverse childhood experiences (ACEs) for children, including poverty. In particular, strong associations were found first and foremost between parenting stress and the child experiencing economic hardship[907], also with parental separation or divorce, followed by mental illness in the household and household substance abuse. The study also noted significantly higher levels of parenting stress according to certain household characteristics: where the child had special needs, or if they lived with a non-parent carer or with a single mother/other carer, and where the household income was below the poverty line. An earlier analysis of (US) cohort studies[908] also found that parenting stress and wellbeing played a substantial part in mediating the association between economic hardship and children's wellbeing – and used the explanatory theory of 'linked lives' of parents and children.

Looking specifically at the *neglect of adolescents*, a survey covering England[909] found that materially deprived young people were two or three times more likely to be neglected than their non-deprived counterparts.

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[905] The cohort of children in the study were born in 2004/05, the analysed data covers their first eight years of life. The analysis of ACEs could not derive information about emotional abuse and physical neglect from the cohort study.
[906] Crouch, E, Radcliff, E, Brown, M & Peiyin, H (2019) 'Exploring the association between parenting stress and a child's exposure to adverse childhood experiences (ACEs)'. *Children and Youth Services Review,* vol. 102, pp. 186-192, https://doi.org/10.1016/j.childyouth.2019.05.019
[907] The survey question was: 'since this child was born, how often has it been very hard to get by on your family's income – hard to cover the basics like food or housing?' Ibid.
[908] Yuan, A S V (2008) 'Exploring the changes in economic hardship and children's lives over time: The "linked lives" of parents and children', Advances in Life Course Research, vol. 13. pp. 321-341 https://doi.org/10.1016/S1040-2608(08)00012-9
[909] Raws, P (2016) Troubled Teens: a study of the links between parenting and adolescent neglect. The Children's Society, https://www.childrenssociety.org.uk/sites/default/files/troubled-teens-full-report-final.pdf [accessed 8 October 2019]

This applied to all four domains of neglect that the study examined (educational support, emotional support, physical care and supervision), but levels of neglect were greatest in the area of emotional support and supervision (18 and 16 per cent, respectively).[910] It is worth pointing out that material deprivation here was specific to the young person, not the family, and it was measured on possession of certain items (including pocket money each week, a personal music player, a pair of designer or branded trainers) and access to certain facilities and experiences (e.g. a family car, family trips once a month). Interestingly, and in contrast, no association was found between proxy measures of the family's economic situation (such as whether the young person had their own bedroom) and domains of neglect. This then led to the tentative conclusion that some of the families where adolescents were neglected may not have been deprived, but allocated resources in such a way that did not favour the adolescents' material needs.

Approaching from the angle of *communities* and *social capital*, there is evidence to support the idea that both the level of social order and social capital in communities influence the risk of maltreatment of children. This particularly matters in communities where there is high social order, but low social capital. Further, evidence also suggests that a distinction should be made between neglect due to poor parenting skills and unrealistic expectations placed on children and that due to social, environmental or other parental risk factors such as mental ill-health and substance misuse. This leads to the conclusion that it is necessary to 'intervene first with the contextual problems as far as is achievable before it is possible to embark meaningfully on tackling neglect'.[911]

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[910] The complexity of parenting adolescents was highlighted by the finding that although more parental input was generally beneficial, when it came to parental support with education and supervision medium (rather than high) input was associated with higher levels of life satisfaction among young people.
[911] Scott, J & Daniel, B (2018a) Tackling child neglect in Scotland. Background Paper Two: Rapid review of the literature on intervention. Scottish Government, https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-

Linking family finances with entering care: causes and pathways

Further to the 'contributory causal' link between poverty and an increased risk of child abuse and neglect and the finding that increasing a family's budget can reduce child abuse and neglect, recent analysis of the evidence[912] suggests that interventions[913] impacting on family budgets can affect both the rate at which children enter the 'care system' and are reunified with their families.

Overall, interventions that effected an increase in a family's budget were found either to decrease the rate at which children entered the 'care system' or had no effect, and those that reduced a family's budget either increased entry or had no effect. The impact on reunification worked in a similar way, e.g. an increase in the family budget either helped or had no (or a mixed) effect.

This is an important piece in the jigsaw because it *extends the (partial) causal link from family material resources to the likelihood of children being looked after by the state*, and because it shows that material help can have a positive impact on children staying safely with their families. To illustrate the magnitude of the potential impact, in Scotland, a recent study found that nearly half (47 per cent) of parents whose child was

analysis/2018/05/tackling-child-neglect-scotland-2-rapid-review-literature-intervention/documents/00535116-pdf/00535116-pdf/govscot%3Adocument/00535116.pdf [accessed 5 September 2019].

[912] Brand, S L, Wood, S, Stabler L, Addis S, Scourfield J, Wilkins D & Forrester D (2019) How family budget change interventions affect children being in care. A rapid evidence assessment. What Works for Children's Social Care, https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_Family_Budget_Change_rapid_evidence_assessment_Full_Report_Aug2019.pdf [accessed 16 August 2019]

[913] Defined as 'any policy or practice that intentionally increases or decreases the amount of money available to a family' and can come in the form of housing subsidies, cash assistance, help with clothes, furniture and other goods (sometimes as a component among other forms of assistance) or, on the reverse, reductions to social security benefits. Ibid.

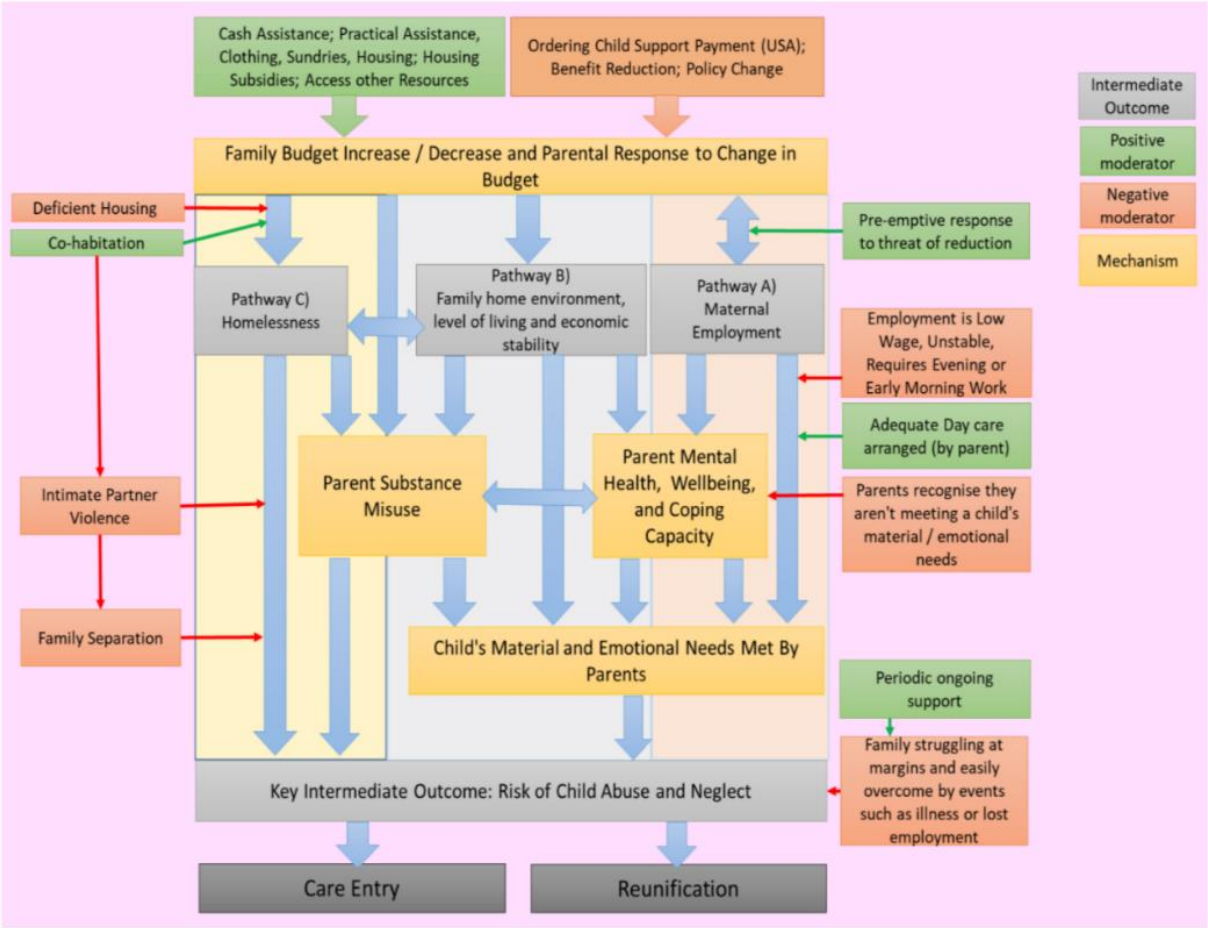
placed on a Compulsory Supervision Order before the age of three had financial difficulties.[914]

Equally importantly, *four pathways* emerge from this study that begin to piece together the mechanisms and their interplay through which the link between family resources and entry into care works, based on a substantial body of evidence, even if mostly from US studies.[915] Three of these show the potential effects of the family budget on a) needing to seek employment (mostly by the mother); b) changes to the home environment, living standard and stability and c) securing or losing the family home. These affect the family's ability to meet the child's physical and emotional needs and consequently increase or decrease the risk of abuse and neglect and thus out-of-home placement (Figure Four). The fourth pathway comes about through providing practical assistance to families, which helps to build relationships and trust and makes it more likely to accept help, as well as leaving more time for families to focus on other things (this will be discussed in more detail later on).

[914] Woods, R, Henderson, G, Kurlus, I, Proudfoot, P, Hobbs, N & Lamb, D (2018) Complexity in the lives of looked after children and their families in Scotland: 2003 to 2016. Scottish Children's Reporter Administration https://www.scra.gov.uk/wp-content/uploads/2018/03/Complexity-in-the-lives-of-looked-after-children-and-their-families.pdf [accessed 18 June 2019]. The study analysed data from a total of 240 case files from six local authorities, from two time points 10 years apart. The sample included children who were looked after at home or away from home. The 47 per cent figure relates to the more recent time point (Appendix, p 42).

[915] Brand *et al* (2019), ibid. The evidence in this review comes from 15 studies, 13 of which were carried out in the US (and the remaining two in Denmark and Canada).

Figure 4. Three key pathways for family budget interventions that impact on the risk of abuse and neglect and entering/staying in care (from Brand et al 2019)



There are still important gaps in this same body of evidence, for example the nature of these intermediate mechanisms (e.g. what the key factors are in the home environment and what it is about them that can cause further problems). Also, the relationship between not meeting a child's material and emotional needs and the increased risk of abuse and neglect lacks detail.

Pilot interventions that include financial help are on-going in the UK and will be discussed later.

In summary

There is substantial evidence to support the conclusion that poverty is a contributory causal factor in an increased risk of child abuse and neglect,

even though it is 'neither a necessary nor a sufficient factor'. A (partial) causal link has also been established between families' material resources and the likelihood of entering and leaving care.

A social gradient to child abuse and neglect also exists, similar to health and housing outcomes, meaning that lower socio-economic status is linked with worse outcomes across all these domains. The social gradient also applies to children's chances of becoming looked after in Scotland: this likelihood is 20 times higher for children living in deprived areas – despite the 'law of inverse interventions'. There are also indications from research that the predominant types of child maltreatment are changing, from physical and sexual abuse to emotional abuse and neglect.

In contrast with the weight of the evidence on the existence of a link between socio-economic circumstances, child abuse and neglect and child welfare interventions, it is not possible to know the reasons from currently collected administrative data in Scotland why children become looked after, nor what their socio-economic circumstances are. This applies to children on the child protection register too. The lack of data supports the suggestion that the child welfare 'system' has become distanced from the socio-economic realities of families. This is particularly concerning now, when poverty and inequality is projected to rise further in Scotland. As well as gathering better data on the different forms of child maltreatment, other important gaps should be filled by research, for example in the understanding of the maltreatment of particular groups, such as disabled and minority ethnic children. More UK-based evidence is also needed on the links between sudden financial change in families' circumstances and increased risk of child maltreatment, and on the role of 'systems' and professional bias in responding to child maltreatment.

On a more positive note, emerging evidence shows that rates of child maltreatment can be influenced by increasing the financial resources of families. This body of evidence also helps to understand more about the pathways through which this can be achieved, even though much of the

detail needs further inquiry, including the mediating role of stress. Strong social support for mothers has emerged as a protective factor; this will be discussed further in the next section.

3. The perspectives of people with experience of child welfare interventions and of professionals

Having explored the links between poverty, child abuse and neglect and the likelihood of care experience through evidence reviews and academic and policy papers, it is important to also consider what the processes and outcomes look and feel like from the perspectives of the children, young people and carers whose lives are most closely impacted by the 'care system'. And how does poverty play a part in this?

Understanding the emotions, wishes, motivations and decisions of those most closely involved is as crucial in providing early support as in improving the edges and journeys through care. For the same reason, it is important to understand professional perspectives too, both on and away from the front line. Ultimately, it is the relationships between people that glue the 'system' together - how they do and should work will be reflected on at the end of the section.

Children, young people and carers

Care experience and poverty

Participants in the engagement work undertaken as part of the Care Review for Scotland described how poverty can 'reduce to tears those doing their best to survive, to succeed'. They called for poverty to be recognised as 'a key factor which directly impacts a parent's ability to provide the basics for children', this also applied to kinship carers. Participants strongly felt that poverty should be dealt with so that children

wouldn't end up being removed from their families. They also advocated for early, good, supportive help, including parenting education.[916]

Stigma and cold-hearted encounters with professionals

Discussing what the best 'care system' in the world would look like, young people with care experience spoke about how professionals stigmatised them without even being aware of it (e.g. focusing on the bad things only in reports). Children and carers wanted childhoods to be as 'ordinary' as possible, not to be singled out and identified as different, for example friends' parents having to go through risk assessments, police checking if the young person is staying with friends, reviews being held at school and so on. Discrimination, stigma, prejudice, but also curiosity and pity, were strongly disliked by young people, and were described as serious barriers, for example in securing a tenancy.[917]

Stigmatising and 'cold-hearted' encounters were also recalled in recent research by families who experienced a range of child welfare services in England[918], when they felt that professionals had made up their minds about them without making an effort to find out more, or failed to recognise families' feelings, particularly in situations which were highly emotionally charged. It was argued that humane practice could have at least helped to reduce the antipathy generated by these encounters among family members, even if it hadn't changed the problem at stake.

These experiences were underlined by participants engaging with the Care Review: they felt they hadn't been heard, because professionals were very busy, and this prevented them from 'letting [your] emotions out and talk'. They also recognised how difficult it could be to accept support and

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[916] 1000 Voices and the Care Review Secretariat (2019) Summary voice Report: Early Themes from Participation, The Care Review, unpublished draft, May
[917] Baker, C (2017) What would the best 'care system' in Scotland look like to you? The views of children and young people, their parents, carers and professionals. The Care Review,
[918] Morris, K, Featherstone, B, Hill, K, & Ward, M (2018) Stepping Up, Stepping Down. How families make sense of working with welfare services. Family Rights Group, https://www.frg.org.uk/images/YFYV/Stepping-Up-Stepping-Down-Report.pdf [Accessed 10 August 2019]

interventions, which they put down to 'cultural factors' in the first place, but feeling judged and evaluated added to the reluctance to be seen as not coping.[919]

As discussed in section One, people with experience of poverty speak of feeling stigmatized, misunderstood, shamed and being discriminated against because of living in poverty. This applies to dealings with child protection services too: in her testimony, a mother with direct experience of poverty describes that she was wrongly accused by the hospital of 'making things up' when seeking help for her child with mental health problems. She was also told by social services that using food banks means she cannot budget and that her house needs re-decorating after two and a half years. Her overall experience is of being looked down upon, not listened to and not believed. 'They don't listen to us or take the medical evidence we provide. They will only accept evidence if a professional tells them it directly despite us having letters'[920].

People with severe and multiple disadvantages also noted that a sense of hope for the future, something worth living for, and the possibility to 'give something back' were mainly absent in their interactions with services. Notably, those who were able to formulate plans, consistently focused on three related priorities: overcoming addictions, a settled home, and building positive relationships with families, particularly their children. It was also noteworthy that where they had a longer-term engagement with a service (including social work), perceptions depended very much on how individual workers related to them: not as a 'case', but as an individual, who needed emotional as well as practical support.[921]

[919] Summary voice Report
[920] ATD Fourth World (2019) https://atd-uk.org/2019/09/30/let-me-tell-you-about-social-discrimination/ [accessed 7th October 2019]
[921] Bramley *et al* (2019) Hard Edges Scotland

Help with strings attached

Families in England who had experience of the child welfare 'system' found[922] that when they sought help voluntarily, they 'rarely, if ever' were simply asked to talk about their needs in the first instance. As well as having to jump through a series of administrative hurdles between multiple services, sometimes instead of help came repeated assessments, investigations, or indeed a much more extensive service than expected, that 'made things worse'. The help that eventually was provided commonly came with conditions of compliance with pre-set requirements (attending appointments, courses, signing agreements of domestic arrangements and so on), as well as various limits (time, age, geography etc). The families felt that these conditions and limits at times made the help less valuable or difficult to access. Finances could also make access difficult, which families thought was not duly recognised by service arrangements, such as the cost of travel to clinics out of the area, or when timings would have meant having to give up earnings.

The value of help on offer was also reduced by a lack of responsivity, services rarely being able to 'roll with' the family and its multi-faceted, changing needs. The families drew a firm distinction between receiving services and help – what was helpful was not always the formal content of the service, but the time and empathy of workers, sorting out practical things or advocating on the family's behalf.

Professional guidance and judgements

There is no one go-to source for professional perspectives on how poverty, deprivation and disadvantage is linked with child abuse and neglect and how this then influences decisions about child welfare interventions – they are reflected in (and framed by) statutory and other guidance's, assessment tools, alongside research and evaluation reports.

[922] Morris *et al* (2018), Stepping Up, Stepping Down

How does professional guidance link poverty, deprivation and disadvantage to child abuse and neglect?

National Guidance for Child Protection in Scotland and the National Risk Framework

The mechanism through which poverty, deprivation and disadvantage may (or may not) be considered to play a part in child abuse and neglect in individual cases is the risk assessment and management process. The current statutory guidance in Scotland for professionals[923] recommends a multi-dimensional approach, which draws closely on the National Risk Framework[924]. Looking at the way in which socio-economic factors are discussed in these documents helps to uncover the way they are thought to be linked to child abuse and neglect.

In the 'My World Triangle' tool (developed as part of the GIRFEC model[925]), recommended for information gathering. The three sides of the Triangle relate to domains concerning the development of the child, the things they need from the people who look after them, and potentially relevant factors in their wider world. Several of the wider-world items are about the socio-economic circumstances (e.g. 'not enough money', 'work opportunities for my family', 'comfortable and safe housing' and 'local resources').

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[923] Scottish Government (2014) National Guidance for Child Protection in Scotland, https://www.gov.scot/publications/national-guidance-child-protection-scotland/ [accessed 8 August 2019]

[924] Calder, M C, McKinnon, M & Sneddon, R (2012) National Risk Framework to Support the Assessment of Children and Young People. Scottish Government, https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2012/11/national-risk-framework-support-assessment-children-young-people/documents/national-risk-framework-support-assessment-children-young-people-2012/national-risk-framework-support-assessment-children-young-people-2012/govscot%3Adocument/00408604.pdf [accessed 29 October 2019]. In 2016 the Framework was used as an additional tool in 15 of the 24 Child Protection Committees responding to a survey (Jones and Daniel 2018, see later), this means at least half of the Committees in Scotland (30 in total).

[925] 'Getting it right for every child (GIRFEC) supports families by making sure children and young people can receive the right help, at the right time, from the right people.' See https://www.gov.scot/policies/girfec/

The National Risk Framework suggests that the gathered information should be interpreted using a range of generic risk indicators drawn from research and practice. The indicators are a mix of individual characteristics (e.g. 'high stress levels [in parent] such as poverty, isolation, loss'), behavioural patterns, history (including history of abuse in the parent), and a few which are linked to socio-economic circumstances, e.g. 'neighbourhood characterised by poverty' or 'housing quality poor'.

The next set of risk indicators (again relating to the child, the parent and the wider world) are situated within a matrix of resilience/vulnerability and protective factors/adversity. On one axis of the matrix, socio-economic circumstances appear as indicators of vulnerability, such as poor/overcrowded housing, homelessness and financial difficulties. On the other, living in a safe and secure neighbourhood, the family being settled in their home and having sufficient income and good living standards are classed as protective factors. The third set of risk indicators are related to commitment/resistance to engaging with services and implementing change, mostly on the part of parents – including 'threatening workers' and '[having] a different perception of the problems/risks'.

The National Risk Framework recommends that all identified risk indicators should be subsequently weighed up and considered in a matrix of high/low concern and high/low strength. This will help to identify children where low strength in parents is combined with high concern for the children - they will be the primary focus of child protection. Next in the rank of priorities are families where there is a high concern for the children, but this is combined with high strength in parents/carers. A key feature in both groupings is *parents' motivation to change*, framed as individual change. For example, in the high concern/low strength category, parents are likely to be at the 'pre-contemplative stage and unlikely to move from this position', whereas 'parents may be more willing to change' in the high concern/high strength category. It is also worth noting some indicators of low concern that are stress-related: stressors being 'within normal range of

day-to-day circumstances' and the parent/carer displaying capacity to cope with stress[926].

To sum up, the National Guidance for Child Protection and the National Risk Framework treat socio-economic circumstances together with all the other risk and protective factors present in a child's life within the complex process of sifting through a large amount of information. The majority of the risk indicators in the National Framework are about individual characteristics and behaviours. By perceiving change only in terms of individual parents/carers capacity to change, the focus is firmly on their attitudes, motivation, thinking and behaviour, whereas their circumstances become a 'given', i.e. not an intrinsic part of potential solutions. It could be argued that by acknowledging that stress affects parents/carers capacity to look after children, and that this stress may be induced by external circumstances (poverty being portrayed as one of the stressors), an opening has been made towards linking socio-economic circumstances with a mostly individualistic account of child abuse and neglect. Whereas stress is still open to 'individualisation', given its key mediating role, it is a starting point that could be built on in the future, towards a greater appreciation of the significance of socio-economic circumstances in both creating the problem and providing the solutions.

NICE guidance on child abuse and neglect

The 2017 NICE (The National Institute for Health and Care Excellence) guidance for professionals on child abuse and neglect applies to England only, but is relevant because of its wide influence and key role in feeding good quality evidence into practice. It does mention poverty, in two particular contexts. Similar to the Scotland Guidance, it recommends taking socioeconomic vulnerability factors into account for child abuse and neglect, 'such as poverty and poor housing' (in conjunction with other

[926] Ibid. p 34. The National Risk Framework also draws attention to the message from research that higher levels of stress in the family is associated with a higher risk of exposure to further abuse and neglect.

vulnerability factors), because these are 'known to increase the risk of child abuse and neglect'.[927]

When considering 'alerting features' for physical neglect, particularly hygiene and food provision and an unsafe environment, the guide warns that 'Be aware that it may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents' or carers' ability to meet their children's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.'[928]

This is a clear attempt at warning of the risks of conflating neglect and poverty, and recognising that most people in poverty care for children well - but making such judgements is complex. The complexity lies not only in having to decide when circumstances between one family and another are 'similar', but also the standard that is good enough in meeting children's needs when material resources are scarce.

Professional judgements

Forming a judgement on 'good enough' standards of child care is fraught with difficulties because it opens up fault lines in divergent cultural, social and even professional norms.

The 2012 review of child neglect in Scotland[929] quoted a respondent to the survey undertaken among Child Protection Committees[930] in Scotland, on different standards used between professionals from different fields (such as health, police, social work) on what they saw as neglect. These so-called

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[927] NICE (2017) Child abuse and neglect. NICE guideline 76, https://www.nice.org.uk/guidance/ng76/resources/child-abuse-and-neglect-pdf-183763758714l (p 14-15) [accessed 8 August 2019]
[928] Ibid, p. 23
[929] Daniel, B, Burgess, C & Scott, J (2012) A Review of Child Neglect in Scotland. Scottish Government, https://www.gov.scot/publications/review-child-neglect-scotland/ [accessed 30 July 2019].
[930] "Child Protection Committees are locally-based, inter-agency strategic partnerships responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their locality and in partnership across Scotland." National Guidance for Child Protection in Scotland (2014) ibid, p. 39

'threshold issues' were thought to be solve-able by better integration over time, as GIRFEC became gradually embedded into local practice.

An additional, longer-standing problem identified by practitioners in some urban areas was a 'cultural acceptance' of a lower standard of care, particularly where this was seen as an inter-generational norm. This was thought to carry a risk that professionals working in these areas would get accustomed to the local norm, instead of 'addressing' it. The research then linked these social norms, low aspirations, lack of hope and poverty together in these localities with the higher prevalence of children living in neglect:

> *"In some areas the numbers of children who were living in these circumstances were almost overwhelming and poverty was clearly part of the issue for some of these families, coupled with low aspirations and little or no hope of future change and improvement in their lives and those of their children."*[931]

Poverty is seen as part of the problem in this quote, but on low aspirations the evidence discussed earlier suggests otherwise: poverty appears to be not coupled with low aspirations, but *moderated down* in light of the experience of living in poverty – this distinction is important because it points to poverty as the primary issue, rather than both poverty *and* low aspirations, (with the latter shifting some of the responsibility on the individual).

By the time a follow-up survey was carried out among Child Protection Committees five years later[932], the backdrop had significantly altered, most notably, demand on services had grown, amidst looming reductions in funding. At this time poverty and deprivation were highlighted by Committees among the *structural* barriers to providing services that meet

[931] Daniel *et al* (2012), p. 37
[932] Scott, J. and Daniel, B. (2018b) Tackling Child Neglect in Scotland. Follow-up survey 2016. Scottish Government, https://www.gov.scot/publications/tackling-child-neglect-scotland-1-follow-up-survey-2016/ [accessed 8 August 2019]

children's needs, but alongside poor parental experience of parenting, high levels of drug and alcohol use and mental health issues affecting parents.

Among *cultural* barriers to providing services that meet children's needs, stigma was mentioned in the first place, as well as the possibility that staff could be inhibited from taking action because they felt they were making value judgements rather than professional assessments. Other cultural barriers included 'disguised compliance' (no meaningful engagement) by families, and no or sporadic acceptance that parental lifestyle or lack of care caused harm to children, which echoes the earlier view on cultural acceptance of a lower standard of care.

Based on these surveys, it seems that there is an awareness that poverty and deprivation plays a part in child neglect, but it is also seen as filtered through 'cultural issues', which could also be used as code for being working-class (among other characteristics). Other research (conducted with social work professionals in six sites, four in England, two in Scotland) seems to support this view: 'through their depiction of service users, our respondents demonstrated a tendency to focus on those stigmatizing cultural signifiers associated with underclass narratives'[933]. As the authors further explain, the effect of ubiquitous underclass stereotypes is that it strips white working-class people of respect, and serves to obscure the 'causes of the causes'. It also allows the 'toxic trio' of domestic abuse, substance abuse and mental ill-health instead to become the dominant explanatory factors in practice at individual level, and to facilitate stigmatising class-biased narratives more generally. The study asserts that this was happening irrespective of local differences in policy and practice.

[933] Morris, K, Mason, W, Bywaters, P, Featherstone, B *et al* (2018) Social work, poverty and child welfare interventions. *Child & Family Social Work* vol. 23, pp. 364-372. doi: 10.1111/cfs.12423 p368. Alcohol consumption, allowing children to play in the street, choice of clothing and shouting at children were mentioned as examples of culture and class.

Further, some respondents to the 2012 child neglect review in Scotland[934] pointed out that there was a lack of recognition of the neglect of some children and young people in middle-class families, for example letting them drink and party. This was described as neglect in a different way, and something that was difficult for agencies to recognise (but there was no further explanation available as to why).

In line with the analysis of the statutory guidance in Scotland (section three, two, one above), the research by Morris *et al*[935] observed that the 'core business' of focusing on individual parenting skills and capacity was reinforced by the assessment tools and the practice theories in use in social work. This happened either through directing attention to risk factors detached from social determinants, or partial use of the assessment frameworks in practice. The accounts of practitioners pointed to three key factors that, combined, affected social work priorities in a way that detracted attention from families' socio-economic circumstances: process and procedural demands, particularly timescales; increasing caseloads; and risk-averse practice cultures. Additionally, and perhaps most significantly, the research found that '[o]verall, our case study respondents described an occupational environment that was saturated by poverty to such an extent that it ceased to become a topic of critical engagement', it became 'the wallpaper of practice: too big to tackle and too familiar to notice'[936].

Many research participants expressed ambivalence when asked whether there was a link between poverty and child abuse: 'yes and no', 'yes' because poverty caused difficulties for families, but 'no' because accepting a causal relationship could acquit parents from responsibility and could be stigmatising to people in poverty who look after their children well. Paradoxically, practice detached from its context was framed as an

[934] Daniel *et al* Ibid.
[935] Morris *et al* (2018) Social work, poverty and child welfare interventions
[936] Ibid. p 370.

equitable approach (dealing with behaviours rather than circumstance). However, the study asserted that not engaging with poverty and disadvantage and its consequences in cases of child abuse and neglect is a risky path for policy and practice. It is chiefly because it risks rendering the role of poverty and disadvantage invisible to practice, despite the evidence on its linkage to child abuse and neglect. Having practitioners who are able to engage confidently with poverty and its consequences means reducing the risk of harm to children, but at present they are not supported by processes, 'systems' and resources to do so.[937]

Structuring professional judgements on neglect: the Graded Care Profile (GCP)

Introducing structured assessments is one way of reducing confusion about definitions, increasing consistency and lessening concerns about value judgements and cultural assumptions. Arguably it is also a way of consistently encoding value judgements and acceptable assumptions.

The GCP is a tool originally developed in the 1990s which, according to its first national evaluation by the NSPCC in 2015, was used in over 60 local authorities across the UK.[938]

The key findings of the national evaluation mostly concentrated on the views of practitioners and paint a mixed picture. Practitioners found the tool helpful in contributing to a constructive working relationship with the family through identifying strengths as well as weaknesses, creating a participative process that promoted parental engagement and helping parents to understand professionals' concerns. They also thought it enabled a more objective, evidence-based assessment, a better focus on impacts for the child and helped to make neglect more 'visible' to

[937] Ibid.
[938] Johnson, R & Cotmore, R (2015) NSPCC National evaluation of the graded care profile. https://bit.ly/2lGd6qA [accessed 6 September 2019]. The tool has been updated by NSPCC following the evaluation (it is now called GCP2), some of the language issues and gaps have been addressed, but the principles and structure remained the same. [The version used in Glasgow and discussed in this paper appears to be the original GCP.]

themselves as well as to parents and others. There was a view among practitioners that the scoring made the assessments more 'objective' (it had removed their own subjective judgement-making) and made the evidence more acceptable to parents.

As regards the concerns about making value judgements and cultural assumptions, however, the tool did not seem to live up to expectations. Some of its language was found to be complex, judgemental and needed interpreting to families, and some statements were implying 'outdated' and 'white middle-class' value judgements, with idealistic expectations of family life (for example of the necessity of eating together at a table).

As in Scotland, practitioners in the evaluation saw 'low aspirations' in families (with regard to looking after their children) as symptomatic of a broader set of structural issues such as employment, housing, health and education. Concerns about problems with finances, however, were mentioned only in the context of non-engagement, including 'fibbing' to professionals:

> *"... a lot of things like telling us that they have a full roast dinner every Sunday but then you go and actually the cupboards are bare and there's no money on the meter so the house is freezing cold, and things like that."*[939]

The GCP, or a locally adapted version, was in use in 2016 in at least eight local authorities in Scotland[940], including in Glasgow[941]. A study evaluated its use (not its outcomes) in one Scottish local authority between 2008-2010, shortly after its introduction.[942] This study concluded that the tool was useful in some respects, for example highlighting elements where most targeted support was needed. In some cases it also allowed a constructive

[939] Ibid.
[940] Scott and Daniel (2018) ibid.
[941] The Glasgow-version of the GCP is available at: https://www.glasgowchildprotection.org.uk/CHttpHandler.ashx?id=12903&p=0
[942] Sen, R *et al* (2014) 'Grading the Graded Care Profile', *Child Abuse Review* 23, pp 361-373

dialogue with the family about children's care, but this was in tension with its diagnostic use for grading quality of care (and particularly, substandard care). The study also pointed out the possibility that, similar to other assessment tools, "attaching a numerical grade to care within the GCP gives a misleading veneer of objectivity to what is a professional judgment call"[943].

It is somewhat simpler to form a view on how living in poverty could affect the scoring of the areas of care where parents are prevented from meeting the needs of their child because they can't afford it. It is still a matter of judgement though, much of which is based on prevailing social norms (and professional/research knowledge e.g. on child development, filtering into social norms). It is not known, however, how the norms driving the statements in the GCP had been originally arrived at; the description of the first field trial back in the 1990s does not mention who contributed to the original version.[944]

As discussed earlier, norms also change over time - for example, on the necessity of having an option of nursery care in order to provide good development opportunities for children, or on the importance of being able to transport children to out-of-school activities. It is possible to bring these norms to the surface and agree the goods and services necessary to achieve them (also cross-checking with current professional knowledge where relevant) and then price them up.[945] The cost relating to bringing up children is assessed for the Child Poverty Action Group in the annual 'Cost of a Child' publication[946]. It could be investigated whether elements of the GCP can be costed the same way and what income would be necessary to meet them.

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[943] Ibid p 371.
[944] Srivastava, O P & Polnay, L (1997) 'Field trial of graded care profile: a new measure of care'. *Archives of Disease in Childhood* vol. 76, pp 337-340. doi: 10.1136/adc.76.4.337
[945] See the discussion on the Minimum Income Standard in section 1.
[946] The 2019 calculations and analysis is available at https://cpag.org.uk/sites/default/files/files/policypost/CostofaChild2019_web.pdf

It is more difficult to make an assessment of the effect of other factors directly or indirectly associated with poverty that moderate the risk of neglect upwards (housing conditions, low-paid work or no work, physical or mental ill health, stress, substance misuse) – it depends on how these factors are accounted for in the overall view taken on the risk of neglect, and how the tool is used in conversations with parents.

More broadly, given the experience and perception of families in contact with child welfare services (see previous section), dialogues between families and professionals seem to be high-stake, but not necessarily good quality. One of the fundamental issues is that parents living in poverty can feel judged and blamed for living in poverty and for not being good-enough parents, especially if the problems and solutions are framed as dependent on their motivation to change as individuals.

Finding it difficult to show vulnerability and to accept help is not unique to the child welfare system[947], but it is a hugely important issue, one closely bound up with relationships based on trust. In individualistic societies, including the UK, the dominant culture promotes independence, resilience and the ability to cope, which makes it difficult to say that 'I need help'. It goes against a person's dignity and brings a fear of being judged harshly by others.[948] Saying this to professionals is risky too, particularly where there is little appreciation of the social context of families' lives, no relationship built on trust and understanding, and the consequences can be severe. Finding it hard to accept help can also become construed as 'not engaging'.

[947] The National Risk Framework considers willingness to receive help as a protective factor. See Calder *et al* (2012).
[948] Allen, M, Spandler, H, Prendergast, Y & Froggett, L (2015) Landscapes of helping: Kindliness in neighbourhoods and communities. Joseph Rowntree Foundation, https://www.jrf.org.uk/report/landscapes-helping-kindliness-neighbourhoods-and-communities [accessed 22 October 2019]

The centrality of relationships

Many ingredients need to be in place for the best 'care system' in the world, but it is the relationships that will ultimately make it work.

Relationships are named as one of the key building blocks in an overarching framework drawn up by the NSPCC in 2015 to prevent child neglect and to provide early help to families.[949] The report asserts that 'child neglect happens when relationships do not form or when they break down', meaning both that supporting and improving the parent-child relationship is the key to preventing and ending child neglect, and that the presence and quality of relationships *surrounding* this key relationship are the ones that make this possible. These additional relationships include the ones between the parents and practitioners; the child and practitioners; practitioners working together; and between parents and their support networks and wider community. The NSPCC framework places an emphasis on trusting relationships between children and professionals in universal services (including teachers and health care professionals) because, in the first place, child abuse and neglect remain mostly hidden.

A lot of work will need to be done on relationships, as at present the gap between the main actors seems rather wide. As discussed earlier, families, children and young people with care and child welfare experience often see their relationship with professionals as low-trust, stigmatising and tinged with fear. They also report not being listened to and not receiving effective help. People in poverty speak of their relationships with professionals in similar terms. For those who live in poverty *and* have experience of child welfare interventions the two sets of experiences merge into one overarching narrative on what it means to live in poverty. As also discussed earlier, for social work professionals in particular, daily

[949] Haynes, A, Cuthbert, C, Gardner, R, Telford, P & Hodson, D (2015) Thriving Communities. A framework for preventing and intervening early in child neglect. NSPCC, https://letterfromsanta.nspcc.org.uk/globalassets/documents/research-reports/thriving-communities-framework-neglect-report.pdf [accessed 9 October 2019]

work is saturated by poverty, to the point of invisibility and lack of critical reflection, alongside organisational pressures and lack of support with navigating complex issues of ethics and values in real-life situations. At the same time, powerful cultural stereotypes of the 'underclass' abound and have been absorbed by many.

The narrative built by contributors of participatory research[950] links stigma, blame and judgement, one of the key dimensions of living in poverty, to the loss of potential in people at the receiving end. Discrimination instead of help by social services was seen by some research contributors with direct experience of poverty as a manifestation of this process:

> *"'Social Services constantly looking over your shoulder especially when you have been in care yourself', 'Social Services taking young children away instead of helping them at home', 'Social Services blocking the return of a child to their parents'. Some parents believe that this results in 'children being wrongly adopted'."*[951]

Looking at the detail of what gets in the way and what helps to build trust and confidence; families with experience of child welfare services found it hard to build relationships with constantly changing workers.[952] This also often compounded the instability already present within and around the family. Being frequently reminded of limited resources did not help either. Families also reported that if they had challenged professional views or decisions, this became construed as problematic behaviour. On the other hand, alongside a sustained relationship, good inter-personal skills such as courtesy, respect, honesty, empathy, clarity and politeness were appreciated and increased the chances of constructive working relationships, as did good time keeping and flexibility to work with the whole family.

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[950] ATD Fourth World (2019) Understanding poverty in all its forms
[951] Ibid, p. 21
[952] Morris *et al* (2018) Stepping Up, Stepping Down

Young people quoted in the NSPCC framework report[953] argued that to build trust, relationships needed to be long-term, friendly and, in the case of school staff, include contexts outside the classroom that made staff look 'more human'. The report also suggested that professionals' relationships with parents needed to be 'positive, trusting and challenging', qualities that ensure successfully engaging parents with early help. Whereas the report maintained that the ability to engage positively is an attitude rather than a technique, the proposed solution was to train professionals in engagement skills (such as motivational interviewing) and provide reflective supervision.

People with care experience[954] were clear that they wanted a workforce with understanding and empathy, who they can have genuine, long-term relationships with. When care-experienced voices talked about love, they wanted to connect with people who believed in them, had time for them, who they could rely on, who didn't get bogged down in rules and formal boundaries. Care-experienced voices also clearly wanted to maintain their bonds and relationships with their birth families, particularly with siblings. The intentions formed at the end of the Discovery stage are predicated upon relationships that work: with birth families (where possible), with young people, between professionals, between components of the 'system' and with the wider community and the general public.

Relationships are of course not a panacea and it is not easy to build and maintain them in contexts where there is often hardship, where values and beliefs can clash (for example on what constitutes a sufficient standard of care and how it can be achieved) and sometimes complex decisions have to be made. There are also risks involved in relational

[953] Haynes *et al* (2015) Thriving Communities
[954] The Care Review (2018) Information to Workstream Co-Chairs: Discovery Stage Findings, unpublished report

practice in public service, such as the requirement for fairness which, arguably, greater discretion and autonomy might undermine.[955]

A recent qualitative study[956] looking at the role of relationships in altering the lives of young people with severe and multiple disadvantage noted that a standard approach that focused on reducing risks and dealing with needs is problematic and often leads to disconnect from services despite great need – because of young people's sense of shame at their situation and because of mistrust, having been repeatedly let down by potentially supportive relationships. This description of the relationships that worked is close to that people with care experience said they wanted:

> *"[The relationships that worked] looked more like natural relationships than therapist-client relationships and eventually came to resemble family relationships. The connection was fiercely tested by the young people who drew on past experience of being let down by others. The helper compensated with extra care and persistence. Their objective was to establish a bond.... By encountering and overcoming a series of difficulties together, the relationships deepened. The workers used personal ethics to maintain healthy boundaries in the relationships, not the guidance of professional organisations."*[957]

From the accounts of individuals and families with experience of poverty and of child welfare interventions, some other key themes emerge. People often talk about the importance of hope - sadly, most often in the context of its loss - hope for a better future, which includes leaving poverty and disadvantage behind, good family relationships, helping others.

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[955] For a full discussion see Unwin, J (2018) Kindness, emotions and human relationships: the blind spot in public policy. Carnegie UK Trust, https://www.carnegieuktrust.org.uk/publications/kindness-emotions-and-human-relationships-the-blind-spot-in-public-policy/ [accessed 3 September 2019]
[956] Sandu, R D (2019) What aspects of the successful relationships with professional helpers enhance the lives of young people facing significant disadvantage? *Children and Youth Services Review* 106 104462. https://doi.org/10.1016/j.childyouth.2019.104462
[957] Ibid, p. 11

Nevertheless, as hope is the key to persevering and striving for better things, it is perhaps the first, but beyond doubt difficult, task to restore and sustain.

Another key theme, the desire for a human and humane experience in encounters with services and professionals, something relational rather than transactional and cold-hearted, is closely connected with the first. Practice can only foster hope if it has established a relationship based on trust and mutual respect. These take time to build, require stability and an enabling infrastructure that families and professionals can rely on. Importantly, it is an infrastructure that connects practice with people's context.

In calling for a paradigm-shift to poverty-aware social work, Krumer-Nevo compares the conservative and structural social work paradigms.[958] The former basically applies the deficit-model to individuals in poverty and from a stance of mistrust and surveillance focuses on changing their behaviour and attitudes. The perspectives discussed earlier in this section point to the prevalence of this paradigm in the UK, including in Scotland. In contrast, the structural paradigm attributes poverty to the workings of social structures and institutions, and recommends community empowerment and activism and policy change. Whilst the poverty-aware social work that Krumer-Nevo advocates is rooted in this paradigm, she nevertheless concludes that it 'tends to abandon the interpersonal relationship, and has never inspired fully fledged casework management and practice'. In applying the poverty-aware paradigm, practitioners form relationships with service users, stand by them in fighting poverty, identify and tackle micro-aggressions, use their privilege to benefit their service users and actively advocate and mediate for them. This does not mean uncritically agreeing with service users all the time:

[958] Krumer-Nevo, M (2016) Poverty-Aware Social Work: A Paradigm for Social Work Practice with People in Poverty. *British Journal of Social Work* vol. 46, pp. 1793-1808. doi:10.1093/bjsw/bcv118

> *"Paradoxically, taking the side of service users creates a space in which social workers can actually criticise them, because clients believe social workers really care about them and the relationships are built on trust"*[959]

In summary

The accounts of people with experience of child welfare services, including the 'care system', are clear on what works and what does not work for them. They want encounters with workers that are non-stigmatising, respectful and that provide early, supportive help (as different from inflexible services and interventions with 'strings attached'). They also want working relationships that are long-term and trusting, with people who are 'human', who listen to them and understand them and their circumstances.

Statutory guidance and practice tools make reference to socio-economic circumstances as part of the 'wider world' of children, but the focus firmly remains on individual characteristics, attitudes and motivation to change. Evidence also highlights that social work practice sees individual change and accountability detached from socio-economic circumstances as 'core business'. In addition, poverty seems to have become such an everyday backdrop in a high-pressure work environment that practice has become detached from reflecting on it critically. Instead, it looks upon it with ambivalence and recalls narratives of a 'culture of poverty'. It is a function of the same approach that associating poverty with an increased risk of child abuse and neglect is viewed with concern, in case it stigmatises people in poverty who look after children well.

It is suggested that relationships in the child welfare 'system' that work well are a key ingredient in preventing and reducing child abuse; they are also at the heart of a 'care system' that works well for the children and young people it looks after. The relationships that young people want are

[959] Ibid. p1804

long-term, trusting and which resemble more family relationships than professional interactions. Establishing a practice with relationships at the heart needs to overcome several obstacles, one among them is the lack of engagement with poverty as a 'cause of the causes' and related to this, the primary focus on individual deficiencies and change, as well as practices and workloads that are not conducive to building relationships.

It was argued that building relationships with people means seeing their circumstances, understanding their difficulties and being 'on their side', which in turn allows trust to build and makes it also possible to challenge views and actions.

4. Policy and practical interventions

Given the volume of the evidence on the existence of a link between poverty, deprivation and disadvantage and child abuse and neglect (and more broadly, adverse childhood experiences or ACEs), and also on the positive impact that increasing family budgets can have on children not entering care or being reunited with their family, it is beyond doubt that improving families' socio-economic circumstances should be part of the range of solutions.

For this same reason it is essential that child welfare practice becomes more 'alive' to the context of the families it works with. Yet it is not enough, to focus only on finances, because as it has been shown, poverty is not only a lack of money, it is a condition that affects people in a multitude of ways. Perceiving poverty in financial terms only would get in the way of developing practice rooted in a deep understanding of the causal paths of child abuse and neglect and in relationships that work.

This section summarises some ideas and solutions that are targeted primarily at reducing child poverty, or specifically at families subject to a child welfare intervention, including care. It is beyond the scope of this paper to give an account of the full range of anti-poverty policy and action in Scotland.

Current Scottish Government policy and action on child poverty and maltreatment

Judging by recent top-level Scottish Government policies, it seems that there is acknowledgement of a relationship between poverty and abuse and neglect within the wider concept of Adverse Childhood Experiences (ACEs), but it seems to be approached primarily from a policy objective of reducing child poverty. As discussed earlier, poverty is not often

considered in child protection policy or practice as an 'active ingredient' that can make a difference to child abuse and neglect. If mentioned at all, it is mostly seen as a general background.

Looking at the way in which the links are perceived in policy on child poverty first, it is helpful to remember that Scotland alone among the UK nations has a target for reducing child poverty to ten per cent by 2030/31. The Tackling Child Poverty Delivery Plan 2018-2022 (Every child, every chance)[960] identified parental employment, cost of living and social security cuts as the main drivers of child poverty in Scotland. The Plan approached addressing all ACEs *as a route to tackling poverty,* as it noted that living in a low-income household is associated with higher levels of ACEs. It also announced investment in developing approaches that are more effective at *preventing* ACEs. Both actions were part of the theory of change in the Plan to prevent today's children and young people from becoming poor parents. One of the potential measures discussed in the Plan, the provision of an income supplement to low-income families, has since been actioned in the form of the Scottish Child Payment. As discussed earlier, analysts suggest that it will make a significant, tangible difference to thousands of children in poverty in Scotland.

A wide range of additional actions to reduce child poverty have been summarised in the one-year progress report[961], including intensive employment support for parents and a Financial Health Check service. The report asserted that directing state investment to low-income children and their families was a government priority, which came to almost £302m in 2018/19. This investment included the Attainment Scotland Fund, Free

[960] Scottish Government (2018a) Every child, every chance. The Tackling Child Poverty Delivery Plan 2018-2022, https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/03/child-chance-tackling-child-poverty-delivery-plan-2018-22/documents/00533606-pdf/00533606-pdf/govscot%3Adocument/00533606.pdf [accessed 5 September 2018]. The Plan announced a £50m Tackling Child Poverty Fund.
[961] Scottish Government (2019d) Tackling child poverty: first year progress report (2018 to 2019), https://www.gov.scot/publications/tackling-child-poverty-delivery-plan-first-year-progress-report-2018-19/ [accessed 13 November 2019]

School Meals, Education Maintenance Allowance, the Best Start Grant and others. The report estimated that additional spending on low-income households (with or without children), such as Affordable Homes and Council Tax Reduction, also benefited children in poverty to the value of about £225m.

It is much harder to discern how child protection policies think about linkages with poverty and disadvantage. The Scottish Government website, discussing adverse childhood experiences, notes that "[a]s well as these ten ACEs there are a range of other types of childhood adversity that can have similar negative long term effects. These include bereavement, bullying, poverty and community adversities such as living in a deprived area, neighbourhood violence etc."[962] The obvious problem with placing poverty as another type of childhood adversity alongside ACEs is that it says nothing about the relationship between them, which then puts poverty outside the range of causes and solutions to consider in tackling child maltreatment and other ACEs.

In the national policy that sets out the Scottish Government's vision for protecting children and young people[963] the overarching public health approach of the GIRFEC framework is visualised as a triangle with universal services at the base, then early help, targeted support and child protection interventions at the top. None of the examples of universal or non-universal services that might help to keep children safe refer to improving families' material circumstances, neither is the role of poverty in higher rates of abuse and neglect mentioned anywhere. On the other hand, the list of government directorates with shared responsibility for keeping children safe does include the Housing and Social Justice Directorate (which is responsible for child poverty), housing and social justice

[962] The list of ACEs include abuse (physical, verbal and sexual) and neglect (emotional and physical) https://www.gov.scot/publications/adverse-childhood-experiences/
[963] Scottish Government (2018b) Protecting Scotland's Children and Young People – National Policy, https://www.gov.scot/publications/protecting-scotlands-children-national-policy-and-draft-child-abuse-prevention-activity/ [accessed 8 August 2019].

strategies are also referred to as relevant, as are the Child Poverty (Scotland) Act 2017 and the Poverty and Inequality Commission (but without detail of specific roles or responsibilities). This is the same in the summary document accompanying the policy that gathers together on-going and emerging activities on preventing child abuse and neglect.[964]

The government strategy on looked after children (Getting it right for looked-after children and young people)[965] refers to poverty only once, when discussing improving quality of care for children who are subject to corporate parenting. When discussing the main outcomes (relationships, improving education, health and wellbeing), it notes that looked after children share many of the same health problems as those who have not been looked-after, but may have been exposed to additional risk factors to their wellbeing, 'including poverty, abuse, neglect and other adverse childhood events', without referring to any relationship between these. The envisaged solution is support from Health Boards to access high-quality health and social care services. The nature of early engagement with families with children at the edge of care is not discussed (other than that it should build on and support the assets within families). The importance of protecting and improving relationships in the 'care system' is clear from the strategy, unlike the role of tackling poverty in achieving outcomes for looked-after children.

The Scottish Government's focus on reducing child poverty, and as part of it, adverse childhood experiences, is a progressive policy approach. However, it does not seem to connect up with child protection policies. In

[964] Scottish Government (2018c) Protecting Scotland's Children: Child Abuse Prevention Activity March 2018, https://www.gov.scot/binaries/content/documents/govscot/publications/factsheet/2018/03/protecting-scotlands-children-national-policy-and-draft-child-abuse-prevention-activity/documents/prevention-document-pdf/prevention-document-pdf/govscot%3Adocument/Prevention%2BDocument.pdf [accessed 8 August 2019].
[965] Scottish Government (2015) Getting it right for looked after children, https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2015/11/getting-right-looked-children-young-people-strategy/documents/00489805-pdf/00489805-pdf/govscot%3Adocument/00489805.pdf [accessed 8 August 2019].

light of the evidence (see section three) on child protection professionals' focus on individual parenting skills and capacity, and the lack of critical reflection on families' material circumstances, it is no surprise that high-level policy does not spell out either the contribution of poverty to family hardship, nor its link with a higher risk of child abuse and neglect and of entering care. The 'care gradient' is not a traceable concern in national policies either. 'Making room' for poverty in child protection policies does not mean that all current policies and practices are wrong. But it would mean a re-modelling of causal links and a greater sensitivity towards families' material circumstances and the impact of poverty on their lives.

Targeted interventions including financial help

Of the two broad types of experimental intervention programmes aimed at reducing child maltreatment (those providing financial help, and various prevention programmes such as parental education, home-visiting and community programmes), there is stronger evidence on the effectiveness of (US-based) programmes that include financial help. The prevention programmes, which showed more variable results, mostly didn't investigate families' socio-economic circumstances. This was noted also of those UK-based studies that followed up children who had been at risk of harm and were in contact with child welfare services. These studies found that children who remained away from their parents, in alternative families, appear to have had better outcomes on a variety of measures than those who remained at, or returned to, their parents. The lack of systematic evidence on socio-economic circumstances of parents and foster carers, however, led the reviewers to question whether material circumstances were similar at the foster and parental homes, including a weekly allowance payable to carers, but not to parents.[966]

[966] Bywaters *et al* (2016) The relationship between poverty, child abuse and neglect

Devolved budgets pilots

The effectiveness of targeted interventions including financial help in reducing the rate of children entering care and in reuniting them with their families was discussed in section two. UK-based pilots have been underway in three local authorities in England to provide devolved budgets to social workers and their managers. These budgets could be used to work with families to provide early, tailored solutions to particular issues (but not to fill gaps in other services such as children's mental health). In one site, the discretionary budget allocated to selected families was up to £1,000 per family in the first instance, if seen as beneficial, further approval could be given for up to £10,000.[967]

Examples from the interim reports included practical support with living conditions such as helping with a house move; small payments enabling building relationships with children and families (meals out, activities, rewards for good behaviour); helping parents to build practical skills (e.g. driving lessons) and expedited access to assessment and treatment. The interim results are encouraging and the support provided this way has been seen as helpful in engaging with families and in building relationships. Process-related issues such as confidence in decision making and dealing with paperwork were also reported.[968]

Social Justice Premium for care leavers

In essence, this premium is state-funded compensation to vulnerable people for harms suffered over their lifetime, which could take the form of payments and services. For example, government-top ups for savings accounts for looked-after young people was recommended by the Joseph

[967] Grey, J, Folkes, L & Westlake, D (2019) Darlington Change Project: devolved budgets. Interim report August 2019. What Works for Children's Social Care and Cardiff University, https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_interim_report_Devolved_Budgets_Darlington_Aug_2019.pdf [accessed 4 September 2019]

[968] What Works Children's Social Care: Interim results from Devolved Budgets pilots. Press release 19 August 2019 https://whatworks-csc.org.uk/blog/interim-results-from-devolved-budgets-pilots/ [accessed 4 September 2019]

Rowntree Foundation in order to ensure that these young people had the opportunity to accumulate assets similar to their peers.[969]

Targeted work with families on child maltreatment, in the context of low income

Addressing Neglect and Enhancing Wellbeing (ANEW)

Facilitated by the Centre for Excellence for Looked-After Children in Scotland (CELCIS), the programme is one of nine work streams within the Scottish Government's Child Protection Improvement Programme. The programme originates from the recognition that children who are 'on the radar' but whose needs are not sufficiently high for triggering a child protection response should be identified and supported at an earlier stage. It has started in 2016 and is still on-going in Dundee, Inverclyde and Perth & Kinross. From a poverty perspective, as discussed earlier (see Figure one), the three areas have differing rates of child poverty: Dundee City has the second highest in Scotland, whilst Perth & Kinross is among the lowest third of local authority areas. Improvement and innovation is specific to each locality and is 'system'-wide, using a multi-step Active Implementation methodology.[970] For example, in Perth & Kinross the focus is on pre-birth and into the first year of a child's life, supporting pregnant women who are deemed vulnerable. The main partners are Perth & Kinross Council, NHS Tayside and CELCIS.[971]

Home visit programmes

These are a type of programme where health or social care professionals (e.g. midwives, support workers, social workers) provide support and guidance to pregnant and new mothers where there is judged to be a risk

[969] Joseph Rowntree Foundation (2016) UK Poverty: causes, costs and solutions
[970] CELCIS (2018b) Addressing Neglect and Enhancing Wellbeing Programme. Frequently Asked Questions, https://www.celcis.org/files/4115/2466/9416/Addressing_Neglect_and_Enhancing_Wellbeing_Programme_FAQ.pdf [accessed 22 November 2019]
[971] Perth & Kinross Child Protection Committee (2019) CPC Improvement Plan 2018-2020. Year 1 Progress/Update Report https://www.pkc.gov.uk/media/44746/CPC-Improvement-Plan-2018-2020-Year-1-Update/pdf/PK_CPC_Improvement_Plan_2018_-_2020_Year_1_Update_.07.31.pdf?m=637013889952670000 [accessed 25 November 2019]

of child maltreatment. Most of the evidence comes from programmes in the US, Australia, Canada and New Zealand, but one programme is based in the UK (Family Partnership Model, run by the Centre for Family and Child Support[972]). The evidence suggests that home visits were effective in reducing child maltreatment, particularly where the risk was medium or high (low income was one risk factor within the low and medium risk categories); where the intervention lasted longer; was more intensive; and where other services (e.g. visits to clinics, transportation) were provided alongside visits.[973]

Social support for mothers

Whilst this is not a specific intervention, it is worth recalling the evidence discussed earlier in this paper indicating that social support for mothers had benefits for their children and reduced parental stress. Evidence from Scotland showed that the strength and quality of support for, and closeness by, family and friends for mothers in the lowest income quintile was associated with significantly higher social, emotional and behavioural wellbeing in their children. Other UK evidence also indicated that social support for mothers reduced the risk of child abuse and neglect (whereas being a young parent, poorly educated and from a background of poverty increased the risk).

Intensive Family Preservation Services (IFPS)

IFPS is a range of programmes intended to prevent children being placed away from the home. They are assessed to be effective in cases of neglect (physical and emotional), as well as abuse (physical, sexual and emotional), substance misuse and threat of harm. The key components that seem to make it effective are the child being at imminent risk of placement;

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[972] For more detail on the model see http://www.cpcs.org.uk/index.php?page=about-family-partnership-model

[973] El-Banna, A, Maxwell, N & Pitt, C (2019) EMMIE Summary – Home visiting programmes for the prevention of child maltreatment. What Works for Children's Social Care and Cardiff University https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_EMMIE_Summary_home_visitation_programmes_for_the_prevention_of_child_maltreatment_Nov_2019.pdf [accessed 22 November 2019]

contact with the family within 24 hours of referral; the caseworker being available round-the-clock and having a low caseload of no more than three families at a time. The reason why these programmes are mentioned here is because the studies included families where children were at imminent risk of care because of acute financial stress or other acute problem such as substance misuse, carer's illness, child disability, or unacceptable behaviour e.g. risk of criminality.[974] More detail is available in the Care Review publication reviewing the evidence on the edges of care.[975]

Developing poverty-aware practice and good working relationships between parents and professionals

Anti-Poverty Practice Guide for Social Work (British Association for Social Work)

The recently released BASW guide[976] outlines why poverty must be of interest to social work and offers up messages for practice. Although not addressing directly the social gradient to child welfare interventions and care (other than briefly mentioning that poverty leads to further problems such as rising numbers of children in care), it argues that the root causes of poverty are structural, and asserts that poverty must be of interest to social workers because it is a matter of social justice and social work principles.

Practice messages include the need for the profession to challenge policies that lead to profound and damaging inequalities; whereas locally, as a starting point, it recommends discussing poverty, its impact on the people that practice teams work with and ways of addressing it. It also recommends better knowledge of the profile of the community (based on

[974] Bezeczky, Z, El-Banna, A, Kemp, A, Scourfield, J, Forrester, D & Nurmatov, U (2019) Intensive Family Preservation Services to prevent out-of-home placement of children: a systematic review and meta-analysis. What Works Centre for Children's Social Care, https://whatworks-csc.org.uk/wp-content/uploads/WWCSC-Intensive-Family-Preservation-Services-to-prevent-out-of-home-placement-of-children-v2.pdf [Accessed 16 August 2019]
[975] Waterton, J, Baker, C & Griesbach, D (2019) Edges of care: entering and leaving the 'care system'. The Care Review for Scotland, Unpublished report
[976] British Association for Social Work and Social Workers (2019) The Anti-Poverty Practice Guide for Social Work, https://www.basw.co.uk/resources/anti-poverty-practice-guide-social-work [Accessed 22 November 2019]

data and on-the-ground knowledge) that practitioners are working with, connecting people to local opportunities, involving people with lived experience of social work; and having conversations that are not based on individual complaints. The guide calls for community social work (and building professionals' skills in this practice); a relationship-based practice framework (including understanding people's life stories and building rapport and trust); and an advocacy-approach, particularly when it comes to helping service users to maximise their income, including ensuring that they claim the support they are entitled to.

These practice messages correspond with the main outline of Krumer-Nevo's poverty-aware social work paradigm and provide a starting point for developing a practice framework that makes poverty and relationship-based work a central concern again to social work. It is also useful to remember here the evidence[977] on the professional approach found to work more successfully with young people who experienced severe disadvantage, which eventually resembled long-term 'natural' relationships.

The work of Children 1st, CELCIS and Social Work for Scotland on poverty-aware social work

The three organisations have recently explored the extent to which poverty is a concern in contemporary social work in Scotland – has it become the 'elephant in the room'?[978] There is recognition that poverty should be part of everyday social work practice and it's time to ensure that it happens. Next steps are in development.

[977] Sandu, R D (2019) What aspects of the successful relationships with professional helpers enhance the lives of young people facing significant disadvantage?
[978] Hill, L (2019) Bread and Butter: Why addressing poverty should matter to social workers. Guest blog for Children 1st https://www.children1st.org.uk/who-we-are/news/blog/bread-and-butter-why-addressing-poverty-should-matter-to-social-workers/ [accessed 31 August 2019]

Mutual Expectations Charter

The Charter has been developed by parents and practitioners as part of the work of the Your Family, Your Voice Alliance. It is for parents and carers, local authorities, their partner agencies, and the people working for them. The aim of the charter is 'to promote effective, mutually respectful partnership working between practitioners and families when children are subject to statutory intervention'[979], including child welfare and family justice. The expectations (what parents can expect from professionals and what professionals can expect from parents) speak to many of the themes set out earlier such as mutual respect, courtesy and honesty; working together to keep children safe; being open to hear each other's views; sharing information; being able to contribute to and challenge decisions; and timely and honest communication. Poverty is not mentioned directly, but it is referred to indirectly in parents' expectation that their feelings and circumstances are understood and that they are not to be blamed for things beyond their control.

Family group conferencing and family group decision making

A Family Group Conference 'is a process led by family members to plan and make decisions for a child who is at risk'. It is a voluntary process, with the participation of family members, professionals, and often the child (frequently with an advocate)[980]. It is available in five local authority areas in Scotland (and elsewhere in the UK). An academic review noted the relatively modest amount of evidence on outcomes for children as a result of this process compared with 'traditional' child protection interventions. It concluded that family group conferencing was no less effective (even though it could not argue that it was more effective) than traditional interventions, and besides, evidence showed it to be an empowering,

[979] Family Rights Group (n.d.) Mutual Expectations – A Charter for Parents and Local Authority Children's Services, https://frg.org.uk/involving-families/your-family-your-voice/mutual-expectations-a-charter-for-parents-and-local-authority-children-s-services [accessed 8 August 2019]

[980] For more information see https://www.frg.org.uk/involving-families/family-group-conferences

restorative and strength-based approach that promoted partnership between families and the state.[981]

Linked to Family Group Conferences, *Lifelong Links* is a life-long support plan for a young person who has been looked-after for less than three years and there is no plan for them to live within their family or be adopted. The plan is supported by adult family members and other adults who care about the child (including former foster carers and teachers), who are willing to make a life-long commitment to the young person. The plan is drawn up and reviewed via Family Group Conferences. The approach has been trialled since 2017 and includes five Scottish local authorities. CELCIS is one of the evaluators of the programme. Initial data indicates that in Scotland a participating young person's network has increased by 25 people on average as a result of Lifelong Links.[982]

In summary

At the level of national policy in Scotland, there is greater recognition of the need to tackle adverse childhood experiences (ACEs) in order to reduce child poverty than of the role of (child) poverty in child protection and in caring for looked-after children. This is by and large similar to the way statutory and other professional social work guidances approach the issue. However, a new anti-poverty guidance from BASW, and emerging work in Scotland, both wish to steer social work towards a more poverty-aware practice.

Beyond general Scottish Government policies on reducing (child) poverty, there are a range of approaches with potential to support families, children and young people with experience of child welfare interventions in the context of low income. Some of these include targeted interventions to provide financial help to families (currently piloted in England), and paying

[981] Frost, N, Abram, F & Burgess, H (2014) 'Family group conferences: evidence, outcomes and future research', *Child and Family Social Work* 19 501-507. doi:10.1111/cfs.12049
[982] For more information see https://www.frg.org.uk/involving-families/family-group-conferences/lifelong-links#what-is-the-evidence-of-the-impact-of-lifelong-links

a social justice premium to care leavers. Other interventions are aimed at child maltreatment, such as ANEW in Scotland, home visiting, social support for mothers and intensive family preservation programmes.

People with experience of child welfare interventions have contributed to the Mutual Expectations Charter, which aims to improve relationships between families and professionals. They also play a key role in programmes that are focused on better outcomes for children (Family Group Conferencing, or Lifelong Links for looked-after children). They are important exemplars of partnership working between families and professionals.

5. Trans-generational patterns of care

Similar to children's situations prior to becoming looked after, there is no systematic data collection and reporting on intergenerational and recurring cycles of care in Scotland.[983]

The already quoted research report by the Scottish Children's Reporter Administration (SCRA) indicates that the recurrence of child protection interventions is significant. It found that approximately 60 per cent of children who were placed on a Compulsory Supervision Order before the age of three had a parent (or parents) who had had social work involvement as a child and/or had been a victim of abuse or neglect as a child.[984]

People with care experience engaging in the work of the Care Review also confirmed the existence of a trans-generational care experience, interconnected with poverty, and transmitted through social norms (described by them as 'a culture'):

> *"....Both my parents were care experienced and it's a thing in my family. A culture within impoverished communities, that's a cycle."*[985]

As child maltreatment is a major (even if not the only) reason why children and young people are in state care, it is relevant to look into its trans-generational transmission in order to learn more about the trans-generational pattern of the care experience. It is a recognised concern in

[983] CELCIS (2018a) Statistical overview for the Care Review
[984] Woods, R, Henderson, G, Kurlus, I, Proudfoot, P, Hobbs, N & Lamb, D (2018) Complexity in the lives of looked after children and their families in Scotland: 2003 to 2016. Scottish Children's Reporter Administration https://www.scra.gov.uk/wp-content/uploads/2018/03/Complexity-in-the-lives-of-looked-after-children-and-their-families.pdf [accessed 18 June 2019]. The study analysed data from a total of 240 case files from six local authorities, from two time points 10 years apart. The sample included children who were looked after at home or away from home. The 60 per cent figure was similar at both time points (Appendix, p 42).
[985] 1000 Voices and the Care Review Secretariat (2019) Summary voice Report: Early Themes from Participation

child protection practice; for example the National Risk Framework considers parental experience of unresolved childhood trauma, poor or abusive parenting and being abused as a child to be risk factors to children's wellbeing, whereas a strong relationship with the parent's own parents/carers and no previous history of abuse are seen as protective factors.[986]

Evidence from a recent meta-analysis of 84 studies from Western countries has found that parental experience of maltreatment is a significant predictive factor in child maltreatment, thus 'the odds of the maltreatment history repeating itself are substantial'[987]. And yet, similar to the link between poverty and child abuse and neglect, parental maltreatment is 'neither a necessary nor a sufficient factor' in the reoccurrence of child abuse and neglect. Some parents who were not maltreated as a child maltreat their children and the majority of parents who were maltreated do not maltreat their own children, which means it is possible to break the cycle.

The study identified parental experience of maltreatment as one of *several* risk factors in committing child abuse and neglect – others identified by various research studies were attachment insecurity, social isolation of parents, young parental age, stress, poverty, parental mental health problems, maternal substance abuse and parents' (current) violence victimisation. The study also noted that parenting has changed over the years: what would have counted as acceptable parenting would count as maltreatment later. Protective factors include escape from poverty and having social support, as well as supportive relationships with non-abusive adults (both as a child and as an adult). The study did not look to identify causal chains between the factors and was unable to investigate whether

[986] Calder, M. C. *et al* (2012)
[987] Assink, M. *et al* (2018) The inter-generational transmission of child maltreatment: a three-level meta-analysis. *Child Abuse & Neglect* 84. 131-145. doi.org/10.1016/j.chiabu.2018.07.037. p. 142. The study also called for substantial research that would make it possible to quantify the risk of trans-generational transmission more accurately.

different types of maltreatment increased or decreased the risk of transmission (but added that different types of maltreatment are known to co-occur, which makes establishing such links more complex).

An earlier cohort study undertaken in Essex, England,[988] did indeed show that it was possible to break the cycle, and that the vast majority of parents who had been abused as a child did so. This study found a six point seven per cent transmission rate of abuse in the child's first year of life (nine out of 135 families with a parental history of abuse), but warned that prospective studies such as this may under-estimate figures (whereas retrospective studies tend to over-estimate). Significantly, the Essex cohort study found that those parents who broke the cycle of maltreatment had similarly high risk profiles to those who maintained the cycle, and also to those who maltreated their children without a history of their own. This profile included increased prevalence of: mental illness, substance misuse, living with a violent partner, being a young parent and less positive parenting styles. The difference was in the *protective* factors that cycle breakers had. In contrast with those who maintained the cycle of abuse, feelings of social isolation and serious financial difficulties were less prevalent in parents who broke the cycle. Compared with parents who maltreated their children but did not have a history of abuse of their own (zero point four per cent of those not reporting a history, but in terms of numbers, twice as many parents as those who had a history), a lower proportion of cycle breaker parents were single parents and/or had serious financial problems. From this, the study concluded that *better social support* and *financial solvency* are protective factors against maltreatment.

[988] Dixon, L, Browne, K & Hamilton-Giachritsis, C (2009) 'Patterns of Risk and Protective Factors in the Intergenerational Cycle of Maltreatment', *Journal of Family Violence*, vol. 24, no. 2, pp. 111-122. https://doi.org/10.1007/s10896-008-9215-2. The study only collected data on physical/sexual abuse as one general category.

Beyond the importance of social support and freedom from financial stress, other important factors have been highlighted by research that had a role in breaking the cycle.

Approaching from a psychological perspective, it has been suggested that parents who had been abused as children but did not abuse their own children had gone through a *conceptual change* (in the sense of both as a process and as an outcome) on their own accord[989]. This consisted of switching their own belief from their parents' belief that abuse was *not wrong* (80 per cent reported that their parents had believed this); being able to distinguish between what was not within their control (having been abused) and what *was* (their own actions as parents); and adopting coping mechanisms – some positive (such as learning about abuse or meditating), some less so (e.g. over-eating), but not using justifications or excuses.

Developing this work, a qualitative (US) study[990] looked at how parents who did maltreat their children perceived and connected their own experiences of childhood abuse with maltreating their own child. According to this study, parents may differ in their awareness of intergenerational patterns of maltreatment in their families; likewise, they may or may not want to be different as parents (including their beliefs about what a 'good parent' does), and if they want to be different, their actions may or may not be consistent with their intentions. The practical relevance of this is that targeting therapeutic interventions for parents who have maltreated their children according to where they are on these dimensions, and co-ordinating therapy with other help, such as mitigating financial pressures, would have a better chance of success.

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[989] Wilkes, G (2002) 'Abused child to Nonabusive Parent: Resilience and Conceptual Change', *Journal of Clinical Psychology*, vol. 58, no 3, pp. 261-276. https://doi-org.knowledge.idm.oclc.org/10.1002/jclp.10024. Wilkes suggests that the conceptual change non-abusive parents go through is a fundamental shift that cognitive psychology describes as 'strong (or radical) restructuring'.
[990] McWey

In addition, a recent evidence review for the Scottish Government pointed out that 'their child's manifestation of stress may evoke powerful feelings stemming from their own traumatic experiences' in parents. Past traumas may interfere with their own parenting role, and parents with unresolved traumas are at higher risk of adopting 'atypical' parenting behaviours. Such parents may themselves require parenting and nurturing, but may be fragile and not yet ready to receive support.[991]

At a conceptual level, it may be helpful to return to the idea of *linked lives,* a key principle in life course theory, which gives an account of patterns in human lives[992] (briefly mentioned in section two, in the context of economic hardship and parental stress[993]). Parents and children live intricately linked lives, sharing contexts and history, thus much of children's socialization happens through this relationship. As we have seen earlier, the link between lives also extends to stressors in parents' lives that deeply affects children's wellbeing and future material circumstances. It is perhaps not surprising then that some negative patterns of parenting are more likely to be repeated by the next generation. This narrative is consistent with the analysis of people with care experience quoted above. It also seems that essentially the same risk factors contribute to child maltreatment in general as those that transmit it to the next generation (as well as a history of maltreatment being a risk factor), and there is a similarity in protective factors too.

In summary

Evidence from people with care experience and indicative figures from research in Scotland suggest a higher proportion of care experience among children whose parents also had been in care. There is more substantial evidence to show a higher transmission rate of child abuse and

[991] Scott, J & Daniel, B (2018a) Tackling child neglect in Scotland
[992] Elder, G H Jr (1998) 'The life course as developmental theory' Child Development, vol. 69, no. 1, pp. 1-12 https://doi-org.knowledge.idm.oclc.org/10.1111/j.1467-8624.1998.tb06128.x
[993] Yuan, A S V (2008) Exploring the changes in economic hardship and children's lives over time

neglect to children of parents who had been maltreated as a child. Importantly, most parents with a history of maltreatment do not maltreat their own children, and some parents who do, do not have a history of being maltreated as a child.

Additional risk factors of trans-generational transmission of maltreatment include: mental illness, substance misuse, living with a violent partner, being a young parent and less positive parenting styles. Key protective factors that help people break the cycle are better social support and financial solvency. Qualitative evidence suggests that parents who break the cycle also undergo a conceptual change.

6. Conclusions

The overall picture on poverty, child abuse and neglect, and the care experience in Scotland is a decidedly mixed one: important things that are known and others that are not, some concerns, dilemmas, some positives and some glimpses of hope.

What *facts* are known and unknown:

- Poverty, including child poverty, is lower in Scotland than elsewhere in the UK: this is positive, but the upward trend over the last few years is a concern, and rates are expected to rise further.
- The majority of people in poverty live in households where someone is in work: this includes almost two-thirds of children; work is no longer a reliable way out of poverty for many.
- The high proportion of children living in families where someone has a disability is concerning, and so is the proportion of children in poverty in single parent families.
- Poverty affects key outcomes for people (such as healthy life expectancy) and is consistently in the background of serious and multiple disadvantage – many of these disadvantages (such as substance misuse, mental ill-health, domestic violence) also increase the risk of children suffering abuse and neglect.
- Poverty is stressful, and it can affect people's decision-making processes, and the way they relate to the outside world.
- Official figures do not exist on the socio-economic circumstances of children and young people who have come into contact with the child welfare 'system'. This applies both to those who experienced, or are at risk of, abuse or neglect, and looked-after children.
- There is no official data on the transmission of maltreatment and the care experience across generations, nor on the role of socio-economic circumstances in this.

What is known and not, about *links*:

- There is sufficient evidence to show that entry to the 'care system' has a social gradient in Scotland: the more deprived an area a family lives in, the more likely that the children enter the 'care system'. The social gradient is also evident when children are placed on the child protection register.
- The evidence also supports the existence of a link between poverty (or socio-economic disadvantage) and an increased risk of child poverty and neglect: poverty is deemed to be a contributory causal factor in child maltreatment. This too shows a social gradient. However, evidence is lacking on important detail, such as demographic patterns.
- The existing evidence suggests a higher rate of transmission of child abuse and neglect to the children of parents with a history of maltreatment as a child (compared with parents who had not been maltreated) – less is known about the transmission of care experience, but as child maltreatment is a key factor in children entering care, it is reasonable to conclude that some transmission is likely.
- The link between poverty and the risk of abuse and neglect seems to exist independently of any biases in the 'system' – but there is little evidence on the nature of the links between poverty and different types of abuse, likewise on the extent to which ''system'-related' factors play a role (including various types of bias).
- Despite the increased risk, the majority of families in poverty do *not* maltreat their children, neither does maltreatment happen only in families living in poverty. This also applies to the transmission of maltreatment across generations: the majority of parents with a childhood history of maltreatment do not maltreat their child, and parents with no history of maltreatment may still maltreat their child.

What is known to make a *difference*:

- Changes to families' financial situation can increase, or reduce, children's chance of experiencing neglect and abuse, as well as their entry to and exit from the 'care system'; much of the evidence is US-based and there is not yet enough known about the mechanisms through which change happens. The absence of financial stress also appears as a protective factor in the trans-generational transmission of abuse and neglect.
- Good social support for mothers appears repeatedly as a positive factor: helping to prevent stress from developing into depression; helping to ensure better outcomes for the children of low-income mothers; as well as being a protective factor in child maltreatment and in its transmission.
- Some risk factors emerge in the evidence that are common to child abuse and neglect and its transmission: such as being a young parent, poorly educated, from a background of poverty, having mental ill-health, living with domestic violence and having a less positive parenting style. It is also important to appreciate that these factors cannot be simply added up – they interact with each other in ways that affect the outcome.
- Stress acts as an important mediating factor between various pieces of the jigsaw: between poverty and factors that make family life harder (such as anxiety and depression, short and long-term health conditions, domestic violence, substance misuse, harsh parenting), and also between parenting and an increased risk of abuse and neglect.

Poverty, deprivation, child abuse, neglect, and care experience are not often discussed side-by-side, let alone get considered in an integrated way, in current policy and practice. As this paper has argued, reducing child poverty is a national policy focus in Scotland, and tackling adverse childhood experiences (including abuse and neglect) is seen as one of the

ways of achieving it. In national policy on child protection and looked-after children, however, poverty and deprivation only appear as marginal or background issues, if at all – much of the focus is on parents' individual risk factors and capacity to change. It is no surprise therefore that official data is absent on families' socio-economic circumstances. For practice, poverty and deprivation have thus become akin to a 'wallpaper'[994] that looms large in the background but for the most part goes unobserved.

There are signs of change, however. The recent BASW Anti-Poverty Practice Guide, as well as the on-going work of CELCIS, Children 1st and Social Work Scotland, point to the recognition that practice has become too detached from the material circumstances of the families it works with, and from the structural factors that drive poverty and disadvantage. The pilot programmes in England which include financial assistance to families are also part of broadening the focus to include material circumstances.

What is less clear so far is the extent to which the social gradient in child protection interventions and state care, and particularly in rates of child abuse and neglect, are recognised as part of the newly emerging anti-poverty practice. The latter is an especially challenging issue in an environment where individual parental capacity is still the cornerstone of policy and practice; and where highlighting this link could well be taken as confirmation that parents in poverty are less capable parents. It could also compound the stigma already attached to poverty, and indeed many professionals are reported to prefer not to speak about poverty in child protection practice so as to avoid stigmatising parents.

To ensure that this does not happen, anti-poverty (or poverty-aware) social work should, as the BASW guide outlines, be ready to call for policy to recognise 'systemic' issues in child protection (such as its detachment

[994] This expression was used by Professor Kate Morris and her colleagues in their article 'Social work, poverty and child welfare interventions'.

from socio-economic circumstances), advocate on behalf of individual families in poverty, and build relationships with the families it works with. Further, it is also necessary to develop a deeper understanding of the various ways in which poverty affects people who live with it, beyond the immediately visible lack of material resources, including (but not stopping at) the mediating role of stress. The purpose of this is not to become uncritical advocates, but to be able to work with people in a more humane, kind, and also more effective way.

The voices of families and individuals with experience of child welfare interventions and state care tell much the same story about the way the 'system' currently works, from feeling judged and blamed, to wanting better recognition of their circumstances, and better relationships with staff. In particular, voices with care experience spoke of wanting relationships with people who understand and care about them, rather than more detached 'professional' transactions. There is also some evidence to suggest that for young people with severe disadvantage the relationships that tend to work best are indeed those that resemble 'natural' relationships.

The contribution of people with experience of child welfare interventions to the Mutual Expectations Charter, as well as their role in Family Group Conferencing and Lifelong Links, show their willingness and capacity to work with professionals and others to keep children safe and well. It is also important to remember that people exercise agency in their own lives - such as parents with a history of child abuse who make a conceptual shift and do not go on to abuse their own children - but those who have good social support and are free from financial worries are more able to do so.

To summarise, the main take-aways for the Care Review for Scotland are:

- to call for a shift that recognises the role of poverty and disadvantage in child welfare policy and practice

- to support anti-poverty practice initiatives in child welfare services, targeted interventions that improve families' material circumstances, and those that enhance relationships between families, individuals and professionals
- to advocate for a deeper understanding of the many ways in which poverty affects people's lives
- to bring the evidence regarding the social gradient in child welfare interventions, state care, and child maltreatment out into the open, making it clear that poverty is *one* contributory factor and tackling it is a route to improve outcomes for children
- more broadly, to highlight the crucial importance of, and encourage every effort to, tackle child poverty in Scotland.

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Parents' Experience of the 'Care System'

A Review of the Literature

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1. Introduction

Navigating Scotland's complex 'care system' is a challenging experience not only for children and young people but also for parents and families.

This paper will consider parental experiences of the 'care system'; the challenges, obstacles and supports from an international perspective. This report will include consideration of both parents who have lived experience of the 'care system' and those who have engaged with the 'system' through their own children.

2. Parents experience of the 'care system'

Much of the existing literature which explores the experiences of parents within the 'care system' does not distinguish between parents who have personal experience of the 'care system' and those who experience the 'system' through their children.

Existing research has noted that where there are child protection concerns, balancing the needs and wellbeing of care experienced parents with that of their child is described as a point of conflict. Parent's perception of social work can change from seeing workers as a source of support to that of feeling caution and fear.[995] One mother articulated the feeling of '*being under a magnifying glass.*'[996] This included feeling under suspicion of harming their child/ren or placing them at risk. Many of the mothers who contributed felt any mistakes they made were exaggerated and thus instigated child protection referrals. Additionally, parents spoke of social workers threatening child protection investigations if they had missed a doctor's appointment or re-established contact with the birth father.[997] This intense state focus on those with care experience was further explored in interviews with older care experienced parents who reported feeling judged and stigmatised due to their 'care label' which they

[995] Chase, E., Maxwell, C., Knight, A. and Aggleton, P. (2006) Pregnancy and parenthood among young people in and leaving care: what are the influencing factors, and what makes a difference in providing support? *Journal of Adolescence*, *29* (3), pp.437, 445
[996] Haight, W., Finet, D., Bamba, S. and Helton, J. (2009) The beliefs of resilient African-American adolescent mothers transitioning from foster care to independent living: A case-based analysis. *Children and Youth Services Review*, *31*(1), pp.53, 58-59
[997] Ibid pp.53, 58

acknowledged had led to feelings of insecurity, isolation and low self-confidence.[998]

Feelings of suspicion caused some parents to feel judged and incapable of being a good parent. One young mother who was residing in foster care with her baby expressed the emotional impact of feeling judged just because she was in care.

> *"Being in foster care for me and with my kids as well, it hurts a lot emotion wise because…they make…you feel like a horrible person. They make you think you are a bad mother."* [999]

One parent described the change in attitude from social work she felt when she became a parent. Despite the fact the state should have had a responsibility towards her as a child in their care, she found that services only became increasingly involved when she had a child and the child's needs, as opposed to her own, were deemed as a priority.

> *"Social services where not in my life when I was pregnant, but the moment he was born, they were in on me, there in my face in five minutes, making it very stressful."* [1000]

This prioritisation is reflective of modern child protection 'systems' which place a focus on the child to the detriment and the expense of the parent. The concept of the 'best interests of the child' is described as having 'international currency' whereby social work has been reformed into overtly formalised state intervention under the guise of early intervention

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[998] Weston, J.L (2013) Care leavers experiences of being and becoming parents. PhD Thesis. University of Hertfordshire. Available at: https://uhra.herts.ac.uk/bitstream/handle/2299/13227/10280098%20Weston%20Jade%20final%20DClinPsy%20submission.pdf?sequence=1&isAllowed=y [Accessed: 5 November 2019] p68

[999] Haight, W et al (n2) pp.53, 57

[1000] Chase, E. et al (n1) p437, 445

and prevention which utilises the law to remove children at an earlier stage and place them for adoption.[1001]

Complex 'systemic' processes were felt to exacerbate mothers' fears of their children being removed without tangible support being provided to help them and without recognition of the trauma they had experienced in their own childhoods.[1002]

This is summed up by Rutman et al.

> *"While risk assessment processes contribute to the ministry's stigmatization and (hyper) scrutiny of young mothers in care, these processes do not necessarily result in young mothers gaining access to the services and assistance that they say they need in order to have support in caring for their own children."* [1003]

This results in care experienced parents having to work even harder than non-care experienced parents to maximise their potential and use their current skills, capabilities, and qualities to offset their history.

[1001] Featherstone, B., Morris, K. and White, S. (2013) A marriage made in hell: Early intervention meets child protection. *British Journal of Social Work*, *44*(7), pp.1735, 1736
[1002] Broadhurst, K. and Mason, C. (2013) Maternal outcasts: raising the profile of women who are vulnerable to successive, compulsory removals of their children – a plea for preventative action. *Journal of Social Welfare and Family Law*, 35 (3), pp. 291, 298.
[1003] Rutman, D., Strega, S., Callahan, M. and Dominelli, L. (2002) 'Undeserving' mothers? Practitioners' experiences working with young mothers in/ from care. *Child & Family Social Work*, 7(3), pp.149, 158.

3. Conflating poverty with neglect

Gupta et al. argue that prior to making assessments relating to parental failure in providing reasonable care for a child, exploration is needed as to the various personal, social, and environmental factors that can affect a parent's capabilities, such as poverty and deprivation.[1004]

Gupta et al. argue that risk assessments that do not account for poverty and structural inequalities result in evidence being presented at Court which is stripped of context and potentially blaming care experienced parents for their experiences of deprivation.[1005] Entwistle and Watt highlight the need for social workers to utilise their role to promote the strengths and capabilities of parents.[1006]

A joint briefing paper produced by CELCIS, Children 1st and Social Work Scotland highlights that there is a complex link between poverty and neglect which suggests that poverty may be a tipping point for some families leading to their children being taken into care, whereas more affluent families tend to go under the radar.[1007] Failing to engage with the parent and child as a family unit and taking a holistic approach to needs can lead to parents being blamed for matters out with their control, such as unstable housing, mental health issues and lack of social supports.

[1004] Gupta, A., Featherstone, B. and White, S. (2016) Reclaiming humanity: From capacities to capabilities in understanding parenting in adversity. *The British Journal of Social Work*, *46*(2), pp.339, 350
[1005] Ibid pp.339, 350
[1006] Entwistle, V.A. and Watt, I.S. (2013) Treating patients as persons: a capabilities approach to support delivery of person-centered care. *The American Journal of Bioethics*, *13*(8), pp.29,39
[1007] Hill, L., Riddell, C. and McEwan, B. (2018) *Addressing Poverty and Child Welfare Intervention: What do we need to do differently in Scotland?* Glasgow: CELCIS, Children 1st and Social Work Scotland.

In a society where class, race and gender inequalities remain so vast[1008] studies have found that risk profiling is likely to reinforce existing inequalities in the 'system' rather than reduce them.[1009] State intervention in these circumstances risks adding further trauma to the parent and the child thus perpetuating an intergenerational cycle. The trauma caused by overly punitive and non-holistic approaches within child protection are reiterated by one parent who felt scrutinised rather than supported.

> *"As a child I cried out for help to child protective services. But the system didn't help me when I was a child, and it hasn't helped me as a parent. Almost as soon as my older son was born, child protective services came into my life saying my son needed protection from me, and it has remained in my life to this day. Instead of helping me, it weakened my family and left me vulnerable. Because of the system, my child lives with anger and anxiety."*[1010]

[1008] Meloni, M. (2016) *Political biology: Science and social values in human heredity from eugenics to epigenetics*. New York: Palgrave MacMillan.
[1009] Wilson, M.L., Tumen, S., Ota, R. and Simmers, A.G. (2015) Predictive modelling: potential application in prevention services. *American journal of preventive medicine*, *48*(5), pp.509,519
[1010] Harris, S. (2019) No Escape – The system failed me as a child but now it won't leave me alone. Rise Magazine. Available at: http://www.risemagazine.org/2019/09/no-escape/#more-3810

4. Impact of the 'care system' on care experienced parents

A consistent theme across existing research was the commonly held belief of an intergenerational cycle whereby parents who have experienced trauma and abuse as a child would go on to repeat the same pattern, thus leading to the removal of their own children.

These beliefs are described by Burman as being grounded in stigma.[1011] The belief in the intergenerational cycle is focused on a person's deficits and risks profiling vulnerable families. Goffman refers to this as projecting a virtual identity onto someone based on assumptions of their attributes.[1012] These beliefs left parents fearful that they would harm their children and that social workers were waiting to remove their child at any time.[1013]

> *"That's always what I worried about initially, that what they are saying to you is true, that you know you're damaged and therefore will go onto damage."* [1014]

> *"Adults who were maltreated have been told so many times that they will abuse their children that for some it has become a self-fulfilling prophecy. Many who have broken the cycle are left feeling like walking time bombs."*[1015]

[1011] Burman, E. (2003) Childhood, sexual abuse and contemporary political subjectivities. In Reavey, P. and Warner, S. (Eds) New feminist stories of child sexual abuse. New York: Routledge, pp.35, 52.
[1012] Goffman, E. (2009) Stigma: Notes on the management of spoiled identity. New York: Simon and Schuster. P. 2.
[1013] Weston, J.L (2013)] (n4) p49
[1014] Ibid p48
[1015] Kaufman, J. and Zigler, E. (1989) The intergenerational transmission of child abuse. *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect*, pp.129,150.

Research conducted by Keddell explores whether children from disadvantaged and ethnic minority backgrounds have disproportionate contact with the child protection 'system' due to bias in risk assessments used by social workers whereby interventions are based on statistical likelihood of future behaviour.[1016] Furthermore, recent research has supported an increase in observation for parents who are identified as potentially a high risk for providing poor quality care for their children.[1017] Chaffin et al. state therefore that this fails to take into context social and material circumstances such as poverty that undermines parents' capabilities.[1018] Care experienced parents are therefore, due to their own childhood experiences, increasingly likely to experience continued state intervention[1019] thereby increasing the likelihood of a child being taken into care.[1020]

In some local authorities in England, child protection proceedings are automatically instigated for every care leaver who becomes a young parent.[1021] The impact of feeling judged by their past was felt strongly by care experienced parents which often acted as another barrier when trying to succeed and move beyond their childhood experiences. Furthermore, such stigma directly impacted parents' feelings of reluctance

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[1016] Keddell, E. (2018) Risk prediction tools in child welfare contexts: the devil in the detail. Blog Available at: http://www.husita.org/risk-prediction-tools-in-child-welfare-contexts-the-devil-in-the-detail/ [Accessed 13 October 2019].
[1017] Widom, C.S., Czaja, S.J. and DuMont, K.A. (2015) Intergenerational transmission of child abuse and neglect: Real or detection bias? *Science*, *347*(6229), pp.1480,1485.
[1018] Chaffin, M., Kelleher, K. and Hollenberg, J. (1996) Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child abuse & neglect*, *20*(3), pp.191,203.
[1019] Garland, D. (2014) What is a "history of the present"? On Foucault's genealogies and their critical preconditions. *Punishment & Society*, *16*(4), pp.365, 384.
[1020] National Foster Care Association (1997) cited In Warwick, I., Knight, A., Chase, E. and Aggleton, P. (2008) Supporting young parents: Pregnancy and parenthood among young people from care. Jessica Kingsley Publishers.
[1021] Sale, U.A. (2007) Care leavers parenting skills doubted by social workers. Community Care Website Available at: http://www.communitycare.co.uk/articles/28/11/2007/106611/ [Accessed 18 September 2019]

to seek help when necessary due to concerns about appearing incapable or neglectful.[1022]

> *"I have strikes against me…As soon as I walk in the door, that's what you're going to see: a black young mother. I am going to get the stereotypes you know. Being in foster care, that's kinda another strike against me because kids in foster care are already looked at as bad asses…they probably got in foster care because of something they did…I have extra baggage on top of everything."* [1023]

Existing evidence suggests that many workers felt that early childhood experience determines adult behaviours.[1024] This was reflected in the research which explored practitioner's experiences of working with young care experienced mothers.

> *"I think when the bonding process between mother and child is disrupted, that child is probably going to be into a lifetime of uncertainty and chaos…if that doesn't happen, you know you're sunk. We have a lot of kids who have never bonded with anyone and probably won't. Those formative years are so important."* [1025]

Edwards et al. refer to this belief as *'overly fatalistic'* and an attempt to simplify otherwise complex physical, psychological and emotional human development and responses to trauma.[1026] Moreover, Cleaver et al. conclude that parents provided with adequate support are often able to be effective and loving parents and present little risk of significant harm to

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[1022] Rutman, D. et al (n9)
[1023] Haight, W et al (n2) pp.53, 57
[1024] Rutman, D. et al (n9) pp.149, 152
[1025] Ibid
[1026] Edwards, R., Gillies, V., Lee, E., Macvarish, J., White, S. and Wastell, D. (2017) The Problem with 'ACEs'. Blog submitted to the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention. Available at: https://blogs.kent.ac.uk/parentingculturestudies/files/2018/01/The-Problem-with-ACEs-EY10039-Edwards-et-al.-2017-1.pdf [Accessed 19th September 2018].

children.[1027] However, for parents who are experiencing interlinking, multiple problems, such as mental health and wellbeing issues, experience of domestic violence, or having experience of abuse themselves, there is a substantial increase in the likelihood that children will be exposed to maltreatment.[1028]

> *"They have a lot of history which can't just be ignored. There's some good things, but there's some flags. And especially if you have been working with the family over the generations. It's a worry."* [1029]

Moreover, some workers suggested an assumption that parents would ultimately fail due their own lack of a positive parenting experience.

> *"These kids have never been parented and so they are not going to be parents, so it's kind of becomes a vicious circle."* [1030]

Roberts and Weeks propose that negative beliefs about particular groups may be so deeply ingrained within society that there was potential for unconscious bias to arise.[1031] In this way, workers were noted to pre-judge outcomes for people, including those related to an intergenerational cycle and inevitability of care experienced parents following in their parents footsteps.

> *"This one girl, I was really happy or heartened that she would say to me and her foster mother, after years of a chaotic abusive history that she did not want to repeat the cycle...and then she went and got*

[1027] Cleaver, H. and Unell, I. (2011) *Children's needs-parenting capacity: child abuse, parental mental illness, learning disability, substance misuse, and domestic violence*. 2nd ed. Norwich: The Stationery Office.
[1028] Dixon, L., Browne, K. and Hamilton-Giachritsis, C. (2005) Risk factors of parents abused as children: a mediational analysis of the intergenerational continuity of child maltreatment (Part I). *Journal of child Psychology and Psychiatry*, *46*(1), pp.47,57.
[1029] Rutman, D. et al (n9) pp.149, 152
[1030] Ibid (n9), pp.149, 152
[1031] Roberts, J. and Weeks, E. (n27) p.488

> *pregnant. And of course, the child was apprehended and now she's pregnant again."* [1032]

Kaufman and Zigler report there is a dearth of empirical evidence to support the belief of the intergenerational cycle.[1033] Research found that the majority of maltreated children do not become abusive parents and other factors such as personality, coping skills and social supports may act as a buffer to prevent trauma being passed on through parenting.[1034]

[1032] Rutman, D et al (n9) pp149-159, 152
[1033] Kaufman, J. and Zigler, E. (1987) Do abused children become abusive parents? *American journal of orthopsychiatry*, 57(2), p.186.
[1034] Szilagyi, M., Kerker, B.D., Storfer-Isser, A., Stein, R.E., Garner, A., O'Connor, K.G., Hoagwood, K.E. and Horwitz, S.M. (2016) Factors associated with whether pediatricians inquire about parents' adverse childhood experiences. *Academic pediatrics*, 16(7), pp.668, 669.

5. Teenage pregnancy and those with care experience

The majority of studies exploring issues around care experienced young people who become pregnant is focused predominantly on young mothers, either currently in foster care or those who have recently transitioned out of care.

Chase et al. explored the impact young women's experiences, both prior to and during care, had on their decisions relating to pregnancy and in particular how their experiences of care influenced how they viewed and engaged with services.[1035] Similarly, Aparicio highlights how research on teenage motherhood in foster care is underpinned by a risk management lens to the detriment of not exploring the nuances and complexities of motherhood for those with care experience.[1036] With a similar critique of the risk-based narrative, Gillies et al. explained that teenage pregnancy is frequently framed as a public health problem constructed under divisive assumptions that parents with a care background will not parent adequately, thus risking poor outcomes and early intervention by professionals.[1037] Barn and Mantovani argued that the consequences of treating teenage pregnancy as a risk reflects a much wider structural distinction between deserving and undeserving populations, specifically in relation to behaviours and values deemed socially, culturally and economically unacceptable.[1038]

[1035] Chase, E. et al (n1)
[1036] Aparicio, E.M. (2017) 'I want to be better than you:' lived experiences of intergenerational child maltreatment prevention among teenage mothers in and beyond foster care. *Child & Family Social Work*, *22*(2), pp.607, 616.
[1037] Gillies, V., Edwards, R. and Horsley, N. (2017) *Challenging the Politics of Early Intervention: Who's' saving Children and why*. London: Policy Press.
[1038] Barn, R. and Mantovani, N. (2005) Young mothers and the care system: Contextualizing risk and vulnerability. *British Journal of Social Work*, *37* (2), pp.225-243.

6. Stigma and judgement

Goffman theorised that behaviours which deviate from the social norms of a society can discriminate and exclude individuals causing them to feel dehumanised and discredited.[1039]

Link and Phelan refer to stigma as a form of status loss and discrimination facilitated by labelling and stereotypes which serves to create a moralistic distinction of *'them and us'*.[1040]

Similar to the feelings of shame imposed on teenage mothers[1041] a number of studies have evidenced those who are care experienced feeling judged, stereotyped and scrutinised by practitioners and social policies.[1042]

The consequences of these two stigmatising identities are recognised as detrimental to those both with a background in care and being a teenage parent. Chase et al. found this group to experience long-term social exclusion and poor outcomes comparative to their peers.[1043]

Indeed, whilst many parents found the transition to motherhood a positive one, Coler noted that those with care experience were much more likely to have to contend with the critical assumptions that professionals pre-imposed on their parenting abilities, leaving them feeling under increased pressure.[1044] This also was found by Weston to cause parents to have feelings of insecurity, isolation and low self-confidence.[1045]

[1039] Goffman, E. (2009) (n18)
[1040] Link, B.G. and Phelan, J.C. (2001) Conceptualizing stigma. *Annual review of Sociology*, *27* (1), pp.363-385.
[1041] Rutman, D et al (n9) p149,
[1042] Weston, J.L (2013) (n4) p21
[1043] Chase, E. et al (n1) pp437, 438
[1044] Coler, L. (2018) "I Need My Children to Know That I Will Always Be Here for Them": Young Care Leavers' Experiences with Their Own Motherhood in Buenos Aires, Argentina. *SAGE Open*, *8*(4), p.1, 2
[1045] Weston, J.L (n4) p68

Chase et al. found that pessimistic attitudes held by professionals were often as a consequence of teenage parents going against professional advice in proceeding with a pregnancy.[1046] A specialist nurse for children in care attributed this advice to the fear of the potential implications of a young adult in care becoming pregnant.[1047] Rutman et al refer to this as reinforcing the stigma of teenage pregnancy.[1048] These value judgements are felt by parents and have a negative impact on their self-esteem and their belief in their abilities as a parent.

> *"To other people your child is a mistake because you were not married or because you did not plan it, but your child is a full blessing in your life... the people want you to fail because that's what they expect out of a young mother."* [1049]

[1046] Chase, E. et al (n1) pp437,443
[1047] ibid
[1048] Rutman, D et al (n9) p.149
[1049] Participant Nevaeh in Haight, W. et al (2009) (n2) pp.53, 57

7. The structural impact of the 'care system'

A body of research highlights the structural difficulties which adversely restrict young adults' capacity to successfully support themselves as they transition out of the state's care, most notably, in relation to housing, employment, education and issues relating to their physical and mental health.[1050]

One of the key challenges for those 'ageing out' of care is the lack of stable housing which Curry and Abrams[1051] found can led to lost opportunities to create stable support networks due to the frequency of house moves and even more significantly, greater rates of homelessness within care leavers.

Lack of stable housing was raised by both professionals and care experienced parents as being a significant concern and described by Chase et al as a 'major stumbling block' with various examples of poor quality housing leaving parents feeling vulnerable and exposed to danger.[1052] Rutman et al identified that whilst workers were aware of these challenges, they felt the situation was outwith their control.[1053] Frequent moves within inadequate accommodation had a detrimental impact on parents ability to create a stable life for themselves and their child(ren), with one parent detailing the impact of feeling unable to protect her child from danger.

> *"You have the responsibility to make sure that your child comes into a safe home. I was in a hostel and then I moved to a mother and baby hostel, it was like a drug house...it was disgusting...rats and mice*

[1050] Haight, W. et al (2009) (n2)
[1051] Curry, S.R. and Abrams, L.S. (2015) Housing and social support for youth aging out of foster care: State of the research literature and directions for future inquiry. *Child and Adolescent Social Work Journal*, *32*(2), pp.143,153
[1052] Chase, E. et al (n1) pp. 437,444
[1053] Rutman, D. et al (n9) pp. 149, 156

> *and ants. I begged everyone to move me on. In the end I was lucky to have a decent social worker and a decent council worker."* [1054]

Rutman et al. noted through consultation with professionals, that workers often felt bound by procedures outside of their control.[1055] These workers conveyed their frustration at the lack of structural support for these vulnerable parents arguing that the state is often setting them up to fail.[1056] Research has identified examples of practice and procedure which has directly constrained vulnerable young parents opportunities to successfully transition out of care into independent living.[1057] One example is a young parent transitioning out of care having her child removed as a consequence of being homeless rather than it being deemed the responsibility of the state to provide accommodation and support.[1058]

[1054] Chase, E. et al (n1) pp.437, 444
[1055] Rutman, D. (n9)
[1056] Rutman, D. (n9) pp.149, 156
[1057] Schelbe, L. and Geiger, J.M. (2017) Parenting under pressure: Experiences of parenting while aging out of foster care. *Child and adolescent social work journal*, *34*(1) pp51,58
[1058] Ibid pp.51, 58

8. Support and opportunities

Additionally, factors which have been found to adversely impact those with care experience include a lack of stable employment and lower attainment within education. Existing research has explored and identified the challenges and barriers that exist for young people, including placement instability, school moves, additional support need, and absenteeism.[1059]

Hook and Courtney have argued that for young people who remain in care past age 18 there are notably increased levels of educational attainment, which translates into improved employment outcomes and opportunities.[1060] Leathers and Testa elucidate that without a permanent family to provide an emotional or practical safety net, care experienced parents are recognised as being more likely than the general population to be below the poverty line and have poor educational outcomes.[1061] These challenges are compounded by the early trauma and fractured relationships which have an impact on individuals' mental health and overall emotional wellbeing.[1062]

[1059] Hook, J.L. and Courtney, M.E. (2011) 'Employment outcomes of former foster youth as young adults: The importance of human, personal, and social capital.' *Children and Youth services review*, 33 (10), pp.1855,1865.
[1060] Ibid pp.1855-1865.
[1061] Leathers, S.J. and Testa, M.F. (2006) Foster youth emancipating from care: caseworkers' reports on needs and services. *Child Welfare*, *85*(3) pp463, 493
[1062] Schelbe, L. and Geiger, J.M. (2017) (n63) pp.51-64.

9. The 'care system's' impact on stable support networks

Research into young care leavers' experiences of motherhood outlined that care experienced mothers often leave the 'care system' feeling notably unprepared and unequipped for motherhood, which is often made worse due to their lack of family support networks and absence of parental role models.

Furthermore, this study highlighted the loneliness a lack of parental role models can have on new mothers and the adverse impact this absence can have on their ability to cope on their own.[1063] Moreover, many parents articulated the need for increased financial and material supports alongside emotional and practical support and guidance. [1064] A key concern for young parents was not having someone they could contact to ask simple questions, advice or seek reassurance.[1065] Research also noted how a lack of support directly impacts a parent's ability to maintain consistent attendance at work or education due to a lack of accessible childcare.[1066]

> *"That's why I really need childcare… I can't rely on other people even though that's my daughter and they love her as much, you know, I can't take other people's time."* [1067]

The lack of a positive parent role model was perceived as pre-emptive of failure. Research also found parents acknowledged feeling strength and support in 'other mothers' who acted as surrogate parents and mentors.

[1063] Coler, L. (2018) "I Need My Children to Know That I Will Always Be Here for Them": Young Care Leavers' Experiences with Their Own Motherhood in Buenos Aires, Argentina. *SAGE Open*, *8*(4)
[1064] Schelbe, L. and Geiger, J.M. (2017) pp.51,64.
[1065] Leathers S. and Testa M. '(n67) pp.463,493
[1066] Ibid (n63) pp.51,57
[1067] Ibid pp.51,57

Having a mother figure to model healthy parenting was said to be incredibly valuable both emotionally and practically.[1068] This was particularly evidenced amongst teenage parents who resided in specialist mother and baby foster placements who described feeling nurtured and valued having someone to teach them how to be a parent. One parent describes how her positive relationship with her foster carer has been a constant source of emotional and practical support for her.

> *"Well I do have a mother. My last foster home, she was a great mother figure for me. I met her when I was 15 and I already had a son. Every time I go to her house I sleep in the old bed I used to sleep in. It's so relaxing. Its home to me. She basically taught me how to become a mother."* [1069]

Additionally teenage parents yearned for someone they could speak to for support and to help reduce the feelings of isolation they felt as a result of stigma they experienced. Research noted that for parents who had attended sessions delivered by fellow young care experienced parents, the experience was extremely valuable as these groups felt non-judgmental and 'normal' amongst other parents with lived experience.[1070] For some, it was a source of therapy, being able to vent about frustrations with others who understand the challenges of being a teenage mother.

> *"It's about making you aware of the different ways to deal with stress, cause sometimes being a teen mom can be stressful. You know, just having an outlet. Having someone you can talk to."* [1071]

Evidence from parents identified that young mothers are an untapped source of support to one another. Speaking to others with shared experiences felt positive, empowering and a positive way forward to bridge the gap for parents who lack family and social supports, but also helps to

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[1068] Aparicio, E.M. (2017) (n42) pp.607, 612
[1069] Haight, W. et al (n2) pp.53, 59
[1070] Aparicio, E.M. (2017) (n42) pp.607, 612
[1071] Aparicio, E.M. (2017) (n42) pp.607, 611

build upon their resilience to overcome the challenges of being a parent.[1072]

> *"I would like to see, actually have a mentor group with foster kids. Like somebody at my age. I would love to go back and mentor…and tell that young girl that just had a child "This is not the end honey…you can go on" … I've been there, I've lived that."* [1073]

For vulnerable care experienced mothers talking with other parents with lived experience of the 'care system', offered a sense of empathy and compassion.[1074] The advice given was more readily accepted and valued as it had been 'lived' as opposed to advice from workers who had been formally trained.

> *"They got degrees and they did a lot, but their parents probably got money. We don't have parents. We don't have anybody. So, they have to understand where we are coming from. They need to put their minds where we are at."* [1075]

[1072] Schelbe, L. and Geiger, J.M. (2017) (n63) pp.51,62
[1073] Haight, W. et al (n2) pp.53, 60
[1074] Schelbe, L. and Geiger, J.M. (2017) (n63) pp.51, 52
[1075] Haight, W. et al (n2) pp.53, 60

10. Parents as advocates

Recently there has been a growing movement towards parental advocacy whereby parents who have lost children to the 'care system' act as mentors towards other parents to improve their capabilities and confidence. Tobis reports that it has massively reduced the number of children in care.[1076]

> *"The parent advocates movement has lifted the pessimism that was persuasive amongst child welfare affected parents…They have a voice and are making a difference in their own lives and the lives of parents throughout the city. Parents have overcome enormous difficulties and have helped move an intransigent system."* [1077]

Tobis explains that a parent advocate is someone who has gone through the difficult experience of having their child placed in care and who has managed to overcome previous difficulties resulting in their child being returned.[1078] The advocate is trained to work with other parents who are going through child protection proceedings and can be based in law firms, social services departments and grass root advocacy organisations.[1079]

Research by Charlton et al. has highlighted the need for parent advocacy as a means of having someone to help navigate through and explain the child protection process to parents as well as give the parent a voice in the

[1076] Tobis, D. (2013) *From Pariahs to Partners: How Parents and Their Allies changed New York City's Child Welfare System.* New York: Oxford University Press.
[1077] Tobis, D. (2013) *From Pariahs to Partners: How Parents and Their Allies changed New York City's Child Welfare System.* New York: Oxford University Press.
[1078] Tobis, D. (2013) *From Pariahs to Partners: How Parents and Their Allies changed New York City's Child Welfare System.* New York: Oxford University Press.
[1079] Tobis, D. (2019) Mom knows best: the new role of parents in children's social welfare: Can parent advocates change the way we view social services?' Available at: https://apolitical.co/solution_article/can-parent-advocates-reform-childrens-social-welfare/?fbclid=IwAR15DVFdepF3gVNmf8vOySq9Uj1fIPPVibQs0eu1ZXqrKCzSHCrjsaDZJ-c [Accessed 21 September 2019].

proceeding, thus suggesting that parent advocacy can lessen parents' anger and feelings of powerlessness.[1080]

One of the most profound consequences of the parent led network is that parents who have faced stigma, shame and isolation find a sense of empowerment and normalisation. There are weekly groups for example which are described as a safe and trusting environment allowing parents to speak freely and discuss their experiences without judgement.

> *"The support group is a pressure valve. It is a weekly meeting without an agenda in which parents are free to rage, cry, whine, and vent with impunity. The group is led by parent organizers. Therefore, the person sitting across the table from you is unlikely to say, "You shouldn't act that way," or "you shouldn't feel that way," or "that is damaging or counterproductive." They are more likely to say, "I remember when I felt exactly that same way. If you like, I can tell you how I lived through it and stayed focused on my goals."* [1081]

Kenny and Barrington refer to numerous research findings that show women's formal and informal support networks are a '*protective factor against child removal*'.[1082]

[1080] Charlton, L., Crank, M., Kansara, K. Oliver, C. (1998) Still screaming: Birth parents compulsory separated from their children. Manchester: After Adoption.
[1081] Tobis, D. (2013) *From Pariahs to Partners: How Parents and Their Allies changed New York City's Child Welfare System.* New York: Oxford University Press.
[1082] Kenny, K. and Barrington, C. (2018) "People just don't look at you the same way": Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children and Youth Services Review, 86*, pp. 209-216.

11. Children as a source of motivation in parent's resilience

Despite the significant challenges care experienced parents encounter such as financial instability, stigma and professional attitudes, it has been noted that teenage parents demonstrated a great deal of resilience which they drew from their own experience of care.[1083]

Aparico found that motherhood brought about a sense of renewed purpose, responsibility and motivation with parents returning to school or gaining employment in the desire to be a good parent and provide independently for their child.[1084]

> *"I think if he wasn't here I wouldn't be in school. I hate school...I want him to see that I finished high school and that I actually became something in life and he can do the same...Every time I look at him (sigh), I'm doing this for you, that's why I get up every day and go there."* [1085]

Across the research, teenage parents spoke very positively about becoming a mother, describing themselves as 'strong' and 'proud'.

> *"Giving birth was one of the best things ever. I'm really proud of my son and of myself for the way I've brought him up and the fact I've done it myself."* [1086]

[1083] Schelbe, L. and Geiger, J.M. (2017) (n63) pp.51, 61
[1084] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54.
[1085] Schelbe, L. and Geiger, J.M. (2017) (n63) pp.51, 58
[1086] Chase, E. et al (n1) pp.437, 443

These findings are reflective of young parents seeking a sense of self. Thus, being a mother enables them to develop a sense of family and having someone to love.[1087]

> *"I thank God for giving me my kids at an early age because it helped me mature more and it helped me understand it's not just me I have to worry about…it gives me someone to love and I never had love and things like that as a child…to give that love to another child and call that child my home is rewarding."* [1088] *"When I became a mother everything changed. Everything was so different. It looked, it actually looked a lot better to me. The world looked a lot…it made a little more sense."* [1089]

Findings suggest that the love from their child fills an emotional void which stems from their feelings of loss relating to a sense of home, of not belonging and longing for love and acceptance.[1090] For many care experienced parents, having a child is the first time they have experienced unconditional love. Having a child brought about a sense of hope for parents, notably in '*providing an anchor in an otherwise extremely disrupted life*.'[1091] The sense of love and family was meaningful to mothers who lacked this in their own childhoods.

> *"He definitely showed me love, like the love that I was missing."* [1092]
> *"The only friend I've got is my baby. And that's why I said I would keep*

[1087] Coler, L. (2018) (n50) p.1, 3
[1088] Participant Arianna in Haight, W., Finet, D., Bamba, S. and Helton, J. (2009) (n2) pp.53, 57
[1089] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54
[1090] Ibid pp.44-54.
[1091] McGuire, C. and Corlyon, J., 1999. *Pregnancy and Parenthood: The views and experiences of young people in public care*. London: Jessica Kingsley Publishers.
[1092] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54.

> *my pregnancy because I've got no family. If I have my baby that's one close family that will never lose me."*[1093]

Pregnancy was seen as a crucial turning point for some mothers, particularly as an opportunity to quit drinking, drug taking and/or other self-destructive behaviours which may have developed as a result of their own lived experiences.

> *"I had one mum who had a child. She was working the streets. She was involved with cocaine and drugs, and she became pregnant as a result of working the streets. When she became pregnant she totally turned her life around."* [1094]

Evidence found that parents felt it was of fundamental importance for their children to not be exposed to the 'care system'. Parents also described a motivation to be the opposite of their own parents and protect their child/ren from the life that they had experienced.[1095]

> *"Definitely a drive that I, there's no way I'm being like them and I don't want my kids to go through what I went through."* [1096] *"I want my daughters' life to be better than mine (emphasis added). Definitely better. I can't expect everything to be perfect, but I don't ever want her to have to deal with the 'system'. Ever. I don't want her to be hungry or nothing…I'm glad to be living and breathing, but I went through a lot of things that I didn't have to go through because my parents just didn't care. I care, so I think that's gonna make a difference."* [1097]

This reflected findings which spoke of parents seeking stability for their child which represented an entirely different pathway and approach to

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[1093] Chase, E. et al (n1) pp.437, 442
[1094] Rutman, D. et al (n9) pp.149, 153
[1095] Ibid
[1096] Weston, J.L (n4) p54
[1097] Schelbe, L. and Geiger, J.M. (2017) (n63) pp.51, 57

that which they had experienced in their own childhoods.[1098] Parents felt determined that their children should experience the opposite of what they encountered such as love, happiness and 'normality'. Parents reflected on their own parents' poor choices and their lack of commitment towards them.

> *"I don't want the chain of abuse to continue. The mistreatment ends with me."* [1099]

Research highlighted that where early abuse was experienced in one's own childhood the process of reflecting on one's own experiences (and making sense of them) may be the key factor in interrupting the cycle of poor parenting and abuse.[1100] This was particularly healing for older care experienced parents who now had some time and distance from their own childhood to reflect and understand their own approach to parenting. It was found that some parents engaged with counselling when they got older which they found helped them to separate their own issues and needs from that of their child's.

> *"Just take what's happened to us, try to understand why that's happened, understand, how that might manifest itself in us, deal with it, and then, resolve to be a better parent."* [1101]

The concept of what it means to be a good parent was an issue that arose consistently in the literature reviewed. Many parents with care experience spoke of being a good mum but with little knowledge of what being a good mum looked like given their own lack of parental role models. For many parents, they simply sought to do the opposite of what they experienced as negative or abusive as a child.

[1098] Coler, L. (2018) (n50) p.1, 5
[1099] Ibid p.1, 5
[1100] Fonagy, P., Steele, M., Steele, H., Higgitt, A. and Target, M. (1994) The Emanuel Miller memorial lecture 1992 the theory and practice of resilience. *Journal of child psychology and psychiatry*, *35*(2), pp.231-257.
[1101] Weston, J.L (n4) p51

Trusting and positive relationships were key to working through the struggles of parenting and having someone they could talk openly with as a source of support. Some parents described having positive role models in the form of foster carers, the community and social workers. Parents felt most supported and capable when those around them were encouraging and believed in their potential to achieve, which in turn served to build self-esteem, confidence and feelings of acceptance for individuals.[1102] Aparicio et al. highlighted the need for parents to feel nurtured whilst learning how to be attuned to the needs of the child.[1103]

Having their own children provoked reflection into individuals own experiences of being parented. Parents spoke of their mothers failing to protect them from sexual abuse, not meeting their basic needs or attempting to cause serious harm to them.[1104] Examining painful memories from the past was countered by parent's determination to achieve the opposite for their own child/ren.[1105] For many, this meant ensuring stability and consistency, including having a consistent caregiver and not having their child endure multiple house moves.

> *"I don't want my child to grow up like how I grew up, like from place to place and people neglecting them. I didn't want to be in care with*

[1102] Ridley, J., Larkins, C., Farrelly, N., Hussein, S., Austerberry, H., Manthorpe, J. and Stanley, N. (2016) Investing in the relationship: practitioners' relationships with looked-after children and care leavers in S ocial W ork P ractices. *Child & Family Social Work*, *21*(1), pp.55-64.
[1103] Aparicio, E.M., Gioia, D. and Pecukonis, E.V. (2018) "I can get through this and I will get through this": The unfolding journey of teenage motherhood in and beyond foster care. *Qualitative Social Work*, *17*(1), pp.96-114.
[1104] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54
[1105] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54

> *a baby…I just had a fear of moving from place to place with my son."* [1106]

Many parents desired a *'normal and happy family life'* for their children.[1107] The fear that parents articulated relating to the possibility of their children entering foster care was an indication of the negative, and at times traumatic, experience that those parents recalled from their own lived experience.

Research found that when parents reflected on their own parents, it was predominantly their mothers who were at the forefront of their mind. This may be understood in terms of it being mother figures who they yearned for in the absence of a positive parental figure to model their own parenting on.[1108] Many parents re-established contact with birth relatives in the hope that now having a child of their own it would improve the bond and unite them as a family.[1109] However Chase et al. note that for some, attempts to re-establish contact with parents led to family breakdown, volatile relationships and lack of consistent emotional or practical support.[1110] Similarly Coler reported how one care experienced parent returned to live with her family following the birth of her child and it left her feeling judged, humiliated and questioning her own parenting style.[1111] For many young mothers, it was a repeated rejection.

> *"It's just new blood in the family and everybody is interested only for five minutes."* [1112]

[1106] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54
[1107] Weston, J.L (n4) p56
[1108] Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54
[1109] Chase, E., et al (n1) pp.437, 445; Aparicio, E., Pecukonis, E.V. and O'Neale, S. (2015) "The love that I was missing": Exploring the lived experience of motherhood among teen mothers in foster care. *Children and Youth Services Review*, *51*, pp.44-54
[1110] Chase, E. et al (n1) pp.437, 445
[1111] Coler, L. (2018) p.1,5
[1112] Chase, E. et al (n1) pp.437, 445

As such, research has highlighted the need for professional support workers to develop a greater understanding of the emotional needs of care experienced parents[1113] and develop more sensitive, individualised relationships to help these parents overcome feelings of mistrust and fear.[1114]

[1113] Ibid p437, 447
[1114] Ibid p437, 447

12. The threat of state involvement on parents

Recent research has explored the impact that high profile cases of child harm have had upon approaches to child protection services leading to increasing examples of the needs of parents and children being in opposition.[1115]

The demands on the social 'care system' are prevalent, with Parton arguing that there has been a move towards a more authoritarian approach to families within child protection services.[1116] Furthermore, Smithson and Gibson describe a child protection 'system' focused on meeting the demands and objectives of Government, which features formal processes and targets that strip social workers of discretion and relationship based practice.[1117] Therefore it is noted that within such a depersonalised 'system', there is little time to stop and reflect on the longer term impact on parents. [1118]

The majority of findings represented a great deal of fear and confusion amongst parents who experience the 'system' and workers as punitive, disempowering and unsupportive.[1119] The lack of power felt by parents and hence their lack of voice within child protection proceedings came across strongly within the research. Care experienced parents described a deep-rooted fear of having their children taken into care. [1120]

[1115] Featherstone, B., Morris, K. and White, S. (2014) *Re-imagining child protection: Towards humane social work with families*. New York: Policy Press.
[1116] Parton, N. (2014) The politics of child protection: Contemporary developments and future directions. Hampshire: Palgrave Macmillan.
[1117] Smithson, R. and Gibson, M. (2017) Less than human: A qualitative study into the experience of parents involved in the child protection system. *Child & Family Social Work*, *22*(2), pp.565-574.
[1118] Smithson, R. and Gibson, M. (2017) Less than human: A qualitative study into the experience of parents involved in the child protection system. *Child & Family Social Work*, *22*(2), pp.565-574.
[1119] Chase, E. et (n1) pp 437, 445
[1120] Hall, C. and Slembrouck, S. (2011) Interviewing parents of children in care: Perspectives, discourse and accountability. *Children and Youth Services Review*, *33 (3),* pp. 457-465.

Accusations of maltreatment along with the threat of child removal are noted to be stressful and traumatic for any parent, but for care experienced parents who have already been exposed to abuse or neglect, the child protection process can lead to multiple and ongoing stressors leading to what Haight et al. terms as *'moral injury'*.[1121] Moral injury is explained as lasting psychological, spiritual and social harm caused by others, particularly in high stakes situations such as the threat of losing a child and the breaking up of a family.[1122] Therefore, a child protection process which fails to convey empathy and understanding of parental need risks increasing the vulnerability of parents and causing long lasting harm. It is necessary therefore to explore the impact of the child protection process through the eyes of parents themselves.

Research highlighted that parents felt overwhelmed and stressed by the 'care system' process and ill equipped for what was to come.[1123] Smithson and Gibson ascertained from interviews with parents that they felt unprepared for child protection meetings with many not having received paperwork in advance of the meeting and therefore having little understanding of the purpose and consequences of the meeting.[1124] One parent explained the pressure of reading a report for the first time at a meeting which subsequently led to a great deal of anxiety and confusion.

[1121] Haight, W., Sugrue, E. Calhoun, M. and Black, J. (2017) Basically I look at it like combat: Reflections on moral injury by parents involved with child protection services. *Children and Youth Services Review, 82(1),* pp. 477-489.
[1122] Haight, W., Sugrue, E. Calhoun, M. and Black, J. (2017) Basically I look at it like combat: Reflections on moral injury by parents involved with child protection services. *Children and Youth Services Review, 82(1),* pp. 477-489.
[1123] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.
[1124] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.

> *"The proper report was given just before I went into the conference…she told me to have a read…I wasn't even reading it properly…I was just flicking through it because I was that nervous."* [1125]

The formal process of attending child protection meetings was also felt by parents to be an intimidating experience and one in which they did not feel treated as equal to the professionals in attendance.[1126] One parent describes her experience as disempowering and leaving her feeling inadequate.

> *"Everyone else in the room had the big fancy important words. They had serious concerns, and I was just left floundering. I am University educated and yet, I had never felt more stupid or broken."* [1127]

The impact of this was that it reduces parents' capacity to engage in meetings or contribute in any meaningful way to discussions or plans about their own child.

Parents also felt judged and experienced stigma and shame when they were not valued or enabled to participate in decision making around their child. Many parents spoke of not having had the opportunity to contribute and feeling prejudged, with decisions being made based on inaccurate reports.[1128]

> *"I had waited patiently through everyone else's dialogue, having not had a single occasion to speak. It turned out the panel had decided that they were closed to discussion. I was tutted at, and then they*

[1125] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.
[1126] Ghaffar, W., Manby, M. and Race, T. (2011) Exploring the Experiences of Parents and Carers whose Children Have Been Subject to Child Protection Plans. *British Journal of Social Work, 42(5),* pp.887, 897
[1127] Mellon, M (2019) 'In their Own Words' Available at <https://www.youtube.com/watch?v=YqPiKqE98DM [Accessed 21 September 2019]
[1128] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.

> *went on to commence their deliberations without ever hearing me. As a mother, and my child's voice, I felt humiliated as though I had failed my child."* [1129]

Research conducted by Smithson and Gibson describe parents feeling attacked and belittled at meetings, and incidences where parents felt cut off by workers and not listened to.[1130]

> *"I felt attacked to be honest with you...when you're sitting around that table, it just feels everyone is against you."* [1131]

Cleaver and Freeman note that, whilst child protection investigations may be routine for professionals, for families, they can be a traumatic event that seriously disrupts family life.[1132] Nussbaum stressed the need for workers to take a capabilities approach based on the importance of valuing parents' contributions and treating parents with dignity and respect.[1133] This is particularly significant given that the majority of children remain at home or return home following concerns of abuse and the impact of allegations has lasting effects long after social services disengage with parents.[1134]

[1129] Mellon, M (2019) 'In their Own Words' Available at <https://www.youtube.com/watch?v=YqPiKqE98DM [Accessed 21 September 2019]
[1130] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.
[1131] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.
[1132] Cleaver, H. and Freeman, P. (1995) Parental Perspectives in Cases of Suspected Child Abuse. London: HM Stationery Office.
[1133] Nussbaum, N. (2009) Creating capabilities: The Human Development Approach and its Implementation. *Hypatia, 24(3),* pp. 211-215.
[1134] Buckley, H., Whelan, S. Carr, N. and Murphy, C. (2008) Service Users Perceptions of the Irish Child Protection System. Dublin: Office of the Minister for Children and Youth Affairs.

13. Relationships with 'care system' practitioners

It has been argued that families' views of services are strongly related to their relationships with social workers.[1135] In Dale's study of child protection services, families valued social workers being supportive, listening, honest, up front and most importantly - human.[1136] Parents sought a positive relationship that moved away from blame and shame and more towards care and compassion.[1137]

One of the most significant findings across the research was the notion of a power imbalance between workers and parents which had an impact on how parents experienced and responded to their involvement with child protection services. Dumbrill highlights the differences in how power is used as a form of control or as a means of support to parents which notably led to differing responses from parents.[1138] For those who reported negative experiences the response was defiant and included fake co-operation.[1139] Parents reported that they had reluctantly complied with a 'voluntary' protection plan on the basis of a threat that their child/ren would be taken into care if they did not do so.[1140] Parents therefore felt constrained and having to do as expected through fear.

[1135] Bilson, A. (2002) Family Support: messages from research. *Representing Children*, 15(1), pp. 10-20.
[1136] Dale, P. (2004) Like a fish in a bowl: Parents perceptions of child protection services. *Child Abuse Review, 13(2),* pp. 137-146.
[1137] Altman, J.C. (2008) Engaging families in child welfare services; workers versus client perspectives. *Child Welfare, 87(3)*, pp. 41-61.
[1138] Dumbrill, G.C. (2006) Parental experiences of child protection intervention: A qualitative study. *Child Abuse and Neglect, 30(1)*, pp. 27-37.
[1139] Dumbrill, G.C. (2006) Parental experiences of child protection intervention: A qualitative study. *Child Abuse and Neglect, 30(1)*, pp. 27-37.
[1140] Dale, P. (2004) Like a fish in a bowl: Parents perceptions of child protection services. *Child Abuse Review, 13(2),* pp. 137-146.

Whilst Kemp recognises there was a strong sense of mistrust amongst parents, he suggests that this could be alleviated through workers understanding the defensive approach and changing their approach to seek to break down barriers rather than respond also in defence to what they may perceive as an attack. [1141] Taking an interest in the parent and demonstrating a down to earth and compassionate approach was valued by parents.

> *"The social workers that we've had … a year now, she understands everything. She understands my frustrations. She understands the kids and she understands what needs to be done."* [1142]

Good communication, being contactable, viewing them as a family and not as just another number on their caseload, was also said to help families feel less threatened and develop a more trusting relationship with workers.

> *"Every time she comes "Is there anything you need or are there any questions? She just listens to me. Just like having a friend really, we just talk. She makes you feel comfortable and at ease."* [1143]

Additionally, difficulties were articulated with regard to workers developing relationships with parents while also acting as agents of the state and being under pressure to adhere to child protection procedures. For care experienced parents, it goes back to the social worker being seen as the 'Guardian' when they were a child in care and then their role as a child protection officer taking precedence when the child in care becomes a parent.

[1141] Kemp, S.P. Marcenko, M.O., Hoagwood, K. and Vesneski, W. (2009) Engaging parents in child welfare services: Bridging family needs and child welfare mandates. *Child Welfare, 88(1),* pp. 101-126.
[1142] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565-574.
[1143] Smithson, R. and Gibson, M. (2018) Less than human: a qualitative study into the experienced of parents involved in the child protection system. *Child and Family Social Work, 22(2),* pp. 565, 568

> *"I saw her (family support worker) as a friend and told her everything…But I realised in the end that everything that I told her was brought up at the case conference and used against me…she stabbed me in the back. I didn't have other people to talk to, I was on my own with the baby, I didn't see mum or dad, I saw her as a friend, that's why I can't trust them no more."* [1144]

It was noted that working in collaboration can help parents achieve a change in thinking and reflect on ways in which they could change their behaviour.[1145] Supporting parents through a process of discovery and transformation, which recognises and supports their strengths achieves far greater results for the parent/worker relationship. [1146]

[1144] Chase, E. et al (n1) pp437, 446
[1145] Gupta, A., Featherstone, B and White, S. (2016), (n10) pp. 339, 351.
[1146] Ibid pp. 339,351.

14. Loss and grief when children are removed by the state

Within the literature reviewed is was evident one of the key ways in which the child protection 'system' impacts on care experienced parents is through the loss and grief they experience from having their child removed from their care, particularly through adoption.

Research from the Centre for Social Justice highlighted a worrying rate of care leavers' children being taken into care.[1147] The findings were reported to be as much as one in ten care experienced parents having their children removed in a single year.[1148] Furthermore, research has identified findings which noted parents feeling resigned to the loss of a child and incapable of preventing it.[1149] This finding was supported within research by Roberts et al. who found that the level of appeals to adoption decisions were lower for those parents with care experience, with suggestions that the lack of appeals by care experienced parents may be because they felt any challenge was futile or they lacked the necessary psychological and practical resources to pursue an appeal.[1150] Roberts et al. noted the need for further exploration of the relationship between care leaver parents and the state was needed to understand the power imbalance felt by parents who were brought up in state care.[1151] This is relevant in the context of parents referring to adoption procedures as a fight.

[1147] Centre for Social Justice (2015) cited in Roberts, L. et al (2017) Care leavers and their children placed for adoption. Children and Youth Services Review, 79(1), pp. 355, 356
[1148] Ibid pp. 355, 358
[1149] Neil, E. (2006) Coming to terms with the Loss of a Child: The feelings of birth parents and grandparents about adoption and post-adoption contact. *Adoption Quarterly, 10(1),* pp. 1, 10
[1150] Roberts, L. et al (2017) (n153) pp. 355, 358
[1151] Ibid pp. 355, 361

> *"I couldn't even change how I was because I was so depressed. I mean I couldn't even look after myself never mind two kids. I suppose I lost the will to fight."* [1152]

As a consequence of state intervention to remove children, parents were left feeling resentment and anger towards the justice system and social work.[1153] A study by Mason and Selman found that parents reported being excluded from case conferences, were not informed of their rights and were often alienated from support networks.[1154] Some parents attributed their anger at feeling 'forced' into the adoption by social work as a result of their life circumstances.[1155] In addition, Dumbrill refers to the adversarial nature of Court proceedings as incredibly damaging and debilitating for parents, having their personal details picked apart, criticised and judged.[1156] Case records were said to be heavily weighted towards the failings of the parent and lacking in positive observations.[1157] This can leave parents feeling a sense of injustice, feeling unheard and betrayed by the professionals involved. Broadhurst and Mason stress that such anger and resentment towards social work and Court is likely to carry over into subsequent pregnancies and create a barrier to developing trusting and productive relationships.[1158]

In order to fully appreciate the gravity of parents' loss, it is necessary to understand how it feels first-hand by parents. Findings by Carolan et al. demonstrate the stages of loss and emotion for parents who have had a child removed.

[1152] Neil, E. (2006) (n155) pp. 1,11
[1153] Broadhurst, K. and Mason, C. (2017) Birth parents and the Collateral Consequences of Court-Ordered Child Removal: Towards a Comprehensive Framework. *International Journal of Law, Policy and The Family, 31,* pp. 41, 48.
[1154] Mason, K. and Selmon, P. (1997) Birth parents experience of contested adoptions. *Adoption and Fostering, 21(1)*, pp. 21,28
[1155] Neil, E. (2006) (n155) pp. 1, 14
[1156] Dumbrill, G.C. (2006) Parental experiences of child protection intervention: A qualitative study. *Child Abuse and Neglect, 30(1)*, pp. 27-37.
[1157] Payne, E. and Littlechild, B. (2000) *Social work ethics, politics, principles and practice*. London: Kingsley Publishers
[1158] Broadhurst, K. and Mason, C. (2017) (n159) pp. 41, 48.

> *"It's impossible to describe and capture the extent of emotional deprivation that is involved in temporarily losing custody and then permanent removal and loss of custody of your children. The pain of the process of initial loss and then watching over other women provide mothering for your children, of being judged by all those around you, and finally, of knowing that your life will be devoid of the presence of your children forever."* [1159]

Interviews with parents who have their child removed by social services reveal a deep sense of failure and shame at having failed in their role. Parents silently carry the burden of a grief which is not culturally acknowledge or supported.[1160]

Parents are expected to prioritise the needs of their children and are judged by society on the belief that they have failed and are therefore subject to blame if unable to do so.[1161] There was a deep sense of stigma felt amongst parents which Bauman describes as a side effect of being cast as *'unfit'* or *'undesirable'*.[1162] This would be particularly damaging for care experienced parents who have already had to fight against unwarranted stigma as a child then as a parent.

> *"It was horrible because when your kids go into care people look at you differently, talk to you differently."* [1163]

[1159] Carolan, M., Burns-Jager, K. Bozek, K. and Escobar Chew, R. (2010) Women who have their parental rights removed by the state: the interplay of trauma and oppression. *Journal of Feminist Family Therapy*, 22(3), pp. 171, 183
[1160] Schofield, G. et al (2010) Managing loss and a threatened identity: Experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. *British Journal of Social Work*, 41(1), pp. 74, 92
[1161] McCarthy, J., Edwards, R. Gillies, V. (2017) Making families: Moral tales of parenting and step-parenting. New York: Routledge-Cavendish.
[1162] Bauman, Z. (2004) Wasted lives modernity and its outcasts. London: Policy Press.
[1163] Schofield, G., Moldestad, B., Höjer, I., Ward, E., Skilbred, D., Young, J. and Havik, T. (2010) Managing loss and a threatened identity: Experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. *British Journal of Social Work, 41(1)*, pp. 74-92.

Findings from Broadhurst et al. suggest that strong kin networks and professional help can assist parents in coping with the loss of a child.[1164] Again, the lack of family support networks for care experienced parents would serve to compound such difficulties. Many parents struggled to come to terms with the fact that their children were not returning to them and feeling the loss of a child even in the knowledge they are still alive and well.

> *"Awful. The hardest thing really is the grief. The children are alive, they are healthy, and they are safe, but you have still lost them." "When you're a parent separated from your children, what you see everywhere is loss, pain and grief."* [1165]

However, findings also highlighted the views of parents who felt that adoption was the best decision for their child due to them having their needs met in a way that they, as the birth parents, were unable to.[1166] Parents acknowledged that though they had harmed their children, through for example drug taking or neglect, they would still describe themselves as having done their best and as loving their children. Schofield refers to this as parents creating a narrative that they could live with, a means of coping with their loss or guilt.[1167]

> *"I agree with social services because I knew that, whatever happened, the kids needed and deserved regular meals, clean clothes, a warm bed...just a normal childhood."* [1168] *"I never regretted the decision. I feel she's happy and probably growing up wonderful,*

[1164] Broadhurst, K., Shaw, M., Kershaw, S., Harwin, J., Alrouh, B., Mason, C. and Pilling, M. (2015) Vulnerable birth mothers and repeat losses of infants to public care: is targeted reproductive healthcare ethically defensible?' *Journal of Social Welfare and Family Law*, 37(1), pp. 84, 93

[1165] Mellon, M. (2019) 'In their Own Words' Available at https://www.youtube.com/watch?v=YqPiKqE98DM [Accessed 21 September 2019].

[1166] Christian, C.L. et al (1997) Grief resolution of Birthmothers in Confidential, Time-Limited Mediated, Ongoing Mediated, and Fully Disclosed Adoptions. *Adoption Quarterly*, 1(2), pp. 35,49

[1167] Schofield, G. et al (n166) pp. 74-92.

[1168] Ibid pp. 74-92.

but I always wondered what it would have been like if I raised her…every year on her birthday … for a while I just think about her." [1169]

[1169] Christian, C.L. et al (1997) n172) pp. 35, 50

15. Abandoned parents

Following the removal of children, the situation of birth parents too easily falls outside service provision and consideration.

With the child in care deemed as safe, the need to engage with the birth parent and provide any follow up support and guidance lacks urgency amidst a service in high demand.[1170] Masson et al. refers to individuals as *'lost parents.'*[1171] Furthermore, workers also acknowledge the severity of the separation between social services and the parent once the child is removed.

> *"It's as though the spotlight has been on the parent right through care proceedings...and then they are almost abandoned."* [1172] *"After the order is made, all the professionals are saying "Oh well, that's good, it is all finished." There's a sense of achievement...but I just think Oh God, this person has just lost her children."* [1173]

Parents are therefore left on their own to make sense of the lifestyle and relationship circumstances that have led to compulsory child protection intervention. Many women felt they had not been listened to or taken seriously. The most common advice was to *'forget it, look forward, not back'*.[1174] Some parents described having depressive or suicidal feelings, isolating themselves from friends and having no quality of life.[1175] They either had no one to talk to about their grief or felt the pain was too much

[1170] Broadhurst, K. and Mason, C. (n8) pp. 291, 292
[1171] Masson, J., Harrison, C., Pavlovic, A. (1997) Working with children and "lost" parents: putting partnership in practice. Joseph Rowntree Foundation: York Publishing Ltd.
[1172] Schofield, G. et al (n66) pp. 74-92.
[1173] Ibid pp. 74-92.
[1174] Logan, J. (1996) Birth mothers and their mental health: unchartered territory. *British Journal of Social Work* 26(5), pp. 609-617.
[1175] Kenny, K. and Barrington, C. (2018) "People just don't look at you the same way": Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children and Youth Services Review, 86*, pp. 209, 214

to revisit. Others spoke of trying to keep themselves busy, returning to an abusive relationship or focusing on future contact with their children.[1176]

Compulsory removal was found to lead to a downturn in parents functioning with many turning to drugs or alcohol as a means of coping with their pain.[1177] Parents were reluctant to seek professional help due to fear of social work using this against them, reaffirming the view of social work that the parent was not capable.[1178] Seeking professional help was felt to increase surveillance for parents which they felt to be humiliating and stigmatizing.[1179] For many parents, life had lost its meaning, thus mirroring earlier findings whereby teenage parents associated motherhood with a sense of self and giving life meaning and purpose.

Findings relating to parental mental health post adoption found that symptoms reached clinically significant levels and in particular, acute emotional distress at the point of initial removal.[1180] Despite research which evidences the impacts of the 'care system' on birth parents, current child protection services do not consistently address women's feelings of victimisation and socio-economic disadvantage, either pre or post compulsory removal of children.[1181] Broadhurst and Mason summarise the consequences of failing to take into consideration the needs of the parent and working with the family in a rehabilitative way.

> *"The risk is that we fail to respond holistically to the needs of mothers, state intervention to protect children simply has iatrogenic effects – adding another layer of damage to the lives of these women."* [1182]

[1176] Schofield, G. et al (166) pp. 74-92.
[1177] Ibid pp. 74-92.
[1178] Schofield, G. et al (n166) pp. 74-92.
[1179] Kenny, K. and Barrington, C. (2018) (n181) 209, 214
[1180] Neil, E., Cossar, J., Lorgelly, P. and Young, J. (2010) Helping birth families: services costs and outcomes Norwich: Centre for Research on the Child and Family. University of East Anglia.
[1181] Broadhurst, K. and Mason, C. (2013) (n8) pp. 291, 292
[1182] Ibid pp. 291, 299

This concept of a cycle of damage is found in research by Broadhurst and Mason which focuses on recurrent care proceedings whereby women get pregnant again within a short timescale as a means of filling the emotional void in their lives.[1183] As referred to earlier, the lack of post adoption support or rehabilitation for parents' only causes a return to the initial difficulties whereby unmanaged addiction, mental ill health or lack of positive change instigates social services and for some, repeat court proceedings leading to a cycle of loss.[1184] Findings indicate that a proactive approach to birth parents, giving them a sense of agency could assist them to take greater control of their lives as well as help them to address the issues leading to their child being removed.[1185]

Roberts et al. describes it as a missed opportunity for the State not to intervene in a way that positively changes the life course for these vulnerable parents.[1186]

[1183] Ibid pp. 291, 304
[1184] Broadhurst, K. and Mason, C. (20170 (n159) pp. 41, 43
[1185] Warrington, W. and Siddall, E. (2014) in Boadhurst, K., et al (2015) Vulnerable birth mothers and repeat losses of infants to public care: is targeted reproductive healthcare ethically defensible?' *Journal of Social Welfare and Family Law, 37(1),* pp. 84,98
[1186] Roberts, L et al (2017) (n153) pp. 355,360

16. Conclusion

Findings have identified consistent themes of stigma, othering and negative judgements having a disempowering impact on parents. Findings also identified a high level of distrust towards professionals and the 'system' more generally from parents due to the degree to which they felt intensely monitored and scrutinised rather than supported, which inhibited vulnerable parents from seeking help.

Insights from parents consistently spoke of a lack of empathy and compassion within social services and particularly, child protection proceedings.

The importance of workers taking a holistic approach to aid parents in rehabilitation aimed at strengthening families and keeping them together was highlighted as crucially important. Parents' powerful depictions of loss demonstrate the need to move away from shame and blame and work with parents to recognise their loss and provide ongoing tailored support that is sensitive, and parent led.

Findings also identified the extent to which vulnerable parents were living in poor quality, unsafe housing conditions, lacking in support and living in poverty, all of which increases the likelihood for social work intervention and therefore parents were at higher risk of having their child removed.

It has been argued that the current 'care system' as set up to be in best interests of the child, falls short of supporting care experienced parents by not providing the practical, emotional and social supports needed. Evidence of poor outcomes for care experienced young people highlights the poor preparation individuals receive in order to make the transition to adulthood, which inevitably places them at a disadvantage when they

become parents. These disadvantages are compounded by stigma and the consistent critical gaze of professionals. Research noted that both parents and professionals are aware of the increased monitoring of parents with care experience and the expectation of failure which could lead to parents being prejudged. The lack of trust in professional relationships and experiences of power imbalance have led to the Parent Advocacy movement, thus providing a voice and agency to parents.

Secure Care

A review of the evidence on the purpose, use, experience and impacts of secure care services in Scotland and the possible alternatives

Dawn Griesbach, Jennifer Waterton and Claire Baker

October 2019

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Note about terminology

Throughout this report, where the term 'young people' is used, it refers to children and young people.

1. Introduction

Background

In Spring 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant the 'care system' in Scotland.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research, and (iii) focusing on evidence which had been gathered from young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[1187]

Secure care

This report presents a review of the evidence in relation to the following questions:

- What evidence is available about secure care services in Scotland?
- What do we know about (i) the young people who are referred to secure care services, (ii) what young people say about the experience of secure care, (iii) what their outcomes are, and (iv) what alternatives there are to secure care?

[1187] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

The report also examines evidence of the use of secure care services in England, and highlights international research on alternatives to secure care.

Structure of the report

The report is structured as follows:

- Section 2 reports relevant findings from the Discovery stage of the Care Review.
- Sections 3-5 provide background, context and 'scene setting' material on what secure care is (Section 3); the process of placing a young person in secure accommodation in Scotland (Section 4); and the profile and experiences of those entering secure care in Scotland (Section 5).
- Section 6 discusses the use of secure care in England and internationally
- Section 7 examines what is known about the outcomes for young people who enter secure care
- Section 8 discusses good practice in providing secure care, based on two large international studies.
- Section 9 examines alternatives to secure care.
- Section 10 discusses the use of physical restraint the single separation in the context of residential care services for young people.
- Finally, Section 11 presents some concluding remarks.

A note about the evidence

Secure care in Scotland is used for young people under 18 who either have welfare needs or who have been convicted of offences. In undertaking this review, we found more evidence on the use of secure services for young offenders, and less on the use of secure services for young people with welfare needs.

2. Findings from the Discovery stage of the Care Review[1188]

The Discovery stage of the Care Review found that:

- A small number of young people who participated in the 1000 Voices consultation described secure care as a positive experience. These young people reported that they experienced a supportive environment where they had access to staff who are knowledgeable, skilled and caring. (1000 Voices report)
- More commonly, however, young people expressed negative views about their experience of secure care. The main aspects which they highlighted in their descriptions of secure care covered:
  - A lack of trust in the decision-making processes which resulted in their move into secure care
  - The view that young people with mental health problems should not be held in secure care as this can further damage their mental health
  - The view that those with mental health problems and / or those who self-harm should not be held in the same place as offenders
  - The lack of preparation for a move into secure care – including a lack of information about how long they will stay, when they will be released, and what to expect in practical terms
  - A view that they were 'lied to' and that 'false promises' were made about their situation and when and how certain things will happen (including, but not limited to, contact with their families and release from secure care)
  - The inability to exercise their rights and their ability to do 'normal' things such as watch TV, go for a walk, make phone calls, etc.

[1188] Note that this section also incorporates material from the Journey Phase 2 Voice report.

- The trauma associated with the use of physical restraint, both in relation to their own situation and in witnessing the restraint of others
- The stigma they experienced because they had been held in secure care
- A belief that secure care is simply a stepping-stone to prison – this was linked to a view that secure care can 'introduce' someone to offending
- A general view that there is insufficient support available to young people in secure care. (1000 Voices report)

Research has found that those in secure care face specific issues regarding contact with their families; on occasion, young people in secure care are told that contact with their family is dependent on their behaviour. (Baker review, 2017)

The CELCIS statistical overview report did not contain a section dedicated to secure care. It simply records that as of 31st July 2017, there were 56 young people aged 12-17 in secure care accommodation, and that 39% of these were recorded as having at least one disability. (CELCIS, statistical overview report).

3. Secure care in Scotland – Legislative framework and description of services

As of 31 July 2018, there were an estimated 14,738 looked after young people in Scotland. Of these, 52 (less than 0.5% of all looked after young people) were in secure accommodation on 31 July 2018.[1189]

This section sets out the legislative framework for the use of secure accommodation services in Scotland. It provides a description of these services and basic information about their capacity and use. It also outlines the commissioning and contract management arrangements for secure care services. Much of the statistical information presented in this section is based on the most recent official statistics relating to the use of secure accommodation in Scotland on 31 July 2018.[1190] Where appropriate, comment is provided about the trends in these statistics over recent years.

Note that, the focus of this paper is on the use of secure accommodation services. Thus, it does not cover in any detail provisions for detaining young people in hospital under the Mental Health Act.[1191] However, it is worth noting that, over the past 10 years, there has been an increasing number of young people under 18 being compulsorily detained through this legal

[1189] Scottish Government (2019) *Children's Social Work Statistics, 2017/18*. See https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/pages/3/, Table 1.1. Accessed October 2019.
[1190] https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/
[1191] Mental Health (Care and Treatment)(Scotland) Act 2003.

framework.[1192] A small proportion of these young people are looked after young people.[1193]

This paper also does not discuss the use of young offenders institutions for under-18s who have given custodial sentences through the courts. The issue of 16- and 17-year olds being sentenced to custody in the adult justice system has been discussed in the Justice Review.

The legislative framework for secure accommodation services

A 'secure accommodation service' is a form of residential care service that is used to restrict the freedom of young people under 18. (In practice, secure care is used for children and young people aged 10-18.[1194]) It is used for a small number of young people who pose a significant risk to themselves or to others and provides a way of managing the needs and risks of these individuals in a closed and controlled residential setting.[1195]

A secure accommodation service is defined in legislation as a form of 'care service' (see Section 47 of the Public Services Reform (Scotland) Act 2010).[1196] Schedule 12, paragraph 6 of the 2010 Act provides further information about the nature of secure accommodation services[1197]:

[1192] Mental Welfare Commission for Scotland (2019) *MHA Monitoring Report 2018/19. Annual statistical monitoring.* See https://www.mwcscot.org.uk/sites/default/files/2019-10/MHA-MonitoringReport-2019_0.pdf – accessed October 2019. In the ten-year period between 2009/10 and 2018/19, there have been substantial increases in the rate (per 100,000 population) of emergency detention certificates (EDCs) and short-term detention certificates (STDCs) applied to young people under 18.

[1193] The Mental Welfare Commission monitors the number of young people under 18 who are admitted each year to non-specialist hospital wards (i.e. not specialist CAHMS wards) for treatment of their mental health problems. Non-specialist wards include general adult mental health wards, and Intensive Psychiatric Care Units (IPCUs), which are specialist secure adult wards. In 2017/18, there were 103 admissions of 90 under-18s to non-specialist wards. Of the 89 admissions that the Mental Welfare Commission was given additional information about, 57 (64%) related to young people who had a social worker at the time of their admission, and 14 (16%) related to 'looked after and accommodated' young people.

[1194] See IRISS website: https://content.iriss.org.uk/youthjustice/sc-secure-care.html

[1195] Scottish Government youth justice webpage: Secure care. See https://www.gov.scot/policies/youth-justice/secure-care/ - accessed October 2019.

[1196] Section 47, Public Services Reform (Scotland) Act 2010. See http://www.legislation.gov.uk/asp/2010/8/section/47.

[1197] See http://www.legislation.gov.uk/asp/2010/8/schedule/12.

A "secure accommodation service" is a service which—

a) provides accommodation for the purpose of restricting the liberty of children in residential premises where care services are provided; and

b) is approved by the Scottish Ministers for that purpose.

The use of secure care facilities is governed by the Secure Accommodation (Scotland) Regulations 2013.[1198] Section 9(4) of these regulations spells out the circumstances in which a child may be placed in secure accommodation. Note that a child may not be placed in a secure accommodation service unless one or more of these conditions (often referred to as the 'secure care criteria') are met:

a) that the child has previously absconded and is likely to abscond again and, if the child were to abscond, it is likely that the child's physical, mental or moral welfare would be at risk;

b) that the child is likely to engage in self-harming conduct; and

c) that the child is likely to cause injury to another person.

Section 5 of the 2013 Regulations stipulates that it is the responsibility of the managers and head of the secure accommodation service to safeguard and protect the welfare of any child placed in the service. All young people placed in a secure accommodation service are considered to be 'looked after children' as a result of being placed in this type of service, whether or not they were not looked after prior to their admission.

Secure care is among the most intensive and restrictive forms of care available for young people in Scotland. Its purpose is to provide intensive support and safe boundaries to help highly vulnerable young people re-engage and move forward positively in their communities. As the legal

[1198] Secure Accommodation (Scotland) Regulations 2013. See https://www.legislation.gov.uk/sdsi/2013/9780111020463

definition of 'secure accommodation' makes clear, secure care is intended to be seen as a form of care service, rather than a form of imprisonment (or punishment), even in cases where a young person has been found guilty of a serious offence. Nevertheless, as will be seen in Section 5 of this paper, young people who have been accommodated in a secure care service often report that, because of the restrictions secure care places on their liberty, they see it as a form of punishment.

Description and capacity of the secure care estate

There are currently five secure accommodation services ('secure care units') in Scotland with a total capacity of 84 secure places as follows:

- Edinburgh Secure Services (6 secure care beds)
- Good Shepherd Centre (Bishopton) (18)
- Kibble Safe Centre (Paisley) (18)
- Rossie Secure Accommodation Services (Montrose) (18)
- St Mary's Kenmure (Bishopbriggs) (24)

In addition, St Mary's Kenmure has three respite beds that are registered (by the Care Inspectorate) for use up to 28 days; and Kibble, Good Shepherd and Rossie all have one emergency bed, registered for use up to 72 hours.[1199]

Edinburgh Secure Services is delivered directly by Edinburgh City Council. The remaining four centres are run by independent, charitable organisations under a national contract managed by Scotland Excel on behalf of the Scottish Government and the 32 Scottish local authorities.

Each secure care centre has a number of locked children's houses / units, each having four, five or six individual ensuite bedrooms and each with its own communal living, dining and relaxation spaces. The individual secure units are connected to a school or education base, recreational spaces,

[1199] An 'emergency bed' is defined as a bed that can be used at short notice, for example, when a young person is admitted during the night as it is less disruptive for the other young people. The young person is usually admitted to the main facility the following day.

activities rooms and areas for family visits which are in the same building or linked by secure corridors.[1200] Units are staffed at all times and have high levels of staffing. In addition, each of the four independent units employ differing ratios of qualified clinicians (e.g. clinical and forensic psychologists), nurses, therapists and psychiatrists. In recent years, there has been an investment across the sector in training staff in trauma-informed and wellbeing-focused approaches.[1201] The facilities are approved and licenced by the Scottish Government and registered, monitored and inspected by the Care Inspectorate and Education Scotland.

Following the publication in 2009 of a review of the use of secure care services in Scotland, the capacity of the secure care estate was reduced from (then) 124 places in seven units to (initially) 118 places in seven units.[1202,1203] Since 2011, the number of Scottish young people being secured has been on a downward trend (see below), and the number of places and units have fallen further to the current 84 beds in five units.

Current developments – a planned national secure mental health facility for young people

The Secure Care Strategic Board (2019) reported that, in October 2016, Ayrshire and Arran NHS Board approved a business case to host a 12-bedroom national secure forensic mental health inpatient service for young people.[1204] This service will be the first of its kind in the Scottish healthcare system, and it will provide assessment, treatment and care for

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[1200] IRISS (2019) Secure care. See https://content.iriss.org.uk/youthjustice/sc-secure-care.html - accessed October 2019.
[1201] K Moodie and A Gough (2017) *Chief Social Work Officers and secure care*. Centre for Youth and Criminal Justice. See https://cycj.org.uk/wp-content/uploads/2017/05/Chief-Social-Work-Officers-and-secure-care-report.pdf. Accessed October 2019.
[1202] Scottish Institute for Residential Child Care (2009) *Securing our future: A way forward for Scotland's secure care estate*. The report of the Securing Our Future Initiative. See http://www.wecanandmustdobetter.org/files/3314/2779/2923/Securing_our_future_report.pdf - accessed October 2019.
[1203] Scottish Government (2009) *Securing our future: A way forward for Scotland's secure care estate. A response from the Scottish Government and COSLA*. See https://www2.gov.scot/Publications/2009/04/23163903/0 - accessed October 2019.
[1204] Scottish Government (2019) *Secure care in Scotland. Report of the Secure Care Strategic Board to Scottish Ministers*. See https://www.gov.scot/publications/secure-care-strategic-board-report-to-scottish-ministers/ - accessed October 2019.

young people whose complexity and severity of risk requires a secure setting. It is intended that the treatment provided by the facility will enable these young people to eventually return to their own communities, with support from their local services. The facility is expected to be operational in 2020.

Usage and occupancy of the secure care estate

During the year 2017/2018 there were 211 admissions to secure care and 209 discharges from secure care.[1205] (Note that individuals can be admitted / discharged more than once during the year.)

In terms of the occupancy of the secure care estate, the 2017/18 statistics report that:

- The average (daily) occupancy throughout the year was 81 residents.1206 Of this total, on average
    - 46 residents (57%) came from Scotland
    - 36 residents (44%) came from outwith Scotland
- The minimum number of residents during the year was 75 and the maximum was 86
- Emergency and short-term beds were in use for 287 nights during the year.
- Thus, usage and occupancy during the year was running quite close to capacity.

As far as trends over time are concerned, the main aspects to highlight are:

- The number of admissions (and discharges) in 2017/18 are lower than in any of the previous four years and decreased by 15% (admissions)

[1205] However, the official statistics say that 53 of these 'discharges' were INTO secure care. Moreover, the official statistics report that 64 of the 'admissions' INTO secure care were FROM secure care. The authors of this report have raised these points with Scottish Government officials. Given the outstanding queries about these statistics, there is no information presented here about where children and young people are admitted from, and where they are discharged to.
[1206] These figures are based on daily averages. This explains why the two figures (46 and 36) do not add to the total (81).

and 19% (discharges) from the previous year (2016/17). This suggests that individuals are staying longer in secure care.

- There has been a steady increase in the numbers of placements from outside of Scotland during the period 2014-2018. This has risen from a daily average of 6 (in 2014/15) to 13 (in 2015/16) to 19 (in 2016/17) to 36 (in 2017/18).
- The number of nights that emergency and short-term beds have been required was much higher in 2017/18 (287) than in any previous year (previous maximum was 146 in 2015/16).

Cross-border placements in Scottish secure care services[1207]

Over the past five years, there has been an increasing number of young people from outside of Scotland who have been placed in Scottish secure care services. As noted above, in 2017/18, on average 36 of the 84 secure care beds in Scotland were occupied on a daily basis by young people from outside Scotland. In most cases, these young people were from England and Wales.

The reasons for the large increase in cross-border placements are not discussed in the Scottish Government statistical publication and the reasons for this increase are not entirely clear. However, annual statistical publications on secure care for England and Wales record that the number of approved secure care places in England and Wales decreased from 390 (in 2006) to 300 (in 2012) and to 254 (in 2015).[1208,1209] The number of secure places in England and Wales has been stable since 2015.

[1207] The term 'cross border placement' is used where a young person who is ordinarily resident and under the jurisdiction of one country within the UK is placed in secure care in a different country of the UK.

[1208] Department for Education (2010) *Children accommodated in secure children's homes at 31 March 2010: England and Wales.* National Statistics publication: SFR 21/2010. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/218890/sfr21-2010v2.pdf – accessed October 2019.

[1209] Department for Education (2018) *Children accommodated in secure children's homes at 31 March 2018: England and Wales.* National Statistics publication. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714071/SCH_2018_Text.pdf – accessed October 2019.

In September 2018, the Centre for Youth and Criminal Justice (CYCJ) published an information sheet on the topic of cross-border placements.[1210] This describes the circumstances of the 'Munby Judgement'[1211] in 2016, which concluded that orders made by the English courts placing a child in a secure care centre north of the border could not be enforced or recognised in Scotland and recommended urgent action and a review of the law. However, following further deliberations, the Scottish Government gave 'legislative consent' to enable such cross-border placements.[1212]

The information sheet points out that:

> *'There has been limited public debate about the issue, though some lawyers and children's rights organisations have commented. Some advance the argument that where there is such a lack of safe care provision in any part of the UK, cross-border placements are required to provide sometimes lifesaving secure care for very vulnerable children who would otherwise not be kept safe. Others outline the breach of fundamental rights which occurs when children are placed in another country and the significant implications for safeguarding, governance and accountability.'*

[1210] Centre for Youth and Criminal Justice (2018) *Secure care in Scotland: Cross border placements. Information sheet 76.* See https://www.cycj.org.uk/resource/cross-border-placements-information-sheet/ - accessed October 2019.

[1211] Sir James Munby issued a High Court Ruling in 2016 after considering the cases of two young people who, under the care of English Councils, had been placed in secure care centres in Scotland due to no places being available in England. In his judgement he reviewed relevant law and concluded that a judge in England could not make a secure accommodation order under section 25 of the Children Act 1989, if the child was going to be placed in a secure care setting in Scotland. This was because section 25 (and the then equivalent legislation in Wales, section 119 of the Social Services and Well-being (Wales) Act 2014) only allowed for looked-after children in England or Wales to be placed in secure accommodation in those two countries.

[1212] In the Legislative Consent Memorandum, which Deputy First Minister John Swinney lodged with the Scottish Parliament in 2016, the changes were described as necessary to "deal with a gap in the law." The Memorandum states that allowing local authorities in England and Wales to continue to place children in Scottish secure accommodation "provides valuable flexibility in the secure accommodation estate across the UK and is in the best interests of the children involved." The Scottish Government also outlined the financial implications of these changes, stating one or more secure units north of the border could be forced to close without them.

More recently, Williams *et al* (2019) explored the experiences and outcomes of young people from Wales receiving Secure Accommodation Orders. This study found that more than half the young people from Wales receiving Secure Accommodation Orders during the relevant period (2016-2018) were placed in secure accommodation in England or Scotland.[1213] (Note that it is not known how many were placed in England and how many in Scotland.)

Commissioning arrangements

In 2010, following the acceptance by Scottish Government and COSLA of the recommendations of the national review of secure care 'Securing Our Future Initiative'[1214] (SOFI), Scotland Excel was appointed to manage the secure care estate. In 2011, Scotland Excel awarded framework agreements for the provision of the four independent secure care centres. Local authorities wishing to place a young person in a secure care unit must first contact the units to identify which ones have a bed available. (The unit with available beds may not necessarily be geographically closest.) Local authorities pay for secure care places on a spot-purchasing basis.

Gough (2016) has highlighted some of the effects of these arrangements:[1215]

> *'The existing contracts between Scotland Excel and each of the four independent charitable secure care centres deal with the secure care sector as a market.... [O]verall, whilst the contracts framework has brought far greater clarity and accountability to placement by placement purchasing arrangements, this approach to*

[1213] A Williams, H Bayfield, M Elliott, J Lyttleton-Smith, R Evans, H Young, S Long (2019) *The experiences and outcomes of children and young people from Wales receiving Secure Accommodation Orders*. A report for Social Care Wales. See https://socialcare.wales/resources/report-about-the-experiences-and-outcomes-of-children-and-young-people-from-wales-receiving-secure-accommodation-orders - accessed October 2019.

[1214] Scottish Government (2009) *Secure our future: A way forward for Scotland's secure care estate. A response from the Scottish Government and COSLA*. See https://www2.gov.scot/Publications/2009/04/23163903/0 - accessed October 2019.

[1215] A Gough (2016) *Secure care in Scotland: Looking ahead. Key messages and call for action*. See https://www.cycj.org.uk/resource/secure-care-in-scotland-looking-ahead-2/ - accessed October 2019.

> *commissioning the most extreme form of care is problematic. Planning for the future should include consideration of preventative, alternative, complementary and step on services, within a strategic programme for the future development of new approaches to safe care, and close support services.'*

Gough goes on to say that:

> *'The current commissioning and quality assurance arrangements are also disjointed. They set out the terms and conditions for the purchase and provision of individual places in secure care. They ensure that each individual secure care service is inspected against regulations. But they do not provide a national framework fully aligned to GIRFEC principles, to underpin the commissioning and governance mechanisms and enable ongoing evaluation of the impact, experiences and outcomes for young people.'*

These points largely corroborate findings from an earlier report by Moodie (2015) which examined the development of outcome measures within secure care and the sharing of good practice.[1216] In this report, the author comments that:

> *[W]ith the secure estate now effectively splintered and competing for business with one another, concerns were raised that not only were individual secure units no longer collaborating and edges of care, they were also not sharing good practice. This tension between competition for business and sharing good practice could potentially impede overall improvement of the service.*

Thus, there are questions about the extent to which current commissioning arrangements in Scotland are effective. It should be noted that the research (referred to above) by Williams *et al* (2019) for Social Care

[1216] K Moodie (2015) *Secure care in Scotland: A scoping study. Developing the measurement of outcomes and sharing good practice.* See https://cycj.org.uk/wp-content/uploads/2015/12/CYCJ-Secure-Scoping-FINAL.pdf - accessed October 2019.

Wales on the experiences and outcomes of young people from Wales receiving Secure Accommodation Orders recommends, amongst other things, that a national commissioning strategy should be developed (for Wales).[1217]

Future of secure care in Scotland

Between 2015 – 2018, the Scottish Government funded the Secure Care National Project to review secure care provision in Scotland and work with sector leads and stakeholders to make recommendations about the future purpose, function and delivery of secure care services in Scotland.[1218]

Recommendations from the project led to the establishment of a national Strategic Board to provide leadership and direction, and to involve care experienced young people in decisions about the future of secure care provision in Scotland. As part of this, STARR (secure care experienced advisory group) was created, bringing together adults and young people with lived experience of the secure care system. Work has been carried out under the auspices of the Secure Care Strategic Board to develop a statement of 'vision and purpose', and a draft national pathway and standards framework for secure care.[1219]

The current secure care national contract (managed by Scotland Excel) runs until April 2020. Work is currently underway to commission and procure secure accommodation services for another two years from 2020 – with the option for a further 12-month extension, if required. The Care Review has been given the responsibility for considering the long-term future of secure care services in Scotland.

[1217] A Williams et al (2019) *The experiences and outcomes of children and young people from Wales receiving Secure Accommodation Orders*. A report for Social Care Wales. Note that it is not clear whether from the report whether the recommendation for a 'national commissioning strategy' relates to Wales only or is intended to be UK-wide.
[1218] See CYCJ website: Secure care. https://www.cycj.org.uk/what-we-do/secure-care/. Accessed October 2019.
[1219] Scottish Government (2019) *Secure care in Scotland. Report of the Secure Care Strategic Board to Scottish Ministers*. See Annex B, https://www.gov.scot/publications/secure-care-strategic-board-report-to-scottish-ministers/ - accessed October 2019.

4. The process of placing a child in secure accommodation in Scotland

This section provides details about the process of placing a young person in a secure accommodation service, and the various responsibilities of the Children's Hearings System, the courts and local authorities in decision-making.

How do young people in Scotland get placed in secure care?[1220]

All young people in secure care have either been sentenced or remanded through the courts or placed through the Children's Hearings System. The local authority has a role in deciding how to implement the decisions of the Children's Hearings and the courts.

Placements into secure care through the Children's Hearings System

Those placed through the Children's Hearing System will all be looked after children, subject to a Compulsory Supervision Order (CSO) or an Interim Compulsory Supervision Order (ICSO), with an authorisation for secure accommodation issued by a children's hearing.

Before a young person can be placed in secure accommodation through the Children's Hearings System, the children's panel must ensure that the young person meets the legal criteria set out in section 83(6) of the Children's Hearings (Scotland) Act 2011. That is:

- having previously absconded, is likely to abscond unless kept in secure accommodation, and, if he absconds, it is likely that his physical, mental or moral welfare will be at risk; or

[1220] Most of the information provided in this section comes from two sources: (i) Scottish Institute for Residential Child Care (2009) *Securing our future: A way forward for Scotland's secure care estate.* Report of the Securing our Future Initiative. See http://www.wecanandmustdobetter.org/files/3314/2779/2923/Securing_our_future_report.pdf - accessed October 2019 and (ii) IRISS (2019) Secure care. See https://content.iriss.org.uk/youthjustice/sc-secure-care.html

- is likely to injure themselves or some other person unless they are kept in such accommodation. The panel must also consider other options available (including a movement restriction condition) before issuing a secure accommodation authorisation.

Responsibility for implementing a secure accommodation authorisation rests with the Chief Social Work Officer (CSWO) within the relevant local authority[1221] and can only be done with the consent of the manager of the secure unit. In considering the possibility of placing a child in secure accommodation, the CSWO's decision will depend on certain conditions being met which are set out in section 9 of the Secure Accommodation (Scotland) Regulations 2013. These state that a child may **only** be placed in secure accommodation if:

- such a placement will be in the best interests of the child, and
- (b) the CSWO is satisfied that, by placing the child in a particular secure accommodation establishment, that establishment is able to meet the child's specific needs.

Secure placements, once made, are only for so long as it is in the best interests of the child. If the CSWO is satisfied that these conditions are met, the local authority is then responsible for the payment of the secure care placement, and transport to and from the secure unit. The suitability of the placement must be reviewed at intervals of not more than three months, or sooner if necessary or appropriate in light of the child's development.

In addition, only the CSWO has the authority to decide whether to transfer a child who is subject to a Compulsory Supervision Order (or Interim Compulsory Supervision Order) to a secure accommodation service in

[1221] The Social Work (Scotland) Act 1968 requires local authorities to appoint a single Chief Social Work Officer (CSWO). This post is held by a senior social worker. Scottish Government guidance provides details of the competencies required by the role, the scope of the role, and the CSWO's responsibilities for promoting values and standards of professional practice, decision-making, leadership, and reporting. See Scottish Government (2016) *The role of the Chief Social Work Officer. Guidance for local authorities.* https://www.gov.scot/publications/role-chief-social-work-officer/pages/4/.

cases of urgent necessity (i.e. emergency admissions). In such cases, the Children's Reporter must be notified, and the child brought before a children's hearing within 72 hours.

In these cases, the CSWO may also consider alternatives to secure care, if they conclude that the child's interests will be better served, and the child's needs best met, by **not** being placed in secure care. (Alternatives to secure care are discussed in Section 9.)

Court-related detentions

A young person who appears in court accused of an offence, where bail is not considered appropriate, can be remanded to the care of the local authority responsible for the young person under section 51 of the Criminal Procedures (Scotland) Act 1995. Local authorities may then take a decision (but are not obliged) to place that young person in secure care. If the child is placed in secure care, the local authority is responsible for payment of the placement, and for transport to and from the secure unit.

A young person **sentenced to detention** under section 44 of the Criminal Procedure (Scotland) Act 1995 (summary procedure; the young person has been ordered to be detained in 'residential accommodation' for a period not exceeding one year), it is for the local authority to determine the appropriate residential placement and this can include secure care.

For a young person **sentenced to detention** under sections 205(2) or 208 of the Criminal Procedure (Scotland) Act 1995 (solemn procedure, relating to the most serious offences), the Scottish Government (the Secretary of State) is responsible for the determining the most appropriate residential placement for the child. This may include secure care, and in such cases, the Scottish Government is responsible for payment of the placement and transport to and from the placement.

Note that, since 2017, young people who have been detained in secure accommodation under section 44 of the Criminal Procedure (Scotland) Act 1995, have the right to appeal the decision by the local authority to

place them in such accommodation by virtue of section 91 of the Children and Young People (Scotland) Act 2014.[1222]

Referral routes into secure care / reasons for being in secure care

There are no official statistics on the reasons that young people in Scotland are placed in secure care. However, Gough (2016) reported that most young people (between 75% and 80%) in secure care services in Scotland are there for their own protection rather than as a result of offences they have committed.[1223] More recently, the Secure Care Strategic Board (2019) reported that *'at any one time, around 90% of the young people from Scotland in secure care have been placed there by the Children's Hearings System'*.[1224] These young people have been exposed to extreme danger, such as repeatedly spending time in unsafe situations which have caused or are likely to cause them serious harm (for example sexual abuse and exploitation, harmful alcohol and drug use, etc.) or they have engaged in life threatening self-harming behaviours.

Decision-making about secure care (Moodie and Gough, 2017)

As noted above, Chief Social Work Officers (CSWOs) have a key decision-making role in relation to whether or not a child or young person in Scotland is placed in secure care.

[1222] Section 91, Children and Young People (Scotland) Act 2014. www.legislation.gov.uk/asp/2014/8/section/91/enacted

[1223] A Gough (2016) *Secure care in Scotland: Looking ahead. Key messages and call for action.* Centre for Youth and Criminal Justice. See https://www.cycj.org.uk/resource/secure-care-in-scotland-looking-ahead-2/ - accessed October 2019.

[1224] Scottish Government (2019) *Secure care in Scotland. Report of the Secure Care Strategic Board to Scottish Ministers.* See https://www.gov.scot/publications/secure-care-strategic-board-report-to-scottish-ministers/ - accessed October 2019.

Moodie and Gough (2017) carried out qualitative research among CSWOs in Scotland to explore how these decisions are taken.[1225,1226] The study found that, although CSWOs had discretion in relation to the decisions taken by Children's Hearings and the courts regarding the placement of a young person in secure care or detention, there was not a coherent perspective among this group of professionals about the role of secure care.

CSWOs had varying perceptions, experiences, and expectations of secure care. The majority said that they had little or no first-hand knowledge of the current secure care centres in Scotland, since secure care is used so infrequently.

There were differences between CSWOs in terms of whether they saw secure care as part of a 'continuum' of care services, or as an entirely separate response, used only in certain situations. Some CSWOs expressed a lack of clarity about the purpose of secure care (whether for protection or punishment) and its place in the wider care system for looked after children, and health and youth justice systems. In fact, the majority of CSWOs thought that secure care should be a nurturing environment and have no element of punishment. However, there was less clarity about whether all 16- and 17-year olds should be secured rather than imprisoned in cases where there is no alternative to detention.

Despite their relatively low level of direct knowledge of secure care services, and their general reluctance to use these services – except 'as a last resort' – all CSWOs nevertheless indicated a need for secure care, probably for a very small and further reducing number of young people, for the foreseeable future.

[1225] K Moodie and A Gough (2017) *Chief Social Work Officers and secure care*. Centre for Youth and Criminal Justice. See https://cycj.org.uk/wp-content/uploads/2017/05/Chief-Social-Work-Officers-and-secure-care-report.pdf - accessed October 2019.
[1226] All 32 of Scotland's CSWOs were invited to participate in the study. Individual interviews were carried out with CSWOs from 21 local authorities. CSWOs from three other local authorities attended a half-day feedback / discussion meeting.

5. The profile and experiences of young people in secure care in Scotland

This section provides information about the profile and experiences of young people in secure care in Scotland. Section 7 presents information about the outcomes for those who have been placed into secure accommodation services.

The information presented here about young people in secure care is based on the most recent official statistics, which relate to the position on 31 July 2018.[1227] These figures include young people from England / Wales that have been placed in Scottish secure care services. Where appropriate, comment is provided about the trends in these statistics over recent years.

Profile of young people in secure care

Note that the information presented in the official statistics is limited; covering only gender, age at admission, disability and length of stay for those who were in secure care on 31 July 2018. No published statistical information is available to cover other salient aspects such as mental health and well-being, family circumstances, substance misuse, educational attainment, or destination and outcome on leaving secure care.[1228]

[1227] Scottish Government (2019) *Children's social work statistics, 2017-2018*. See section on Secure Accommodation, page 24, https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/pages/5/. Accessed October 2019.

[1228] Note that researchers in the Netherlands have developed a self-report questionnaire to elicit more detailed information about young people's perceptions of living in secure residential care. The purpose of this tool is to ensure that young people in secure care have a voice about their living environment. For details, see MDC ten Brummelaar, WJ Post, PA Arkesteijn, ME Kalverboer, AT Harder and EJ Knorth (2017) Perceived living conditions of young people in secure residential care: Psychometric properties of the best interest of the child – self-report questionnaire (BIC-S). *Child Indicators Research*. See https://core.ac.uk/download/pdf/81074124.pdf. Accessed October 2019.

Age

Of the 85 young people in secure care on 31 July 2018:

- 15% were 13 or under
- 21% were 14
- 29% were 15 and
- 34% were 16 or over.

The proportion of young people aged 13 or under in secure care has increased substantially over recent years from 6% (2013/14) to 8% (2014/15) to 10% (2015/16) to 18% (2016/17). In 2017/18 the proportion fell slightly to 15%.

Gender

Of the 85 young people in secure care on 31 July 2018, 47% were male and 53% were female. The proportion of females in secure care has increased substantially over recent years. Between 2013/14 and 2015/16 the proportion of female residents was in the range one-quarter (26%) to just over one-third (36%). In 2016/17 this proportion rose to 43%, and in 2017/18 it rose again (to 53%).

Disability

Of the 85 young people in secure care on 31 July 2018, the proportion with a disability was 51%. Given that the way disability was defined changed in 2016[1229], trend data on this statistic is not (yet) available.

Length of stay

Of the 85 young people in secure care on 31 July 2018:

- 18% had been in secure care for less than 2 months
- 18% had been in secure care for between 2 and 3 months
- 33% had been in secure care for between 3 and 6 months

[1229] The new question in 2016 asked: 'Does the young person have a mental or physical impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities?'. This replaced the previous question, which asked whether the young person had 'additional support needs'. The previous question did not match the definition of disability from the Equalities Act.

- 15% had been in secure care for between 6 months and 1 year.

In previous years, substantial numbers of those in secure care (between 15% and 33%) had been in secure care for less than one month. By contrast, in the previous year (2016/17), no residents had been in secure care for more than 6 months. (Research undertaken by Moodie and Gough (2017) found that the average length of stay in secure care is currently around four months.[1230])

Young people's experiences of secure care

This section: (i) identifies the main sources of evidence in relation to young people's experience of secure care (in the UK), (ii) highlights the key themes in young people's accounts of their experience, and (iii) briefly describes the development of a new data collection tool to elicit information about the experience of secure care.

This review found three main sources of evidence in relation to young people's experience of secure care in the UK as follows:

- In 2008, Who Cares? Scotland, published a report on young people's perceptions and experiences of secure care.[1231] The report was based on data collected from 76 individuals who had experience of secure care.
- In 2016, the Centre for Youth and Criminal Justice published a report presenting key messages and calls for action about secure care based on the accounts of 60 care experienced young people, most of whom were in secure care when they contributed to the project.1232
- In 2019, Cardiff University published a report for Social Care Wales about the experiences and outcomes of young people from Wales

[1230] K Moodie and A Gough (2017) *Chief Social Work Officers and secure care.* Centre for Youth and Criminal Justice.
[1231] M Barry and K Moodie (2008) *This isn't the road I want to go down. Young people's perceptions and experiences of secure care.* Who Cares? Scotland. https://strathprints.strath.ac.uk/20234/1/strathprints020234.pdf – accessed October 2019.
[1232] A Gough (2017) *Secure care in Scotland: Young people's voices.* Centre for Youth and Criminal Justice. https://cycj.org.uk/wp-content/uploads/2017/10/Secure-Care-Young-Peoples-Voices.pdf – accessed October 2019.

receiving Secure Accommodation Orders.[1233] The report was based on administrative data and case files, and interviews with young people, social workers and other professionals, and concerned the experience of all 43 young people who were subject to a Secure Accommodation Order during the period 1 April 2016 and 31 March 2018.

In addition, the views about secure accommodation gathered during the course of the ICR and set out in the 1000 Voices report and the Journey Phase 2 Voice report, have been set out in Section 2 above.

Overall views

These three reports paint a complex and nuanced picture of the experiences that young people have had of secure care. Whilst overall there is a strong sense from these accounts that the 'system' of secure care is inadequate and unsatisfactory in a wide variety of ways, there is also a recognition that secure care is sometimes necessary and can provide a safe, caring and secure environment for young people with very complex needs. Indeed, many young people on reflection say that secure care helped them in some way, and some say that the help and support they had experienced in secure care had been transformative – and quite literally 'saved their life'.

Young people see staff in the secure care setting as both supportive and punitive. This 'dual remit' (of care and control) is difficult for young people to understand; and in general, they feel there is a greater emphasis on control and punishment, and a lesser emphasis on care.

[1233] A Williams, H Bayfield, M Elliott, J Lyttleton-Smith, R Evans, H Young and S Long (2019) *The experiences and outcomes of children and young people from Wales receiving Secure Accommodation Orders.* CASCADE, Cardiff University. https://socialcare.wales/cms_assets/file-uploads/The-experiences-and-outcomes-of-children-and-young-people-from-Wales-receiving-Secure-Accommodation-Orders.pdf – accessed October 2019.

Key themes

The key themes, which emerge across all three studies are described briefly below. Many of these resonate with themes that have been discussed in other evidence reviews in relation to the care system more generally. These themes are sometimes framed as 'things about secure care which need to change' but are often simply offered as observations or comments on the experience which young people have undergone.

The key themes cover:

- **The importance of loving, stable relationships:** Young people say that if they are to move on successfully from secure care, then they need loving and stable relationships. The relationships that help young people to progress and develop are wide ranging and cover relationships with their families and carers, their social workers and other professionals, their friends and peers, and the wider workforce. The stability and continuity of these relationships are vital. Specific mention in this regard is made of being able to keep good contact with their families whilst they are in secure care including having frequent visits which may require practical help for families; young people emphasise that it is important for this contact that they are not held in secure accommodation which is far from their home residence.
- **The importance of being properly prepared, listened to and 'having a say' in decisions that affect them:** Young people do not feel that they are always able to participate as much as they would wish to in decisions that affect them. This covers all aspects of the secure care experience including: the reasons for – and the process of – admission to secure care (this is often done in an emergency situation and can feel rather haphazard; the decisions about what they are and are not allowed to do whilst in secure care; their involvement in any discussion of sanctions; their options for involvement in activity programmes; the formulating of their care

plans; their transition out of secure care and consideration of – and commitment to – their ongoing support needs, etc.) Exit plans in particular were seen as inadequate, partly because of the lack of resources and other potential placements in the community.

- **The importance of trauma informed support in relation to their mental health and well-being:** Young people in secure care do not always think that there is sufficient understanding of their circumstances, and the adverse situations they have faced and they often feel they are being punished and controlled – rather than being supported and cared for – in secure care. Young people did not want to be labelled as 'bad kids' or as 'problematic' or 'aggressive'; rather they wanted support to overcome any trauma they have experienced. However, the relatively short stays in secure accommodation were identified as a barrier to effective therapeutic treatment, even where high quality treatment was available.
- **The adverse impacts of (witnessing) physical restraint:** Young people describe the impact of physical restraint – both of themselves and when they witness others being restrained – in particularly traumatic and dramatic terms. There is widespread belief amongst young people that some professionals use physical restraint in inappropriate circumstances and to an inappropriate degree.
- **The (physical and social) environment of secure care:** Young people often find the physical environment of secure care very daunting, difficult and traumatic. They feel they are not well prepared for the locked doors, the lack of freedom of movement and association, the extent to which they require permission to do 'ordinary things' (such as make phone calls, watch TV, or use the toilet). This can result in them getting off to a 'bad start' in secure care. However, there is also a strong theme that once they have 'settled in' and got used to the routines, then the environment seems less hostile, more comfortable, and safe. In addition, opportunities for leisure and recreation were seen to be rather

limited, which young people thought was unfair. Finally, there were also mixed views about whether those in secure care for welfare reasons should be separated from those who are there because of offences they have committed.

6. Secure care in England and elsewhere

This section discusses the use of secure care and other secure placements in England, since arrangements for commissioning secure care services in England – and placing a young person in a secure setting – is somewhat different to that in Scotland.[1234]

At the end of this section, evidence is presented from a study which carried out an international comparison of the use of secure (custodial) services for young offenders.

Secure care in England

Legislative framework

Warner *et al* (2018) reported that there are three legal frameworks which allow young people under the age of 18 in England to be deprived of their liberty[1235]:

1. The Mental Health Act (1983, as amended 2007) allows for a young person to be placed in a secure hospital.[1236]
2. Section 25 of the Children Act (1989) allows for a young person to be placed in a secure children's home. (This type of secure residential accommodation is most similar to secure care in Scotland.)

[1234] This paper does not look in detail at the use of secure services in Wales or Northern Ireland. Wales has one secure children's home, one secure hospital unit for under-18s, and one young offender institution. Northern Ireland has two secure children's homes, one secure hospital unit and one juvenile justice centre. An independent review of secure services in Northern Ireland was published in 2018. See: *Review of Regional Facilities for Children and Young People – Review Report*. https://www.health-ni.gov.uk/publications/review-regional-facilities-children-and-young-people-review-report. Accessed October 2019.

[1235] L Warner, H Hales, J Smith and A Bartlett (2018) *Secure settings for young people: a national scoping exercise*. St George's University of London and NHS England. See https://www.england.nhs.uk/wp-content/uploads/2018/10/secure-settings-for-young-people-a-national-scoping-exercise-paper-1-scoping-analysis.pdf. Accessed October 2019. Note that the scoping study did not look at secure units in Northern Ireland, the Channel Islands and Isle of Man.

[1236] As noted in Section 3, children and young people in Scotland may also be detained in hospital settings under the Mental Health (Care and Treatment)(Scotland) Act 2003; however, this paper does not discuss these provisions in any detail.

3. Under the youth justice system, young people can be placed on remand or serve a sentence in (i) a secure children's home (if they are aged 10-14), (ii) a secure training centre (if they are under 17) or (iii) a young offender institution (if they are aged 15-21).

Description and capacity of secure services in England

Warner *et al* (2018) reported the number of secure units in England as follows:

- 28 hospitals (a mixture of high dependency units, psychiatric intensive care units, and low and medium secure units):
- 14 secure children's homes
- 3 secure training centres
- 4 young offender institutions.

Both the independent sector and the NHS provide secure hospital beds (the independent sector dominate psychiatric intensive care and low secure provision and the NHS dominates medium secure provision). Secure children's homes are run by local authorities or charities. Placements in secure children's homes are commissioned either by local authorities (welfare placements) or the Youth Justice Board (see below). Secure training centres are run by private companies, and young offender institutions are run by the Prison Service and private companies.

Beds in secure units are allocated for specific purposes, and their use depends upon the legal framework under which a young person is detained. Thus, the 1,773 beds available in secure units in England are allocated as follows:

- Just under two-thirds (1,260) are allocated for Youth Justice Board placements (111 in secure children's homes, 243 in secure training centres and 906 in young offender institutions)
- Just under a quarter (402) are allocated for young people detained under the Mental Health Act (27 in high dependency units, 147 in

psychiatric intensive care units, 138 in low secure and 90 in medium secure units)

- 6% (111) are for welfare placements (all in secure children's homes).

Note that, while Warner *et al* found that young people from England had been placed in secure accommodation and young offenders institutions in Scotland, there appears to be no provision for young people from Scotland to be placed in secure children's homes in England (or Wales).[1237] This review could also find no information about whether young people from Scotland are (or could be) detained in secure training units, young offender institutions or secure hospital units in England.

Decision-making in relation to secure care in England (Hart and LaValle, 2016)

Section 4 of this report discussed the findings of qualitative research among Chief Social Work Officers in Scotland, which explored the factors influencing their decisions about the use of secure care. A similar (though smaller) study was undertaken in England by Hart and La Valle (2016) to explore local authority decision making in relation to the use of secure welfare placements.[1238,1239]

This study found that there was consensus among senior local authority managers that secure welfare placements are required (and that there is no other appropriate alternative) for a small number of children. Senior managers also agreed that placing a young person in a secure children's home is a 'draconian' step that should be avoided wherever possible. Where opinions diverged was in relation to (i) the level of risk that makes it ethically justifiable to restrict a child's liberty, (ii) the extent to which secure

[1237] See Secure Children's Home (England and Wales): http://www.securechildrenshomes.org.uk/referrals-new/

[1238] D Hart and I La Valle (2016) *Local authority use of secure placements.* Department for Education. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582375/Local-authority-use-of-secure-placements.pdf. Accessed October 2019.

[1239] The study involved a desk based review of the international evidence on welfare secure accommodation from 2004 onwards; telephone interviews with senior managers in 12 English local authorities; and children's case studies in five of these authorities.

care is effective in improving children's outcomes in the longer-term, and (iii) the threshold when other types of placement can no longer be considered viable. In addition to these three issues, two other factors that influenced decision-making were:

- Whether an authority has its own SCH, or one nearby: There were perceived to be benefits in placing a child close to the home authority because it helped with transition planning. Nevertheless, distance was not generally cited as a reason for not using them.
- Personal and authority beliefs: Although no-one ruled it out completely, some respondents expressed their reluctance to use secure care because they thought it was 'wrong' and likened it to a prison-like environment.

Whilst some local authority senior managers saw secure accommodation in a more positive light than others, the study found no evidence to suggest that secure placements were used unless the (secure care) criteria were met **and** professional judgement was that the child would benefit.

Profile of young people from England in secure settings (Hales et al, 2018)[1240]

In England (as in Scotland), there is a lack of centralised information about the number and profile of young people in secure care services.

However, Hales *et al* (2018) recently carried out a detailed census of young people from England in secure care. This study looked at all under-18s from England in all types of secure settings on 14 September 2016. This study found that, a total of 1,322 young people from England were

[1240] H Hales, L Warner, J Smith and A Bartlett (2018) *Census of young people in secure settings on 14 September 2016: characteristics, needs and pathways of care*. St George's University of London and NHS England. See https://www.england.nhs.uk/wp-content/uploads/2018/10/secure-settings-for-young-people-a-national-scoping-exercise-paper-2-census-report.pdf - accessed October 2019.

accommodated in a secure setting on the day of the census – 1,260 in England, 38 in Wales and 24 in Scotland.[1241]

The census found substantial variations in relation to the use of secure placements by gender. For example, approximately four times as many young men were detained on the day of the census as young women. More young women were detained under the Mental Health Act and Children Act and more young men were detained through the youth justice system. Similarly, the ethnicity of the young people, their country of birth and the distance from home of their placement varied according to the type of secure placement. White young people were more likely to be detained under the Children Act and least likely to be detained through the youth justice system, while minority ethnic young people were more likely to be detained through the youth justice system and the Mental Health Act.

The nature of a young person's current secure placement strongly correlated with their previous involvement, or not, with statutory services from the same system. Thus, those who had previous involvement with youth offending teams were generally placed in youth justice secure services; those with previous involvement with social services tended to be placed in secure children's homes; and those who had previous experience of child and adolescent mental health services (CAMHS) were generally detained in secure hospital settings. As a result of this correlation, the authors considered that a proportion of young people in secure settings were in placements that were inappropriate for their needs. (Especially, they considered that 61 young people were inappropriately placed - most of these were in hospital or detained under the youth justice system.)

[1241] The census covered **not only** children and young people placed in secure children's homes under the Children Act 1989, but also those detained in youth justice settings and in secure hospital settings. Follow-up census information was received for 93% of the 1,322 young people.

An international comparison of secure services for young offenders

An international review carried out by Hart (2015) compared secure care services for young offenders in Finland, Spain, the USA and England.[1242] Some of the key differences in the structural arrangements for secure services for this group were related to:

- **Age of the young person:** Both the minimum age when children are considered to be criminally responsible, and the age when they transfer to the adult criminal justice system varied across countries.
- **Who decides?** There was no international consensus about whether justice or welfare systems should predominate when it comes to the proper response to offending behaviour.
- **Types of establishment:** Children may be placed in anything from an open children's home looked after by care staff, through to a high security prison staffed by prison guards.
- **Fixed or flexible sentences:** In England, sentence length was usually determined by the courts, but other countries believed it should be linked more closely to progress within custody.
- **Case management:** The role of the secure / custodial establishment in planning and resettlement varied widely, with some taking a primarily containment role whilst others (outside the establishment) managed the case.
- **Professional input:** Mental health and social work practitioners were an integral part of the work done with children in custody in most countries, more so than in England.
- **Workforce:** There were different expectations among the different countries about the skills, experience and qualifications needed by staff to look after children in custody on a day to day basis.

[1242] D Hart (2015). *Correction or care? The use of custody for children in trouble.* Prison Reform Trust. See: https://www.wcmt.org.uk/sites/default/files/report-documents/Hart%20Diane%20Report%202015%20Final.pdf – accessed October 2019.

- **Safety and security:** Other countries placed children in establishments with different levels of security, ranging from open to high-secure. England was unusual in having only secure placements, and in its risk averse approach.

7. Outcomes for young people (who have been) in secure care

This section sets out the evidence in relation to the outcomes for young people in Scotland and elsewhere in the UK (who have been) in secure care. Evidence from a study in the Netherlands is also included at the end of this section. The section begins with a broader discussion about how to measure outcomes for young people in secure care.

Measuring outcomes from secure care

In 2015, the Centre for Youth and Criminal Justice (CYCJ) carried out a scoping study to review the literature in relation to the measurement of outcomes for young people in secure care in Scotland, and to identify current evidence gaps through discussion with heads or deputy heads of service within each of the five secure units in Scotland.[1243]

The scoping study identified a range of complex challenges in relation to the development of a comprehensive approach to measuring outcomes from secure care including:

- Identifying which baseline measures should be collected (e.g. quality of life outcomes? process outcomes? change outcomes?)
- Specifying what constitutes a positive (or a negative) outcome
- Deciding how to combine individual outcomes into an overall measurement
- Determining when / how long after someone has left secure care outcome measures should be collected

[1243] K Moodie (2015) *Secure care in Scotland: Developing the measurement of outcomes and sharing good practice*. See https://cycj.org.uk/wp-content/uploads/2015/12/CYCJ-Secure-Scoping-FINAL.pdf - accessed October 2019.

- How individuals who have been in secure care can be followed up / tracked over time given that secure care units have no responsibilities or infrastructure to achieve this
- Whether and how any changes which are found can be attributed to any particular intervention or placement.

These complexities were also seen to be compounded by the commissioning arrangements, whereby individual secure care units compete for business, and do not always collaborate or share information. Thus, individual secure care units in Scotland were reported to be effectively developing their own outcome models in isolation – an approach that, according to the author of the scoping study, did not seem appropriate given the scale and challenge of the task.

In 2016, the CYCJ report *Secure Care in Scotland: Looking Ahead* stated that 'a research proposal for a longitudinal study [about the longer term outcomes from secure care] is in development at the University of Strathclyde'.[1244] However, at the time of writing no further information about this proposal has been uncovered.

Although not directly relevant – because they focus on the 'care system' more generally and not simply on the secure system itself – there are two other recent reports which have undertaken substantial programmes of work which address (at least in part) some of the questions identified in the scoping study as set out above. These are:

- A report published in June 2018 which examines the feasibility of conducting a longitudinal study on children and young people in care or children leaving care within the Irish context[1245] and

[1244] A Gough (2016) *Secure care in Scotland: Looking ahead.* See https://cycj.org.uk/wp-content/uploads/2016/10/Secure-Care-in-Scotland-Looking-Ahead.pdf - accessed October 2019.
[1245] C Devaney and C Rooney (2018) *The feasibility of conducting a longitudinal study on children in care or children leaving care within the Irish context.* UNESCO Child and Family Research Centre. See http://www.childandfamilyresearch.ie/media/unescochildandfamilyresearchcentre/docu

- A report published in July 2019 which sets out an approach to developing an outcomes framework for children's social care services.[1246]

Both of these reports provide valuable contributions in relation to the discussion about measuring outcomes from secure care in Scotland.

Outcomes from secure care

Overall, there is a dearth of evidence about the outcomes for young people who have been in secure care. Official government statistics provide only very limited information on outcomes for young people who have been accommodated in secure care services. Thus, evidence of outcomes must be gathered from published research studies.

Below, brief descriptions are given of the findings from five studies. Two of these (listed first below) relate specifically to Scotland. Of the two Scottish-based studies, one relates to data collected in 2002/03 and one to data collected in 2009; thus they are fairly out-of-date and the findings may not be considered particularly relevant to the Care Review given the change in profile of young people in secure care services since these studies were carried out.

It will be seen that the specification of 'outcomes' is extremely varied across these studies, and so it is not possible to draw general conclusions about the overall 'outcomes' from secure care. However, the individual studies resonate with the findings presented above (in Section 5) which has described a very mixed, nuanced and complex picture of the experience of secure care.

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mentspdf/Feasibility-Study-on-Longitudinal-Study-of-Children-In-Care-or-Leaving-Care-in-Ireland.pdf - accessed October 2019.

[1246] I La Valle, D Hart and L Holmes with VS Pinto (2019) *How do we know if children's social care services make a difference? Development of an outcomes framework. Summary.* University of Oxford. See http://www.education.ox.ac.uk/wp-content/uploads/2019/07/CSCS-Outcomes-Framework-Summary.pdf - accessed October 2019.

The outcomes of secure care in Scotland (Kendrick et al, 2008)[1247]

Data were collected on 53 young people (from a potential sample of 146) shortly after their admission to secure accommodation between October 2002 and 2003. Information on the progress of the young people was collected approximately two years after their admission into secure care. A rating was made in relation to each young person in terms of whether the outcome had been 'good' (26%), 'medium' (45%) or 'poor' (28%). These ratings were based on the following variables:

- Whether the young person was in a safe and stable placement
- Whether they were in work or education
- Whether the behaviour which resulted in their admission had been modified
- Social worker's rating of their general well-being compared with that on admission.

Young people whose rating was positive on all four dimensions were considered to have had a 'good' outcome. Where at least one was negative the rating was 'medium' and where no aspects were positive, the outcome was considered to be 'poor'.

The spread of ratings was similar across age, gender, placing local authorities, units where young people were held, and placement prior to the secure admission. The authors say that:

> *Good or poor outcomes could not be attributed to single factors, but rather emerged from how several elements of the situation came together. There was a close correspondence between ratings of change in behaviour and well-being. Those whose problematic behaviour had increased were typically involved in drug use, often with associated offending. In terms of moving on, most social workers*

[1247] A Kendrick, M Walker, A Barclay, L Hunter, M Malloch, M Hill, G McIvor (2008) The outcomes of secure care in Scotland. *Scottish Journal of Residential Child Care, 7(1) February / March: 1-13.* https://dspace.stir.ac.uk/bitstream/1893/20053/1/SJRCC_Feb-Mar08-web.pdf - accessed October 2019.

preferred that there could be a gradual 'step-down approach' from the structure and supervision of the secure setting. Outcome data from the study supported this view in that half of the young people with good outcomes (7 of 14) had clearly had a full step-down approach and for a further two some elements were incorporated, for example daily contact with an after-care worker. None of the 17 young people for whom a full step-down approach applied had had a poor outcome.

Secure authorisations in Scotland's Children's Hearings System: An exploration of decision-making, placements, outcomes and social backgrounds. (SCRA, 2010)[1248]

The Scottish Children's Reporter Administration (SCRA) examined the outcomes of 100 young people who had been subject to a secure care authorisation in 2008/9. They found that within six months:

- 96% of the young people were still involved in the Hearings System six months after their first secure authorisation of 2008/09.
- 25% of the young people were still subject to secure authorisations six months after their initial secure authorisation of 2008/09. 92% (n=23) of these were still in a secure placement.
- 71% of those without secure authorisations at six months were subject to other forms of compulsory measures.
- 81% had further referrals to the Children's Reporter within the six months.

This study also looked at longer-term outcomes for this group of young people and found that:

- It was difficult to say with any certainty how many of the young people had positive or negative outcomes as many had a mixture of

[1248] This report is available from SCRA upon request. See http://www.scra.gov.uk/wp-content/uploads/2017/02/SCRA-Research-pre-2011.pdf.

both. However, the majority of the young continued to offend and struggle with drug and alcohol misuse and mental ill-health.

- The lives of 24% of the young people had improved. This was assessed on whether they had achieved two or more of the following criteria: no further referrals to the Reporter; significantly reduced / ceased offending; improved relationships with family; achieved academic qualifications; at college, in training or employment; engaging with services; had matured and / or able to understand the consequences of their behaviour; ceased substance misuse; and had attained independent living.

The experiences and outcomes of young people from Wales receiving Secure Accommodation Orders (Williams et al, 2019)[1249]

The report is based on administrative data, case files, and interviews with young people, social workers and other professionals. It focuses on the experiences of all 43 young people from Wales who were subject to a Secure Accommodation Order during the period 1 April 2016 and 31 March 2018. In relation to outcomes, the report states that:

- On leaving secure accommodation, just over a third of the young people had good first placements, whereas the rest had poor or mixed experiences.
- Most young people continued to follow the positive, negative or mixed journeys begun when they left secure accommodation. These trajectories saw the majority of post-secure placements breaking down as they were unable to adequately meet the needs of the young people.

[1249] A Williams, H Bayfield, M Eliott, J Lyttleton-Smith, R Evans, H Young and S Long (2019) *The experiences and outcomes of children and young people from Wales receiving Secure Accommodation Orders.* Social Care Wales. See: https://socialcare.wales/cms_assets/file-uploads/The-experiences-and-outcomes-of-children-and-young-people-from-Wales-receiving-Secure-Accommodation-Orders.pdf - accessed October 2019.

- During the time between leaving secure accommodation and the study (between a few months and two years), more than a quarter of young people received additional Secure Accommodation Orders, with others entering the criminal justice system or a secure psychiatric placement.
- Young people who saw little progress or a deterioration since leaving secure accommodation tended to re-experience a series of broken placements, associations with people who promoted problem behaviours and, despite the re-emergence of worrying behaviours, little or no use of / access to mental health support services.
- Where positive outcomes were achieved, these appeared to be dependent on the quality of the placements, especially having consistent relationships with key adult(s) and for some receiving sufficient mental health support.

Six years on: a prospective cohort study of male juvenile offenders in secure care in Northwest England (Chitsabesan et al, 2012)[1250]

In this prospective cohort study, 97 male juvenile offenders admitted to four local authority secure units within North West England were assessed initially on admission, two and six years later. Interviews were conducted with 54 offenders at the six-year follow-up and included an assessment of psychosocial need, mental health and psychopathy. Outcome data on offending behaviour were collected on a total of 71 offenders. The study found that, at the six-year follow-up:

- About a half of the offenders were in neither employment nor training.
- Many offenders continued to reoffend despite receiving offence-related interventions and custodial care.

[1250] P Chitsabesan, J Rothwell, C Kenning, H Law, L-A Carter, S Bailey and A Clark (2012) Six years on: a prospective cohort study of male juvenile offenders in secure care. *European Journal of Child and Adolescent Psychiatry (21):* 339-347. See http://www.biblioteca.cij.gob.mx/Archivos/Materiales_de_consulta/Drogas_de_Abuso/Articulos/76401358.pdf - accessed October 2019.

- Almost nine out of ten offenders had a substance misuse disorder and a similar number met the criteria for a diagnosis of antisocial personality disorder. A diagnosis of antisocial personality disorder and living with friends and family were both significantly associated with persistent offending behaviour.

The authors concluded that interventions currently aimed at reducing recidivism in more severe offenders appear to be ineffective. They stated that persistent offenders would benefit from a multi-modal approach based on individual needs, rather than receiving generic interventions.

The authors note that young male offenders in secure care (the focus of this research) are likely to represent a subset of early-onset offenders. The study also highlighted examples of three interventions where there is evidence of effectiveness for early-onset offenders with multiple vulnerabilities, including experience of local authority care. These are:

- Multi-systemic therapy (MST)
- Multi-dimensional foster care (MTFC)
- Functional family therapy (FFT).

Transition secured? A follow-up study of adolescents who have left secure residential care (Harder et al, 2011)[1251]

This study examined the experiences and outcomes for a group of 24 adolescents in the Netherlands who left secure residential care. The authors explain that:

> *'The results show, in line with previous studies, that many adolescents experience problems during their transition from secure care, especially with regard to finances, school and employment, and living arrangements. In contrast to other studies, a majority of the*

[1251] AT Harder, EJ Knorth and ME Kalverboer (2011) Transition secured? A follow-up study of adolescents who have left secure residential care. *Children and youth services review, 33(12): 2482-2488.* See: https://doi.org/10.1016/j.childyouth.2011.08.022 - accessed October 2019.

adolescents' report to have received support in the year following their departure. Relatively few adolescents move to independence after their departure, which suggests that many adolescents are not ready for making a true transition into adulthood yet.'

8. Good practice in providing secure care

As was seen in Section 7, there is a dearth of information about outcomes for young people in secure care. There is a similar lack of evidence in relation to 'good practice'.

There is, however, some information available on good practice from two international reviews, both of which focused on approaches to providing secure services for young offenders. Although these two studies were specific to a youth justice context, the good practice points identified would likely apply more generally to any type of secure service for young people.

First, however, evidence of good practice among secure care services in Scotland is presented.

Evidence of good practice among secure care services in Scotland

In relation to secure care services in Scotland, it is worth highlighting that there is evidence from the Care Inspectorate that the quality of these services is very high. As mentioned in Section 3 of this paper, all secure care services in Scotland are inspected by the Care Inspectorate. These inspections generally take place annually and are unannounced. At their last inspection, all five of the secure care units in Scotland were graded as 'excellent' or 'very good' on all four of the following criteria: (i) quality of care and support, (ii) quality of environment, (iii) quality of staffing, and (iv) quality of management and leadership. The only exception was in relation to Rossie which received a 'good' grading for quality of staffing.[1252]

Meeting the mental health needs of young people in secure care

[1252] See the Care Inspectorate website: https://www.careinspectorate.com/index.php/care-services, select Secure Care services.

It has been highlighted that young people in local authority care settings have a higher rate of mental health difficulties than the wider population.[1253] Furthermore, there is now clear evidence that a disproportionate number of young people in secure care services, in particular, have experienced childhood adversity and trauma.[1254] Scotland's current Mental Health Strategy 2017-2027 acknowledges this: Action 5 in the strategy refers to 'young people on the edges of and in secure care' and seeks to ensure that this group's mental health needs are considered in their care pathway.[1255]

In early 2014, the Mental Welfare Commission and the Care Inspectorate carried out a series of visits to all five secure care services in Scotland, and spoke to 27 of the 65 young people who were resident in these services at the time.[1256] The young people who took part had identified mental health difficulties and were supported by or referred for assessment to specialist Child and Adolescent Mental Health Services. The report highlighted positive aspects of the care provided within secure care services for young people's mental health difficulties. This work also resulted in a number of recommendations for local authorities and health boards, service providers and Scottish Ministers. These were focused on:

- Ensuring the continuity of provision of mental health care when young people are in transition into and out of secure care, and improving communication between services
- Ensuring staff undertaking therapeutic work are sufficiently well trained and experienced – the consent for and impact of

[1253] T Ford, P Vostanis, H Meltzer and R Goodman (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. British Journal of Psychiatry, 190(4): 319-325.
[1254] See the Justice and Care review.
[1255] Scottish Government (2017) *Mental health strategy 2017-2027.* https://www.gov.scot/publications/mental-health-strategy-2017-2027/ - accessed October 2019.
[1256] Mental Welfare Commission for Scotland (2015) *Visits to young people in secure care settings.* Report of a joint Mental Welfare Commission and Care Inspectorate visits. https://www.careinspectorate.com/images/documents/2166/visits_to_young_people_in_secure_care_settings_final.pdf. Accessed October 2019.

interventions should be documented and accompany the young person as they move through the care system

- Implementing standardised care and discharge pathways to ensure continuity of responsibility for the provision of health care and ensuring young people are fully involved in plans for discharge ensuring there is equal access to specialist child and adolescent mental health services in secure settings.

A separate study undertaken by the clinical director in one secure care unit in Scotland has examined how trauma-informed principles can be translated into tangible practice in residential and secure care in the UK.[1257]

Hart (2015)

An international review carried out by Hart (2015) compared secure care services for young offenders in Finland, Spain, the USA and England.[1258] Across all these countries, the key elements within positive secure services for children were found to be:

- Small units, caring for children in groups of no more than 12
- Close to home to allow for successful reintegration into family and community
- A continuum of placements, with levels of security based on risk and need
- Stream-lined case management systems, with the establishment playing a central role
- A regime that promotes adolescent development, based on a theory of change

[1257] D Johnson (2017) *A best fit model of trauma-informed care for young people in residential and secure services.* Kibble Education and Care Centre. https://www.kibble.org/wp-content/uploads/2017/08/best-fit-model-trauma-informed-care.pdf. Accessed October 2019.
[1258] D Hart (2015). *Correction or care? The use of custody for children in trouble.* Prison Reform Trust. See: https://www.wcmt.org.uk/sites/default/files/report-documents/Hart%20Diane%20Report%202015%20Final.pdf – accessed October 2019.

- Active and continuous engagement by front line staff, who are seen as key agents of change
- A clear pathway to success that offers children meaningful rewards linked to their progress
- Family engagement to support parents to regain control over the child's behaviour
- A phased rather than abrupt return to the community.

Lambie *et al* (2016)

A large international review of the literature on youth justice secure residences carried out by Lambie *et al* (2016) found a lack of evidence regarding interventions or combinations of services that help promote the short and long-term outcomes of young people in youth justice secure residences. However, the authors were able to highlight evidence of best practice in relation to the delivery of specific aspects of these kinds of secure settings, including the assessment process, rehabilitative programmes, education programmes, vocational skills development, staffing and physical environment, among others. Some of the 'good practice' points made in this review were that:[1259]

- Secure residential care should be reserved only for the most high-needs and at-risk young people, be used as a last resort, and only for a limited amount of time. The review notes that there has been a shift internationally toward the use of community-based services as an alternative to secure residential placement, where possible.
- No clear guidelines were identified regarding the maximum length of time a young person should be detained in secure residential care. However, two of the studies included in the review suggested that

[1259] I Lambie, A Krynen and C Best (2016) *Youth justice secure residences. A report on the international evidence to guide best practice and service delivery.* *https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/youth-justice/youth-justice-report-secure-residences-11-fa.pdf* - *accessed October 2019.*

young people should only be held in residence for up to 150 days.[1260]

- No guidelines regarding the ideal mix of professionals for a secure residential care facility were identified. However, based on the evidence, the authors concluded that the "best mix" of professionals within youth justice secure residences is likely to include qualified front line staff with extensive training in how to work with young people with offending histories, and mental health and behavioural difficulties. There should be medical and mental health staff on-site, as well as education staff (preferably registered teachers) and vocational staff.
- Staff who work with at-risk, high-needs young people should have strong pro-social attitudes and behaviour, warmth, and effective communication skills. The review notes that there has been a shift towards increasing professionalism and higher levels of education (graduate or post-graduate) among staff in secure residential services.
- There are no guidelines concerning the optimal staff-client ratio in secure residences. However, a high staff to young person ratio will help ensure staff are not overworked – reducing staff burn-out and turnover – and allow for an appropriate distribution of tasks across staff.
- A warm and home-like environment in residence (including providing kitchens, dining areas, lounges and individual bedrooms) is believed to: (i) help support the transition of the young person into residential care and help them to feel safe and more 'at home' and (ii) assist them to cope within the restrictive care environment.

[1260] The authors cite: (i) BL McCurdy and EK McIntyre (2004) And what about residential …? Reconceptualizing residential treatment as a stop-gap service for youth with emotional and behavioral disorders. *Behavioral Interventions, 19,* 137–158, and (ii) AL Zakriski, JC Wright and HW Parad (2006) Intensive short-term residential treatment: A contextual evaluation of the "stop-gap" model. *The Brown University Child and Adolescent Behavior Letter, 22(6),* 1–6.

- To help facilitate family involvement in the rehabilitation process, the young person should be placed in a secure residence that is as close to home as possible.
- To facilitate good outcomes for a young person post-residence to transition, it is important to plan and implement appropriate, individualised and effective interventions which align with the young person's identified strengths and difficulties from assessment, as opposed to a 'one size fits all' approach. Multi-dimensional interventions and rehabilitative programmes involving educational, mental health, cultural, medical, speech and language, and family-based interventions are likely to be most effective in addressing the wide range of difficulties the young person may be experiencing.
- Given the philosophy of detaining young people in a secure residence for the shortest period of time possible, therapeutic and rehabilitative work that requires long-term delivery should not be started while a young person is in a secure residence unless the young person is transitioning back into a community where this intervention can continue with minimal disruption and they can continue to see the same therapist / clinician.

9. Alternatives to secure care

This section discusses alternatives to secure care. Alternatives to secure care are interventions and supports which are designed to address the needs of young people who meet the 'secure care criteria', but do not involve detaining the young person in a secure accommodation service.[1261, 1262]

Alternatives to secure care may also refer to interventions and supports used when a young person is regarded as being 'on the edges of secure care' – for example (i) to prevent such a placement (including in situations where a young person has previously experienced secure care and is still regarded as being at very high risk) and (ii) where a young person is in secure care but is at the stage of moving into a less restrictive setting.

This review found evidence of effective alternatives to secure care and / or custody for young offenders, for women and girls, and for young people (both girls and boys) at risk of sexual exploitation. Scottish Government guidance (2011) to local authorities on alternatives to secure care and custody also included a review of effective alternatives.[1263]

Why are alternatives to secure care needed?

In recent years, with an increasing awareness of international human rights standards, there has been a growing ambivalence in Scotland, and indeed, in countries around the world, about the use of secure care or any

[1261] K Moodie and A Gough (2017) *Chief Social Work Officers and secure care*. Centre for Youth and Criminal Justice. See https://cycj.org.uk/wp-content/uploads/2017/05/Chief-Social-Work-Officers-and-secure-care-report.pdf - accessed October 2019.
[1262] D Hart and I La Valle (2016) *Local authority use of secure placements*. Department for Education. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582375/Local-authority-use-of-secure-placements.pdf - accessed October 2019.
[1263] Scottish Government (2011) *Alternatives to secure care and custody:* guidance for local authorities, community planning partnerships and service providers. https://www.gov.scot/publications/alternatives-secure-care-custody-guidance-local-authorities-community-planning-partnerships/. Accessed October 2019.

other service which involves depriving a child or young person of their liberty. Concerns about the use of secure care in Scotland have also focused on: (i) the fact that the vast majority of young people accommodated in these services are there for their own protection, rather than as a result of offences they have committed, (ii) a lack of suitable placements in these services which means that young people are often placed at a distance from their homes, (iii) a lack evidence about the outcomes from these services, and (iv) the challenges of creating continuity of care when young people leave secure care services.

In addition, the current policy focus in Scotland on early intervention, prevention and (for young people who come to the attention of the police) diversion from prosecution, where possible – has led many local authorities to begin planning / commissioning more local services to identify and respond to very high risks and vulnerabilities, without the need to detain young people in a locked environment.[1264]

Alternatives to secure care / custody for young offenders

Current Scottish Government policy states that where it is possible to meet the needs and risks of high-risk young people safely and cost effectively in their communities, these opportunities should be maximised.

Guidance developed for local authorities by the CYCJ has set out the current options available to local authorities and children's hearings wishing to avoid the use of secure accommodation. This guidance highlights the use of the Whole System Approach (WSA), the use of Movement Restriction Conditions and the use of Parenting Orders as alternatives to secure accommodation.[1265]

[1264] K Moodie and A Gough (2017) *Chief Social Work Officers and secure care*. Centre for Youth and Criminal Justice. https://cycj.org.uk/wp-content/uploads/2017/05/Chief-Social-Work-Officers-and-secure-care-report.pdf - accessed October 2019.
[1265] Centre for Youth and Criminal Justice (2019) *A guide to youth justice in Scotland: policy, practice and legislation*. See https://www.cycj.org.uk/wp-content/uploads/2019/06/2019-Section-1.pdf - accessed October 2019.

Whole System Approach (WSA) (Scotland)

The Whole System Approach for young people who offend (WSA) aims to prevent unnecessary use of custody and secure accommodation wherever possible. It does this by seeking opportunities to engage such young people, by putting into place a more streamlined and consistent response that works across all systems and agencies (a 'whole system' approach) to achieve better outcomes for young people and their communities. The ethos of WSA is based on a view that many young people involved in offending behaviour could and should be diverted from statutory measures, prosecution and custody through early intervention and robust community alternatives. The approach involves:

- Early and effective interventions, offering support and advice to young people in order to address need and change behaviour
- Diversion from prosecution, where the needs and risks of the young person are addressed
- Robust alternatives to secure care and custody where young people's risks and needs can be managed in the community
- Effective risk management measures by partners through the children's hearing system as opposed to adult courts
- Supporting young people in court to assist their understanding of the processes and to advise decision makers of community options
- Support in reintegration and transition back to the community from secure care and custody
- Encouraging cases to be dealt with through the children's hearing system rather than an adult court
- Retaining more young people on compulsory supervision orders through the children's hearing system, where there is a need to do so.

The Whole System Approach began to be rolled out across Scotland in 2011, and an evaluation[1266] carried out in three local authorities in 2015 found evidence of improved outcomes for the young people who had participated. At the same time, however, the evaluators identified a need for greater consistency in implementation of WSA and emphasised that ongoing work was needed to ensure that WSA values were sustained across and within partner agencies, particularly if WSA resources and responsibilities are allocated to different agencies or partners.

Use of a Movement Restriction Condition (Scotland)

An alternative to secure accommodation available to children's hearings under the Children's Hearings (Scotland) Act 2011 is the use of a Movement Restriction Condition (MRC). This refers to a restriction placed on a young person's freedom of movement in the community through the application of electronic monitoring (EM) technology (a tag). Section 83(6) of the 2011 Act allows for an MRC to be used only where the secure care criteria have been met (see Section 3 of this paper). Indeed, section 83(5)© of the 2011 Act requires that, before any decision is made to authorise the use of secure accommodation, alternatives (including the use of an MRC) should first be considered.

Scottish Government guidance on the use of MRCs is available.[1267]

Parenting Orders (Scotland)

Section 128 of Children's Hearings (Scotland) Act 2011 requires consideration to be given if a Parenting Order is needed in respect of a

[1266] K Murray, P McGuinness, M Burman and S McVie (2015) *Evaluation of the whole system approach to young people who offend in Scotland.* See http://www.sccjr.ac.uk/wp-content/uploads/2015/06/Evaluation-of-the-Whole-System-Approach-to-Young-People-Who-Offend-in-Scotland.pdf - accessed October 2019.
[1267] Scottish Government (2014) *Intensive support and monitoring system. Guidance on the use of Movement Restriction Conditions (MRCs) in the Children's Hearings System. Revised guidance – October 2014.* https://www.webarchive.org.uk/wayback/archive/20180516091917/http://www.gov.scot/Resource/0046/00461160.pdf. Accessed October 2019.

parent of a child under section 102 of the Antisocial Behaviour etc. (Scotland) Act 2004 (asp 8) (the "2004 Act").

A Parenting Order is a court order that can make parents do something to change or improve their children's behaviour and / or their own behaviour. A Parenting Order can help if a child is behaving badly and the child's parents are not taking any action themselves, and in cases where the behaviour of the child or young person is so bad, the parents either refuse or are unable do anything about it. Parenting Orders are intended to improve the welfare of the child by helping with, for example, parenting skills and education. Thus, they are not intended as a punishment. The idea is to help and support parents in improving or stopping antisocial behaviour. It is, however, a criminal offence if a parent does not comply with the order.

CYCJ reports that to-date, no Parenting Orders have been issued in Scotland.[1268]

Intensive fostering (international)

Păroşanu *et al* (2015) explored the use of intensive fostering services as an alternative to custody for young offenders in 28 European countries.[1269] This work was part of an EU-funded international research project which aimed to develop and promote fostering programmes as an alternative to custody, in accordance with Article 40 of the UNCRC. This states that detention should be used as a last resort and emphasises the role of diversion, restorative justice and alternatives to detention in the administration of juvenile justice.

[1268] Centre for Youth and Criminal Justice (2019) *A guide to youth justice in Scotland: policy, practice and legislation*. See page 18.
[1269] A Păroşanu, I Pruin, J Grzywa-Holten, P Horsfield (eds) (2015) *Alternatives to custody for young offenders and the influence of foster care in European juvenile justice*. European Union Project JUST/2011-2012/DAP/AG/3054. http://www.oijj.org/sites/default/files/comparative_report_alternatives_to_custody_for_young_offenders.pdf. Accessed October 2019.

The study found that foster care is an option in the juvenile justice systems in some countries but is not used in practice in most systems. Remand fostering (where young people are 'remanded' by the court to the care of a specially trained foster carer) has been introduced in the juvenile justice system in England. In addition, a new concept of 'treatment foster care' has been introduced in the juvenile justice systems of England and the Netherlands. The concept of 'treatment foster care' was originally developed in the United States by the Oregon Social Learning Centre. It is based on a structured six to nine-month foster care model that includes therapeutic services for the young person, the young person's biological family, their foster family, and minimal exposure to peers involved in offending. Evaluations of the intervention has shown positive results for the young person but have also found difficulties in maintaining the positive changes in the lives after the period of intensive fostering ended. There have also been concerns in some countries about whether mandatory foster care is consistent with children's rights.

Scottish Government guidance on alternatives to secure care and custody for young people involved in offending

In 2011, the Scottish Government published guidance for local authorities and their community planning partners in relation to alternatives to secure care and custody.[1270] This guidance included a review of the literature on effective alternatives for reducing offending among young people. The review highlighted that interventions for this population are likely to be most effective where there is a:

- Focus on the nature and consequences of the offending behaviour
- An emphasis on problem solving and behaviour change, cognitive development, personal or social skills
- A diversity of methods of intervention
- Use of positive authority

[1270] Scottish Government (2011) Alternatives to secure care and custody: guidance for local authorities, community planning partnerships and service providers.

- An emphasis on community integration.

'Community-based wrap-around approaches' have been found to be most effective. This type of approach brings together the efforts of significant individuals in the young person's life, where they exist, to develop a comprehensive plan for supervision. These individuals may be supplemented by trained volunteers and (as required) by specialist professionals. The approach aims to identify and build on the strengths of the young person and their family to encourage pro-social behaviours.

Alternatives to secure care / custody for women and girls

The majority of available provisions to address offending behaviours are derived from theories about male offending and do not necessarily meet the needs of woman and girls.[1271] Mitchell *et al* (2012) carried out a scoping study to explore existing knowledge about girls and young women at risk of secure care or custody, and ways in which earlier intervention strategies and alternatives to secure care and accommodation could be developed to address the specific needs of this group.[1272,1273]

The study found that community-based alternatives to secure care or custody take many forms, but all include an element of intensive, and, often, structured support. Some operate as accommodation-based programmes, such as intensive fostering or close support in residential care services. Some provide a level of wrap-around support for young people living in a range of circumstances (in their family home, supported

[1271] Scottish Government (2011) Alternatives to secure care and custody: guidance for local authorities, community planning partnerships and service providers. https://www.gov.scot/publications/alternatives-secure-care-custody-guidance-local-authorities-community-planning-partnerships/. Accessed October 2019.
[1272] F Mitchell, A Roesch-Marsh, and L Robb (2012) *Taking stock of alternatives to secure accommodation or custody for girls and young women in Scotland.* Criminal Justice Social Work, Development Centre for Scotland. http://www.socialwork.ed.ac.uk/research/grants_and_projects/archived_projects/taking_stock_of_alternatives_to_secure_accommodation_or_custody_for_girls_and_young_women_in_scotland. Accessed October 2019.
[1273] The study involved a review and appraisal of existing national data sources; a review of existing empirical studies of secure care, youth custody, and community alternatives used in the UK; and a consultation with key informants from across Scotland to map the availability and use of community alternatives with girls and young women.

lodgings, children's homes or foster care). Those operating as part of a manualised approach, such as Multi-Systemic Therapy and Multi-Dimensional Foster Care, have been subject to rigorous evaluation; while others have been subject to some research that explores their development and operation. However, none provide clear evidence regarding their use and impact on outcomes for girls and young women.

Practitioners working for services offering community based alternatives (operating as early intervention models, direct alternatives, and after care for young people exiting secure care) raised a number of concerns about current service provision for girls and young women, including: (i) the lack of access to services focused on treatment and recovery for children and young people who have experienced sexual abuse, (ii) approaches to risk assessment and decision-making which appear to result in lower thresholds for girls and young women being admitted to secure care, (iii) the current nature of secure care provision, with young people placed together but for different reasons, with different needs and in mixed gender institutions, and (iv) the lack of accessible and responsive mental health support, either at an early or a late stage (given that girls and young women present with high rates of post-traumatic stress disorder and poor mental health).

Practitioners suggested that services could be developed by:

- Increasing awareness of and gender focused practice for both girls and boys
- Increasing awareness of trauma and developing trauma-informed practice
- Increasing awareness of the effects of experiences of sexual abuse, and helping practitioners to feel more confident and skilled in supporting young people with experiences of sexual abuse

- Increasing awareness of and capacity for recognition of mental health problems, and enabling better access to effective treatment for drug and alcohol dependency
- Understanding that girls and young women require responses that offer continuity over time, irrespective of where they live.

Alternatives to secure care for young people at risk of sexual exploitation

A review carried out by Creegan *et al* (2005)[1274] found that interventions with young people experiencing, or at risk of, sexual exploitation should be informed by the following principles:

- The intervention should occur as soon as possible after concerns have been identified.
- Intensive contact with the young person addressing the key areas of vulnerability is vital.
- Continuity and stability of care should be prioritised, and risk managed within the young person's home / community, where possible.
- Parents / carers should be actively involved in planning and decision-making, with additional support and guidance provided to them.
- Safe accommodation should be provided at the lowest level of physical security necessary and incorporate the highest level of relational security possible.

The study found that specialist fostering, intensive community interventions, close support and secure care were all appropriate interventions for young people at risk of sexual exploitation, and that these types of interventions need not necessarily be mutually exclusive.

[1274] C Creegan, S Scott and R Smith (2005) *The use of secure accommodation and alternative provisions for sexually exploited young people in Scotland.* Barnardo's Policy and Research Unit. http://www.barnardos.org.uk/secure_accommodation_and_alternative_provisions_for_sexually_exploited_young_people_in_scotland_2005.pdf. Accessed October 2019.

The use of electronic tagging was not seen to be an effective means of responding to the needs of young people involved in sexual exploitation.

10. The use of restraint and single separation

One of the issues often raised in research into young people's experiences of secure care (and indeed other forms of residential childcare services) is the use of physical restraint.[1275]

This section considers this issue together with the use of 'single separation' (sometimes also referred to as 'isolation', 'removal from association' 'segregation' or 'seclusion') by (i) setting out what is meant by 'restraint' and 'single separation', (ii) highlighting the issues relating to the use of these practices, (iii) describing young people's views, (iv) setting out good practice in the use of restraint and single separation, and (v) identifying strategies for avoiding the use of physical restraint.

Note that the issues of restraint and single separation are relevant not only within a secure care context, but also in relation to non-secure residential childcare services, in psychiatric hospitals where young people are being treated for mental health problems, in schools, and in young offender institutions.

What is meant by 'restraint' and 'single separation'

The Scottish Government (2015) has published information for young people who are looked after in secure care about their rights.[1276] The document explains restraint (or 'safe holding') as follows:

> *'Care staff have a duty to protect and promote the safety and welfare of young people. Where your behaviour is considered to be a significant risk to yourself or others, staff will try to calm you or the*

[1275] Issues relating to the use of restraint are currently being debated on the CELCIS blog: https://www.celcis.org/index.php/blogsearch/?search_paths%5B%5D=%2Fknowledge-bank%2Fsearch-bank%2Fblog&query=restraint&submit=Search. Accessed October 2019.
[1276] Scottish Government (2015) *Rights. Information for young people who are looked after in secure care (Scotland).* https://www.webarchive.org.uk/wayback/archive/20170702034601/http://www.gov.scot/Publications/2015/08/6809. Accessed October 2019.

> *situation down using acceptable methods (this is called de-escalation). As a last resort, they may use physical restraint / safe hold.'*

'Single separation' is explained as follows:

> *'Care staff have a duty to protect the safety of all young people and they may decide that young people require to be isolated from the group when their behaviour presents a serious risk of harm to themselves or others. This is sometimes called single separation, isolation or segregation. The secure placement that you are in will have rules they have to follow about this.'*

Single separation involves sending (or taking) the young person to a safe space (which may be their own room) and preventing them from leaving that space until they have calmed down.

Different secure establishments have different rules that they use in relation to restraint and single separation. For example, in young offender institutions in Scotland, normally single separation should continue for no longer than three hours in any 24-hour period and for no more than two separate occasions in 24 hours. Statute requires that every use of this practice is recorded and places strict limits on its implementation. During the period of segregation, the young person will be monitored at least every 15 minutes.

What considerations in relation to human rights are relevant?

Scotland's Children and Young People's Commissioner has highlighted that the use of restraint may be considered a violation of children's rights to respect for their bodily integrity under Article 8 of the ECHR. Seclusion may constitute deprivation of liberty, which is a breach of children's rights under Article 5 of the ECHR.

However, the UN Committee on the Rights of the Child recognised in 2007 that there are 'exceptional circumstances' in which dangerous behaviour by children may justify the use of 'reasonable restraint to control it'. The Committee has stated that 'restraint or force can be used only when the child poses an imminent threat of injury to him or herself or others, and only when all other means of control have been exhausted'.[1277] The Committee has also stated that:

> *'The principle of the minimum necessary use of force for the shortest necessary period of time must always apply. Detailed guidance and training is also required, both to minimise the necessity to use restraint and to ensure that any methods used are safe and proportionate to the situation and do not involve the deliberate infliction of pain as a form of control.'*[1278]

Similarly, the UK Joint Committee on Human Rights acknowledged that short-term separation may be used to allow 'cooling off' after difficult incidents, and that longer-term separation is sometimes necessary for medical observations and treatment (although it poses risks). However, they considered that separation is not appropriate for other purposes. The Committee concluded that the use of separation from human contact is harmful to children if used for more than a few hours at a time, and beyond that, it can amount to inhuman and degrading treatment.[1279]

Young people's views on restraint and single separation

The UK Joint Committee on Human Rights recently carried out an inquiry (2019) into the use of solitary confinement and restraint in the context of youth detention.[1280] The inquiry covered young people detained in

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[1277] UN Committee on the Rights of the Child (UNCRC), General Comment No. 10 on Children's rights in juvenile justice, April 2007, paragraph 89.
[1278] UN Committee on the Rights of the Child (UNCRC), General Comment No. 10 on Children's rights in juvenile justice, April 2007, paragraph 15.
[1279] UK Joint Committee on Human Rights (2019) *Youth detention: solitary confinement and restraint. Nineteenth Report of Session 2017-19*, paragraph 45.
[1280] Joint Committee on Human Rights (2019) *Youth detention: solitary confinement and restraint. Nineteenth Report of Session 2017-19.*

hospitals for therapeutic care, those detained in custody due to criminal convictions, and young people placed in secure residential children's homes for their welfare. The Committee spoke to a range of individuals who had experience of different types of restraint. The points made by these individuals were that: (i) restraint can be painful, (ii) restraint can cause injuries, (iii) restraint can be distressing and psychologically harmful, both at the time and afterwards, (iv) the use of restraint can make a child's time in detention counterproductive; and (v) it harms the relationships between children and staff – inhibiting the provision of care and the modelling of normal relationships.

In relation to the use of seclusion / separation, the Committee heard from witnesses that: (i) separation causes psychological harm, (ii) it can reinforce existing mental health problems, particularly if the individual is placed in isolation for a lengthy period of time, and (iii) the use of separation can undermine the aims of detention.

These points were made earlier in a wide-ranging consultation carried out by Ofsted (the Office for Standards in Education, Children's Services and Skills) (2012) which involved 94 children and people in care from across England. The purpose of the consultation was to ask young people for their views on and concerns about the use of physical restraint.[1281] This consultation was a follow-up to a previous (2004) consultation – the results of which had informed the development of UK Government statutory guidance for children's homes.[1282]

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https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/994.pdf. Accessed October 2019.

[1281] Ofsted (2012) *Children's views on restraint.* *https://webarchive.nationalarchives.gov.uk/20141105214919/https://www.ofsted.gov.uk/sites/default/files/documents/surveys-and-good-practice/c/Children%27s%20views%20on%20restraint%202012.pdf*. Accessed October 2019.

[1282] Children Act 1989 Guidance and Regulations Volume 5: Children's Homes.

The consultation involved posing a series of questions to young people in discussion groups. The questions, and their views on the questions, included:

- **How does restraint make a child feel?** Young people said that being restrained is likely to make a young person angry and resentful. A phrase used by many to describe the experience of being restrained is 'feeling pissed off'. Others said it makes the young person feel trapped, out of breath, paranoid, sorry, uncomfortable, frustrated, 'walked all over', not having any rights, 'crazy and in pain'. However, for others, restraint helps a young person 'calm down'. For some, the experience of being physically restrained was 'the worst thing ever'.
- **How does it feel to see someone else being restrained?** Young people pointed out that seeing someone else being restrained also has an impact on the young people who witness the restraint – and that it is usually unpleasant for them to see it. They described their feelings as being upset, insecure, curious, shocked, feeling sorry for the person being restrained, wanting to help the person being restrained. Young people's feelings also depended, to some extent, on the relationship they had with the young person being restrained.
- **When is it right to use physical restraint?** Young people said it is right to use restraint to prevent injury to anyone – the child themselves or anyone else – or to stop a child damaging property.
- **Should restraint be used straight away or as a last resort?** Young people generally thought that restraint should be used as a last resort; and that staff should always try to calm things down before getting to the stage where restraint is needed. However, some also said that in very dangerous situations (e.g. if a child is carrying a weapon, or about to jump from a window), then restraint should be used straight away without waiting or trying other things first.

- **What can trigger the need to use restraint?** Young people suggested that restraint often follows a small trigger that has escalated – sometimes it relates to an overreaction to something very minor. Among those who had experience of being physically restrained themselves, common reasons were related to damaging property, hitting someone, or attacking staff.

The young people who took part in this consultation made suggestions about 'rules' in relation to physical restraint, as well as the types of physical restraint that should not be allowed. They also had views about groups of young people for whom restraint should never be used. These views are set out below together with information about other good practice guides on the use of restraint

Good practice in the use of restraint and single separation

Because the use of physical restraint and single separation infringe upon an individual's human rights, the practices are strictly controlled, and organisations which use them in Scotland must have clear rules about how and when they are used. Any incidents of their use should be recorded, and the views of young people for whom they have been used should also be recorded.

Recently (2018), Scotland's Children and Young People's Commissioner raised urgent concerns about the inconsistent use of restraint and single separation within Scottish schools, and the fact that some local authorities had no policies or guidance in place in relation to the use of restraint or single separation among pupils, and that some local authorities had no record of incidents.[1283]

However, practice guidance exists in relation to the use of restraint and / or single separation in all other contexts where young people may be legally

[1283] Children and Young People's Commissioner Scotland (2018) *No safe place: Restraint and seclusion in Scotland's schools.* https://www.cypcs.org.uk/advice/restraint-and-seclusion. Accessed October 2019.

detained, held in custody or secure care, or living in other (non-secure) residential accommodation. For example:

- Residential childcare services (Scottish Executive, 2005) – sets out practice guidance in relation to the use of restraint (or safe holding).[1284]
- Mental health / hospital settings (Mental Welfare Commission, 2013 and 2019) – note that this guidance does not relate specifically to restraint / seclusion of young people – although both documents includes sections which discuss the use of restraint / seclusion of young people under 18.[1285, 1286]
- Young offender institutions - Rule 95 of The Prisons and Young Offenders Institutions (Scotland) Rules 2011 states that removal from association is used for the purpose of: (i) maintaining good order or discipline, (ii) protecting the interests of any prisoners, (iii) ensuring the safety of other persons and only where there is a clear justifiable reason and for the minimum time necessary.[1287]

[1284] J Davidson, D McCullough, L Steckley and T Warren (eds) (2005) *Holding safely. A guide for residential child care practitioners and managers about physical restraining children and young people*. Scottish Institute for Residential Child Care, Scottish Executive and Social Work Inspection Agency. https://www.celcis.org/files/7914/3878/4811/holding-safely-2005.pdf. Accessed October 2019. This document was updated in 2012, but the authors of this paper could not find a copy of the revised version online.
[1285] Mental Welfare Commission for Scotland (2013) *Rights, risks and limits to freedom. Good practice guide*. https://www.mwcscot.org.uk/publications?type=39. Accessed October 2019.
[1286] Mental Welfare Commission for Scotland (2019) *Use of seclusion. Good practice guide*. https://www.mwcscot.org.uk/publications?type=39. Accessed October 2019.
[1287] Scottish Government (2017) *Universal period review of human rights in the United Kingdom 2017: response to recommendations*. See in particular, section 4.12 (removal from association and restraint) on page 58. https://www.gov.scot/publications/universal-periodic-review-human-rights-united-kingdom-december-2017-scottish/pages/8/. Accessed October 2019.

In England, statutory guidance and regulations relating to the operation of children's homes also includes guidance on the use of restraint and single separation.[1288]

Young people's 'rules' on the use of restraint

As part of the Ofsted consultation described above, young people were invited to suggest 'rules' that they thought should operate in relation to the use of restraint. The main themes in these suggestions related to:

- **Preventing the need for restraint.** For example: *'Use rewards as well as sanctions to encourage good behaviour'; 'Give children the opportunity and space to be alone to calm down'.*
- **Using restraint as a last resort.** For example: *'Try to calm the child down first, before using restraint'; 'Give the child a number of warnings to stop what they are doing and tell them that if they carry on, they will have to be restrained'...*
- **Avoiding harm to the child / young person being restrained (or the staff member restraining them, or by-standers).** For example: *'Don't hurt a child during restraint'; 'If you are hurting the person, let go'; 'Do not use restraint in a dangerous place for the child or staff member (e.g. where there are knives around, in a kitchen or on stairs)'; 'Make sure there is nobody else close enough to get hurt'.*
- **Considering other issues about the young person before restraining them.** For example: *'Know whether a child has been sexually abused and take this into account in deciding whether to restrain them'; 'Have both genders of staff on duty, and always at least two members of staff'.*

Young people also highlighted types of restraint that should **not** be used. In general, young people thought these types of restraint were dangerous

[1288] Department for Education (2013) *Children Act 1989 guidance and regulations – volume 5: children's home. Statutory guidance for local authorities.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/275695/ch_guidance_final_master_for_pub_oct_2013.pdf. Accessed October 2019.

and could harm the young person being restrained (and could also potentially result in harm to the staff member doing the restraining). Examples included: holding around the neck; the 'single wrap' or 'sleeper hold' because they can stop the child breathing; the 'basket hold' (because it hurts and still allows the child to kick or head butt the person restraining them); holding the child face down on the floor (with knees on their back); sitting on the child; dropping a child to the floor with a foot behind their knee; putting the full weight of a person on the child; moving a child around on the floor.

Young people also identified certain groups of young people who should never be restrained. These included very young children, children who had only just come into care, disabled children, children with certain medical problems (asthma, diabetes, epilepsy, etc.) for which the use of restraint could trigger problems or an attack, children who have been sexually abused, a young person who was likely to hurt the staff member trying to restrain them. Ofsted summarised the views of young people on the use of physical restraint in four words: *'Only do it carefully.'*

Strategies for avoiding the use of restraint

Most practice guidance on the use of restraint with young people emphasises the importance of avoiding the need to use physical restraint and promotes the use of de-escalation techniques and other non-physical methods to calm things down.

In an international review of best practice in youth justice secure residential settings, Lambie *et al* (2016) concluded that the use of restraint may be necessary as a last resort for the purposes of safety for the young person and staff.[1289] However, the authors note that, in general non-violent methods are both appropriate and necessary as an alternative, and they

[1289] I Lambie, A Krynen and C Best (2016) *Youth justice secure residences. A report on the international evidence to guide best practice and service delivery.* https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/youth-justice/youth-justice-report-secure-residences-11-fa.pdf - accessed October 2019.

highlighted two de-escalation and non-violent models of crisis intervention for use with young people in youth justice secure residences. These were (i) Non-Violent Crisis Intervention (NVC)[1290] and (ii) Therapeutic Crisis Intervention (TCI).[1291] They note, however, there has been limited published peer-reviewed research of evaluations of these interventions.

[1290] See www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention - accessed October 2019.
[1291] See https://rccp.cornell.edu/tci/tci-1_system.html. Accessed October 2019.

11. Concluding remarks

Secure accommodation services ('secure care') are used for a very small number of young people in Scotland each year. They do not appear to be well integrated with other elements of the 'care system', and there is limited information available about the circumstances of young people who are placed in secure care, their experiences of secure care, and their destinations and outcomes on leaving.

The information which is available suggests that these young people are extremely vulnerable, often traumatised, and with significant mental and emotional health needs. The reasons for entering secure care are predominantly related to their own protection rather than as a result of offences they have committed.

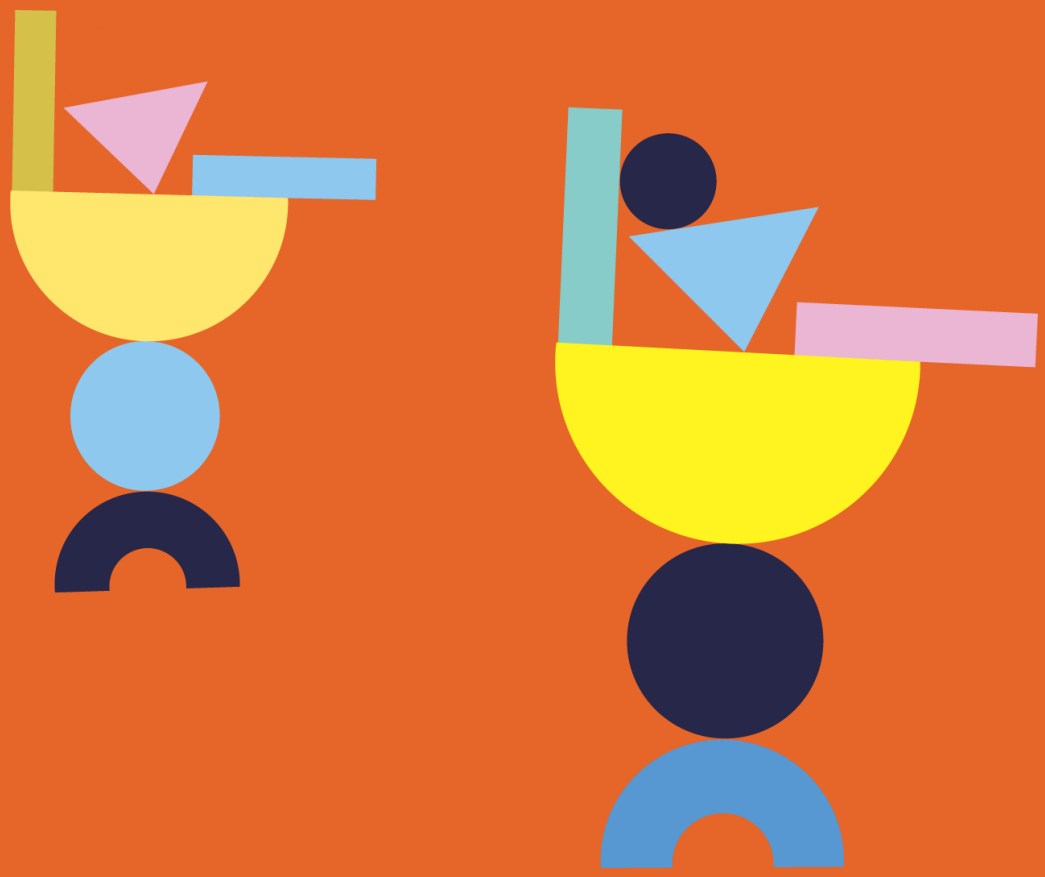
More broadly, there is a lack of clarity about the purpose of secure care in Scotland beyond the purpose of providing a period of stability and containment for a young person who is a risk to themselves or others. Local authority senior managers (CSWOs) who have a key role in placing young people in secure care are ambivalent about the use of these services, whilst accepting that there is likely to be a continuing need for these services; they see secure care as a 'last resort'.

The evidence suggests that countries organise their secure accommodation services in very different ways. Nevertheless, the evidence indicates that, internationally, the use of secure care is decreasing as countries seek to comply with international human rights and child rights standards. This has led to a growing interest in exploring alternatives to secure care which do not place such significant restrictions on the liberty of young people but are able to provide the type of intensive support required.

There is widespread consensus (including among young people) that there are certain circumstances in which physical restraint and / or single separation will be required. However, it is important that these practices are used in accordance with guidance and for the shortest duration possible.

Siblings

Sibling relationships



A review of the evidence on the circumstances and experiences of siblings in the 'care system', and the factors which promote or inhibit relationships

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1. Introduction

Background

In Spring 2019, as part of the Journey stage of the Care Review, a number of distinct, but interrelated evidence reviews were undertaken. These reviews were intended to help inform and shape the conclusions and recommendations of the Care Review by providing up-to-date evidence about a wide range of issues which are relevant the 'care system' in Scotland. Each evidence review aimed to answer one or more questions, identified in collaboration with one of the Care Review workgroups.

Methodology for the evidence reviews

Given the tight timescales for the production of these evidence reviews, a non-systematic approach was adopted which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Researcher judgement was required to limit the scope of the material and to keep the task manageable within the timescale.[1292]

Siblings

This report presents a review of the evidence in relation to the following questions:

- What evidence is available about the circumstances and experiences of siblings in the 'care system'[1293]? What do we know regarding:
    - The impact(s) on sibling relationships of being looked after
    - The barriers to positive sibling relationships

[1292] Note that a team of three researchers worked across all nine reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.
[1293] The evidence review covers both children in care and care leavers

- What works to promote positive sibling relationships

Structure of the report

The report is structured as follows:

- Section 2 reports relevant findings from the Discovery stage of the Care Review
- Sections 3 sets out the definitional issues which informed this evidence review
- Section 4 outlines the importance of sibling relationships for looked after children
- Section 5 gives an overview of sibling placements in the 'care system'
- Section 6 examines the experience of 'sibling contact'
- Section 7 looks at what helps promote positive sibling relationships and positive 'contact' for looked after children
- Section 8 contains some concluding thoughts.

2. Findings from the Discovery stage of the ICR[1294]

In relation to sibling relationships, the Discovery stage of the Care Review found:

- There was near universal agreement on the importance of maintaining relationships between brothers and sisters. Looked after children reported that it was very important that brothers and sisters were placed together whenever possible unless it was not safe or right for them. Separation from siblings was frequently mentioned as one of the biggest negative impacts arising from going into care. Some children shared how, after they went into care, they had been separated from their brothers and or sisters. They detailed how painful and upsetting this was (1000 Voices, 2017).
- Many children shared that in their experience there was often uncertainty about how to keep in touch with brothers and sisters whom they didn't live with. Lots of children talked about how they did not see their siblings as much as they wanted. Some children strongly argued they should have a right to keep in touch with their siblings (1000 Voices, 2017).
- Sometimes children reported that they did not know what had happened to their sisters or brothers; they did not have information on how they were doing. When they could not see them, they often did not know why this decision had been made. Some children argued that children in care should have a right to information about their siblings (1000 Voices, 2017).
- Across research studies children and young people emphasised that what was important to them was making sure the 'contact'

[1294] Note that this section also incorporates material from the Journey Phase 2 Voice report.

arrangements they had with birth family members were right for them. They knew *who* they wanted to see. For many it was their top priority in relation to their care experience. However, there were high levels of dissatisfaction reported by some children about the level of contact they had and the arrangements that had been put in place for them to keep in touch with the family members (including brothers and sisters) they wanted to see (Baker, 2017)

- Children acknowledged that their family relationships were not always perfect. However, children emphasised they (very often) still felt love for their families, especially their parents and siblings (1000 Voices, 2017).
- Consultation with the wider audience showed that many workers and carers echoed children's concerns. Some of the workforce felt that in the current 'care system' there was a lack of emphasis on helping a child or young person maintain links with their siblings (1000 Voices, 2017).
- The government statistical outcomes for looked after children do not cover the characteristics or experiences of looked after siblings. Currently no national data exists on numbers of siblings in care or where they live (together or separated) (ICR, 2018, statistical overview report).
- The importance of sibling relationships was underscored further in the recent work of the Siblings Care Review workgroup which asserted that *'sibling separation has been the number one advocacy issue for care experienced children and young people for the last 40 years'* (Care Review meeting minutes, 2019).

One of the twelve Care Review intentions is particularly relevant to the siblings' work stream:

> *Relationships which are significant to infants, children and young people will be protected and supported to continue unless it is not*

safe to do so. This recognises the importance of brothers and sisters, parents, extended family and trusted adults.

3. Siblings in care: definitions, status and context

This section provides a brief overview of how 'siblings' is defined and understood in the context of this Care Review evidence review.

Defining siblings

Dictionary definition of 'siblings'

The definition contained within the Oxford English Dictionary describes 'a sibling' as *'a person's brother or sister'*. This definition is based on a biological assessment of the relationship.

Wider definition of 'siblings'

Children's views on *who* they view as their siblings is likely to extend beyond the standard dictionary definition and encompass both biological[1295] and non-biological relationships.

Looked after children emphasise that there is also a need to recognise as siblings their close non-biological relationships; such as unrelated step-siblings, adopted siblings, foster siblings and 'sibling-like' relationships they have with peers in residential care.

Given that 'siblings' will mean different things to different children, the best way to understand what brothers and sisters means to each child is to ask them who they consider to be their siblings.

> *Sibling networks of looked-after and accommodated children can be large, diverse in age and spread over multiple households and care types (kinship, foster, residential care and adoption)...the task of*

[1295] In relation to biological siblings the following categorisation has been suggested by one study: (1) familiar (some level of relationship), (2) stranger (not had opportunity to establish any kind of relationship) and (3) undocumented (siblings who exist but are absent from care file recording) (Jones and Henderson, 2017).

> *defining and identifying a sibling relationship in the case of looked after children can be complex. (Jones and Henderson, 2017)*

> Even when a child has never lived with his or her sibling(s), the significance of the relationship may be keenly felt during childhood with a sense of 'what might have been' stretching into adult life. *(Beckett, 2018)*

Legal definition of 'sibling'

'Sibling' is not defined in the legislation relevant to looked after children (Jones, 2018), although relevant guidance says the interpretation of 'sibling' should be individual and based on children's views:

> *The regulation uses the term "any other child in the same family" rather than sibling. This highlights the need for awareness of the child's view of siblings. Many families have complex structures with full, half and step siblings and research has shown that children's perception of brothers and sisters and who is in their family is rooted as much in their lived experience as biological connectedness.*[1296]

In relation to looked after children, Jones (2018) proposes a definition for 'sibling' that is compatible with Article 8 of the European Convention on Human Rights as set out below:

> *'Sibling' includes full sibling, half sibling, step sibling by virtue of marriage or civil partnership, sibling by virtue of adoption, and any other person the child regards as their sibling and with whom they have an established family life.*

Status of 'siblings' within Scottish policy context

In UK policy, the principle has been established that siblings requiring foster care or adoption should be placed together, where this is in the best

[1296] Guidance on Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007 https://www2.gov.scot/Resource/Doc/344490/0114631.pdf

interests of the children (Jones, 2016). Specifically, in Scotland the Children (Scotland) Act 1995 and the supporting regulations and guidance states that siblings in care should be placed together: '*except where this would not be in one or more of the children's best interests*'.

When placement together is not possible, guidance outlines that children and young people should be placed 'near each other' and 'it may be appropriate for frequent contact to be maintained…this should be recognised in its own right and not purely as part of contact with parents'. Furthermore, 'the views of each child should be ascertained, as far as is possible given their age and understanding'[1297].

However, Jones (2018) argues that currently in law:

> *Looked after children have few enforceable rights at present in law in relation to placement and contact with siblings.*

Whilst statutory guidance promotes the maintenance of family relationships when a child becomes looked after, sibling contact is not considered to the same extent as birth parent contact. Decisions regarding sibling contact risk being subsumed under parental arrangements (Jones and Henderson, 2017). Research and policy guidance states that children who live apart from their sibling(s) should be supported to have a relationship with them. Scottish government guidance is clear that contact for looked after children should include not only parental, but also sibling contact, and possibly contact with other members of the child's extended family and friends[1298].

In response to such concerns a coalition of organisations, *Stand up for Siblings*[1299], have come together to campaign to change and improve legislation, policy and practice in relation to looked after siblings.

[1297] ibid
[1298] https://www.gov.scot/publications/guidance-looked-children-scotland-regulations-2009-adoption-children-scotland-act-2007/pages/4/
[1299] https://www.standupforsiblings.co.uk/

A note on evidence

There is no agreed consensus on how 'sibling' is defined. The complexity and variation noted in relation to looked after sibling networks means that studying the experiences and outcomes is challenging. The evidence sources included in this review were highly diverse in terms of their methodological approach. In addition, studies varied in terms of the children they included. For example, some reviews excluded children who had siblings that had not entered care; other work focussed on children in specific types of placements (e.g. 'non-kinship stranger foster care', only children permanently placed away from home, etc.). Much of the existing evidence appeared to focus on children and young people in foster care. As set out earlier in this section, studies also differed in the definition of 'sibling' they adopted in their research (and on occasion it was not always clear what definition the study was using (Jones, 2016). There was a scarcity of longitudinal research on this issue.

Finally, as is the case in other Care Review evidence reviews the voices of looked after children at home, those in residential care and older care leavers appeared less often in the evidence on sibling relationships.

4. Why are sibling relationships important?

Research into the views of children and young people with experience of care has found that relationships with brothers and sisters are often what they value most in family life.

Children have described the sadness and pain they experience when they are separated from their brother(s) and sister(s). Across research studies over many years one of the issues repeated time and again when looked after children's views are sought is the importance of living with, seeing or knowing about their brothers and sisters (Coram Voice, 2015).

This section sets out evidence on the importance and benefits of sibling relationships for care experienced children and young people (and care experienced adults). Positive sibling relationships are important because: (i) children have a right to 'family life' and (ii) they can be a 'protective factor' for children and young people, contributing to positive well-being and sense of identity and providing other benefits which can improve the quality of children's care, and after care, experiences. Conversely, evidence has highlighted how disruptions in sibling relationships can have a damaging effect on children's development and have detrimental long-term impact(s). The section ends by considering what determines the quality of sibling relationships and the potential impact of adversity on this.

Sibling relationships are important for upholding the right to family life

Public authorities (including local authorities, courts and children's hearings) have a duty to act in a way that is consistent with the rights set out in the European Convention on Human Rights (Jones, 2018). These rights include the right to respect for family life (Article 8) which depends on the existence of '*close personal ties*'. Relationships between brothers

and sisters are an important part of the right to family life. Therefore, local authorities need to consider whether there are 'close personal ties' between siblings they are considering taking into care or who are already in care. If ties are present then 'family life' between those siblings in terms of Article 8 exists and any action by a local authority must be '*lawful and proportionate*' (Jones, 2018).

Furthermore, Article 16 of the United National Convention on the Rights of the Child (UNCRC) states that 'no child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence'.

The *Guidelines for Alternative Care of Children* were issued to enhance the implementation of the United Nations Convention on the Rights of the Child regarding the protection and well-being of children who are do not have parental care or who are at risk of living away from parents (Jones, 2018). Guideline 17 in the *Alternative Care of Children* Guidelines states:

> *Siblings with existing bonds should in principle not be separated by placements in alternative care unless there is a clear risk of abuse or other justification in the best interests of the child. In any case, every effort should be made to enable siblings to maintain contact with each other, unless this is against their wishes or interests.*[1300]

Guidance has been developed to assist with the implementation of the Guidelines for Alternative Care of Children:

> *As a general rule, siblings should not be separated from each other in care placements unless there are compelling reasons for doing so. These reasons must always be in the best interests of any of the children concerned. While this may seem an obvious policy directive, the number of documented cases where siblings are separated without regard to their best interests made it necessary to stipulate it as a general principle of the Guidelines.*

[1300] https://resourcecentre.savethechildren.net/node/5416/pdf/5416.pdf

> *…Where siblings are separated, [national policy should] facilitate contact so that meaningful links can be maintained*[1301].

Implementation of the UNCRC is monitored by the UN Committee on the Rights of the Child – an elected group of 18 independent experts chosen from countries around the world.[1302] All countries that have signed up to the UNCRC must submit regular reports to the Committee explaining how the rights of children are being implemented. The most recent periodic report from the UK (the fifth report)[1303] highlighted concerns about children being placed at a distance from their biological families which prevents them from keeping in contact, and siblings being separated from each other without proper reason. It was emphasised that wherever possible the 'State party' should find a placement for the child which will facilitate contact with his or her biological parents and siblings[1304] (evidence cited in Jones, 2018).

Positive[1305] sibling relationships provide continuity, enhance well-being and support identity development

Evidence from research relating to the placement of looked after children demonstrates that sibling relationships can have a myriad of benefits; this section expands briefly on these reported benefits.

Sibling relationships can provide support and reassurance during care experience

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[1301] Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children', CELCIS 2012, pages 38 & 95

[1302] UN OHCHR, Committee on the Rights of the Child. See https://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx - accessed May 2019.

[1303] The most recent UK report to the Committee on the Rights of the Child was the fifth periodic report (CRC/C/GBR/5), submitted in May 2014. A copy of this is available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G15/044/91/PDF/G1504491.pdf?OpenElement – accessed July 2019.

[1304] https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRC/C/GBR/CO/5&Lang=En

[1305] Not all studies defined what constituted a 'positive sibling relationship'; an exception to this was Wojciak et. al. 2013 (cited in Jones 2016) where a positive sibling relationship was defined as one where there were positive perceptions of the relationship, a desire for more contact with the sibling and more frequent face-to-face contact with the sibling.

Entering care is a time of uncertainty for children and young people; children and young people report feeling sad, worried and unsettled when they are looked after away from home (see Components evidence review). These feelings can be amplified when children and young people are separated from their brothers and sisters and have to move to different placements from their siblings.

The sibling relationship has the potential to provide an ameliorating effect against the trauma, guilt and grief that children often experience prior to and when entering the 'care system' (Office for the Guardian, 2011b).

When siblings enter care and stay together their relationship can be a source of comfort and continuity. Keeping siblings together means that children do not have to experience another loss. Many (young) children may have spent more time interacting with their siblings than anyone else. The presence of (a) sibling(s) can provide reassurance, familiarity and an important link to the past (Ashley and Roth, 2015; Care Inspectorate, 2019). Some looked after children and young people say their brother(s) and sister(s) are the only ones who can really understand what they are experiencing (Coram Voice, 2015).

> *In an unknown, unfamiliar situation, the presence of one or more siblings can play a crucial role in maintaining emotional stability and a sense of safety (Shlonsky 2015 cited in Beckett, 2018).*

> *In the aftermath of maltreatment, when children are removed from much that is familiar to them (biological parent(s), home, school and peers), the sibling relationship is frequently the most viable on-going relationship in their lives. Maintaining a positive sibling relationship may be critical to a foster youth's sense of connection, emotional support, and continuity. The sibling bond may also serve as a source of resilience when other familial resources are unavailable (Feinburg 2013 cited in Kothari, 2017).*

Sibling relationships provide continuity

When children and young people in care build a meaningful and rewarding connection with a brother or sister in childhood this relationship is likely to very often stretch beyond the 'care system' and last throughout adulthood (Beckett, 2018; Kosonen 1996 cited in Office of Guardian, 2011a; Sen and Broadhurst, 2011).

Sibling relationships frequently remain important sources of support through late adolescence, adulthood and old age. The positive impacts of the sibling relationship may endure in later life; research has associated healthy sibling relationships in childhood with improved adult mental health (Kothari, 2017).

Sibling relationships can contribute to well-being and personal resilience

Relationships with brothers and sisters play an important part in children's social development. Spending time with their brothers and sisters helps children and young people to learn to deal with strong emotions (positive and negative) (Beckett, 2018). Even difficulties such as rivalries and jealousy can be beneficial and assist siblings with important life skills such as learning to share, negotiate and co-operate (Ashley and Roth, 2015; Kothari, 2017).

Positive sibling relationships can be a source of resilience for children facing adversity (Jones, 2018). The presence of a sibling in day-to-day life can also serve to provide long-term attachment, which is fundamental to a child's healthy development (Office of the Guardian, 2011a).

> *Children who have positive relationships with their siblings are less likely to exhibit internalizing behaviours (i.e., behaviour problems, such as anxiety or depression, that are directed inward or "kept inside") after experiencing a traumatic event... Being placed with siblings or maintaining sibling connections while in care serves as a*

> *protective factor for children's mental health (Child Welfare Information Gateway, 2019).*
>
> *Nurturing sibling bonds not only reduced the impact of some of the negative occurrences while in care, but also provided a valuable support well into adulthood (McDowall, 2015).*

Sibling relationships have repeatedly been identified as key to the emotional well-being of children in foster care (Washington, 2007). There is evidence that placing siblings together can be associated with increased well-being for looked after children and young people (Jones, 2016; Jones, 2018). Though an international review qualified that improvement was dependent on particular circumstances:

> *For certain children in certain conditions, sibling placements together were associated with more favourable mental health outcomes (Meakings, 2017a),*

Sibling relationships can help with identity development

Understanding who we are and where we come from is a crucial component of identity development. Relationships perform an important role in identity formation and provide a platform to make sense of the past (Winter, 2015). Brothers and sisters can help children and young people make sense of their identity. The quality of sibling relationships may have a positive effect on adolescent identity (Kothari, 2017).

Evidence suggests that being a member of a sibling group is a unique part of the identity of a child or young person and can promote a sense of belonging, positive self-esteem and emotional well-being (NICE, 2010). If siblings live together in care, this shared experience can help them develop their identity; however if they do not live together this can compromise the development of their identity (Jones, 2018).

Sibling relationships can be negative as well as positive and nurturing

However, it is also important to sound a cautionary note in relation to the evidence presented in this section. Not all sibling relationships are supportive and nurturing, in some cases, siblings develop unhealthy or abusive relationships with each other[1306]:

> *...sibling relationships have enormous capacity for shared understanding and activity, can stimulate warmth, care and joy and can help to sustain children and adults through distressing times. They also have the potential to be undermining, riven by conflict and marred by difficulty... Interactions between brothers and sisters are characterised by both strong positive features, such as warmth and intimacy, as well as negative qualities, such as intense conflict. Sibling relationships can be harmonious (high warmth, low hostility), affectively intense (high warmth and hostility), hostile (low warmth, high hostility) and uninvolved (low warmth and hostility) (Beckett, 2018).*

Thus, whilst the focus here is on the positive benefits of sibling relationships, it must also be recognised that sibling relationships will vary and some relationships can be difficult. Any consideration of the best interests of the child, therefore, must be alert to the potential of both the benefits and the harms of sibling relationships and consider the *quality* of the sibling relationship.

This is why the assessment of the child's best interests is crucial.

What factors affect the quality of sibling relationships?

Siblings' relationships do not develop in isolation; they are influenced by parenting behaviour and the climate of the home and surrounding environment (Beckett, 2018). Most children who come into care have

[1306] https://www.kcl.ac.uk/scwru/mrc/events2015/27Jan15-LMasonandAGupta.pdf

experienced complex trauma and / or faced significant challenges in their lives. Research has shown that a range of factors are important in determining the quality of sibling relationships. Factors such as whether or not home life was structured and organised, felt safe, focused on each child's needs and whether each parent showed appropriate affection and involvement, explained the quality of sibling relationships more than 'structural' factors such as children's age, sex or intelligence (Pike 2009 cited in Beckett, 2018).

Furthermore, factors such as exposure to domestic violence, paternal behaviours, neglect under the aged of two and exposure to alcohol *in utero,* can increase the risk of aggression in children and young people which has implications for sibling relationships (Selwyn 2014 cited in Beckett, 2018). Children and young people who are exposed to negative parenting – including abuse, neglect and overprotection – are more likely to experience childhood bullying by their peers (Beckett, 2018). A 'spill-over' process has been identified; hostility and conflict between parents and negativity in parent-child relationships were linked to increased conflict between looked after siblings – although research has also shown that some children show 'compensatory' behaviours by forming closer relationships with their siblings that help to protect them from 'adjustment problems' (Beckett, 2018).

> *When children have experienced early adversity such as poor parenting they may not have learned core social-emotional skills during preschool years. This 'gap' in their development is likely to make it harder for them to get on well with brothers and sisters, but is also likely to impact adversely on relationships with peers (Beckett, 2018).*

The way a child is viewed and treated within the family can have an effect on their behaviour and may impact on sibling relationships. A child or young person may have been treated differently by one or both parents.

There may be differences in relation to gender (boys may be more sensitive to differential treatment), siblings close in age may experience conflicts more intensely and the impact of differential treatment may be more marked for children than adolescents (Beckett, 2018). Differential treatment by a parent has been linked to greater conflict among siblings and, for the less favoured child, poorer adjustment (Feinberg cited in Selwyn, 2018) (Section 7 looks at interventions to support sibling relationships).

Summary

Research on sibling relationships (mainly focused on adoption and fostering placements) concludes that the placement of siblings together appears to be protective in terms of placement stability, achieving permanence and child well-being.

The evidence identifies a range of benefits associated with positive sibling relationships in terms of continuity, well-being and identity formation. At the same time, the degree to which these benefits are experienced is likely to depend on the nature of individual sibling relationships.

5. Overview of sibling placements[1307] in the 'care system'

Children and young people in care generally say they want to live with their brothers and sisters (Morgan, 2009; Beckett, 2018). Reviews of the evidence (on foster care) support the co-placement of sibling(s) in care, unless there is a justifiable child-centred reason for separation (Meakings, 2017a; Washington, 2007).

Despite this and the principle that has been established in Scottish Policy that siblings requiring foster care or adoption should be placed together, where this is in their best interests, there is much evidence demonstrating that separation of siblings is a common experience for looked after children (Jones et. al, 2019).

This section looks at the issue of sibling placements in the 'care system' in relation to: (i) prevalence of sibling relationships in care that are separated, (ii) decision-making and the barriers that exist to placing siblings together and (iii) the stability of sibling placements. Where information is available differences in relation to different types of placements are discussed.

Prevalence of siblings in the 'care system'

National data available on sibling relationships for looked after children is inadequate and incomplete partly due to the complexity and lack of consensus on definition. In particular, we do not know:

- how many looked after children and young people in Scotland have siblings (however defined)

[1307] Researchers have differentiated three types of sibling arrangement in relation to biological siblings: those who lived with all their siblings in the placement ("together"); those who resided with at least one sibling in their home but another sibling lived elsewhere ("splintered"); and those children who had no siblings in the home ("split") (Hegar and Rosenthal 2011, cited in McDowall, 2015)

- how many looked after children and young people in Scotland have siblings also looked after
- how many looked after children and young people in Scotland are placed with (all or a subset of) their siblings
- how many looked after children and young people in Scotland are separated from (all or a subset of) their siblings.

There is, however, some limited information available in relation to *fostering households*. The latest Scottish Government statistics show that:

- In 31 December 2018, there were 1,042 sibling groups in the Scottish fostering system.
- Nearly a quarter (24%) of sibling groups were separated upon placement; a similar figure to the previous year (Care Inspectorate, 2019).

The figures show there are differences between independent fostering services and local authority fostering services: independent services were less likely than local authority services to place siblings separately:

- 34% of the 666 sibling groups using local authority fostering services were separated upon placement
- In comparison only 6% of the 376 sibling groups using independent fostering services were separated.

Note however, that the published statistics do not differentiate between children and young people who have been assessed to be placed separately and children and young people who were assessed to be placed together but who end up being placed apart.

In addition, the published statistics do not provide any further assessment about children's and young people's experiences of living together or apart and whether this has changed over time (e.g. that previously they had been separated but are now placed together, or some other scenario).

Estimates of scale of sibling placements in the 'care system'

The only estimates, therefore, that exist about the scale of separation (or placement together) come from specific research studies. These suggest that a large majority of looked after children and young people have siblings (for example, between 87% and 92% of looked after children or those adopted from care have at least one biological sibling (Jones et. al, 2019).

Looking across studies it is suggested that between 50-80% of looked after children and young people are separated from some or all of their siblings, specifically:

- Between 17% and 37% of children (in research samples) were placed apart from all siblings ('split')
- Between 33% and 74% were separated from a least one sibling ('split' or 'splintered') (Jones et. al, 2019).

Higher rates of separation were reported by studies sampling older children and infants, collecting data directly from children, and where analyses included siblings both within and outside care. Lower rates were reported by studies relying solely on administrative data (Jones et. al, 2019).

One study based in Scotland[1308] found very high rates of sibling separation; with seven in ten relationships between a looked after child and their sibling classified as 'estranged' and half of all siblings classified as 'strangers' (siblings having never lived together and no record of any communication or meetings between the child and sibling) (Jones et. al, 2019).

Research has found that being adopted is the most serious risk to the continuity of sibling relationships (Monk and Macvarish, 2018). For

[1308] Study used administrative and case file data from the Children's Hearings System in Scotland and looked longitudinally at the circumstances of 204 children and young people from 50 sibling networks.

example, one study[1309] of children and young people in adoptive placements showed half of adopted children and young people had no contact whatsoever with any of their brothers and sisters who lived elsewhere, a quarter had contact by letter correspondence and only a quarter were able to continue to meet up with their siblings face to face (Neil, 2018b).

It seems clear from the research reviewed that separation from siblings was a common experience for looked after children and young people (Jones and Henderson, 2017).

Decision-making in relation to sibling placements

> *It is good practice to place siblings together and where this is not considered to be in children's best interests the assessment of this should be well evidenced and clear (Care Inspectorate, 2019).*

Sibling relationships need to be carefully assessed and understood when making decisions about placements. Four key dimensions have been suggested as relevant when assessing sibling relationships:

1. The degree of warmth
2. The degree of conflict
3. The degree of rivalry
4. The degree to which a child nurtures or dominates another sibling (Furman and Buhrmester 1985 cited in Beckett, 2018; Wilson, 2004).

Current guidance suggests that when decisions are made to separate sibling groups the following should be taken into account:

- record clearly and explain sensitively to the child or young person the reasons for separation
- make robust plans for on-going sibling contact according to the wishes of the child or young person

[1309] Study in England – survey responses from 319 adoptive parents

- ensure social workers coordinate any on-going contact desired by the child or young person, arranging appropriate supervision where necessary and supporting foster or residential carers
- review a separation decision if the circumstances of a sibling change
- ensure siblings have same social worker (NICE, 2010).

Professionals' personal values and emotional responses regarding the importance of sibling relationships may influence the weight and importance given to placement options[1310]. Monk and Macvarish (2018) examined the legal or practical factors which shaped the decisions made about the placement of looked after siblings. They found there were common 'assumptions' underpinning decisions and reported that some of the 'rationales for separation were concerning'. For example, those making decisions were prone to distinguishing between different types of sibling(s) (full, half, step, foster siblings), and they tended to place these different sibling relationships into a hierarchy where some relationships were valued more highly than others. The authors found that relationships between step siblings, and especially foster siblings, were rarely given much weight in legal decision making. The distinctions made by professionals about different types of siblings did not necessarily equate with children's and young people's own views of who mattered most to them.

Factors involved in sibling separation

As noted earlier, the official data on looked after children and young people is sparse in relation to sibling relationships. Data on reasons *why* siblings are not placed together is patchy, although there is some information from fostering services in Scotland which were asked to record the most common reasons for siblings being separated. The latest data shows that local authority services reported the two main reasons were: (i) lack of resources and (ii) 'emergency situation'. For independent

[1310] https://www.kcl.ac.uk/scwru/mrc/events2015/27Jan15-LMasonandAGupta.pdf

services the reason selected most often was 'following assessment' (Care Inspectorate, 2019). The evidence available – apart from official statistics – suggests that there are a variety of reasons that siblings in care may not be placed together. Some of these reasons are discussed below.

Shortage of suitable placements available to enable sibling groups to live together

There is a shortage of placements able to accommodate sibling groups. National data is only available in relation to *fostering* households. Recruiting enough carers to foster sibling groups was reported to be a challenge for around half of all fostering services in Scotland (Care Inspectorate, 2019). This was particularly difficult for local authority services, with over two-thirds (69%) of these services finding it difficult to recruit carers for sibling groups compared to 31% of independent services (Care Inspectorate, 2019). The main reason described by services was 'accommodation constraints'. The increased demand on placements arising from the introduction of continuing care[1311] was also cited as a reason (Care Inspectorate, 2019). Therefore, argues Jones and Henderson (2017), placement decisions regarding sibling separation or co-location are often dictated by the placements available rather than children's needs or preferences.

Other factors that impact on the placement of siblings together

Sibling group size:

- The size of the sibling group affects placement; larger sibling groups were more often split up compared to smaller groups (Jones et. al, 2019 expands on this: *'large sibling group size both decreases the likelihood of being placed with all siblings and increases the likelihood of being placed with some siblings'*).

[1311] Under the continuing care provisions of the Children and Young People (Scotland) Act 2014, young people in care on their 16th birthday may opt to remain in their existing placement

Timing of children's entry into care:

- Siblings who enter care at the same time (or within about one month of each other) are more likely to be placed together. If children enter the 'care system' at different times to their brothers and sisters, they may be unable to join their siblings as the placement does not have space for them to live together.
- Children who are initially placed together are more likely to remain together.

The age and stage of children's care journeys:

- A larger age gap between siblings may increase the risk of separation.
- Older children face an increased risk of separation; they may be particularly at risk of having their wishes de-prioritised '*in the pursuit of a permanent placement for their younger siblings*' (Monk and Macvarish, 2018).
- Some of the children and young people in a sibling group may not want a permanent placement or adoption (or even when they do it may be difficult to find a placement for all the different aged children together).
- Differences in relation to 'birth order'; first-born children may be less likely than last-born children to be referred to the Children's Hearing system or looked after. Lastborn children tended to be looked after at an earlier age and were more likely to be adopted than their older siblings.
- In contrast younger children may be more likely to find a long-term placement.

Type of placement:

- Children and young people in kinship care are more likely than those in 'stranger' foster care to be living with (at least one) sibling

- Children and young people in residential care are less likely to live with their siblings[1312].
- Children and young people who are placed permanently away from their birth parents (e.g. adoption) experienced a high degree of estrangement from their siblings.

Assessment indicates that some children require a separate placement:

- There are varying relationships between brothers and sisters. Some get on well and want to be together, others do not.
- Children and young people in a sibling group may also have substantially different needs, which cannot be provided for in one placement. In particular, behavioural and mental health problems can be barriers to co-placement or a reason for separation of a child from their siblings.
- There may be a risk to one child from another. For example, children may be separated because of abusive or problematic interactions (such as intense rivalry and jealously; exploitation; chronic scapegoating of one child; maintaining unhelpful hierarchical positions; highly sexualised behaviour with each other or acting as triggers to each other's trauma).

Factors that influence placement decisions are likely to interact in different ways (Washington, 2007; Beckett, 2018; McDowell, 2015; Jones and Henderson, 2017; Monk and Macvarish, 2018; Jones et. al, 2019; Miron et. al, 2013; Office of the Guardian, 2011b; Meakings, 2017a; Ashley and Roth, 2015).

When children were asked for their opinions about the main reasons that might make it right to separate siblings in care they suggested that this should occur in one of three situations: (i) when brothers and sisters really

[1312] Out of those who had siblings in care, 99% of those in children's homes were in a different placement from any of their brothers or sisters, compared with only 66% of those in foster homes – based on 311 survey response from children and young people in England (Morgan, 2009)

didn't get on with each other, (ii) if there was danger to any of them, and / or (iii) if they wanted to be separated (Morgan, 2009).

Risks associated with sibling co-placement

> *All siblings have some fall-outs and for most children there is underlying warmth for one another such that they quickly make up. When conflict is frequent and there is little emotional warmth, brothers and sisters may experience shared placement as unhelpful and undermining (Beckett, 2018).*

A strong recurring theme across the evidence reviewed was the positive benefits that often result from maintaining and developing sibling relationships and making joint placements in care (see section 4). Less information appeared available on the risks of sibling co-placement. For individual children their well-being and stability may be adversely affected by co-placement and so separation for some children and young people may be in their best interests. Separating siblings when being placed in care can, sometimes, lead to improved relationships as rivalry and competition are reduced (Beckett, 2018).

Children's involvement in decision-making

As identified in other Care Review evidence reviews, looked after children and young people say they need to feel that their views have been heard in matters of utmost concern to them; such as *where and who they live with* including in relation to living with and seeing their siblings (Coram Voice, 2015; Baker, 2019).

Some children and young people reported feeling that they had limited opportunities to participate in decision-making processes involving their lives, or they had no opportunities at all. Others said that, when they were consulted, they did not feel that their views were necessarily valued or acted upon, or that they had insufficient or inconsistent opportunity to express their views. Some said that they were allowed to influence trivial decisions, but that professionals did not let them participate in decisions

that were very important, such as where they lived or contact with parents and siblings (van Bijleveld, 2015). Yet, there is increasing evidence that involving young people in their placement decisions leads to better outcomes (Meakings, 2017a).

Whatever the reasons for children and young people being separated they are very likely to want to know why this has happened (Selwyn et. al. 2018). Not understanding why key decisions (e.g. about contact siblings) have been made was confusing and unsettling (Baker, 2017). Yet, the reasons and factors associated with the decision to separate children and young people are not always clearly recorded in care files (Office of the Guardian, 2011a). Sometimes workers say that they do not know the reasons why brothers and sisters do not live together (Meakings, 2017a).

Similarly, examination of care records showed that children's and young people's wishes in respect of 'placement arrangements' and 'contact' with their brothers and sisters were frequently not recorded as part of the hearing process, or their views were only partly captured in their care file (Office of Guardian, 2011a; Jones and Henderson, 2017; Porter, 2019[1313]).

Stability and permanence of sibling placements

Joint sibling placements can increase the likelihood of achieving permanency and stability. Studies have found that placing siblings in the same foster home is associated with higher rates of reunification, adoption, and guardianship (Child Welfare Information Gateway, 2019).

[1313] Study examined the records of 160 children who were looked after in Scotland from 2013 to 2017. This included 1,200 individual Hearings, which made a total of 2,003 contact decisions. Clear wishes of children were recorded in relation to just 12 per cent of contact decisions, in an additional 24 per cent the recorded views were unclear and there was no recording of views in 64 per cent of contact decisions (Porter, 2019)

Sibling relationships and placement stability

There are many interrelated factors that can promote or inhibit placement stability. Research reviews show that sibling placements are at least as stable as placement of single children (Jones, 2016; Meakings, 2017a):

> *A review by Heger (2005) that was conducted in the US but covered Canada, the UK and other European countries found that most studies suggested that 'joint sibling placements' are as stable as, or more stable than, placements of single children or separated siblings and that children do as well or better when placed with siblings ...A review in this country [England] by Meakings et al (2017) also concluded that the studies they examined indicated that outcomes for children in foster care who were in shared placements were usually better than for those who were separated from their siblings (Baginsky, 2017)*

Conversely, some studies have indicated that separation from siblings is associated with increased placement disruption, poorer child well-being and reduced likelihood of permanence (Office of the Guardian, 2011a; Jones and Henderson, 2017; Components Care Review review, 2019).

Jones (2016) highlights that notable gender differences have emerged from studies: girls' placements were generally '*more stable when in co-residence as opposed to separated placements*'.

Studies on the outcomes of placing siblings together confirm the benefits of co-placement. Children and young people placed away from their siblings can have poorer outcomes than those placed together; but this may be explained by the fact that children and young people placed on their own have more needs than siblings placed together (Wilson, 2004). In some instances, it may be that the life circumstances of those placed apart are likely to be more difficult (and hence lead to poorer outcomes) than the life circumstances of those placed together.

> *...it may be that children with less trauma and fewer behavioural problems are more likely to be placed with a brother or sister, and thus have better outcomes regardless of placement status.*
>
> *...The direction of the relationship between variables cannot be inferred or assumed from all the studies in the review. Whilst it may be shown, for example, that children in placement with siblings have fewer emotional and behavioural difficulties than those separated from their siblings, it is not known whether higher levels of emotional and behavioural difficulties led to a greater likelihood of being placed separately, or whether being placed separately led to a decline in emotional and behavioural well-being (Meakings, 2017a).*

Sibling placements and permanence

In Scottish policy 'permanence' is defined as providing children and young people with a stable, secure, nurturing home and relationships, where possible within a family setting, that continues into adulthood' (See Components evidence review, 2019).

The evidence in relation to the placement of siblings groups and permanency is mixed (and likely to be linked to range of interrelated factors such as children's age and background):

- Some studies of outcomes of sibling placements have focused on the likelihood of children and young people **achieving permanency** following a period of foster care. These studies have suggested that exits to forms of permanency such as adoption and guardianship are more likely where siblings are placed together (Jones, 2016).
- There is also some evidence to suggest that siblings placed together may be more likely to **return to their birth family** than those placed separately (especially when children and young people enter care at a similar time to one another) (Meakings, 2017a; Jones, 2016). Furthermore, siblings can provide effective support for children and young people returning to their birth family, with the placement

back home more likely to succeed when siblings return together (Office of the Guardian, 2011a).

- Keeping siblings together can influence the route and timing of the pathway's children and young people have in care (Cusworth, 2019). Being part of a sibling group may mean it **takes longer or there are more difficulties in findings a placement**[1314] (Care Inspectorate, 2019). Statistics and research show that some looked after children and young people are less likely to achieve permanence; this appears particularly true for older children, disabled children and sibling groups (Scottish Government, 2015).

Summary

Official statistics are inadequate in relation to sibling placements in care in Scotland. Despite this it is evident from research studies that a significant proportion of looked after children experience separation from their sibling(s). A range of factors influence the reason why children and young people are not placed together; one of the main reasons children and young people do not live together is due to a shortage of suitable placements for sibling groups. It appears that children and young people most likely to be separated from their siblings were those who were older, came from larger sibling groups, had developmental disabilities, were further apart in age, were placed in residential settings, or entered care at different times to their siblings.

Children and young people report that they are not sufficiently involved in these decisions and don't always understand why they can't live with their brothers and sisters.

[1314] At 31 December 2018, 194 children and young people were approved for adoption and waiting to be matched to an adoptive household - 35% were part of a sibling group. In some cases it took 12 months or more to match a child with a family, citing reasons such as difficulty finding matches for larger sibling groups (Care Inspectorate, 2019)

6. Sibling contact

When siblings cannot live together, facilitating regular opportunities to meet up and stay in touch ('contact') is critical to maintaining their relationship. Sibling contact is generally a positive experience for the majority of children and young people (Beckett, 2018). But in practice siblings who are separated can lose touch with each other.

This section examines the evidence in relation to (i) children's and young people's experiences of sibling contact(s), (ii) barriers to sibling contact(s), and (iii) ways to support sibling contact(s).

Children's experience of sibling contact(s)

Children and young people in care generally want to see and keep in touch with their brothers and sisters who they don't live with. They often want to see them more than they do. Across studies there were high levels of dissatisfaction reported about the level of contact they had and arrangements to keep in touch with the family members they wanted to see (Minnis, 2012).

Children and young people can experience strong feelings of loss and anxiety in relation to being separated from their siblings[1315]. When children and young people don't see their brother(s) and sister(s) they worry how they are doing, including being concerned for those they have never met.

When looked after children and young people are separated there is a high risk that contact will be irregular, limited, or non-existent. This can be a source of distress for children and young people, and is an issue that also concerns professionals (Jones, 2018). Gaps in contact, contact ending, or

[1315] https://contact.rip.org.uk/topics/contact-with-siblings/

not having information about what is happening in relation to sibling visits is likely to be very difficult for children and young people (Beckett, 2018).

Below, children's and young people's experience(s) of sibling contact in terms of (i) level of contact and (ii) the environment within which contact takes place are described.

Level of contact between siblings

Studies that have asked children and young people about their contact with siblings have shown high levels of dissatisfaction (Sen and Broadhurst, 2011). Children and young people can feel forced to have contact they don't want or denied contact that they do want. As discussed earlier (in Section 4) they often feel their views are ignored or only partially taken on board when decisions are made about who they are able to see and stay in contact with.

As there are no official figures in the UK on sibling contact[1316], it is difficult to determine the scale of loss of sibling connections as children and young people move through and beyond the 'care system' (Jones et. al, 2019). Research on children's and young people's experiences indicates that contact between separated siblings tends to decrease over time (Jones, 2018; Jones and Henderson, 2017; Young Radicals, 2018). Children and young people have reported that the longer they spend in care, the less opportunities they had to spend time with their family – both parents and siblings (Morgan, 2009).

Research indicates that adolescents (age 11-18) may be particularly unhappy with their level of contact with their siblings compared to younger children (age 8 to 10). However, across all ages there was relatively low levels of satisfaction; just over half (52%) of younger children said arrangements for seeing their sisters or brothers was 'just right' compared to only a third of older children. (Selwyn et. al, 2018)

[1316] One survey of children in foster and residential care in England suggested that about half of children had contact with a sibling once a month (Morgan, 2009).

Children and young people also described how they were able to see some siblings but not others – for example, because the youngest had been adopted and / or because the distance between their respective placements or their large family size made contact difficult. (Selwyn et. al, 2018)

On occasion young people reported they were having too much contact with their siblings; there are likely to be a range of reasons why children and young people feel this way. Some may feel that their parents treated them differently to their siblings during contact and because of this they sometimes wanted less contact. (Selwyn et. al, 2018)

When children and young people have no contact with their brothers and sisters, they may be very unhappy about this. Some may try to find their siblings (via social media[1317]). Sometimes not having the level of contact that was right for them may lead some young people to abscond from their placements, or take steps to see their family members (including siblings) without the knowledge of their social worker (Coram Voice, 2015). This may expose them to dangers associated with unsolicited communication[1318].

Environment for contact

Some children and young people reported how the *quality of the environment* in which their 'contact' took place was poor; contact centres were sparse and boring, with little to do. They felt that 'contact hours' were usually arranged to suit the working patterns of staff rather than needs of children, young people and their families (Selwyn et. al, 2018). Often contact arrangements comprised time-limited meetings sometimes observed by workers. Children and young people complained about this type of contact and wanted more 'normalised' time together. They

[1317] https://www.communitycare.co.uk/2019/05/07/hello-think-youre-sister-can-manage-post-adoption-contact-social-media-age/
[1318] https://contact.rip.org.uk/topics/contact-with-siblings/

reported that 'contact' held in this way felt 'sterile' and devoid of fun things to do.

Planning and supporting contact

In most cases, sibling contact is wanted by children and young people in care and can be rewarding and beneficial. Therefore, it should generally be considered, promoted and supported, unless there is good reason for it not to occur[1319]. Contact between siblings will require planning and support to ensure it happens and is of good quality.

Neil et. al (2015) have developed a model for planning and supporting contact; though aimed at contact after adoption, the principles underpinning the work are likely to be relevant across settings (Beckett, 2018):

- Contact should be **purposeful** (how can contact benefit the child is the central question)
- Contact should be **individualised** (taking account of the particular needs of the child and of the particular characteristics of the children and young people, adoptive parents (or carers) and birth relatives as these can have a bearing on contact
- Contact is a **relationship-based** process that is **dynamic** across time[1320].

Practices that can help maintain or strengthen relationships among separated sibling(s) include:

- Placing siblings nearby to make it easier to see each other regularly
- Ensure regular visits happen

[1319] ibid
[1320] For example, O'Neill's study looked at the experience of adopted people who meet birth siblings in adult life. Most participants had maintained a post-reunion relationship with their birth siblings and the majority referred to these relationships as adding a positive dimension in their lives and they wanted those relationships to continue. Those participants who had not remained in contact with their birth siblings reflected that they found the search and reunion to be worthwhile, as it helped them to fill in aspects of their identity that were previously unknown

- Offer financial and practical help for visits
- Ensure children, young people and carers have access to other ways to keep in touch (letters, email, social media, cards, and phone calls) with siblings
- Involve carers and children in planning 'contact'
- Explore if joint activities (days out together) or residential camps are available (as appropriate)
- Check if siblings can have 'respite' (sleepovers) with each other or if carers can offer babysitting to each other to facilitate keeping in touch and meeting together
- Support children and carers with the emotional impact of 'sibling contact' (Child Welfare Information Gateway, 2019).

Barriers to sibling contact(s)

Research has identified some potential barriers to looked after brothers and sisters who do not live together seeing each other as described briefly below.

- **Sibling contact is not considered to be in the 'best interest of the child'.** Some forms of sibling contact may be problematic or negative when pre-existing problems in the sibling relationship are not addressed. Sibling groups subject to very poor parenting may have learnt to respond negatively to each other and or may try to control each other or blame one another for their separation. In extreme cases, children and young people may be subjected to physical, sexual or emotional abuse by siblings during contact[1321].
- **Carers or workers' attitudes to, and facilitation of, sibling contact may inhibit contact taking place.** Many looked after children and young people in the studies (especially younger ones) were reliant on adults to enable them to see their family (including their brothers

[1321] https://contact.rip.org.uk/topics/contact-with-siblings/

and sisters[1322]) (Baker, 2017). Carers have a crucial role in encouraging, facilitating and advocating for children and young people who do not live together to safely maintain a relationship with each other. Carers have been described as the 'gatekeepers' of sibling contact (James 2008 cited in Beckett, 2018; Sen and Broadhurst, 2011). Research has shown carers can often have mixed feelings and attitudes towards contact with siblings (Jones and Henderson, 2017). Sometimes carers may not know or understand the reasons for contact, they may find the practical arrangements difficult or be concerned that it will upset the child.

- **Contact with siblings may be thought to undermine placement stability.** It may be difficult for some children and young people to understand why some family members remain at home, while they are in care. Contact with siblings who remain with parents may reinforce rejection, compromise a child's sense of safety, or undermine placement stability. Monk and MacVarish (2018) in their work found there could be assumptions made by professionals and others about the expected consequences of allowing sibling contact; that it will deter prospective permanent carers (such as adopters) or that it will undermine the stability of a placement.

[1322] Less evidence is available on how developments in technology are affecting how children in care stay in touch with their siblings they do not live with. One study with 12 children in care found that older teenage siblings who had access to mobile communication devices were able to communicate independently with siblings on platforms such as Facebook. This type of contact may include siblings (such as step-siblings) that are not included in care plans. The author concluded: '*the young people in care were not passive recipients of their familial and friendship networks. They did not deem their interaction with friends and family via mobile communication devices and the Internet as contact, but rather as staying in touch. The characteristics of this new phenomenon of contact included immediacy and reach, communication in real time and duration enabled them to control the who, how and when of staying in touch. Despite the potential of mobile communication devices and the Internet to bring cohesion between young people and individuals from their familial network this was not utilised or supported by either foster carers or social work practitioners. Instead, they saw the approach as a risk or a nuisance'.* (Simpson, in press)

Summary

This review found limited evidence which explored looked after children's and young people's experiences of 'contact(s)' with their brothers and sisters – much of the research in this area focused on experiences of parental contact so the particular views and experiences of siblings were often hidden. Information that was found showed arrangements for brother(s) and sister(s) to spend time together and stay in touch varied in terms of frequency, quality and availability of support. Children and young people experienced a range of barriers to contact and over time the frequency of contact children and young people had with their siblings could diminish.

The next section will look at what works to promote good-quality relationships between looked after siblings, both when they live together and when they live apart.

7. What works to promote positive relationships and positive contact for brothers and sisters in care?

This section looks at what helps promote positive sibling relationships for looked after children and young people. It covers both ways of enhancing the quality of relationships when siblings live together and ways of supporting and improving contact when siblings are separated.

The focus is on interventions that have been shown to be effective (the evidence is restricted to programs designed for looked after children and does not cover programs for siblings in the general population who are not in care). The section ends by considering possible changes to the law as a way to strengthen relationships for looked after siblings.

Strategies for supporting positive sibling relationships

Looked after siblings may benefit from help to repair or improve the relationships that they have with one another. Relationships between looked after brothers and sisters marked by problematic behaviour and aggression can have an impact on the stability of placements and affect other relationships children and young people have, including relationships with their peers (with an increased risk that children and young people who bully their brother or sister may be more likely to also bully other children at school) (Beckett, 2018; Selwyn and colleagues, 2018). Therefore, in some cases it may be appropriate to intervene to provide support to children, young people and families; and, at times, to offer specialist help, to reduce difficulties in relationships when siblings live together.

Some of the types of strategies which have been shown to be useful in improving relationships between looked after siblings are set out below.

Intervening in the early years

Pre-school programmes that target skills associated with peer acceptance and protect against rejection can help promote positive relations between siblings. Skills which can be developed during the pre-school years include:

- Co-operative play skills (taking turns, sharing toys, collaborating in pretend play and responding positively to peers);
- Language and communication skills (conversing with peers, suggesting and elaborating joint play themes, asking questions and responding to requests for clarification, inviting others to play);
- Emotional understanding and regulation (identifying the feelings of self and others, regulating emotions when excited or upset, inhibiting emotional outbursts and coping with everyday frustrations);
- Aggression control and social problem-solving skills (inhibiting reactive aggression, managing conflicts verbally, generating alternative solutions and negotiation with peers) (Kalvin 2015 cited in Beckett, 2018).

Supporting siblings to get along

Some strategies for parents and workers in supporting the needs of all children and young people in a family (including siblings) include:

- Encourage children and young people to share their thoughts and feelings; empathise with and do not minimise their concerns;
- Provide opportunities for fun and positive interactions between children and young people to promote attachment;
- Promote reciprocity between children and young people in the family, for example, if a child destroys the property of another, find a way for the child to make up for the loss;
- Find ways for parents to have meaningful individual time with each child;

- Teach children and young people skills to resolve their own disputes as far as possible;
- Develop a support group for siblings, either informally or through an agency;
- Seek professional help for serious sibling conflicts (James 2009 cited in Beckett, 2018).

Interventions for improving sibling relationships among looked after children

Although the general sibling literature highlights the attributes of sibling relationships that may be beneficial and or detrimental for children, little research exists concerning promising intervention approaches to support the relational needs of siblings in foster care (McBeath et. al, 2014)

Whilst there are a range of interventions aimed at improving outcomes for looked after children and young people and their families[1323], these existing interventions have not tended to be evaluated in relation to their effects on sibling-specific outcomes such as sibling relationship quality (Kothari, 2017). Therefore, there is little information available about sibling focused interventions that target sibling relationship quality, although three studies were found (all from outside the UK). These are covered further below.

McBeath and colleagues (2014) in their review of sibling focused interventions created a typology which classified these kinds of interventions into one of three types:

1. Universal: interventions not targeted to specific types of siblings
2. Selected: psychosocial interventions for sibling groups and or individual siblings

[1323] E.g. behaviour management programs including parent training interventions (e.g. Triple P-positive parenting program) and client centred child mental health interventions (e.g. trauma-focused cognitive-behavioural therapy) (Kothari et. al, 2017)

3. Indicated / Targeted: comprehensive interventions targeting the context of siblings.

See Table 1 below.

Table 1 A prevention science framework for sibling-focused interventions for foster youth (McBeath, 2014)

Prevention level and focus	Population	Intervention approaches
Universal	General foster youth population	• Well-defined sibling co-placement policy • Agency based plans for facilitation and implementation of sibling visitation • Agency-based implementation of needs assessment for sibling groups • Trainings for workers, foster carers and other professionals about sibling issues • Sibling skill-building, either via group based or one on one sessions focused on problem solving, conflict resolution
Selective	Foster youth at risk for poor mental health and child welfare outcomes and or youth most likely to benefit from individualised treatment	• Curricularized interventions focused on sibling relationship skill-building • Sibling co-receipt of therapeutic services • Avoiding sibling co-placement when advisable
Indicated / targeted	Foster youth demonstrating serious needs and behaviour and who are likely to engage in further disruptive behaviour	• Parenting and whole family interventions incorporating sibling relational development • Connection of identified siblings to appropriate community-based social services • Sibling focused inter-organisational coordination between social service agencies, law enforcement, courts

Universal sibling placement strategies: The dominant intervention approach with siblings in foster care is co-placement and or visitation. These approaches are non-targeted and indirectly seek to enhance sibling bonds and permanency (McBeath, 2014).

Selective prevention models for sibling relationship development: These interventions focus directly on sibling relationship development to improve or maintain positive sibling relationships. Such models often involve school-based interventions for young people deemed at risk of developing social or behavioural problems. They often also have a parent (carer) training component.

Targeted interventions: These interventions are focused on problematic sibling relationships; improving sibling relationship quality (often measured by characteristics such as warmth, sibling conflict, and or sibling interaction). Existing sibling interventions tend to take either an *individual* or *dyadic* approach. Dyadic sibling interventions provide information or treatment to both siblings, whereas individual-focused interventions focus only on one child in a sibling group (Kothari, 2017).

For this Care Review evidence review, only three studies were found which have evaluated interventions that aim to improve sibling relationships. All were reported to show promising early findings (McBeath, 2014; Meakings, 2017a). The programme elements and initial findings are described below.

The Promoting Sibling Bonds Programme

Promoting Sibling Bonds (PSB) is a programme (based in the US) for children and young people in foster care aged 5 to 11 years who were previously exposed to child neglect[1324]. It is focused on sibling pairs. The programme aimed to improve sibling relationship quality, reduce sibling conflict and aggression.

> *PSB was developed to (i) equip children with new prosocial competencies; (ii) reinforce positive parenting and train foster parents in conflict mediation strategies that support their children's*

[1324] In this pilot study (based in the United States), sibling pairs(n=22) and their foster carer were randomized into the intervention (n=13) or a comparison i.e. service as usual (n=9) group

newly acquired competencies; and (iii) promote skill generalisation in the foster home.

Linares and colleagues (2015) in their randomised trial investigated whether those receiving the intervention had better outcomes compared to a control group who did not attend the programme and were receiving foster care services as usual. The intervention group of siblings and their foster carers received an 8-week prevention intervention; there were both child and carer components to the programme as detailed below:

Sibling component *targets the following skill areas: cooperating, taking turns, and sharing; developing consistent consequences for sibling aggression; emotional self-regulation (Take a Break); developing prosocial behaviour alternatives (Turn Your Behaviour around); supporting your sibling and identifying common ground; and problem solving and finding mutually acceptable solutions.*

Parent / Carer component *focuses on: sibling cooperation and communication; consistent consequences for sibling aggression; the power of positive attention; self-regulation for yourself and for the children; and developing an organised approach to problem solving / mediation (Get Ready to Listen; Get the Story Straight and the Feelings Right; Help Children Name the Problem; Brainstorm; and Try a Solution).*

The joint component *targets barriers in the home; tracking and applying consequences to specific behaviours; controlled practice and CanDo charts (McBeath et. al, 2014).*

Linares and colleagues (2015) found that children and young people in the intervention group demonstrated improvements in positive interaction quality, lower levels of conflict during low competition play, and lower sibling aggression among older young people. In addition, carers reported more mediation strategies compared to children, young people and carers

in the control group (McBeath, 2014; Waid and Wojciak, 2017; Meakings, 2017a). The evaluators concluded:

> *Data suggest that the PSB intervention is a promising approach to reduce conflict and promote parental mediation, which together may reduce sibling aggression in the foster home (Linares et. al, 2015)*

Supporting Siblings in Foster Care (SIBS-FC)

A second study, undertaken by Kothari and colleagues (2017), reported on the effects of a 'specific dyadic sibling-focused intervention[1325]' on sibling relationship quality among children and young people in foster care. **Supporting Siblings in Foster Care (SIBS-FC)** is a relationship enhancement intervention designed to improve sibling relationships among pre-adolescent and adolescent young people in foster care. It seeks to meet the needs both of children and young people living together and siblings living in separate placements[1326]. SIBS-FC is a 12-session sibling intervention; comprising eight skill building sessions and four community-based activities which provide sibling dyads with the opportunity to practice new skills. The intervention focuses on strengthening sibling cooperation, providing support, managing feelings, and fostering self-advocacy. Two sessions provide specific practice in approaching adults for support[1327].

A randomized clinical trial found significant improvements in sibling relationship quality for siblings enrolled in the programme compared to the control group; the authors suggest that the intervention 'holds promise for improving sibling relationship quality among youth in foster care' (Kothari et al, 2017).

[1325] 164 dyads (328 children and young people) in the sample; each dyad consisted of an older sibling (aged 11-15yrs) and a younger sibling (separated in age by less than 4 years).
[1326] Just over a quarter (27%) of the sample were living apart.
[1327] McBeath and colleagues (2014) outline the 12-session curriculum (pg. 7)

Specialist fostering programme to prepare siblings for permanence

The third study compared outcomes for children in receipt of a specialist fostering programme for siblings, with children and their siblings in receipt of traditional foster care services[1328]. The findings showed that children and young people in the intervention group were more likely to be placed with their siblings and also experienced greater placement stability than those who received traditional foster care (Rast and Rast, 2014, cited in Meakings 2017a). The researchers found that children and young people in the intervention group also achieved permanence more quickly than those in traditional foster care placements (Meakings, 2017a). In addition, the specialist service was shown to be more cost-effective than the standard service (Jones, 2016).

Programmes that improve relationships among separated siblings

'Contact'[1329] for looked after children and young people has a broad meaning and can encompass a wide range of activities; it can involve face-to-face meetings, letters, telephone (what's app, text, social media) or Skype calls, exchange of photographs and the sending of gifts and cards.

As previously mentioned, this review found that much of the evidence on what supports and helps contact for looked after children and young people was concentrated on contacts between young people and their parents. There was limited work that had a specific focus on what helps improve siblings' experience of their contact with each other (Bullen, 2017; Porter, 2019; Sen and Broadhurst, 2011). This section briefly describes

[1328] The evaluation based in the US had a sample of 834 children in foster care with siblings also in care. Half the sample (n=417) received a foster care programme that prepares siblings for permanency and the other half of the matched group of children (n=417) received only traditional foster care services.
[1329] NB: Children generally dislike the term 'contact' and some services have moved away from this terminology and use 'family time' instead e.g. https://www.bbc.co.uk/news/av/uk-northern-ireland-48466031/kids-in-care-changing-the-language and https://www.tactcare.org.uk/content/uploads/2019/03/TACT-Language-that-cares-2019_online.pdf

programmes for supporting sibling contact(s) which have been reported in the research literature.

Organisations working with separated looked after siblings

Some organisations (for example, Siblings Together[1330] and Siblings United[1331]) aim to bring separated siblings together to help improve relationships between children and to enable children and young people to spend time together.

Siblings Together runs a programme which recruits and trains volunteers to become 'buddies' to support and encourage sibling relationships. Buddies facilitate sibling groups on a monthly basis; the focus is on children and young people having fun together and taking part in activities to develop stronger bonds.

An evaluation of the *Siblings Together Buddy Scheme* reported improvements for children and young people in relation (i) their well-being and (ii) their relationships. Findings included:

- Young people enjoyed the 'contact' with their siblings and wanted more frequent contact and for longer;
- Most sibling relationships improved;
- Children and young people developed greater confidence;
- Siblings developed their sense of identity;
- Children and young people were a source of support to one another (Sebba, 2017).

Residential events for separated siblings

Some organisations offer residential events (e.g. Siblings Together summer camp in the UK) for siblings in care, adoption and kinship care; these give brothers and sisters an opportunity to go on holiday together. These kinds of programmes have, in part, been designed to overcome some of the

[1330] http://siblingstogether.co.uk/
[1331] https://www.shaftesburyyoungpeople.org/siblings-united.html#

tensions and frustrations that looked after children and young people report with their usual 'contact arrangements' (as detailed in section 6).

In the United States a summer camp for separated looked after siblings, *Camp to Belong*, has been evaluated. The program provides a week-long summer camp. In contrast to other intervention programmes that require siblings to participate in multiple sessions the summer camp programme can work for siblings who ordinarily live at distance from each other and the camps can potentially accommodate large sibling groups.

Camp to Belong has a structured manual covering two main areas: (i) typical camp experiences such swimming, boating, challenge courses, sing-alongs and meals, and (ii) signature events (opening camp fire, birthday celebration, making and sharing pillows or quilts, life seminar, inspiration night, carnival, scrapbooking and closing camp fire) (see Waid and Wojciak, 2017; Wojciak et. al. 2018 for further detail). The signature events are designed specifically to strengthen the sibling relationship and create lasting memories.

Evaluation findings suggest that participation in *Camp To Belong* may reduce sibling conflict, and lead to improvements in sibling support (Waid and Wojciak, 2017).

Mockingbird Family Model

The Mockingbird Family Model (MFM) is an approach to supporting foster carers and children and young people placed with them, which brings together clusters of between six and 10 'satellite homes' to form a 'constellation'. The constellation is supported by 'hub carers' who provide a range of supports to the adults and young people within the constellation. One of the aims of MFM is to strengthen the relationships children in foster care have including with their siblings. An evaluation in England reported on early findings from eight pilots areas (McDermid, 2016). The results indicated that the model contributes to increased contact between siblings. Furthermore, according to participants the *way* in which contact

took place was positively different, occurring in a more natural way as part of family meet ups and sleepovers:

LifeLong Links

Research evidence has highlighted the diverse and complex sibling networks that can exist for children. It is important to have a system in place to track the location and status of all siblings, including those who (i) are currently in separate placements, (ii) have achieved permanence, (iii) left care or (iv) were not removed from the home.

The LifeLong Links[1332] programme is designed to find and connect (or reconnect) children and young people with important people in their lives. It is currently being piloted in Scotland (and England). The programme aims to identify and engage relatives (known and unknown to the child, including brothers and sisters) and other supportive adults (such as former foster carers or teachers) who connect to a child in care, and who are willing to make a life-long commitment to that child. The programme works with children and young people under 16 who have been in care for less than three years, and for whom there is no plan to return to their family or to be adopted. The Lifelong Links approach draws upon a family-finding model which originated in the United States and a family group conference model which originated in New Zealand. Independent evaluation of the work in Scotland is not yet available but initial indications are reported as positive[1333].

Changes to the law to improve sibling relationships

The previous sections have described ways of strengthening practice and detailed interventions designed to improve sibling relationships. This

[1332] Lifelong Links is being trialled in Scotland in Edinburgh, Glasgow and West Lothian; extended to include Perth and Kinross and Falkirk councils in April 2019.
[1333] https://www.frg.org.uk/involving-families/family-group-conferences/lifelong-links#what-is-the-evidence-of-the-impact-of-lifelong-links *e.g. In Scotland a child who has received a Lifelong Links service will, on average, see their networks increase by an additional 25 people*

section looks at how changes in law[1334] and policy could potentially help improve and promote relationships between looked after siblings.

Jones (2018) and others[1335] have proposed that changes are needed at the legislative level to strengthen and give greater effect to the rights of looked after children, in terms of: (1) children's knowledge of what is planned for their siblings, (2) the degree to which siblings' views are taken into account in planning processes, (3) the likelihood of living together and (4) taking steps to ensure that siblings see each other.

Of particular relevance to this evidence review is the proposal that *a 'requirement to place siblings together in care'* is introduced (unless there are compelling reasons for separating); this would be in line with the *UN Guidelines for the Alternative Care of Children* (see ICR Rights evidence review for further information).

Furthermore Jones (2018) suggests amendments to current legislation are needed to place a duty on *'local authorities to promote and facilitate contact between looked after children and their separated siblings (where it is practical and appropriate in the circumstances of the case)'*. This would extend the existing duty beyond parental contact; currently sibling contact is not recognised in its own right. In addition, it is argued there is a need to amend the legislation to '*introduce (an) explicit right for siblings to make (an) application for contact'*.

In addition, Jones' (2018) work suggests amending the Children's Hearings (Scotland) Act 2011 to '*place a specific duty on the hearing to consider sibling contact at each hearing* and to *give siblings the right to be notified of the hearing and make representations as to sibling contact'* (along with right to appeal decisions). Furthermore, an '*explicit duty on local authorities to take into account views of siblings' when making an*

[1334] See https://www.clanchildlaw.org/news/supreme-court-permission-to-appeal for latest news re: the current law in relation to sibling rights and contact within the children's hearing system in Scotland (an appeal to be heard by the Supreme court)
[1335] https://www.clanchildlaw.org/sibling-contact

assessment in relation to looked after children' would improve the degree to which the views of siblings were heard.

In 2019 Scottish Government announced via the Children (Scotland) Bill and the Family Justice Modernisation Strategy significant proposals to change the law to protect the sibling relationships of children in care:

Actions

Duties on local authorities

- Section 10 of the Children (Scotland) Bill introduces a duty on local authorities to promote direct contact and personal relations between a child and their siblings, where this is both practicable and appropriate and in the interests of the child. Siblings are defined to include individuals with whom a child has an on-going relationship with the character of a sibling relationship.
- Section 10 of the Bill also requires local authorities to seek the views of the child's sibling in relation to contact when it is reasonably practicable for the local authority to do so.

Amendments to Looked After Children (Scotland) Regulations 2009

- The Scottish Government will introduce amendments to the Looked After Children (Scotland) Regulations 2009 to put a duty on local authorities to place siblings under 18 years of age together when they are looked after away from home when it is in their best interests to do so. These regulations will come into force at the same time as the section in the Bill placing duties on local authorities[1336] [1337]

Sibling-friendly services

Recent practice guidance (Beckett, 2018) outlines the features of a 'sibling-friendly' service and what a quality service from the perspective of looked after brothers and sisters who do not live together would look like:

[1336] https://www.gov.scot/publications/family-justice-modernisation-strategy/pages/12/
[1337] https://www.clanchildlaw.org/blog/children-scotland-bill-family-justice-modernisation-strategy-published

For children in foster care:

- I know why it wasn't possible to place us together
- I know where my brothers and sisters are living
- I know how I can contact my brothers and sisters
- I know when I will see my brothers and sisters
- I have photos of my brothers and sisters
- My social worker has talked to all of us about why we are in foster care
- I sometimes have/have had life history sessions that include my brothers and sisters.
- My foster carer knows important details about my brothers and sisters.
- I know that I can talk to my foster carer and social worker about my brothers and sisters – including any mixed up, confusing feelings that I might have.
- I know that my foster carer and social worker will help me to maintain links with my brothers and sisters.
- My social worker has written down the dates of my brothers' and sisters' birthdays and given these to me.
- I know that my foster carer knows how to contact the foster carers of my brothers and sisters.
- I know that my social worker thinks carefully about how to help me and my brothers and sisters and wants to make the best plans for all of us.
- I know that my social worker and foster carer will try to help if I have problems or fall-outs with a sibling.
- I know that my social worker works in a department that thinks relationships between brothers and sisters are really important – not just now but for when I'm older.

For children separated by adoption or other permanent placements:

- I know the reasons why I am not living with all my brothers and sisters.
- I have information and explanations in my life story book about my brothers and sisters.
- I have met the family who care for my brothers and sisters.
- I know that my family have met my brothers and sisters and have photos of us all together.
- I receive news about my brothers and sisters and how they are doing.
- I have recent photos of my brothers and sisters.
- I know when I will see my brothers and sisters (or why I cannot see them).
- I know that I can talk about and ask questions about my brothers and sisters

Summary

Many looked after children are unhappy with how their relationship(s) with their brother and sisters are supported. Changes in the law are proposed to improve the current situation. The research literature highlights a small number of interventions which have been designed specifically to promote positive sibling relationships and to improve contact for looked after siblings. Much of the work described here was from outside of the UK. Those programs which have been evaluated are reported as promising. Overall, it appears there is still a way to go until all services deliver what children would consider 'sibling-friendly' services.

8. Concluding remarks

From the outset this evidence review highlighted the variation in relation to what looked after children understand to be 'sibling relationships'. As a result exact estimates on the number of siblings groups in care are difficult to determine.

Within the complexity, what appears to be clear is that sibling networks of looked after children are often large and exist across different placement settings (children at home, kinship care, unrelated foster care, adoption or living in residential care). Wherever they are found and however they are defined they are very important to children.

Evidence presented in this paper supports the view that joint placement of siblings or sibling contact is generally positive and supportive. Despite this, looked after children's relationships with their siblings are often at risk, relationships can be weakened when children enter care and some children lose touch with their siblings entirely. The likelihood that siblings will be placed together is influenced by placement availability, the age of the children, and sibling group size.

Children say getting things better for brothers and sisters is very important. Messages from the evidence suggest there are areas for improvement, for example:

- It would help if 'sibling' was defined in legislation and for future research to be aligned and transparent on definitions used. There is a dearth of official statistics; collecting more information on looked after siblings based on an agreed definition would elevate the importance of this issue and enable trends over time to be tracked (especially important if changes in the law are enacted).
- Practice in this area needs to be reframed towards more of a rights-based approach where children's relationships with their brothers

and sisters are valued – and their views on *who* they want to live with and / or stay in touch with are also valued. It should be accepted that children's definitions of their 'family' may include people they are not biologically related to, for example step siblings or foster siblings.

- There is a need to improve children's involvement in decisions about their lives; and to ensure there is clear recording of their views on these important relationships in their myriad forms in care records.
- It is important to have a range of carers and placements available for sibling groups. Carers and staff in residential units need to be adequately trained to support these key relationships in children's lives, and need to give contacts between siblings equal weight to contacts with parents.
- The evidence base regarding the effectiveness of interventions aimed at supporting and enhancing the quality of sibling relationships for looked after children needs to be strengthened.

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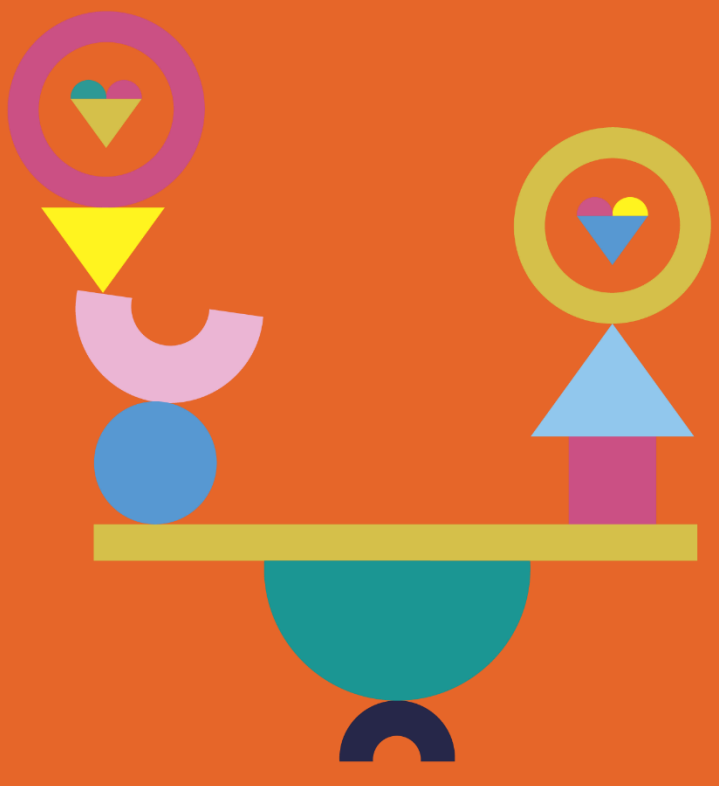
Social Work Perspectives

Social work perspectives and experiences of the 'care system' in Scotland



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31 October 2019

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1. Context

The Care Review was announced by First Minister Nicola Sturgeon in October 2016 as a `root and branch' review of the 'care system' in Scotland. Fiona Duncan was appointed chair in spring 2017.

The overall aim of the Care Review is to identify and deliver lasting change in the 'care system' and leave a legacy that will transform the wellbeing of children and young people. The Care Review is looking at legislation, practices, culture and ethos of the 'care system' across Scotland. Key to change is to hear the views and experiences of those with experience of the 'care system' and providers of care to inform recommendations to improve both the quality of life and outcomes of infants, children and young people.

The four stages of the Care Review are: the **Orientation** stage established the way in which the Care Review would be undertaken and concluded May 2017; the **Discovery** stage met with care experienced children and young people, local authorities, third sectors and other key stakeholders across Scotland and asked two key questions: what would the best 'care system' in the world look like and what should the Care Review look at?; the **Journey** stage began in June 2018 with the aim of delivering improvements to those who experience care in Scotland and continuing to establish clear evidence of what works best for children, young people and their families; and the fourth and final **Destination** stage will produce final recommendations in spring 2020 for the development of the 'care system' in Scotland.

Social Work Scotland is the professional body for social work leaders and together with the Care Review commissioned this study to gather the views of residential workers, social workers, managers and strategic leaders

working with care experienced children and young people and responsible for the provision of local authority or integration authority funded services to children and families across Scotland to inform the Journey stage.

It should be said that from the outset, there was a clear commitment to this study from the social work profession both in the extent and quality of responses to the national survey and interviews, and time and thought given in the discussion groups. There was an overwhelming sense that the profession agreed change was needed and welcomed the Care Review for the opportunities this offered. It is, therefore, important that the reflections from the profession are viewed within this context.

2. Outline of study

Aim of the study

The aim of the study was to understand better the perspectives and experiences of the social work profession about the 'care system' in Scotland through:

a) Gathering the views of social workers responsible for the provision of local authority or integration authority funded services for children and families across Scotland;

b) Identifying the key strengths and challenges of the current 'care system' from the perspective of senior managers and frontline residential and social workers; and

c) Identifying the structures and range of public services which senior and frontline social workers believe need to be in place if Scotland is to significantly improve the wellbeing of those children and families who become involved in the 'care system'.

Methods of data collection

A mixed methods approach was developed to meet the aims and objectives outlined above. The study aimed to gain a better understanding of the current challenges and identify key priorities for the future through a national survey, semi-structured interviews and discussion groups.

National survey

A national survey using SurveyMonkey was developed, piloted, amended and circulated to all 32 councils in Scotland and the networks of Social Work Scotland and the Care Review. The survey, which included both tick box and open questions, asked respondents to identify the key strengths and challenges of the current 'care system', and the structures and range of services which frontline social workers believe are required to meet the needs of children and families who become involved with the 'care system'.

The survey provided a confidential space for workers from the statutory, third and independent sectors to submit their anonymised views.

314 responses were received from those working in the statutory, third and private sectors from across all areas in Scotland representing urban, smaller urban, rural and island areas. 290 (92.4%) of respondents had or currently worked in the 'care system' and almost 60% had 11 years or more experience.

248 (78.9%) were qualified social workers and of the 66 (21.1%), who replied they were not, the majority identified as residential care workers or residential house managers with others as social work assistants, social care workers or youth workers. Of the qualified social workers, just under a fifth (18.6%) had been qualified for fewer than five years, 35.8% had been qualified between six and 15 years and almost half (46.6%) had been qualified for more than 15 years.

Respondents were also asked to identify which sector they currently worked in: statutory, third or private. Predominantly, 92.9% of respondents (n=309) worked within the statutory sector with a further five point five percent in the third sector and one point six percent worked in the private sector. The varying roles are outlined in Table One.

Six (one point nine percent) reported that their current or most recent role was as head of service, 18 (five point eight percent) were service managers, 47 (15.2%) were team managers and 17 (five point five percent) were managers of residential houses. Finally, 50 (50%) respondents were currently or were recently residential care workers and 139 (44.8%) were social workers including senior social workers.

Table One:

Respondents' current role or most recent role in the 'care system'		
Residential Care Worker	50	16.1%
Social Worker	139	44.8%
Manager of residential home	17	5.5%
Team Manager	47	15.2%
Service Manager	18	5.8%
Head of Service	six	1.9%
Other: e.g. family support, link worker, support coordinator	33	10.7%
Total	**310**	**100%**

Interviews with strategic leaders

Chief Social Work Officers and Heads of Service in all 32 Scottish Councils were invited to participate jointly or individually (if the role was combined) in an interview to explore the key strengths and challenges of the current 'care system', and the structures and range of public services they believed should be in place to meet future need. The preference was to complete the interviews face to face, but some telephone interviews were necessary due to busy diaries, the timescale of the study and geography.

37 individuals from 29 Councils participated representing all areas across Scotland with almost a third working in rural communities. In order to classify the Councils which participated to give a breakdown between city, urban and rural, Scottish Government's (2018) *Urban Rural Classification* has been used as a framework. Councils have been classified according to where the greatest proportion of the population resides; for the purposes of this report a local authority may have been classified, as '*other urban*' for example, but had some of its population living across other types of communities (see Table Two).

Table Two

Percent of population in each six-fold Urban Rural category by Local Authority		
Urban rural classification	**Number of local authorities**	
Large urban	7	24.1%
Other urban	13	44.8%
Accessible small towns	1	3.4%
Rural small towns	--	0%
Accessible rural	4	13.8%
Remote rural	4	10.7%

Workshops and discussion groups

- Early emerging findings from the survey and interviews were explored in two workshops at the Social Work Scotland annual conference (June 2019) and through two half-day exploratory discussion groups (August 2019). Emerging findings were presented to each workshop and discussion group and participants were asked to focus on the following questions:
- If there was no 'care system', how would we support children and young people: what would that look like?
- How do we support people to hold risk: what does 'holding risk' look like?
- If children and young people are to stay or return home, what do families really need?
- What does involving communities mean: what does building capacity look like?
- What range of resources do we need: what sort of facilities do we really need to make a difference?

The discussion in all workshops and discussion groups was recorded through flipcharts and notetakers. Over 80 participants took part in the

workshops. Those completing the survey had been asked to express interest in attending discussion groups at the end of the survey or through contacting the lead researcher directly to register interest in participating in the follow-up discussion. This allowed individuals to submit anonymised survey information, but still take part in the follow-up discussion group. 121 respondents expressed interest and were contacted individually. Sixteen participants eventually took part in two discussion groups bringing the total to 96 contributors.

Limitations

The themes to emerge from this small-scale study are based on the views and perceptions of those with experience of working in the 'care system'. While the numbers completing the survey are sizeable, it is a small percentage of the total children and families' social work and social care workforce. It is likely that those completing the survey were motivated or interested in participating and there may be differing views of those who did not take part. It should be noted, however, that the range of roles and length of time of many participants is an indication of the knowledge and experience of those who completed the survey. In addition, the numbers of respondents completing the tick box questions ranged between 310 - 314 and for the open questions ranged between 269 - 290. The time and thought given to completing the survey were clear from the responses recorded.

A second limitation was that this study focused on the perspectives and views of the social work and residential care workforce, however, some of the emerging themes relate to other professions such as health and education reflecting the range of services involved in the lives of children and young people. It was not the intention for this study to gather the views of other professions, but it should be clear that the perceptions discussed are those of the wider social care profession and not of those working in health, education, police, housing or the children's hearing system.

A third limitation is that this study represents the views and reflections of participants expressed at a point in time and, therefore, could be subject to change.

3. Practice today in Scotland

Before considering the themes which emerged from the survey, interviews, workshops and discussion groups, it is worth setting the context in terms of what services are being delivered to children and young people in need of care and support across Scotland today.

In 2004, Milligan, Kendrick and Avan undertook a survey of job satisfaction in residential child care in Scotland. Some key questions asked in the 2004 survey were also included in the 2019 survey, it was useful to repeat the exercise to gain some insight into the morale of the workforce today.

National statistics

According to Scottish Government's most recent statistical publication (Scottish Government 2019), there was an estimated 14,738 looked after children on 31 July 2018, which is a decrease of 159 (one percent) from 2017 with the number of children ceasing to be looked after greater than the numbers becoming looked after during this period.

The statistics report that the proportion of children being looked after at home has decreased over the last decade with an estimated 26% in 2018 compared with 43% in 2008. The proportion of children looked after away from home in community settings had increased with foster care and kinship care the most common settings for looked after children in 2018. Numbers of children looked after in residential care settings have been fairly static over recent years at around ten per cent of the overall total.

208 children who ceased to be looked after between 1st August 2017 and 31st July 2018 stayed in continuing care or were already in continuing care. Continuing care has been available to eligible care leavers from April 2015 and allows young people aged 16 or older to stay in the same kinship, foster or residential care placements when they ceased to be looked after. This

group form a small part of the population of care leavers and the data only includes those who entered continuing care when they left care in 2017-18, therefore, numbers are likely to be an underestimation.

Finally, there were 211 admissions to secure care between 1st August 2017 and 31st July 2018 with an average of 81 residents, which was an increase from an average of 76 in the previous year. Interestingly, there was an 18% decline in the average number of residents from within Scotland and an increase of 89% in the average number of residents from outside Scotland, most of whom were from England (Scottish Government 2019).

Recent research

In recent years, there have a small number of key studies which are helpful is understanding the current context within Scotland. A four-nation study led by Bywaters (2016) aimed to identify the relationship of deprivation, policy and other factors to inequalities in key child welfare intervention rates through separate and comparative studies in the four UK countries. Within each country there was a strong association between the level of deprivation and the proportion of children who were looked after or subject to a child protection plan or placed on the register: each step increase in deprivation was accompanied by higher rates of accommodation or registration. The steepness of the gradient varied between countries, but was steeper in Wales and Scotland than in England and flattest in Northern Ireland.

The study also identified that in Scotland, the rates for children looked after were higher than other areas in the UK. Children in the most deprived ten% of neighbourhoods were around 20 times more likely to be accommodated and 18.5 times more likely to be registered than those in the least deprived; this roughly translated to one child in 21 being 'in care' in the most deprived areas compared with only one child in 400 in the least deprived areas (Bywaters et al. 2016).

The findings of this research could be interpreted to suggest that children are being accommodated quicker in Scotland than elsewhere in the UK, however, recently published research - *Permanently Progressing? Building secure futures for children in Scotland* (Whincup et al. 2019) - explored this further.

Permanently Progressing? is the first in Scotland to investigate decision-making, permanence, progress, outcomes and belonging for children who became 'looked after' at home, or were placed away from their birth parents in 2012-13 when they were aged five and under[1338]. The team followed the progress of 1,355 who were looked after away from home and 481 who were looked after at home for four years (2012 - 2016). More detailed information was gathered from social workers and caregivers on the histories, progress and outcomes of a sub-sample of 433 who remained looked after away from home three to four years later. The study was only the second UK study to use a standardised measure of child maltreatment (Modified Maltreatment Classification System, MMCS[1339]) to assess the nature and, importantly, the severity of abuse and neglect experienced by children before they were placed away from home.

[1338] Phase One ran from 2014-18 and was designed to be the first phase of a longitudinal study following children into adolescence and beyond. Phase One involved a team from the universities of Stirling, York, and Lancaster, in collaboration with Adoption and Fostering Alliance (AFA) Scotland.

[1339] For neglect, for example, the MMCS manual gives the following descriptors of each level of severity: one - misses child's medical appointments; home very dirty; child's clothing usually dirty; child doesn't have regular meals; two - no bed; urine-soaked mattress; does not ensure food is available to child; inappropriate clothing in cold weather; child present when caregiver selling drugs; three - child frequently misses meals; insanitary living conditions; child left in care of poor supervisor; does not seek medical attention for moderately severe medical condition; four - does not seek medical attention for serious illness; extremely unhealthy living conditions; unsupervised for extended period of time; five - child born with foetal alcohol or neo-natal abstinence syndrome; does not prevent child being in a life threatening situation, very severe physical neglect or lack of supervision (English, D.J. and the LONGSCAN Investigators (1997) Modified Maltreatment Classification System (MMCS) https://www.unc.edu/depts/sph/longscan/pages/maltx/mmcs/LONGSCAN%20MMCS%20Coding.pdf

The researchers found from the sub-sample of 433 children, 89% had directly experienced abuse or neglect. The most commonly experienced types of maltreatment were neglect (affecting about 80%) and emotional abuse (affecting about 66%), and there were significant and overlapping concerns about neglect, emotional abuse, physical abuse and sexual abuse. Two thirds of the 433 children had experienced multiple forms of maltreatment and 71% of the children experienced high severity maltreatment of at least one type, which meant the parent(s) did not seek medical attention for serious illness; the child lived in extremely unhealthy living conditions and was unsupervised for extended period of time; or experienced very severe physical neglect.

Abuse and neglect were the most common factors resulting in accommodation, but this was in the context of long-standing and complex family difficulties and for 29% of children an older sibling had previously been accommodated. Unsurprisingly, the three factors which commonly compromised parenting capacity were substance misuse, mental health problems and domestic violence with around three quarters (73%) of families affected by at least two of these and for 39% of children, there were concerns about all three. Over one quarter (25%) of children had been assessed as likely to have relationship and attachment problems[1340] (Cusworth et al. 2019). Poverty and housing problems were reported as being common in the sample, and were equally present for children who subsequently returned home, and those who did not.

These findings echo the findings of review undertaken by Hill, Fowler and Porter (2019) to explore the progress and journeys across thirty-two local authorities in supporting families where children are at risk of becoming looked after through use of Part 12 of the Children and Young Person (Scotland) Act 2014. Their research highlighted a wide range of issues impacting on family life, most commonly identified as poverty, parental

[1340] A standardised measure of relationship and attachment problems was used (the Relationship Problems Questionnaire)

mental health, parental drug and alcohol misuse, domestic abuse and parental learning disabilities. It also identified that in some authorities, support was short term, but services which were open and responsive to families' needs with an 'open door' approach over time was key.

Whincup and colleagues (2019) found clear differences in the sources of support received by children and their caregivers. Carers of children looked after away from home were more likely to have support from formal services, such as social workers and fostering agencies, whereas adoptive parents were more likely to be supported by family or friends. Kinship carers received lower levels of both formal and informal support. The implications are significant. Three to four years after being accommodated, children's emotional and behavioural difficulties were around two to three times those of the general population and there were no significant differences in the level of difficulties among children living with kinship carers, on an adoption pathway or looked after away from home. This has implications for the levels of support and services that may be required by looked after children and their caregivers, particularly as this cohort of children were under five at the time of the study and further emotional and behavioural difficulties may be yet to emerge.

Interviews with Heads of Service and CSWOs

The interviews with Heads of Service and Chief Social Work Officers (CSWO) provided a broad picture of services being delivered locally and, while it was not the aim of this study to assess the provision of services across Scotland, it is helpful to summarise the range of provision to provide a context for the remainder of the report.

The structures through which services were delivered varied considerably across the country. This depended on how children's social work services had been integrated or not in light of the wider health and social care integration, depended on geography and demographics, and whether services were delivered centrally or through locality based teams. Teams

delivering services generally ranged from intensive family support teams or crisis intervention, early intervention, adoption and fostering, residential, disabilities, child protection, to throughcare, aftercare and youth teams.

How corporate parenting was understood and played out in Councils also varied. The duties within the Children and Young Person (Scotland) Act 2014 had for many enhanced relationships and the activity of the Council, particularly in relation to the opportunities for care experienced young people through engagement with elected members or the availability to them of modern apprenticeships.

Recruitment and retention of social work staff, foster carers and kinship carers was also in flux and was discussed by all interviewees, the majority of which thought it a situation unlikely to be resolved in the short term. This was creating significant challenges in many areas, particularly for more rural communities on the mainland and for those working on the islands, and is explored later in the report.

Almost all authorities, at some point, had required external provision of accommodation either through residential school, residential placements or secure care provided either by the statutory, third or independent sectors. The extent of early intervention services and approaches also varied considerably across Scotland and was often commissioned through third sector or independent providers. In some areas, there was very little provision as a result of budgetary decisions taken in the last decade. Some commented that it had '*meant that children and young people [were] coming to the attention of social work at a point when a more extreme response was required i.e. looked after away from home.*' (Interview three, urban area, 2019).

Local initiatives or new approaches were often targeted to localities or to particular communities or families. Authorities remained strongly committed to early intervention and family support, and committed to the importance of keeping children, young people and their families together

and in their communities, whilst recognising that for some children and young people time away from their families was necessary:

> *'We are looking at how we provide intensive support to families who may be at risk of their children being looked after and accommodated. But there is a need to change culture: move from punitive for families to perhaps taking more risks and working with families,...but if children are in really difficult situations then we need to be quicker about making decisions.' [Interview 17, urban area, 2019]*

All areas were tackling the balance of care through three approaches: balancing keeping children at home with the need for some children to be placed in residential, foster care, kinship care and adoption; balancing the 'internal' (within authority boundaries) with 'external' (outwith authority boundaries) placements or provision of services; and balancing statutory provision with services provided through the independent sector including independent foster care and residential placements. Those in transition reflected that while the principle of change was supported, the reduction in one service did not always align easily with the increase in alternative provision and there were costs in the act of doing so:

> *'About five or six years ago, there was a decrease in residential provision as family-based care was thought best, but there were not enough beds and therefore there was a need to leave the area which was a massive cost.' [Interview 19, remote rural, 2019]*

In another area, one interviewee commented that there had been a shift in the balance of care, but they were:

> *'...finding some pressure sustaining that....Our numbers are under average, but increasing. We are seeing placement breakdowns at a younger age so we need to think about this. We are seeing more young people with additional support needs as well as emotional*

> *needs not quite fitting into any type of provision.' [Interview 16, urban area, 2019]*

Despite the current budgetary constraints, many areas were trying to tackle these challenges creatively through adopting evidence based approaches, therapeutic interventions and different ways of working to try and keep families together.

4. Morale and job satisfaction

Morale

In 2004, Milligan, McKendrick and Avan surveyed the morale of 395 residential care workers and managers across all sectors and as the authors noted: '*It is important to recognise that the morale has something of a cyclical character; that it can go up and down quite quickly, therefore, this survey does represent a snapshot of a moving picture rather than a fixed one.*' (p.36). Fifteen years later, the picture had not changed significantly as Table Three shows, however, fewer residential care workers and house managers participated in the 2019 survey.

Table Three

Staff morale as reported by survey respondents		
	2004*	**2019***
High	54 (13.7%)	8 (12%)
Okay	205 (51.9%)	38 (58%)
Low	136 (34.4%)	20 (30%)
Total	395 (100%)	66 (100%)

* Residential Care Workers and House Managers

Interestingly in 2019, 37% of residential care workers, 55% of social workers and 51% of team managers reported low morale compared with 22% of service managers and heads of service (see Table Four). Senior managers tended to report that morale was either *okay* or *high*.

Finally, and similar to Milligan and colleagues findings in 2004, there was no discernible difference between participants working in the voluntary or independent sector and the statutory sector.

Table Four

Staff morale by role								
	Residential Care Worker	**Social Worker**	**Residential House Manager**	**Team Manager**	**Service Manager**	**Head of Service**	**Others**	**All**
High	5 (10.2 %)	6 (4.3 %)	3 (17.6%)	3 (6.4%)	3 (16.7%)	1 (16.7%)	5 (14.7%)	21 (6.7%)
Okay	26 (53.1%)	56 (40.6%)	12 (70.6%)	20 (42.5%)	11 (61.1%)	5 (83.3%)	19 (55.9%)	130 (41.7%)
Low	18 (36.7%)	76 (55.1%)	2 (11.8%)	24 (51.1%)	4 (22.3%)	--	10 (29.4%)	124 (39.7
Total	49 (100%)	138 (100%)	17 (100%)	47 (100%)	18 (100%)	six (100%)	34 (100%)	312 (100%)

Job satisfaction

In 2004, again, Milligan, McKendrick and Avan surveyed the job satisfaction of residential care workers and managers across all sectors and Table Five shows that levels of job satisfaction of residential care workers and house managers remain similar today – albeit, again, the numbers are fewer.

Table Five

Job satisfaction as reported by survey respondents		
	2004*	**2019***
Very satisfied	91 (22.8%)	15 (25.4)
Satisfied	205 (51.3%)	28 (47.5)
Neither satisfied nor dissatisfied	47 (11.8%)	8(13.5%)
Dissatisfied	47 (11.8%)	7 (11.9%)
Very dissatisfied	10 (2.5%)	1(1.7%)
Total	**400 (100%)**	**59 (100%)**

*Residential Care Workers and House Managers

Looking at the figures by role (Table Six), there were higher levels of job satisfaction than the views on morale would suggest, but as Milligan,

Kendrick and Avan (2009) commented in their report, questions about morale focus on the workplace more generally whereas questions about job satisfaction focus on the individual. It is likely, therefore, that some participants were satisfied with their own jobs, but felt that staff morale more generally was *okay* or *low*.

Table Six

Job satisfaction by role							
	Residential Care Worker	**Social Worker**	**Residential House Manager**	**Team Manager**	**Service Manager**	**Head of Service**	**All**
Very satisfied	9 (21.4%)	9(7.1%)	6(35.3%)	10 (22.7%)	3 (17.6%)	2 (33.3%)	39 (15.4%)
Satisfied	20 (47.6%)	67 (52.8%)	8 (47%)	21 (47.7%)	12 (70.6%)	3 (50%)	131 (51.8%)
Neither satisfied nor dissatisfied	6 (14.3%)	29 (22.8%)	2 (11.8%)	8(18.2%)	1 (5.9 %)	1 (16.7%)	47 (18.6%)
Dissatisfied	6 (14.3%)	21 (16.5%)	1 (5.9 %)	4 (9.1%)	1 (5.9 %)	--	33 (13%)
Very dissatisfied	1 (2.4%)	1 (0.8%)	--	1(2.3%)	--	--	3 (1.2%)
Total	**42 (100%)**	**127 (100%)**	**17 (100%)**	**44 (100%)**	**17 (100%)**	**6 (100%)**	**00%)**

The survey explored this further and asked respondents to rank from one (very important) to eight (least important) factors which were important to their work. These factors included: how teams work together; level of support available in your work; knowing that good quality work is valued; good outcomes for children and young people; adequate resources; job security; qualifications; and training and guidance.

Overall the top three factors contributing to job satisfaction were good outcomes for children and young people, adequate resources and level of support available to you in your work. The least important were job security and qualification. There were slight differences by role, however, with social workers and team managers ranking adequate resources higher than all other groups which ranked how teams worked together as

more important (see Table Seven). It should be noted though that many found it difficult to rank these factors and there was very little to separate one from another, particularly factors which were ranked in the middle.

Table Seven

Factors important in your work by role								
	How teams work together	Support available	Quality work is valued	Good outcomes	Adequate resources	Job security	Qualification	Training and guidance
Residential Care Worker	2	3	6	1	5	7	8	4
Social Worker	4	3	6	1	2	7	8	5
Residential House Manager	2	3	6	1	4	7	8	5
Team Manager	4	3	6	1	2	7	8	5
Service Manager	3	4	5	1	6	8	7	3
Head of Service	5	2	7	1	4	8	6	3
All	**4**	**3**	**6**	**1**	**2**	**7**	**8**	**5**

5. Key themes to emerge

Throughout the remainder of the report, the term *participants* is used when discussing the views and reflections of all who contributed through the survey, interviews and discussion groups, but at times it may be necessary to distinguish between those who completed the survey (referred to as *respondents*), those interviewed (referred to as *interviewees*) and those who took part in the workshops and discussion groups (referred to as *contributors*).

The survey, interviews and discussion groups focused on five key questions:

- What is working well?
- What difference do you think you are making?
- What are the current challenges?
- What could we do differently?
- What is needed to make changes?

6. What is working well?

While participants were able to describe what was working well, nearly all qualified their comments and were aware that things could be improved.

Very evident throughout, however, was participants repeated description of their workers, colleagues, teams and carers (adoptive, foster and kinship) as '*passionate*', '*dedicated*' and '*committed*'. Despite the challenges faced, there was a clear sense of a committed and dedicated workforce, including carers, working hard to improve outcomes for the children, young people and families they work with.

One major theme to emerge was that relationships were central to the work of all professionals. For residential care workers, house managers and social workers, relationships with children, young people and their families based on trust and respect which were child-centred and nurturing in approach were central:

> *'When staff are given time to make and sustain positive relationships with young people. Young people respond and engage. Sticking with young people in all circumstances.' [Team Manager, survey respondent 2019]*

> *'Feedback from young people tells us the importance of loving, caring relationships; being supported to achieve positive destinations; increased focus on relational practice.' [Head of Service, survey respondent 2019]*

The more recent focus on relational-based care was welcomed as was the growing recognition of the need to work more effectively with families. Some respondents also commented on the importance of continuing relationships once a young person had moved to more independent living:

> *'Young people in residential units retain relationships with staff after they have moved on - demonstrating the importance of relationships with young people.' [Team Manager, survey respondent 2019]*

Social workers also reported a general improvement in joint working with colleagues across a range of agencies with better communication and collaboration although a few commented on some difficulties in sharing information in light of GDPR; this was mainly in relation to a lack of understanding about what could or could not be shared and anxiety about sharing information inappropriately. Relationships were also key to those interviewed and several interviewees reflected that the recent Children and Young Persons (Scotland) Act 2014 and the Public Bodies (Joint Working) (Scotland) Act 2014 had resulted in a greater focus or re-focus on the development of a shared vision, expectations and commitment to corporate parenting:

> *'Corporate parenting as a statutory duty has really impacted on the commitment of other partners and as a result there some really good practice. For example, housing services prioritise care experienced and have a forward looking interview for people leaving care... All young people have access to free sport and leisure facilities and have workers who working with young people to look at possible destinations and secure work placements. This is for looked after children, but we're looking to see if we can expand this to those on the edge of care.' [Interview ten, accessible rural, 2019]*

A second major theme was that participants believed there was a much better understanding of the impact of trauma and difficulties experienced by a child or young person on their wellbeing and development. It was acknowledged that while there was greater knowledge and understanding, it varied across teams, services and perhaps was not always shared with corporate partners. Nevertheless, there was a clear

sense of how attachment, ACEs and trauma impacted on young people's lives and the challenges that some faced:

> *'Young people in our area are often achieving good outcomes educationally and in work. Having returned to working in residential childcare seven years ago after working in other areas of social work for 12 years, I believe that practitioners are working from a much more attachment and trauma informed basis than previously. Assessment is more accurate and robust and care planning more effective, flexible and individualised to the needs of the young person.'[Residential Manager, survey respondent 2019]*

This had impacted on how workers responded to a child or young person's needs and behaviours, and how many had tried to shift the culture in children's houses from rules and regulations to more nurturing environments:

> *'Relationships with the young people we work with are very important regardless of the qualifications, however training enhances your knowledge and understanding of young people's issues resulting in behaviours.' [Survey respondent 2019]*

More limited, however, was the range of services required to support children and young people.

A third theme to emerge was improvements in engaging with children and young people using services and listening to their experiences. There was a general sense that the views of older children and young people were being reflected in decisions about their lives, and in the development of services in some local areas. Some of the examples shared included the impact locally of the Champion's Board; most areas had set one up or had received funding to do so. One or two interviewees described this work as transformational particularly in developing services with housing colleagues, with their elected members and with wider strategic partners:

> *'Board has done some work around education and has informed decision-making, and also with housing. This work has been quite transformational for raising awareness about how difficult things were for young people leaving care. Initially messages were difficult to hear for managers in housing. Now Champion's Board is putting a bid together with housing for a new model together for providing accommodation, but this takes much time and energy.' [Interviewee 22, accessible small towns, 2019]*

But as another interviewee commented when asked what is working well:

> *'Listening to peoples' experiences, but now time to ask a different question such as what needs to change in terms of services.' [Interview four, other urban, 2019]*

Four areas reported on the development or introduction of apps for young people to share their views, such as *Mind of my Own*, which gives young people the opportunity for selecting which individuals know what information about their circumstances. Another area was in discussion with children and young people about what level of detail was recorded in files about their lives.

Some participants, however, highlighted three groups whose voice was missing or *quieter*: the voices of infants or young children; the voices of children placed at home; and the voices of a child's birth family and wider networks:

> *'I think there is an increased emphasis on gaining the views of service users and using this in a meaningful way to inform practice. I think particularly with children and young people although I do believe that with younger children, they still don't really have a voice and I would like to see that change.' [Team Manager, survey respondent 2019]*

A fourth theme was positive developments or changes in practice supported by a building evidence base. Participants mentioned that approaches such as *Getting it Right for Every Child* (*GIRFEC*) or multi-systemic therapy and models such as Signs of Safety, PACE, Safe and Together and Family Group Decision Making were impacting locally in terms of the quality and timeliness of decision-making. Linked to this was wider recognition that some aspects of legislation, policy and inspections had helped develop practice, but there was equal concern about the complexity of legislation and policy, the unintended consequences of well-intended national policy and cost implications of ongoing legislative and policy change.

Improvements in assessments including risk assessments were said to be resulting in better outcome focused planning. Some participants reflected that, in their area, a drive for improved outcomes and permanence had resulted in greater stability of placements, fewer new placements outside the council area and the development of smaller residential houses:

> *'Some really impressive creative work by individuals and some teams, resulting in settled placements, genuine care and more positive outcomes for some children.' [Social Worker, survey respondent 2019]*

A few participants, however, reflected that a drive and focus on outcomes may not necessary mean improved outcomes for children and young people:

> *'In my team practitioners are passionate about improving outcomes for children but are sadly restricted by resources and the tension between the public and private sector.' [Team Manager, survey respondent 2019]*

One final area to emerge was training, but the experience of participants was more varied. Residential care workers talked about the training available to them, however, other groups of staff mentioned the training

available in relation to specific groups rather than themselves and cited residential care workers, foster carers and kinship carers as those who had access to more consistent training.

7. Are you making a difference?

Measuring outcomes is challenging for any organisation beyond the useful, but more limited statistical data required nationally by Scottish Government and locally to plan services. It is not surprising that some respondents found this a difficult question to answer.

For some, their involvement in a child or young person's life was for a short period only and for others changes may have happened after the worker's involvement. Some also found it difficult to separate out the impact they may have had on a child's life from the other supports and services in place at the time. Others reflected that they helped facilitate the works of others:

> *'I feel that the major contributors to change are the foster carers and the children and young people, particularly when all are engaged and working together.' [Social Worker, survey respondent 2019]*

A small number of respondents (four) found it difficult to identify practice that was making a difference:

> *'I don't think there is anything particularly working well at the moment whilst children are being protected they are also more exposed to adversities as thresholds higher prior to intervention.' [Social Worker, survey respondent 2019]*

> *'There are pockets of very good practice across the 'care system'. However I couldn't confidently say that any aspect of the 'care system' as a whole is working well right now. Mental health support is poor, there's no consistent understanding of trauma and adverse experiences in education settings and children are still moving far*

> *too many times due to lack of carers or resources.' [Social Worker, survey respondent 2019]*

For residential care workers and managers, much of the difference they described involved their ability to '*stick with*' and support children and young people consistently, and make them feel safe. This '*stickability*' was also discussed in relation to foster carers. Workers described helping young people to develop good relationships, providing new experiences, helping to develop practical budgeting and cooking skills, and building the self-esteem and confidence of children and young people:

> *'Young people who left us more often than not stay in touch and regularly tell us about the impact we have had in 'sticking by them' and that the advice, care, support and skills we gave them has helped them more than they ever realised at the time.' [Residential Manager, survey respondent 2019]*

> *'Young people's overall evaluation of the arts project is extremely positive and confirmed by observers. The things they enjoyed were mostly closely related to the artistic work undertaken, with a mixture of learning and fun being emphasised. The staff involved observed evidence of changes in participants that, however individual and fragile, relate to key life skills. 50% of participants reported improved self- confidence, attitude to meeting new people and communication skills and almost 50%, improved team-working abilities.' [Arts Development Worker, survey respondent 2019]*

Residential workers also described the importance of giving young people a voice, to have hopes and aspirations and allowing them to make mistakes, which helped young people prepare for the next steps in their lives. Residential workers were able to provide support emotionally to families at difficult times and practically by giving them a break through respite care. They also supported carers to help them understand the

impact of trauma, ACEs and attachment, and in hearing or listening to the children and young people placed with them.

Social workers and their managers also reflected that they helped children and young people feel safe, secure and reduced the risks in their lives, ensured their voices were heard and helped them move on, when appropriate. Social workers worked hard to sustain placements, reduce the number of unplanned moves and provide opportunities for permanence. Social workers and Team Managers reported a greater focus on engaging with families, carers and adopters in decision about their lives, on making sure they got the support when needed and on working to reunify or keep families together.

Some senior managers and strategic leaders reflected on the need for a change in culture within their organisations and with strategic partners to a strength-based culture which emphasised and valued professional autonomy within a supervisory framework of accountability, but also facilitated reflective practice. Interestingly, several interviewees reflected on the need to '*give staff permission*' to do things differently, to be creative, and importantly to hold more risk. The reflection on holding more risk related to a wider discussion about the need to change how the broader social work and social care profession works with families. Managers recognised this was happening, but greater consistency was needed about working more effectively with birth families and the wider networks to build capacity and to keep families together rather than resort to a '*default*' position of residential care. This, however, meant a shared understanding and ownership of risk across agencies, corporate partners and elected members, which was not thought to be in place across all areas in Scotland.

Reducing drift and delay in decision-making and permanence, working to ensure consistency of worker for the child or young person, implementing corporate parenting across multi-agency teams and professionals, and building relationships were key areas where senior managers and strategic

leaders could support change. Also discussed was re-investing the savings from reductions in the looked after children population and use of external placements into funding family support services, commission early intervention services including family functioning therapy, and fund community development work through restorative practices looking at social cohesion. Other managers commented on restructuring teams to better meet the needs of young people – such as to co-locate housing, leisure and children's rights – and to reduce caseloads, although this remained an aspiration than a reality for most.

Through inspection reports, local evaluations and audits, many but not all strategic leaders reported reduced average placement moves, reduced homeless numbers and reductions of previously looked after children appearing in criminal justice statistics. Some local authorities had recorded improved outcomes in education attendance, attainment and achievement, and more opportunities for further training, apprenticeships, employment and education. This was partly attributed to engaging early with colleagues from housing, education, police, throughcare and aftercare, and criminal justice and with the young person to address issues before they escalated, but was recognised that this did not apply to all young people and there remained concerns about support for children looked after at home. While there was a clear focus on outcomes from all participants, it is important to remember that:

> *'Achieving good outcomes is always the goal but paying attention to the details is also important to ensure that young people's experiences are as positive as they can be.' [Social Worker, survey respondent 2019]*

8. What are the current challenges?

Survey respondents were asked to describe current challenges to delivering support and services to those in the 'care system' under the four broad headings of structures, culture, resources and practice.

The responses from all participants are explored under those four headings.

Structures

The first challenge raised by all groups of participants was perceptions of the extent of ongoing change. There were feelings that '*change was never done*' and while some legislation and policy was felt to have strengthened practice, much had complicated the process for workers and families alike and for some areas there had been unintended consequences. This constant pace of change allowed little time for changes to embed fully in practice or to be piloted and then rolled out across the Council.

One area where legislation and policy was thought to have complicated processes was in relation to *GIRFEC* and the lack of clarity on the Named Person and, although Scottish Government recently announced it was withdrawing the named person legislation, the confusion and lack of clarity about next steps are unlikely to be resolved in the short term. Another area considered complex was in relation to permanence. There was not a shared confidence that the level of knowledge across the profession or Children's Hearing System was consistent in relation to the legislation impacting on decision-making on permanence.

In terms of unintended consequences, participants cited three examples of legislation and policy which had impacted on practice, children and young people: continuing care; the placement of larger sibling groups and the Care Experienced Students Bursary. Strategic leaders were clearly

committed to the principles of continuing care, however, this had had wider budgetary implications of younger people remaining in care longer and restricting placement choices for younger children coming into the 'care system'. During a time of crisis, there was less choice for vulnerable children and young teenagers needing accommodation as residential provision was not always available or suitable due to the ages of the young people already in the house. Some also raised concern that residential houses were not always the appropriate accommodation for older young people in terms of them needing more independence and their own space. This had led to discussions locally with housing colleagues to develop alternative provision while adhering to the principles of continuing care. One example included the development of satellite flats attached to a residential house, which allowed for the continuity of relationships with staff, but provided more independent living for their young people.

Keeping together large sibling groups often threw up practical challenges as there were fewer carers willing to foster large sibling groups and there was a scarcity of housing available to accommodate large families. Finally the lack of clarity about whether the care-experienced college bursary was regarded as income had left young people needing to pay rent from the bursary resulting in rent arrears for many.

A second challenge to emerge under this heading related to the interaction with other systems or agencies. Many referred to mental health provision and CAMHS:

> *'We do not have adequate mental health resources for children and young people. This is about emotional wellbeing and is really important area. We need to have the same consistency and levels of support…CAMHS is an adult model to children and young people which is not an easy fit. Children and young people also need to go to the service.' [Interview 32, other urban, 2019]*

Also limited was access to specialist, therapeutic or practical support, support services for young people and educational support, especially when a young person is not in school and:

> *'When young people opt out of school there can be difficulties in accessing educational support within acceptable timescales to ensure they get the opportunity to remain engaged in some form of learning. If a tutor or teaching support does come into place from school or third sector, this usually takes such a long time that kids are turned off from learning and have disengaged with the notion of achieving qualifications, or their confidence or motivation has dipped significantly.' [Social Worker, survey respondent 2019]*

Challenges of working with the Children's Hearing System was raised by almost ten percent of all participants (n=319: survey and interviews). This was felt to be in two key areas: the adversarial nature of hearings; and the delays in decision-making particularly in relation to decisions about permanence. To some extent, this related to the complexity of the legal framework, greater complexity of children's lives and circumstances, and the increase in solicitors involved in the process, usually on behalf of parents. This was summed up succinctly by one survey respondent:

> *'I believe strongly that parents should have a voice and be supported to express this and given every opportunity to present their case at the Hearing and in the courts. However, in recent years, particularly with the Hearing system, I find that the only voice that is not being listened to is that of the child. I understand the law in relation to article eight of the Human Rights Act. However, who is advocating for that child's right as he drifts in a 'care system' often for years before decisions are made about his future. The Children's Hearing seems to be reluctant to make a decision about moving a child to prospective adopters as this may be seen as pre-empting a court decision.' [Team Manager, survey respondent 2019]*

Culture

Several challenges were discussed in relation to culture and reflections on leadership are discussed here. These related to societal, strategic, managerial and operational cultures. A small number of respondents commented on the wider beliefs that society held about social work and by extension the 'care system':

> *'that the 'care system' is the problem rather than the social structures/practices that result in poor parenting and families reaching crisis.' [Service Manager, survey respondent, 2019]*

> *'Resources are getting tighter due to constraints on local authority budgets...This is compounded by continual negative messages about practice of workers with children and families both via media and at times government.' [Team Manager, survey respondent 2019]*

Strategically, one key challenge in relation to corporate partners was a greater need to share expectations and responsibilities for looked after children and young people. Some positive developments have been discussed previously, but just over a third of those interviewed talked of the need to explore further with partners their understanding and expectation of corporate parenting responsibilities. Two also explored the idea that budgets should be pooled and shared between the agencies which have responsibility such as health, education and social work. One example given was use of Scottish Government's Pupil Equity Funding; in some areas education and social work decided together how this funding was allocated, but in other areas, the decision remained with individual schools despite both agencies working with the same or similar groups of children.

About ten per cent of survey respondents (n=290) commented on the culture of leadership within their organisation. Two respondents spoke of an open culture for learning supported by senior and strategic leaders, but others described a risk-averse culture with leadership which lacked vision

and imagination. Respondents commented on staff anxious about being unsupported, criticised and blamed when things did not work out. As one respondent observed:

> *'Despite a significant focus on the issue of high quality leadership over recent years, I do not think that the 'care system' has enough people with these qualities and the inevitable consequence of this are negative cultures, low morale, inconsistent practice. The pressures at all levels are very high and people with the right qualities have options to work in other sectors with less pressure.' [Head of Service, survey respondent 2019]*

Operationally, responses to this question varied depending on role. Both residential care workers and social workers reported feeling a loss of identity, confidence and feeling undervalued:

> *'need to value the role and contribution of care workers within the whole 'system' approach to working with children.' [Service Manager, survey respondent 2019]*

Some respondents reported the need to change the importance given to residential care; to challenge the presumption that a family placement is always best as sometime group living is more appropriate to meet the needs of a child or young person:

> *'there is a negative culture regarding residential settings and how they are perceived and the children who stay within these which is upsetting.' (Residential Worker, survey respondent 2019).*

Resources

Austerity, resources and limited options was raised by all groups of workers, managers and strategic leaders; almost 62% of participants (n=319: survey and interviews). This was austerity described in terms of the impact on services and the workforce, and crucially also on families and communities. It was interesting to note that there was recognition of the

conflict this presented to strategic leaders needing to save money, but tasked with providing the best supports to children and their families.

Of particular concern was the loss, lack or limited options available to support children and young people, particularly more limited family support and early intervention services, reduced placement options and services to address emotional and mental health wellbeing, which would help prevent children coming into care or sustain placements that might otherwise breakdown:

> *'I think we need to be honest in that for almost a decade now we have witnessed times of austerity and increased financial pressure on local authorities which obviously impacts on the third sector as well. The reality is that this can reduce the number of services available...Examples being mental health service (CAMHS) being able to offer support at a point where a young person may be finally ready to accept this type of specialised support after lots of nurture and encouragement from those caring for them on a 24 hour basis. However often this support is not then available or not provided in a timely way and the 'window of opportunity' is lost. Being able to get education packages in place for young people who are engaging well in their home placement can be difficult. [Residential Manager, survey respondent 2019]*

Where evidence-based approaches had been adopted or new ways of working implemented, it was often difficult to upscale initiatives and projects across the authority, especially if delivered in partnership with the third sector.

Anecdotally, those interviewed described situations where previous decisions to cut either family support services, early intervention services or both were felt to be impacting on a perceived increase in the numbers of older children in late primary school presenting with behavioural difficulties in both schools and their own communities. Alternatively, one

or two strategic leaders linked their continuing early intervention services to the reduction they had identified in numbers of children and young people in care. Local areas offered these reflections and acknowledged that they had no evidence on which to base their views, but it was interesting that this correlation was mentioned in four separate interviews although one area was looking to develop work in this area.

A second challenge reported by the majority of local authorities was limited choice of care placements and, for some areas, significant difficulties in foster care recruitment and retention. In addition to the need for greater numbers of foster carers, more were needed with the skills and experience to foster older children and young people who have experienced significant trauma. The variation in fees and allowances for foster carers across local authorities was challenging in terms of recruitment. This meant the matching process was often limited and driven by what capacity was available rather than the needs of the child. As one respondent observed:

> *'...that some children are being placed well out with their local authorities and that some of the children are being moved through multiple short term placements, which compounds some of the presenting issues for such children and young people.' [Social Worker, survey respondent 2019]*

Several areas reflected that the council was often supporting children in foster care in their communities as they had been placed by a neighbouring local authority because the carers lived in the local authority, but were registered with the neighbouring authority.

The picture on the provision of kinship care was mixed: some areas have developed panels, teams, link workers and had reviewed kinship care payments whereas others were at an earlier stage. Many areas described the use of *formal* and *informal* kinship care, but some interviewees described how the provision of kinship care had grown either because of

the need locally or developments led by elected members and provision needed to be brought more into local strategic planning.

Furthermore, the assessment of kinship carers was described by survey respondents as less robust than those for foster carers and adoptive parents, and placements were subject to less robust review and scrutiny. Kinship carers themselves received less training and support than other caregivers, but this may partly reflect the choices and perspectives of kinship carers themselves.

The use of secure care was also identified as a challenge. Although, this was not a large group of young people, the costs to the authority were significant. The provision of care was, for most, out of the local authority area and for some young people was not felt to be the most appropriate placement as they were more at a risk of harm to themselves than their communities,:

> *'The authorisation and review of secure care for young people who have mental health issues, and girls especially, is another challenge. We may have young people in secure who self-harm and have suicide ideation with extraordinary mental health issues but no clear diagnosis. Managing chronic mental health issues through secure care does not feel appropriate. We need some semi-closed establishments with some security elements that health colleagues can provide the required levels of psychological support. But where do our health colleagues sit with that in terms of funding?' [Interview 25, large urban, 2019]*

> *'Often many of the links are broken and it's difficult to get wraparound care coming back out into the community. Agencies are sometimes wary about getting involved...Our concern can be with young people who are dealing with trauma, have a chaotic family background and possibly ADHD. We can struggle to support them in the community. Secure can be a breathing space for some young*

> *people in the short-term, but sometimes units won't work with young people until they are on our three month order.' [Interview 16, other urban, 2019]*

Finally, the lack of adequate infrastructure was raised particularly by some residential workers and house managers who reflected that current facilities were old and outdated. Interestingly, some workers reported on the significant positive impact that new purpose-built residential facilities had on staff and young people alike. For others, the lack of access to transport created difficulties, which could restrict the activities available to children and young people in residential care and increase travel costs significantly if taxis were necessary on a regular basis.

Practice

One area of challenge raised by almost 40% of survey respondents (37.5%; n=290) was the capacity of the workforce. Respondents described the impact of perennial staff shortages and high turnover on increasing caseloads, increasing levels of paperwork (electronic records) reduced the time for supervision and reflection. Many posts, which had disappeared during the past decade, were the administrative and respondents reported on the loss of this support within teams. The combination of increasing caseloads and less administrative support were felt to impact significantly on social workers with increased levels of stress and anxiety and reduced the time available to spend with children, young people and their families.

Some respondents reflected that there could be poor communication and tension between different groups of staff, for example: between social work and residential staff resulting from a lack of clarity about roles and expectations; and between social workers and reporters due to the reporters busy workloads. One respondent thought that greater attention from strategic leaders and senior managers on the impact of team dynamics would help.

Other comments related to children and young people themselves. One respondent felt that occasionally some difficult and challenging children and young people were seen as less deserving and felt there should be more equity in the treatment of young people, although this was a single voice. A second view expressed was in relation to contact for large sibling groups. It was appreciated that each sibling should have their individual care plan, but sometimes there was a lack of overview of the plan for contact among the sibling group and contact drifted.

Respondents appreciated that attempts should be made to find placements locally for those placed out of the authority when it is in the best interests of the child or young person. A lack, however, of the appropriate accommodation meant that choices were often limited for a young person's return and plans were resource rather than needs led. One respondent also reflected that the focus of work with a child once looked after and their family can shift from reunification to the child's progress in the placement;

> *'there can be a view that the child/young person is not a priority case as they are being looked after elsewhere...work with parents falls away at times and the focus of working to get the child/young person back home is lost as it can then become the focus on how they are getting on in placement.' (Service Manager, survey respondent 2019).*

There were also felt to be areas of significant gaps: resources available to young people when they leave care in relation to supported accommodation and aftercare, although this was not across all council areas; the transitions process for those young people who need support from adult services; variability in the quality of kinship care and arrangements; and clear knowledge and understanding of the progress and outcomes for children placed at home:

> *'Children looked after at home remain the biggest concern. Families have good relationships with workers, but further work is needed.' (Interview seven, large urban, 2019).*

In analysing the responses to the study, most areas were experiencing these challenges to some degree, but it was clear from those working in a predominantly rural or island locations that their geography often intensified the impact of the problem. Difficulties in the recruitment and retention of staff, staff feelings of vulnerability and isolation, and maintaining the skills, knowledge and experience of the workforce was a constant struggle. Staff often had two jobs including farming or crofting which required a degree of flexibility by the organisation in managing services.

Access to services was often more limited with specialist services often requiring long distance travel or limited to the outreach clinics or surgeries provided more locally, but on a more limited basis. There was not always sufficient placement options which meant an over-reliance on external placements often many miles from the authority. This presented significant challenges in maintaining contact with young people. National policy directives often required local 'systems' change yet the budget from Scottish Government to implement change is often proportionate to the size of the authority as opposed to extent of change required.

Those working in rural and island authorities were creative and had adopted strategies to try and address some of these challenges including a focus on '*grow our own*' social workers and encouraging unqualified workers into training and further education.

9. What could we do differently?

It was important not to assume that the social work and social care profession believed that change was needed, so before asking how professionals could work or services be delivered differently, all participants were asked if change was needed.

Overwhelmingly, the response (92%; n=342: survey and interviews) was that change was needed. The majority of participants also commented that significant investment was needed into early intervention, family support services and the 'care system' when children were required to be looked after.

Three distinct stages emerged from the study: before becoming looked after; being looked after; and moving on from care.

Before becoming looked after

A strong message was that more work was required with children and families while they were still living at home. Services should be available to families to provide advice, guidance and support required at an early stage. Children are often returned home in their first year of being looked after (Whincup et al. 2019), so some questioned whether children were being accommodated too quickly and suggested working with families together for longer before a child was removed.

Better assessments and more work was needed with families before a child was looked after as well as during the period of care and once a child returns home. This included family systemic therapy to support families to make changes within the family dynamic and relationships. Participants commented that there was a need to work with families more intensely and for far longer. Some authorities had some intensive provision for the beginning and end of the day, and at weekends, and some had 24/7 intensive crisis intervention available. For most areas, there services were

either targeted to a small number of specific families or based in one particular community or were time limited. There was a strong view that these services needed to be available more consistently across an authority to a wider range of families and for longer periods of time. Services should also be available to parents who have repeatedly had children removed from their care.

This approach sounds simple, but should not be underestimated. There is a general narrative, which also emerged through the survey and interviews that perhaps professionals make decisions to accommodate children '*too quickly*'. Recent research, however, challenges this (Whincup et al. 2019). Furthermore, services will need to be beyond practical support and offer appropriate emotional and psychological supports to all family members. Finally, as Hill and colleagues (2019) identified the most frequent challenges cited by survey respondents in delivering Part 12 of the Children and Young Person (Scotland) Act 2014 were inadequate funding and working with high levels of risk.

National and local government, and corporate parents need to recognise that keeping families together will mean long term support for some with professionals working at the pace of the family to achieve change and will mean the profession working with greater risk. This will need greater cooperation between children and adult services as many of the parents and adults are likely to be involved with addiction and mental health services, and working more effectively with communities, which may currently lack social cohesion and be struggling with poverty, deprivation and unemployment.

Practical suggestions included:

- there may be people who could be *'aunties, uncles, grandparents, friends, supporters, mentors, champions*' to children and young people in their communities;
- restorative work with communities;

- whole family foster care;
- increased provision of family support and early intervention;
- interdisciplinary community based family centres.

Being looked after

While there was clear support for working with families more effectively, there were words of caution:

> *'I also understand the logic behind supporting children to stay with their birth families. There does appear to have been a major change in the last couple of years in terms of keeping children in the community who previously might have been accommodated, and I'm not sure how well resourced this drive has been in terms of supporting kinship options... My fear is that the 'care system' - including fostering - becomes under resourced while the 'cheaper' option of maintain children at home in a context of risk that might not have been tolerated a few years ago becomes the norm. When children can safely remain at home, this should always be the priority, if they have to be accommodated the care we provide needs to be exceptional and this needs to be resourced properly.' [Social Worker, survey respondent 2019]*

If a child was unable to stay at home then a more flexible and bespoke service with greater choice was needed to meet individual need. Increasing the numbers and skills of foster carers and kinship carers, increasing the capacity of residential care workers and social workers, reducing caseloads and reducing bureaucracy could allow for more time could be given to spending time with children and young people and developing relationships. Decisions and clear plans within realistic timescales for positive destinations whether reunification or permanence should be made more quickly. Work also needs to continue with the birth family.

Farmer and Lutman (2010) identified that when children are removed from home as a result of neglect little work was undertaken with the parents to address the issues that lead to neglect in the first place. Children were then returned home to a situation that had not improved:

> *'The parents of the older children received significantly less support than those with younger children, even though many were struggling with their adolescent children's serious emotional and behavioural problems. The older children received more types of help than younger ones but were also more likely to be receiving insufficient support. Lack of specialist help for parents was linked to poorer outcomes for children. In a fifth of cases little or no support was provided. Even when some services were delivered, they were often not at a sufficiently intensive level to meet the severity of parents' and children's needs in order to make and sustain change.' [Famer and Lutman 2010, page two)*

By the five year follow-up, 65% of the returns home of 138 children in the study had ended. In addition, at the two year follow-up, 59% of the children had been abused or neglected after reunification and during the next three years, half of the children (48%) whose cases were open were abused or neglected.

Greater flexibility is needed for children who are looked after in terms of the range of options and the services required to support their needs and development. This would involve provision of smaller two-three bedded units and recruitment of more foster carers and kinship carers perhaps with a focus on recruiting carers for long-term or permanent foster care placements. Again, this needs careful consideration. Whincup and colleagues (2019) found that:

> *'Although children in kinship care, foster care, and with adoptive parents had similar levels of emotional and behavioural difficulties*

> *the level of support they received varied. Kinship carers received less support than other caregivers.'*

Health, psychological and education services should also consider alternative provision to support and develop education, and emotional and mental health wellbeing. There was recognition of the pressure on mental health services and on CAMHS particularly, but many respondents did not feel that this service was always the most appropriate for the individual young person and greater thought should be given to how services could be delivered to address mental wellbeing in a variety of settings and through a variety of routes including use of art therapy and therapeutic approaches.

More flexibility in 'systems' was often mentioned; for example, sometimes appointments were needed at very short notice when the child was ready to engage, but no appointments were available and so the '*window*' is lost. Education services could be more responsive and flexible to the needs of care experienced children and young people especially if not engaging or excluded from school. This might involve a shift in focus from attainment to also include the development of a young person's personal and social skills to allow them to engage more positively with learning. Many children and young people experience speech and language difficulties and greater access to speech and language therapy was also recognised.

Practical suggestions included:

- increased numbers of smaller residential units of two-three beds;
- semi-closed establishments with some security elements that health colleagues can provide the required levels of psychological support access to a wider range of psychological supports and therapies including the creative arts;
- increased range of foster carers;
- national fee structure for carers.

Moving on from care

For children who are reunified with their families, many reflected that support would need to continue. Research has identified that children reunified with their families often re-enter care within five years (Farmer and 2010). As one respondent explained in relation to carers:

> *'Let's attend to this and be open and honest about these challenges and how carers can be better supported to provide nurturing care... Let's have high aspirations for our children and young people, but let's be realistic that some will require lifelong support and that there are no quick fixes and that the impact of trauma can be lifelong for some.' [Team Manager, survey respondent 2019]*

The same could be said of their families. Parents themselves often have their own challenges associated with their own childhood trauma requiring psychological and mental health services as well as support to address addictions or issues arising from domestic abuse. This support may be required during the time their child is looked after, but also once they have returned home as there are likely to be continued stresses from reunification and becoming a family again.

For young people leaving care, more was required when moving on in terms of choices for accommodation, employment, education and training opportunities, and continuing to access to more specialist services.

Several practical suggestions were made:

- specialist mental health worker based in every throughcare and aftercare team;
- national Scheme of assistance for care leavers ensuring all have the same opportunities and access to support;
- national approach for employment of care leavers;
- consideration of the impact of food poverty on care leavers;
- implement the Care Leavers Covenant;

- consideration of whether the college bursary is viewed as income and the gap between the college bursary and universal credit being available during the summer break;
- a national communication visual aid tool allowing children, teachers, parents and social workers to communicate more effectively.

10. What would help nationally and locally?

The final section of the survey and interviews asked for participants views on what would help at a national level and locally.

Many suggestions were considered important at both national and local levels and one considered essential was the need for politicians and elected members to listen to the profession and recognise the value and contribution of the social work and social care profession. This included significant investment in services and the workforce to increase capacity, and afford protected status to social workers similar to teachers and nurses.

Many suggestions related to leadership and culture of the social work profession. Listening and responsive leaders with a clear vision for the workforce and service should support the development of a valued, skilled and more confident workforce able to work differently with children and young people and allow for greater spontaneity and affection while keeping children safe:

> *'Don't see us as the enemy and work with us as we are often the front face of communication with the young person about the most difficult aspects of their lives especially if not going home. Acknowledge that the profession carries some of that pain and can't take it away as dealing with atrocities of people's lives such as abuse and neglect. It is how we go about the work - skilled decision-making.' [Interview six, accessible rural, 2019]*

One key message from interviewees was a re-think on how corporate parenting was understood in terms of their responsibilities to children and young people in their care, which may include re-thinking financial support and commitment; corporate budgets should reflect the needs of children

and young people rather than political and policy priorities, and perhaps be reconfigured or pooled.

Ensuring that all voices were heard in the development of services was also proposed. This included suggestions that:

> *'Strategic planning to heavily involve frontline workers. Or strategic colleagues to rotate back into frontline roles so up to date practice remains fresh in their experience.' (Team Manager, survey respondent 2019).*

Further suggestions were in relation to training and education. There was a strong call for shared training across health, education, social work including adult services, third sector and children's hearing system. Topics identified by respondents included the impact of loss and trauma on children's development and behaviour, trauma-informed care, Adverse Childhood Experiences, assessment and understanding and managing risk. Social work education was thought to have developed a stronger academic base for the profession with a greater appetite for research and evidence, but it did not prepare students fully for the realities of practice. One suggestion included a Joint Professional Training Agency, which recognised the need for and importance of trauma-informed care and practice and to re-think the language of the 'care system'. All carers (foster and kinship) and adoptive parents should be trained in trauma-informed care and relational-based practice to meet the challenges that some children and young people present. There should be consistent assessment of all carers including kinship carers and more support offered to all carers including post-adoption support.

Finally, some suggested that parts of the legal framework needed reviewed including the law in relation to mental health, justice and secure care, and the Children's Hearing System and develop policies with a budget which are '*functional not political*'. There were also suggestions to continue to

grow the evidence base and for greater discussion and sharing of information about what works in practice.

11. Messages to the Care Review

Throughout this small-scale study, there have been opportunities for comment and feedback. Some comments and concerns did not relate specifically to the questions asked, but were considered important for the Care Review to hear. As has been said previously, comments were made in the context of considerable support for the Care Review.

The first message was that the profession was concerned about the expectations raised by the Care Review and the subsequent recommendations about change. There was undoubted support for the aspirations of delivering long lasting change, however, there was some concern that meeting expectations and delivering desired change would create more challenge for local authorities rather than be seen as opportunities. Nor was decision-making always in the gift of social work to make changes strategically and operationally.

The second message was also related to expectations as there was concern about how potential wide ranging 'systemic' change would be funded. As has been described, the financial circumstances of all authorities are difficult and unlikely to improve in the short term, therefore, some consideration to what funding either transitional or more long-term might be available would be welcomed.

A third message was that there were a range of views about some of the learning shared to date. The two particular aspects mentioned were use of *Love* and the placement of sibling groups. Many welcomed bringing *Love* back into the language of care, but some were concerned that the practical implementation of *Love* was more difficult: concerns about the expectations on carers; concerns about what this meant for staff; and concerns about raising the expectations of young people that were

difficult to meet. Instead participants talked about carers being *loving* and workers providing *loving and nurturing* environments. The concern in relation to the placement of large sibling groups was more practical in terms of the housing implications for accommodating this number of children in one placement.

Finally, the profession welcomed this study as a first step in a continuing dialogue with the Care Review, particularly in the concluding months of the final Destination stage and in the plans thereafter. Greater transparency about how and which organisations were engaged and informing the Care Review going forward would be helpful.

12. Conclusion

Keeping families together in communities may not be a radical suggestion, but to do so effectively requires significant cultural, attitudinal and structural change especially in communities where a family may not always be wanted or supported.

Managing higher levels of risk and working with the impact of trauma, neglect, abuse and loss across two or three generations is significantly challenging. Children's lives must be understood within the context of the strengths and difficulties within families, the capacity available within our communities and the wider structural issues impacting on our society. The research suggests that children are being accommodated because of significant unmet need and, while it may be possible to keep families together, some families will need significant support and input from services over extended periods of time.

We need to re-think our attitudes to how as a society we view, understand and respond to families whose disruptive and challenging behaviours may be a symptom of more deep-seated trauma. We need to re-think how we support families through more flexible services which are not time-limited and are based in communities delivered at the families pace of change. Where a child needs to be accommodated, all services need to work together to address the needs of both children and their parents, and if a return home is not possible then decisions about permanence need to be made more quickly. For those leaving care, greater attention is required on the support young people need and to implement the principles of continuing care more effectively for the young people themselves and services more generally.

A more flexible 'system' needs the profession and partners to understand trauma-informed practice and what it means to be a corporate parent; if

these changes are to take place, others such as health, housing, education and leisure need to play a role perhaps including a financial role; for example investing in the delivery of services directly through pooled budgets. This requires a re-think on how corporate parenting is understood in terms of responsibilities to children and young people in their care and how corporate budgets reflect their needs rather than political and policy priorities.

Such change needs supported at all levels from cross-party political support and public recognition of the role of social work and the wider social care profession through to support from external organisations such as the Care Inspectorate and SSSC. Nor is change cost neutral in the short term. If priority is to be given to changing the 'system', then it needs to be recognised that change takes time and needs financial commitment.

Central to the work of all are relationships and effective communication; this is at the heart of the 'care system'. Relationships with children, young people and their families, between individual professionals, and between corporate partners are central to continuing to improve the care provided for children and young people and improve their life chances. Communicating effectively and hearing the voices of children and their families should include those whose voices who may have been quieter, those young people who have been failed and, importantly, those whom the 'care system' has helped.

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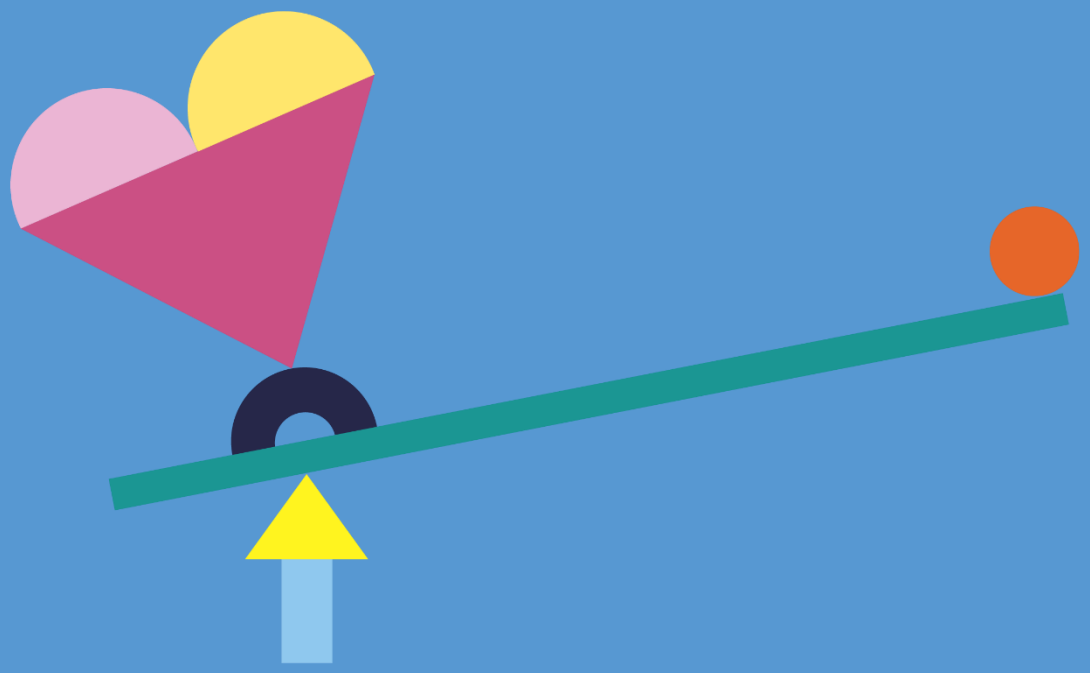

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October 2019

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1. Introduction

Background

During the period April-October 2019, as part of the Journey stage of the Independent Care Review (ICR), eleven (11) interrelated evidence reviews were undertaken.[1341] These reviews were intended to help inform and shape the conclusions and recommendations of the ICR by providing up-to-date evidence about a wide range of issues which are relevant to 'the care system' in Scotland. Each individual review aimed to address a question (or questions) which had been identified by the working groups and / or the secretariat of the ICR. Annex 1 lists the reviews, and the questions addressed in each of them.

These evidence reviews were done within a short timescale, and adopted a non-systematic approach which involved (i) identifying relevant review / overview papers, (ii) identifying significant primary research (often using 'snowballing' techniques from the list of references in any review papers), and (iii) focusing on evidence which had been gathered from children and young people themselves as well as from their parents, carers and workers who support them. Each evidence review drew on between 50 and 150 sources, and overall more than 1000 references of all kinds were considered.

Now that these individual evidence reviews have been completed, there is an opportunity to stand back and reflect on the totality of the evidence which has been assessed. This paper represents those 'reflections'. They are personal reflections, based on the wide reading undertaken by the research team.

Structure of the report

The report is structured as follows:

[1341] Note that a team of three researchers worked across all eleven reviews. Each review was written by a 'lead researcher', but all outputs were reviewed by all members of the research team.

- Sections 2-5 cover our reflections on four key topics namely: 'the care system' (Section 2); the evidence base (Section 3); what matters most to children and young people in care (Section 4); and love in care (Section 5)[1342,1343]. These sections include questions for the ICR arising from our reflections. (Note these are deliberately NOT framed as recommendations.)
- Section 6 contains our reflections on ongoing projects, programmes and initiatives which we think merit follow up in order to learn more about whether they represent promising avenues for development of 'the care system' in Scotland in the future.
- Section 7 concludes with some final reflections.

[1342] Note that any overlaps in the content of these sections have been minimised as much as possible. However, given the interlinked nature of the various topics, some overlap in the discussion is inevitable.
[1343] Note that, given the personal nature of these reflections, we have not provided comprehensive referencing. References have only been included where these are 'new' (i.e. where they were not included in the individual evidence reviews).

2. Reflections on 'the care system'

In this section, we set out our reflections on 'the care system'.

These reflections are addressed under the following headings: (i) context, definition, purpose, status and perceptions of 'the care system', (ii) (lack of) coordination of 'the care system' with other services, and (iii) resource and capacity constraints of 'the care system'.

Context, definition, purpose, status and perceptions of 'the care system'

'The care system' is a complex, fragmented, multi-purpose and multifaceted entity which does not lend itself to easy definition. It provides an enormously wide variety of support arrangements for children and young people (and their families) in a highly diverse range of circumstances, and it involves a vast array of organisations, service providers, professionals and volunteers in its delivery. Moreover, it is not clear whether secure care is viewed as part of 'the care system' or part of the justice system (or both).[1344]

Context within which 'the care system' operates – the wider agenda of poverty and deprivation

The evidence demonstrates that a wide range of factors relevant to the operation of 'the care system' are inextricably linked to poverty and deprivation including: (i) the reasons why children and young people enter care, (ii) the health and wellbeing of children and young people, (iii) the experience of stigma, (iv) contact with the justice system, (v) life chances and opportunities of children and young people and (vi) outcomes for children and young people.

The remit of the evidence review papers (as set by the working groups and the ICR secretariat), did not attempt to directly address issues relating to

[1344] See the evidence review on the topic of 'Secure care' for more discussion of this point.

poverty and deprivation (and how these intersect with 'the care system'), but rather focused as much as possible on factors which are 'internal' rather than 'external' to 'the care system'. Despite this 'internal' focus, the links to poverty and deprivation are discussed repeatedly in a wide range of the papers, and the influence of these 'external' factors permeated our analysis. It is therefore not clear to us that 'the care system' can be fundamentally transformed in the way ICR wishes without directly addressing the wider agenda of poverty and deprivation.[1345]

Question 1: How can ICR ensure the improvements sought in 'the care system' are framed within an analysis which takes into account the wider context of poverty and deprivation?

Public discourse about 'the care system' / understanding of 'the care system'

In public discourse 'the care system' is seen (by policy-makers, the general public, and often the care-experienced community), to a large degree as having low status. It is often described as 'broken' and as 'something to avoid'. It represents 'failure' and is 'a last resort'. In addition, media coverage focuses extensively on 'the care system's' failure to effectively look after children, and news stories can reinforce the public's belief that 'the care system' is dysfunctional.

This predominant narrative in the public discourse has consequences and impacts in that (i) people may be less willing to ask for / accept support (especially at an early stage) and (ii) children and families within 'the care system' may experience stigma as a consequence.

In the broader literature and commentary, there are two main roles identified for 'the care system'.

[1345] For further recent discussion of relevance to this issue see Eisenstadt, N and Oppenheim, C (September, 2019). *Parents, Poverty and the State: 20 Years of Evolving Family Policy*. Policy Press. https://policy.bristoluniversitypress.co.uk/parents-poverty-and-the-state

- In the first, 'the care system' is viewed as a family support service aiming to keep families together. In this articulation, care has a positive role to play as part of a continuum of services to support children in need and their families.
- In the second, 'the care system' is primarily viewed as a response to allegations of abuse; it should only be used when absolutely necessary and entry to care should be avoided where possible. In this articulation care is seen as distinct from a wider continuum of services and is viewed primarily as a 'welfare service'.[1346]

It appears that current public discourse is more closely aligned to the 'welfare service' role of 'the care system'.

In Scotland there is no statement of the purpose or ethos of 'the care system'; what it is for, how it operates and how it supports children and families. It is therefore perhaps unsurprising that there is limited understanding amongst the general public about the wide variety of support which is provided within 'the care system'. The 'model' of 'the care system' which predominates in the public's view is that once children enter care, they stay there for their entire childhood. This is a misperception. In fact, as demonstrated strongly in the evidence reviews: (i) there is a large amount of movement within 'the care system' with many children moving into, through, out of, and back into care (sometimes repeatedly), during the course of their care experience and (ii) individual 'episodes of care' are often very short (just a few weeks or months).

Thus, we think there is a case to be made for undertaking work to improve the public discourse / public understanding of 'the care system' in Scotland.

[1346] Note that the United Nations Guidelines for the Alternative Care of Children states that only in cases of necessity, should the child be placed in alternative care. This principle establishes a clear requirement for the State to provide supportive social work services that aim to prevent the separation of children from their families.

Question 2: Is there a case for developing a statement about the purpose(s) / ethos of care in Scotland? (This would include an explanation of the types of trajectories / care journeys that children and young people experience and would make explicit how secure care links to 'the care system' more generally.)

Question 3: Should the purpose / ethos of care in Scotland align with EITHER the 'family support / continuum of support' OR the 'welfare services / last resort' approach? Or should it encompass BOTH in a more nuanced understanding of the wide variety of support which is available?

Children's rights vs. children's well-being

One specific aspect of the discussion about the definition and purpose of 'the care system' concerns the potential tension in current Scottish Government policy and legislation between a focus on children's rights and a focus on children's well-being. This is part of a broader discussion which concerns not just looked after children, but all children.

It has been argued that a focus on well-being rather than rights should be prioritised because (i) it sits more comfortably within an outcomes-oriented approach to delivering public policy as measuring well-being is easier than measuring the extent to which a child's rights have been upheld and / or have been respected, (ii) focusing on well-being aligns well with the current emphasis in government policy on intervention and prevention, and (iii) there are concerns about whether an increased focus on children's rights could result in an increase in litigation.

While there may be a tension between approaches focusing on children's well-being and those focusing on children's rights, this does not necessarily mean that the two approaches are in conflict. In child protection processes, for example, the aim is both to protect and uphold the child's rights, and to ensure the child's welfare (and well-being). Indeed, there is strong evidence – see Section 4 below – that positive

outcomes for children and young people in 'the care system' (including children's well-being) are strongly linked to children's feelings that their voices have been heard and that they have participated in decisions that affect them (i.e. that their rights have been upheld).

Question 4: What consideration should be given to balancing children's rights and children's well-being in relation to the purpose and ethos of 'the care system'? (How can a children's rights approach best work in tandem with a focus on children's well-being?[1347])

(Lack of) coordination of 'the care system' with other services

The evidence demonstrates clearly that 'joined-up' care is a fundamental requirement for improving the outcomes for care-experienced children and young people. Improvements in the health and well-being of this group can only be achieved through effective coordination by national and local authorities in relation to health, social care, education, housing, justice and other relevant services. However, there are several areas where evidence shows 'the care system' is currently not working in an integrated way with other systems and services, and where young people's journeys into, through and out of care are disrupted or poorly planned.

Better integration / coordination between different systems and processes are required in relation to a wide range of situations and circumstances including:

- **Preventing children from coming into care:** To prevent children from coming into care, intensive, multi-faceted and integrated interventions across a wide range of services are needed.
- **Care leavers:** 'Good' transitions for care leavers require, amongst other things, flexible and 'joined up' systems which provide ongoing access to support from a wide range of services including housing, education, financial planning, etc.

[1347] This question is especially relevant at the present time, as the Scottish Government is currently considering arguments about whether, and how, to more fully incorporate the UN Convention on the Rights of the Child into Scots law.

- **Young offenders aged 16-17:** While the Children's Hearings System provides an integrated and coordinated response to children and young people under the age of 16, this coordinated response can break down for young offenders aged 16 and 17 once they are no longer within the ambit of the Children's Hearings System.[1348]
- **Children leaving secure care:** Moving out of secure care is particularly fraught with danger and requires better transition planning with much more focus on step-down services, continuation of mental health care services (where it is being provided), and support with housing and employment.
- **Children who are at risk of being criminalised within 'the care system':** Where the behaviour of children in residential homes is challenging, there is a risk that 'the care system' may respond to such behaviour through unnecessary contact with the police. A more positive response would involve the development of a joined-up approach across the various relevant agencies.
- **Children whose parents have offended:** The needs, views and rights of such children are currently given little or no attention in sentencing decisions, with potentially severe and negative consequences. A more 'joined up' approach between the agencies and services involved in these cases is therefore required.

Question 5: What steps can be taken to improve the coordination between the wide variety of services and agencies involved in the care of children and young people?

Question 6: Should the ICR take a view on whether (i) to extend the definition of 'a child' to all young people under 18 (as set out in the UN Convention on the Rights of the Child), or (ii) to retain the status quo (whereby Scotland defines childhood in different ways for different

[1348] An inconsistency in Scots Law in the definition of 'a child' (whether that is under 16, or under 18) is at the heart of this issue.

purposes)?

Question 7: If Scotland continues to define childhood in different ways for different purposes, should any steps be taken to ensure that young offenders aged 16 and 17 (many of whom may be recent care leavers) continue to be dealt with through the Children's Hearings system?

Resource and capacity constraints of 'the care system'

The evidence clearly demonstrates that investment in, the capacity of, and the resources available to 'the care system' are currently insufficient. This under-resourcing has a range of detrimental impacts on children and young people, as well as on the workforce who support them. The main areas which the evidence covers are:

- **Shortage of suitable placements**: Local authorities do not have sufficient placement options to meet the needs of each child. The lack of choice is associated with (unnecessary) placement breakdown, placement instability and / or temporary placement arrangements. Sibling groups appear particularly ill served; brothers and sisters can be split up and placed apart due to a shortage of suitable placements. The evidence also indicates that there is a shortage of suitable independent / semi–independent living arrangements and a shortage of placements within secure care services.
- **Unmanageable workloads for social workers:** Social workers are doing a large amount of unpaid overtime. Unmanageable workloads are leading to high levels of stress within the profession, high turnover rates (which compromise relationship stability) and the stated intention of a large proportion of social workers to leave their profession soon (within a year or so).
- **Lack of professional and peer support / training and development opportunities:** Social workers and other professionals say they do not have sufficient professional and peer support. They also do not

think the training and development opportunities within their professions are adequate.

- **Inadequacy of care planning and pathway planning**: There are insufficient resources and assistance available to ensure good care planning and pathway planning, both in relation to children's and young people's journeys into and through 'the care system', and in relation to transitions out of 'the care system'. Linked to this, there is inadequate investment in initiatives and arrangements to prevent children and young people entering care.
- **Lack of investment in therapeutic work and practice**: This is complex and demanding work and requires time, resources, understanding, knowledge and skill. A greater investment in child and adolescent therapists is required.
- **Lack of time and resource for relationship development:** Children and young people repeatedly highlight the lack of time available from social workers to form genuine and caring relationships. This is linked to unmanageable workloads and the lack of time available to spend with individuals and families as well as to the lack of access to therapeutic practice (see above).

Question 8: How can the resources for, and investment into, 'the care system' be increased / redirected / redistributed to fully meet the needs of children and young people? What can be done to increase the focus on prevention? What specific steps should be taken to address the substantial workload / workforce pressures?

3. Reflections on the evidence base

In this section, we set out our reflections on the evidence base. These reflections are addressed under the following headings: (i) missing perspectives in the evidence base, (ii) evidence gaps, and (iii) lack of balance in narrative accounts.

Missing perspectives in the evidence base

Whilst the evidence presented in the eleven reviews is extensive and wide-ranging, it does not necessarily provide a balanced picture of 'the care system' from the perspectives of all relevant stakeholders. There are two reasons for this:

- First, the focus of the reviews was determined by the interests and priorities of the ICR (and its working groups). As a result, the reviews largely focus on the perspectives and experiences of children and young people **within** 'the care system' or (recent) care leavers. The perspectives of professionals working in the system are less prominent in the evidence reviews – although some information, mainly from the perspective of social workers and carers (foster and kin) does feature. The perspectives of parents, wider families, communities, and others who have significant roles in 'the care system' (e.g. children's reporters, children's panel members, child protection committees, the police, teachers, etc.) are almost entirely absent from the evidence reviews. In addition, as already discussed (see Section 2 above) the focus of the reviews was primarily on factors which are internal to 'the care system'; hence there is no explicit focus on wider contextual influences (such as poverty and deprivation).
- Second, although the evidence identified for the reviews makes it clear that children in care (and care leavers) are not a homogeneous

group, it has not been possible in the timescales available to explore in any detail the varying perspectives and experiences of different groups of care-experienced children and young people. In particular, we are aware that the evidence we have drawn on (i) provides only limited information in relation to certain groups (including disabled children, asylum-seeking children, children with special needs) and (ii) does not routinely segment findings in relation to characteristics which are known to affect the experience of care (e.g. gender, age, ethnicity, belong to a sibling group, mental health, previous experience of care, family circumstances etc.).

Question 9: What steps can ICR take to ensure that these missing or underrepresented perspectives are acknowledged and taken into account when formulating the Care Review's recommendations?

Evidence gaps

The reviews highlighted a wide range of gaps in the evidence base, both in relation to the coverage of official statistics and in relation to the wider evidence about 'the care system'. These gaps limit the extent to which policy proposals can be developed (and evaluated) in an evidence-informed way.

Official statistics

The limitations of official statistics have been acknowledged in the statistical overview report which was produced to support the ICR.

An underlying weakness of all official statistics in relation to 'the care system' is that they are not reported on an 'episode of care' basis; rather they present a series of 'snapshots' at (a) point(s) in time. This means that an individual's 'journey of care' (constituted by linking together the individual episodes which make up their care experience), and their progress over time is not represented in official statistics.

The individual reviews identified a range of specific evidence gaps in relation to:

- Subjective well-being of children and young people in care and care leavers (including children's feelings and assessments of their own care experience); this is especially underdeveloped for (i) those aged 16-25 and (ii) those with disabilities, learning difficulties, special needs etc.
- The lack of disaggregation between sub-populations (e.g. children looked after away from home compared with those looked after at home, comparisons of those who entered care with those who nearly entered care). (Note this relates to the earlier point which is discussed above in relation to 'missing perspectives'.)
- The reasons why children in Scotland enter 'the care system'.

Wider evidence base

Individual research studies and reviews tend to focus on specific aspects or particular parts of 'the care system'; different types of placements, specific stages in a 'care journey', individual policies and procedures, or particular groups of children. Few studies look at 'the care system' as a whole and the evidence base is therefore fragmented and incomplete.

The individual reviews identified a range of gaps in relation to the wider evidence base as follows:[1349]

- Evidence is more readily available in relation to some sections of the workforce (in particular social workers, foster carers and to some extent residential workers) and less available in relation to those in less formal roles (unpaid carers, volunteers, etc.).
- The evidence about children and young people with care experience who are no longer receiving services as 'care leavers' is very sparse.[1350] There is therefore a dearth of evidence in relation to the longer-term impacts of care, and the longer term outcomes for those with care experience.

[1349] Note that this list in part repeats the earlier observations on 'missing perspectives'.
[1350] 'Care leavers' as defined in legislation – i.e. those aged over 26

- We did not find any evidence which examined the effects of government actions on the (subjective) well-being of children and young people in care.
- There is a lack of evidence on the question of whether implementing children's rights improves children's lives. More specifically, evidence about the ways in which the Scottish Government is approaching the implementation of the rights of looked after children who are disabled is extremely limited.
- The evidence base for the effectiveness over the long term of strategies to combat stigma is weak.

Question 10: What steps can ICR take to ensure that these evidence gaps are acknowledged and addressed so that policy and practice can be more appropriately informed by high quality evidence?

Lack of balance in narrative accounts of 'the care system'

As has been set out earlier (see Section 2 above), media coverage focuses extensively on cases in which 'the care system' has failed to effectively look after children, and news stories can reinforce the public's belief that 'the care system' is dysfunctional.[1351] The negative outcomes associated with care experience – such as criminal behaviour, mental illness, unemployment or dysfunctional personal relationships – tend to dominate the discourse and reinforce negative stereotypes.

There is therefore scope to increase the focus on 'success stories', and to learn about how 'the care system' can be improved by focusing on positive accounts of the care experience. This will ensure a more balanced picture of the experiences and outcomes for children in care and care leavers.

Question 11: What steps can be taken to increase the focus (especially in media portrayals) on positive accounts of care experience?

[1351] Scotland's first national anti-stigma campaign specifically designed to address misconceptions and negative attitudes towards those who have experience of the care system 'Give me a chance' was launched in 2018. At the time of writing, no evaluation of the effectiveness of this campaign has been published.

4. Reflections on what matters most to children and young people in care

In this section, we set out our reflections on what matters most to children and young people in care. These reflections are addressed under the following headings: (i) relationships (ii) stability and permanence and (iii) being listened to and having a say. It will be seen that these themes are interlinked.

Relationships

Our evidence reviews demonstrated the fundamental importance of relationships to children and young people in care. The quality of these relationships was the factor reported to have the greatest impact on their lives both within, and beyond, 'the care system'. Relationships are highly individual but commonly involve children's families, people they live with and those who work with them.

Children and young people identified the qualities they valued in relationships. They described having positive relationships with people who:

- Were always there for them including beyond childhood
- Loved, accepted and respected them for who they were
- Were ambitious for them and helped them succeed
- Treated them fairly and included them, as part of their family or setting
- Listened to what they felt and what they wanted
- Worked with them as an individual and did not judge them
- Were friendly, kind, not bossy and had a sense of humour
- Took time to understand what they'd been through
- Acknowledged positive changes they noticed in them and

- Kept them updated and fed back in an appropriate way about decisions.

The reviews reported strong evidence about the role these positive relationships play in looked after children's lives in wide range of ways including that they:

- Are very important to children's well-being, quality of life and healthy emotional and social development
- Enhance a sense of belonging and security
- Are important in aiding recovery from trauma
- Support the meaningful participation of the child in decision-making
- Support children and families on the 'edge of care' and help children return to families
- Provide important continuity for those entering and leaving the 'care system' (including secure care)
- Reduce the likelihood of offending and are a factor in reducing the unnecessary criminalisation of looked after children
- Motivate care leavers with regard to their education, training or personal goals and health needs and
- Endure beyond 'the care system' and enable more successful transitions from care to independent living and adult life.

The evidence underscored how it was important to understand and nurture the entire network of children's relationships in order to capitalise on their protective capacity.

Despite their clear importance and positive impact(s) the evidence detailed a worrying picture in relation to the current state of relationships for children in care. There was very strong evidence that:

- Children feel their rights are not always upheld in regard to their relationships.

- Relationships are not always prioritised by decision-makers; they risked being disrupted and arbitrarily severed (especially true for sibling groups; or when children left care (including secure care) or moved placements). This had a detrimental impact on children's well-being.
- Some of the processes and practices in 'the care system' make it hard for children to have – or prevent children from having – good relationships including: (frequent) changes of worker or carers; lack of time to get to know each other; the high workloads for workers; the lack of training, knowledge and skill of staff in relation to understanding the needs of children in care; and the possibility of a culture of 'suspicion and surveillance' where carers, social workers and the wider workforce may be accused of over-involvement.

Stability and permanence

A strong theme in the evidence reviews was the importance of 'stability' and 'permanence' for children and young people. These related concepts were often used in tandem and frequently without differentiation, which can cause confusion.

'Permanence' requires 'the care system' to make sure children achieve the best permanent placement for them with no unnecessary delay. However, achieving 'permanence' *within* 'the care system' is not an aim for all looked after children (not all placements are intended to last so a degree of movement within 'the care system' is inevitable). In Scottish policy 'permanence' involves providing children with a stable, secure, nurturing home and relationships, where possible within a family setting, that continues into adulthood.[1352]

[1352] 'Permanence' as discussed in the literature often relates to specific forms of 'legal status' and does not therefore necessarily cover all looked after children; however, more recently some commentators have argued for a shift in the conceptualisation of 'permanence' towards a principle that underlies planning for **all** looked after children regardless of the type of placement they have or the stage they are at in their care journey.

Regardless of how long or brief their period in care is, children are likely to fare better and have a more positive experience if, during their time in care, they have stability: a secure home and consistency of care. Despite the importance of stability to looked after children, however, many children reported they had too many moves and transitions within 'the care system'.[1353] Children say that:

- Moves are not usually at their own request and are often unnecessary
- Moving often impacts negatively on their lives and well-being
- Moving disrupts their friendships, interrupts their education and affects their wider relationship networks
- They would like moves to be more sensitively managed and to be kept updated about what is happening.

Much of the evidence focuses on two main aspects of stability: the stability and continuity of the placements; and the stability and continuity of relationships.

Placement stability / continuity

The evidence shows that placement stability is important because:

- Stable placements can promote resilience for looked after children by providing the child with a secure attachment (which can help make placement disruption less likely) and
- Stable placements can provide continuity in other areas of life such as school or friendships.

Factors which can negatively affect placement stability / increase placement instability include: (i) lack of placement choice, (ii) placements that are not well matched, and (iii) inadequately supported placements. By

[1353] Note that stability is NOT considered to be a right under the UNCRC. The Alternative Care guidelines state 'where alternative care is deemed to be necessary, and in the child's best interests, ... then the choice of care setting, and the period spent in care, must be appropriate for each child and **must seek to promote** stability and permanence.'

contrast, children having a choice of placement and involvement in planning where they live can have a strong positive impact on placement stability / continuity.[1354]

Stability and continuity in relationships

The evidence on the importance of relationships has been discussed previously in this section. As can be seen from the earlier discussion, stability and continuity are both vital elements in the relationships that children and young people describe as having positive impacts on their lives.

Importance of being listened to and having a say

The evidence reviews referred again and again to the importance that children and young people attach to being listened to, and to having a say in decisions that affect them (as set out in Article 12 of the United Nations Convention on the Rights of the Child and Article 7 of the United Nations Convention on the Rights of Persons with Disabilities).[1355] There is strong evidence that when this right is enacted, there are tangible, long lasting and important benefits for children and young people (including better decisions about their care and more stable placements). However, there is also strong evidence that in the current care system this right is not routinely upheld, with detrimental consequences for children's well-being, self-esteem, confidence and sense of control.

[1354] Note however, as discussed in Section 2 above there are severe resource and capacity constraints in relation to suitable placements.

[1355] Article 12 of the UNCRC states that any child who is capable of forming his or her own views has the right to express those views freely in all matters affecting them. In addition, the views of the child should be given due weight in accordance with the age and maturity of the child. Article 12 also says that, in circumstances involving judicial or administrative proceedings affecting the child, the child should be given an opportunity to be heard (either directly or through a representative or other appropriate body). Article 7 of the UNCRPD states that child with disabilities have the right to express their views freely on all matters affecting them, with their views being given due weight in accordance with their age and maturity, and that States should provide such children with disability and age-appropriate assistance to realise that right.

Children and young people particularly wanted to be listened to and to have a say in relation to decisions about:

- Where they live, who they live with (in relation to siblings) and how – and how often – they move to and from their place of residence
- Day-to-day issues related to their home environment and the things they are able to do
- Plans for their future, including (the timing of) their transition out of care into independent living and
- Which family members they see and how often they see them.

Increasing the extent to which children and young people feel listened to and that they have a say in decisions that affect them, requires all elements of 'the care system' to respond. Better planning, more accessible processes and information, a greater focus on the needs of the child, better communication, etc. are all important aspects. However, the strongest evidence in relation to this topic is that the key to improvement lies in the development of (a) strong and positive relationship(s) between the child or young person and their social worker or other trusted adult(s). It is when a child or young person has a long-term, genuine and caring relationship with an adult that they feel that their right to be listened to, and to have a say in the decisions that affect them, is realised. This means that even if they do not get the outcome (in terms of the decision) that they want, they will be less likely to suffer the detrimental consequences that flow from not being listened to.

Question 12: What actions can be taken to promote positive relationships, to increase stability and permanence, and to ensure that children and young people are listened to? What actions can be taken to remove the barriers to developing these conditions?

5. Reflections on love in 'the care system'

The ICR has 'taken as read' that 'the care system' needs to – as stated by the First Minister – 'have love at its heart'. This is encapsulated in the ICR intention that 'Scotland's infants, children and young people will be nurtured, loved and cared for in ways that meet their unique needs' and is also echoed more broadly within the Scottish Government's National Performance Framework which says that all children and young people should grow up 'loved, safe and respected so they realise their full potential'.

However, as far as we are aware, there is no care system anywhere in the world which is explicitly framed and built around loving the children and young people who live in care. Thus, there is no evidence to either refute or support this idea – it is simply a statement of intent. Moreover, there is as yet no body of work to address major issues in relation to defining and measuring love in 'the care system', monitoring and auditing love, developing policy for love, and orienting regulatory frameworks towards love.

We found strong evidence that:

- Looked after children and young people say love is important to them.
- Looked after children and young people say feeling loved and valued is very important for their well-being.
- Love aids recovery from trauma and adverse childhood experiences.
- Love is crucial for the emotional and social development of children and young people.

- Loving relationships enhance the adult lives of care experienced children and young people.

The main barriers to love in 'the care system' which were identified were:

- The way in which 'professionalism' and in particular 'professional boundaries' are currently defined (for social workers, carers and others) does not allow love to be expressed.
- Enacting love in 'the care system' can be fraught with danger and suspicion, because of the possibility of children being abused or harmed.
- The focus on risk assessment, risk management, and the reduction of risk within professional social care practice can inhibit the expression of love.

By contrast, the factors which were identified as promoting love in 'the care system' cover:

- Giving the workforce 'permission' to love
- Redefining professionalism
- More support for therapeutic care
- Greater continuity and stability in the workforce and
- Broader attitudinal changes within society as a whole.

Question 13: How will the ICR approach the tasks of how to (i) define and measure love in 'the care system' (ii) monitor and audit love (iii) develop policy for love, (iv) orient regulatory frameworks towards love and (v) remove the identified barriers to love?

6. Reflections on a range of current and ongoing initiatives ('ones to watch')

Below, we describe a wide range of current and ongoing projects, programmes and initiatives which we think merit follow up in order to learn more about (i) their contribution to the development of 'the care system' in Scotland (ii) how existing work in Scotland can be built on to further capitalise on any benefits demonstrated and / or (iii) whether they represent promising avenues for consideration in relation to the future development of 'the care system' in Scotland.[1356]

We are aware that this is a fast-changing landscape, and that new material of relevance to the ICR comes to light frequently. We do not claim that our list is comprehensive or systematic; rather it is simply an account of work which we came across in compiling our evidence reviews which we thought was interesting, and worth keeping 'on the radar'. In some cases, the work we have highlighted has only recently come to our attention or was published after the individual evidence reviews were completed.

These initiatives have been grouped into 'International', 'UK-wide', 'England and Wales' and 'Scotland'.

International

New Zealand 'well-being budget'

In May 2019, the government of New Zealand announced the introduction of its first 'well-being budget'. The budget requires all new spending to go toward five specific well-being goals: bolstering mental health, reducing child poverty, supporting indigenous peoples, moving to a low-carbon-emission economy, and flourishing in a digital age. According to New

[1356] Some of these initiatives have a relevance far beyond the care system itself.

Zealand's prime minister, 'the purpose of government spending is to ensure citizens' health and life satisfaction, and that — not wealth or economic growth — is the metric by which a country's progress should be measured.' This work has been ongoing in New Zealand since 2010.[1357]

Stiglitz-Sen-Fitoussi Commission to measure progress using broader measures (than GDP)

The idea that the progress of a country should be judged by a 'broader dashboard of indicators' that reflect wider concerns including the distribution of well-being and sustainability in all of its dimensions – rather than simply relying on Gross Domestic Product (GDP) – was first mooted in the work undertaken by the Commission on the Measurement of Economic Performance and Social Progress ("Stiglitz-Sen-Fitoussi" Commission) initiated by the French Government in 2008. 'Multidimensional subjective well-being' was one of the four substantive areas of progress considered by this commission (the others were income and wealth inequality; multidimensional and global inequalities; and sustainability).

The work of the Stiglitz-Sen-Fitoussi Commission is on-going.

Norway Child Protection Services – commitment to love

In 2015, Norway's Child Protection Services committed to 'meet them (the children) with care, empathy and acknowledging children's needs for security and love'. No definition of what 'love' was meant in this context has been provided; however, this is a rare example of an aspiration to 'love' children which appears in official documents.

Moving Forward: Implementing the Guidelines for the Alternative Care of Children[1358]

Not long after the Guidelines for Alternative Care were published, further work was commissioned to provide a resource to support their

[1357] https://whatworkswellbeing.org/case-study/new-zealand-treasury-the-living-standards-framework-dashboard-2/
[1358] https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf

implementation.[1359] This resource, *Moving Forward: Implementing the Guidelines for the Alternative Care of Children,* was developed by researchers at the Centre for Excellence for Looked After Children in Scotland (CELCIS) in Scotland, in collaboration with hundreds of professionals from governments, non-governmental organisations, UN agencies and universities, and it reflects practice from more than 70 countries around the world.[1360,1361] The resource includes a handbook and 43 examples of 'promising practices'. It explores each section of the Guidelines in detail, discusses the implications for policy and practice development, and provides a set of international case studies to demonstrate what implementation of the Guidelines might look like in different contexts.

UK-wide

A focus on 'kindness' in public policy

A recent report commissioned by the Carnegie UK Trust has explored the role of kindness in public policy. The report builds on a programme of work undertaken over several years (2015-) by the Carnegie UK Trust and the Joseph Rowntree Foundation on the power of kindness and everyday relationships to affect change and support the well-being of individuals and communities.

The report suggests that, whilst talking about kindness in this context is profoundly uncomfortable and potentially highly disruptive, the great public policy challenges of our time – rebuilding public trust and

[1359] Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012). *Moving Forward: Implementing the Guidelines for the Alternative Care of Children*. UK: Centre for Excellence for Looked After Children in Scotland. Available from: https://www.alternativecareguidelines.org/ - accessed May 2019.
[1360] *Moving Forward: Implementing the Guidelines for the Alternative Care of Children* is available from: https://www.alternativecareguidelines.org/ - accessed May 2019.
[1361] Background to Moving Forward, https://www.alternativecareguidelines.org/About/Background/tabid/2814/language/en-GB/Default.aspx - accessed May 2019.

confidence, encouraging behaviour change – demand an approach that is far more centred on relationships and human connection.

In parallel with Unwin's report, UK Carnegie Trust also commissioned work on measuring kindness. Findings from the first quantitative survey on kindness in communities and public services was published in November 2018, based on fieldwork conducted using random sampling methods in each of the five legislative jurisdictions in the UK and Ireland.

More recently, in October 2019, in a continuation of this work, Anderson and Brownlie have published their report 'Public policy and the infrastructure of kindness in Scotland' which contributes to the debate about definitions and understanding (e.g. What do we actually mean when we talk about a kinder Scotland? Is kindness really a concept that belongs in, or has much to say to, the realm of public policy? What are its risks and ambivalences? How exactly might public policy help to enable or sustain an 'infrastructure of kindness'?) and engages with the critical question of what the state and other organisational actors might start to do, stop doing or do differently in pursuit of a kinder Scotland.[1362]

Evidence on outcomes for looked-after children beyond early adulthood

A current study (Principal Investigator Prof Amanda Sacker, University College London) aims to explore the long-term consequences of being cared for in institutional or family settings using data from the Office of National Statistics Longitudinal Study (ONS LS). The study will examine the health and social outcomes in adulthood of sequential cohorts of children, comparing the outcomes of children cared for in residential and foster care family situations (either formal or informal) with children living with relatives (parental and other). The outcomes for looked-after and care-

[1362] Anderson S, and Brownlie J (2019) Public policy and the infrastructure of kindness in Scotland, University of Edinburgh https://www.carnegieuktrust.org.uk/publications/public-policy-and-the-infrastructure-of-kindness-in-scotland/

givers' children in the same household will also be examined, and the study will identify the extent to which mothers who had lived in different care arrangements as children have their own children living with them or elsewhere. The analysis of sequential cohorts offers potential to explore whether outcomes have changed in the context of different policy and practice contexts, and to identify if there is evidence for resilience and recovery over time.

Other work focused on outcomes for looked after children beyond early adulthood was discussed in September 2019, at the annual conference of the Society for Longitudinal and Life Course Studies (SLLS).[1363] One session in this conference was devoted to the topic of 'Out of Home Care During Childhood: Impacts on Individuals and Families'. It featured presentations from the UK, Sweden and Denmark which provided evidence based on longitudinal studies on longer term follow up of children and families who had been in care.

Lifelong Links programme

The LifeLong Links[1364] programme is designed to find and connect (or reconnect) children with important people in their lives. It is currently being piloted in Scotland (and England). The programme aims to identify and engage relatives (known and unknown to the child, including brothers and sisters) and other supportive adults (such as former foster carers or teachers) who connected to a child in care, and who are willing to make a life-long commitment to that child. The programme works with children under 16 who have been in care for less than three years, and for whom there is no plan to return to their family or to be adopted. The Lifelong Links approach draws upon a family-finding model which originated in the United States and a family group conference model which originated in

[1363] https://docs.wixstatic.com/ugd/df1448_a93c5ad45eb04bc9809485845f32f42b.pdf
[1364] Lifelong Links is being trialled in Scotland in Edinburgh, Glasgow and West Lothian; extended to include Perth and Kinross and Falkirk councils in April 2019.

New Zealand. Independent evaluation of the work in Scotland is not yet available but initial indications are reported as positive[1365].

England and Wales

The Bright Spots Programme – measuring subjective well-being

The Bright Spots programme, developed by Coram Voice and the University of Bristol, has created a set of well-being indicators to allow services to design their work around what children and young people say is important to them. Two online surveys – Your Life, Your Care (YLYC) and Your Life Beyond Care (YLBC) – have now been used widely by both English and Welsh local authorities, and national reports have been published on an annual basis since 2015. The intention is that these surveys will continue to be rolled out to further local authorities in England and Wales.

The authors, in their description of the surveys say that 'our surveys are the only ones to capture 'subjective well-being' – how children in care feel about their relationships, the support they receive and how things are going'. This is the only programme of work identified in the evidence reviews which has developed a specific approach for the measurement of the subjective well-being of care leavers.

The Bright Spots Programme helps to identify specific practices and actions which can improve the health and well-being of looked after children and care leavers. However, it is recognised that there is still much to be done to embed these measurements into 'the care system' and use them for improvement.

[1365] https://www.frg.org.uk/involving-families/family-group-conferences/lifelong-links#what-is-the-evidence-of-the-impact-of-lifelong-links *e.g. In Scotland a child who has received a Lifelong Links service will, on average, see their networks increase by an additional 25 people*

National protocol on reducing unnecessary criminalisation of looked-after children and care leavers

In relation to preventing the unnecessary criminalisation of children and young people, in England, a new national protocol has recently been published by the UK Government Department of Education, the Home Office and the Ministry of Justice.[1366] The protocol is aimed at local authority children's services, local care providers (fostering services, children's homes and other arrangements), police forces, Youth Offending Teams (YOTs), the Crown Prosecution Service (CPS) and HM Courts and Tribunal Service (HMCTS), local Youth Panel (Magistrates), and local health services including mental health. Its purpose is to encourage and provide a framework for these agencies to co-develop local arrangements to reduce the unnecessary criminalisation of looked-after children and care leavers.

Relationship based practice[1367]

One local authority (Brighton and Hove, England) have described their journey (since 2015) in implementing relationship-based practice as a whole system change across children's social work services. To date this had led to structural changes, the introduction of new practice processes and cultural changes in relationship-based management and leadership. Specifically, the change has entailed:

- The Brighton and Hove model of practice (which has been evaluated) established a *'Team Around the Relationship'* which involved a move to small social work teams, or pods, which support

[1366] UK Government (2018) *The national protocol on reducing unnecessary criminalisation of looked-after children and care leavers*. See https://www.gov.uk/government/publications/national-protocol-on-reducing-criminalisation-of-looked-after-children - accessed July 2019.

[1367] 'Relationship based practice' is described in the following terms in Ingram, R and Smith M, (2018) Relationship based practice: emergent themes in social work literature Insight 41, IRISS 'In recent years the concept of relationship-based practice (RBP) has become a way of articulating the centrality of the relationship between social workers and service users (Ruch, Turney and Ward, 2010; Hennessey, 2011; Megele, 2015; Bryan and colleagues, 2016). RBP is not a method or an approach to social work that can be picked from a menu of alternatives; rather, it is at the heart of whatever approach might be adopted across different client groups and domains of practice.' https://www.iriss.org.uk/resources/insights/relationship-based-practice-emergent-themes-social-work-literature

children from the assessment stage through the whole of their journey across social work services.

- This model of practice incorporates group supervision, reflective practice groups and a new model of relationship-based assessment and recording as key processes to support whole system change.

The cultural transformation towards becoming a 'relationship-based organisation' is supported by six principles as follows:

- Principle 1 Continuity of social work relationships with families – so families do not have to change social workers or re-tell their stories because of local authority processes
- Principle 2 Consistency of social work relationships with families – so families have support from a team that knows them
- Principle 3 Collaboration between practitioners – so workers share skills and specialisms to promote change for families
- Principle 4 Social workers as change agents – so that support is purposeful, outcome-focused and builds on families own strengths
- Principle 5 Creating a learning culture
- Principle 6 Transformation of the organisational culture from a blame culture to a relationship-based one that inspires trust and confidence.[1368]

Early evaluation findings have concluded that children and families have a better experience of social work than they previously did; social workers feel more supported and more able to make a difference for families; relationship-based practice seems to be supporting safe and stable family lives for children; and the model of practice appears to have decreased demand for social work (during a time of increasing national demand).

[1368] https://www.brightonandhovelscb.org.uk/how-do-you-do-relationship-based-practice/ Relationship

In September 2019, a webinar was published which describes the achievements of the London Borough of Camden in delivering a relational approach from the top down and the bottom up.[1369]

Development of an outcomes framework for children's social care services

In July 2019, a report was published by the Rees Centre, setting out proposals for the development of an outcomes framework for children's social care services (CSCR).[1370] The framework is based on the views of those who plan, deliver and use these services, as well as the research evidence.

The framework identifies a range of intermediate outcomes covering whether: (i) CSCS leaders create the right conditions and the right culture to support good social work practice, (ii) CSCS reach the children and families who need their help, appropriately assess their needs and provide the level of support they require and are entitled to and (iii) children and their families feel valued and empowered by services and the support they receive) as well as a range of user outcomes covering whether: (i) children in need are safe where they live, both at home and in their community, (ii) they have been supported by CSCS to be healthy and happy, that is achieve developmental, physical, cognitive, social and emotional milestones and (iii) they have been supported by CSCS to make progress in education and to have positive educational experiences.

The report describes specific, observable and measurable indicators to assess if the intermediate and child outcomes outlined above are achieved. The report explains that the next stage would require a pilot to further develop and test the feasibility of compiling the proposed indicators and how useful the data is in informing service planning and delivery.

[1369] https://www.scie.org.uk/children/relationships/webinar20190904
[1370] http://www.education.ox.ac.uk/research/measuring-outcomes-for-childrens-social-care-services/

Improving organisational resilience in Child and Family Social Work – the Social Work Organisational Resilience Diagnostic tool

A new online tool has recently been developed by researchers from the University of Bedfordshire which aims to assess the extent that organisational factors and conditions support the wellbeing of (Child and Family Social Work) staff. It includes a diagnostic survey and workbook that will provide targeted tasks and strategies to support organisational improvements and to promote best social work practice. The tool has been coproduced with partners from across the children's social care sector.[1371]

Scotland

Scottish Government National Performance Framework – commitment to well-being and love

The description of Scotland's National Performance Framework (NPF) notes that 'while economic progress is important, success is about more than Gross Domestic Product (GDP). That's why the purpose at [the heart of the National Performance Framework] is opportunities for all**, improved wellbeing** and sustainable and inclusive economic growth.'

The NPF identifies a National Outcome for its children and young people that they should grow up 'loved, safe and respected so they realise their full potential'. The NPF explains this further as follows:

> *We are dedicated to providing the essential conditions of love, respect and understanding through which our children can become the happy, fulfilled and successful adults they all have a right to be.*
>
> *We do all we can to ensure our children grow up in an atmosphere of happiness, love and understanding. We enhance their life chances through our early years provision and by supporting families when*

[1371] https://www.rip.org.uk/news-and-views/latest-news/assessing-organisational-resilience-and-wellbeing/?utm_source=Non-Partner+bulletin&utm_campaign=a04cf33285-Non_Partner_bulletin_Aug2019_COPY_01&utm_medium=email&utm_term=0_4146f9bdbb-a04cf33285-38031849

> *they need it. We ensure childhood is free from abuse, tobacco, alcohol, drugs, poverty and hunger. Our children are not left worried or isolated. We include and involve children in decisions about their lives and world, and protect their rights, dignity and wellbeing. Our communities are safe places where children are valued, nurtured and treated with kindness. We provide stimulating activities and encourage children to engage positively with the built and natural environment and to play their part in its care. We provide the conditions in which all children can be healthy and active. Our schools are loving, respectful and encouraging places where everyone can learn, play and flourish. We provide children and young people with hope for the future and create opportunities for them to fulfil their dreams.*

Adverse Childhood Experience (ACE) – Development of Hub

The Scottish Government has emphasised the impact of adverse childhood experiences (ACEs) on peoples' life chances, and has stressed the moral imperative to 'do more, not only to prevent them from happening in the first place, but to limit the damage they do to people, families and communities in the longer term.' It has identified that tackling adverse childhood experiences (ACEs) requires public services to work collaboratively, and with communities, across early years, education, health, justice, social work and more.

The Programme for Scotland 2019/20 describes progress in relation to this agenda and the plans to extend the National Trauma Training Programme so that it can reach those supporting looked after children as follows:

> *We have invested £1.35 million in the National Trauma Training Programme, enabling workers to recognise and respond to psychological trauma. Over 3,000 people across our public services, including police officers, nurses and social workers, have been trained to date, with training for a further 2,000 workers planned. We will*

> *expand the programme over the next two years, providing the opportunity for more frontline staff to receive training, such as those supporting Looked After Children and women receiving maternity care who have experienced sexual violence and abuse.*

It should be noted however, that a recent systematic review (published in 2019), concluded that there was very limited evidence that trauma-informed models improve outcomes for children in out-of-home care. (Note that all the studies reviewed were conducted in the US.)[1372] Moreover, a recent paper (White et al, 2019) provides a critique of the evidence underpinning policy and practice in relation to ACEs. The authors conclude that:

> *'ACEs can provide a useful concept for bolstering arguments about the need for family support. However, there is no definitive evidence and measurement for ACEs. Reliance on ACEs can lead to a focus on intra-familial circumstances and ignore the wider material and social conditions of families. It can also lead to 'marking out a population of predominantly poor families as biologically damaged' and for stigmatising and demoralising families'.*[1373]

Improvements to Children's Hearing system

In its Programme for Government 2018/19, the Scottish government has committed to improving experiences of the Children's Hearings system, and to responding compassionately to traumatised and neglected children and young people. In this document, the Scottish government also say they will introduce a Family Law Bill to: ensure that the child's best interests are at the centre of any contact or residence case or Children's

[1372] Bailey, C, Klas A, Cox R, Bergmeier H, Avery J and Skouteris H (2019). Systematic review of organisation-wide trauma-informed care models in out-of-home care (OoHC) settings. Health & social care in the community 27 (3) 10-22

[1373] White, S., Edwards, R., Gillies, V., & Wastell, D. (2019) All the ACEs: A Chaotic Concept for Family Policy and Decision-Making? Social Policy and Society, 18(3), 457-466.

Hearing; ensure that the voice of the child is heard; and ensure that cases and hearings are dealt with in an efficient way.

Review on the use of family support services to prevent children going into care

The Scottish Government's Programme for Scotland 2017-18 made a specific commitment to 'commission a progress review on the use of family support services (which can be seen as a form of 'early intervention and prevention') to prevent children going into care'.[1374]

The findings from this review will be useful to commissioners, service planners and practitioners in relation to the use of family support services.

Sentencing reform / sentencing guidelines

In relation to children affected by parental imprisonment, in June 2019, the Scottish Sentencing Council published a public consultation paper and a proposed draft guideline on the sentencing process.[1375] The consultation invited views on the draft guideline, which included possible mitigating factors which (it was proposed) the courts should take into account when making sentencing decisions. The family circumstances of the offender were one of the mitigating factors in the list.

Secure mental health facility for young people

The Secure Care Strategic Board (2019) reported that, in October 2016, Ayrshire and Arran NHS Board approved a business case to host a 12-bedroom national secure forensic mental health inpatient service for young people. This service will be the first of its kind in the Scottish healthcare system, and it will provide assessment, treatment and care for young people whose complexity and severity of risk requires a secure setting. It is intended that the treatment provided by the facility will

[1374] Note that at the time of wring we were not able to establish what – if any – progress had been made in commissioning this review.
[1375] Scottish Sentencing Council (2019) *The sentencing process*. See (https://consultations.scottishsentencingcouncil.org.uk/ssc/the-sentencing-process/) – accessed June 2019.

enable these young people to eventually return to their own communities, with support from their local services. The facility is expected to be operational in 2020.

Frameworks Institute: Telling the stories of care experienced people

Evidence suggested that, to address issues of stigma, there was a need to create a new narrative about the experience of care. This would involve promoting a more balanced picture of 'the care system' and its outcomes for children and young people. The literature also suggested better ways of telling the stories of people with experience of care. The on-going work in Scotland by the Frameworks Institute suggested ways to create a more balanced narrative about 'the care system'. Suggestions included work to:

- Define 'the care system' more widely to include all the services provided (kin carers, children looked after at home etc.)
- Broaden public understanding of the outcomes associated with care experience, show how they vary widely and emphasise that not all young people have poor outcomes
- Celebrate the many achievements of children in care and care leavers
- Increase understanding of the contribution care experienced people make to society
- Highlight what 'the care system' can and does do to support care experienced children.[1376]

Anti-stigma campaign: 'Give me a chance'

Previously the Scottish Government supported Who Cares? Scotland to develop a campaign to challenge stigma and reduce discrimination experienced by care experienced young people. This led to the development of the '*Give me a Chance*' campaign. To date, there appears to have been no evaluation of the impact of this work. However, earlier this

[1376] https://frameworksinstitute.org/assets/files/scotland/robertson-map-the-gaps-final-2018.pdf

year (February 2019) Who Cares? Scotland secured further Ministerial commitment for a public education campaign that is voice led and experience driven. At the time of writing further details of the work are not yet available.[1377]

Changes to the law to improve sibling relationships

In 2019 Scottish Government announced via the Children (Scotland) Bill and the Family Justice Modernisation Strategy significant proposals to change the law to protect the sibling relationships of children in care as follows:

Actions

Duties on local authorities

Section 10 of the Children (Scotland) Bill introduces a duty on local authorities to promote direct contact and personal relations between a child and their siblings, where this is both practicable and appropriate and in the interests of the child. Siblings are defined to include individuals with whom a child has an on-going relationship with the character of a sibling relationship.

Section 10 of the Bill also requires local authorities to seek the views of the child's sibling in relation to contact when it is reasonably practicable for the local authority to do so.

Amendments to Looked After Children (Scotland) Regulations 2009

The Scottish Government will introduce amendments to the Looked After Children (Scotland) Regulations 2009 to put a duty on local authorities to place siblings under 18 years of age together when they are looked after away from home when it is in their best interests to do so. These regulations will come into force at the same time as the section in the Bill placing duties on local authorities[1378] [1379]

[1377] It will be important for this campaign to be evaluated.
[1378] https://www.gov.scot/publications/family-justice-modernisation-strategy/pages/12/
[1379] https://www.clanchildlaw.org/blog/children-scotland-bill-family-justice-modernisation-strategy-published

Care experience as a 'protected characteristic'

Who Cares? Scotland (echoing calls in the past, 2009[1380]) want to make it unlawful to discriminate against a person on the grounds of their care status. The #LifetimeOfEquality campaign asked for the UK Parliament to amend the Equality Act 2010 and make 'care experience' a protected characteristic (February 2019).[1381]

The Equality Act 2010 protects people against discrimination. Under the Act, there are nine protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

Under this legislation it is unlawful to discriminate, harass or victimise someone because they have or are perceived to have one of the characteristics protected under the Act, or if they are associated with someone who has a protected characteristic. It provides legal rights, reinforces anti-stigma and discrimination messaging and provides an accountability framework.

Currently, the characteristic of 'care experience' is not protected under the Act.

The argument is that making care experience a protected characteristic would provide care experienced young people with protection from discrimination and harassment because of their care identity. They argue that this would:

- Ensure that any discrimination of someone with care experience is treated with the same seriousness as discrimination against people sharing any of the existing protected characteristics.

[1380] https://www.cypnow.co.uk/cyp/news/1039002/children-in-care-face-exclusion
[1381] http://www.corporateparenting.org.uk/wp-content/uploads/2018/02/Protected-Characteristics-and-Care-Experience-final-draft-5-Feb-2018.pdf

- Raise consciousness about the discrimination faced by care experienced young people and the importance of providing support to this group.
- Allow corporate parenting and equality and diversity work to be more closely aligned. Importantly, the protection and support would be life-long rather than stopping once a young person reaches their 26th birthday (when currently the right to aftercare support ends).

In September 2018 SCRA (Scottish Children's Reporter Administration) backed the campaign to make care experience a protected characteristic.[1382]

[1382] https://www.scra.gov.uk/2018/09/equality-for-care-experienced-children-young-people-and-adults/

7. Final reflections

The ICR has set out a clear ambition to radically transform 'the care system' in Scotland.

This paper is intended to contribute to the debate and discussion around this stated aim by:

- Providing our reflections, based on a wide reading of the relevant literature, on some of the key challenges and opportunities facing the Care Review
- Setting out a range of questions which the ICR may wish to consider in framing its recommendations and
- Describing a range of ongoing projects, programmes and initiatives which may, in time, provide helpful intelligence in relation to the development of Scotland's care system.

We hope our paper will spark debate, discussion and ideas!

8. Appendices

Annex 1: Evidence reviews for the ICR

The eleven evidence reviews produced for the ICR are listed below in alphabetical order, together with the question(s) that each review addressed. These questions were discussed and agreed with the relevant ICR workgroups, as well as with the ICR secretariat.

Best Place

What evidence is available about how Scotland compares with other countries on a range of indicators of 'a good childhood'?

What do we know about:

- Whether Scotland is improving, getting worse or staying the same in relation to indicators of a happy childhood?
- The factors which explain Scotland's position in relation to other countries?
- How children in care are currently doing in relation to the indicators of a 'good childhood'?

Care journeys / Components of care

What evidence is available about the experience of children and young people's 'journey(s)' through 'the care system'?

What do we know about:

- The factors which help facilitate 'good journeys' through 'the care system'?
- The factors that help to mitigate negative consequences in relation to moves and transitions in 'the care system'?

'Edges' of care – entering and leaving 'the care system'

What evidence is available in relation to entering and leaving 'the care system'?

What do we know about:

- What supports families to stay together so that children do not become looked after?
- The outcomes for care leavers over the short, medium and long term?
- The provision of lifelong support to care leavers?
- The impacts over the life course of experiencing 'the care system'?

Health and well-being of children and young people in care[1383]

What evidence is available about the factors which children and young people within 'the care system' identify as important to their well-being?

What do we know about:

- What promotes the factors children and young people identify as important to their health and well-being?
- The barriers to positive health and well-being among children and young people in care?

Justice: where the justice system meets 'the care system'

What evidence is available about three specific situations where children and young people with significant welfare needs come into direct or indirect contact with the justice system?

What do we know about:

- The unnecessary criminalisation of children and young people in care?

[1383] Note that, here and elsewhere, 'children and young people in care' is taken to **include** care leavers

- Inconsistencies in the way in which 16- and 17-year old offenders are dealt with by the justice system?
- The imprisonment of parents?

Love in care: the experience of love for children and young people in and beyond care

What evidence is available on the experience of love for children in care?

What do we know about:

- What promotes a loving environment for children in and beyond care?
- The barriers to providing a loving environment for children in and beyond care?
- What can the workforce do to create the conditions to allow children to flourish?

The rights of children in care

What evidence is available about the rights of children in care?

What do we know about:

- The extent to which current international legislation / guidance / frameworks on the rights of children are being upheld for children in care?
- The impacts / benefits of upholding / respecting the rights of children in care?
- The challenges / barriers to respecting the rights of children in care?
- What helps to support / facilitate respecting the rights of children in care?

Secure care

What evidence is available about secure care services in Scotland?

What do we know about:

- The children and young people referred to secure care services?

- What children and young people say about the experience of secure care?
- The outcomes of secure care?
- What alternatives there are to secure care?

Siblings in care

What evidence is available about the circumstances and experiences of siblings in 'the care system'?

What do we know about:

- The impact(s) on sibling relationships of being looked after
- The barriers to positive sibling relationships and what works to promote positive sibling relationships.

Stigma of children and young people in care

What evidence is available about the effectiveness of approaches to reduce stigma for marginalised groups (including, but not restricted to children in care, care leavers and those working with these groups)?

What do we know about:

- The points in 'the care system' where children experience stigma and the characteristics of stigmatising practice?
- The types of interventions which are successful in reducing stigma and changing attitudes towards stigmatised groups?

Workforce

What evidence is available on what helps the workforce to support and care for looked after children?

What do we know about:

- What helps promote the well-being of the workforce?
- What facilitates and what hinders relationship-based practice?

Annex 2: Questions for the ICR

Below we recap all the questions which are threaded through the text in Sections 2-5.

Question 1: How can ICR ensure the improvements sought in 'the care system' are framed within an analysis which takes into account the wider context of poverty and deprivation?

Question 2: Is there a case for developing a statement about the purpose(s) / ethos of care in Scotland? (This would include an explanation of the types of trajectories / care journeys that children and young people experience and would make explicit how secure care links to 'the care system' more generally.)

Question 3: Should the purpose / ethos of care in Scotland align with EITHER the 'family support / continuum of support' OR the 'welfare services / last resort' approach? Or should it encompass BOTH in a more nuanced understanding of the wide variety of support which is available?

Question 4: What consideration should be given to balancing children's rights and children's well-being in relation to the purpose and ethos of 'the care system'? (How can a children's rights approach best work in tandem with a focus on children's well-being?[1384])

Question 5: What steps can be taken to improve the coordination between the wide variety of services and agencies involved in the care of children and young people?

Question 6: Should the ICR take a view on whether (i) to extend the definition of 'a child' to **all** young people under 18 (as set out in the UN Convention on the Rights of the Child), or (ii) to retain the status quo

[1384] This question is especially relevant at the present time, as the Scottish Government is currently considering arguments about whether, and how, to more fully incorporate the UN Convention on the Rights of the Child into Scots law.

(whereby Scotland defines childhood in different ways for different purposes)?

Question 7: If Scotland continues to define childhood in different ways for different purposes, should any steps be taken to ensure that young offenders aged 16 and 17 (many of whom may be recent care leavers) continue to be dealt with through the Children's Hearings system?

Question 8: How can the resources for, and investment into, 'the care system' be increased / redirected / redistributed to fully meet the needs of children and young people? What can be done to increase the focus on prevention? What specific steps should be taken to address the substantial workload / workforce pressures?

Question 9: What steps can ICR take to ensure that these missing or underrepresented perspectives are acknowledged and taken into account when formulating the Care Review's recommendations?

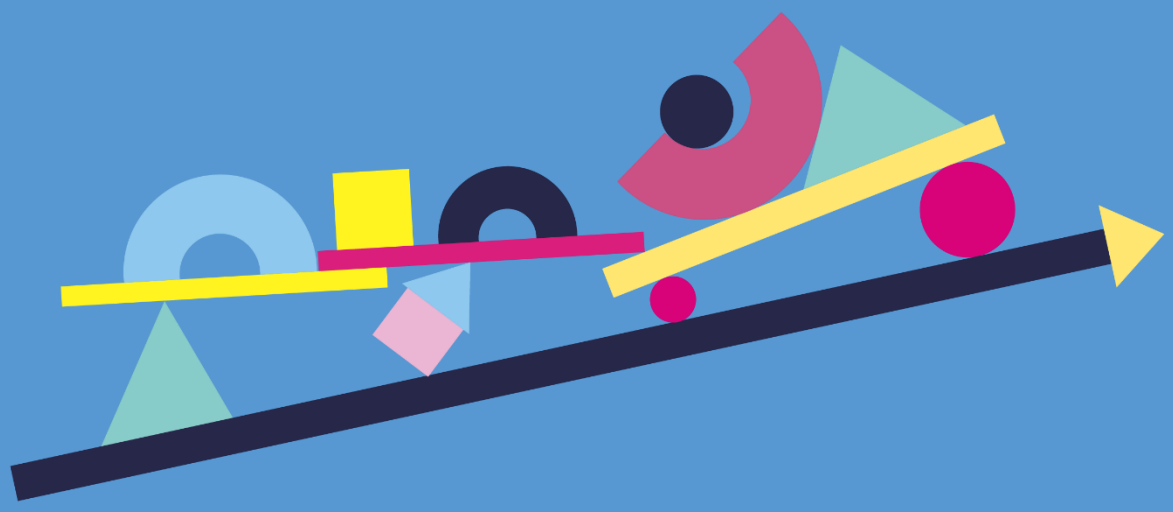
Question 10: What steps can ICR take to ensure that these evidence gaps are acknowledged and addressed so that policy and practice can be more appropriately informed by high quality evidence?

Question 11: What steps can be taken to increase the focus (especially in media portrayals) on positive accounts of care experience?

Question 12: What actions can be taken to promote positive relationships, to increase stability and permanence, and to ensure that children and young people are listened to? What actions can be taken to remove the barriers to developing these conditions?

Question 13: How will the ICR approach the tasks of how to (i) define and measure love in 'the care system' (ii) monitor and audit love (iii) develop policy for love, (iv) orient regulatory frameworks towards love and (v) remove the identified barriers to love?

Other promising approaches in Scotland



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1. Barnahus model standards

Healthcare Improvement Scotland (HIS) and the Care Inspectorate were commissioned by the Scottish Government to develop standards for a Barnahus response to victims and witnesses of Violence.

At the time of writing, the standards were currently in development following a scoping workshop to establish a recommended direction of travel and scope for the standards which took place in June 2019. The results of that scoping workshop can be accessed here.

What is the Barnahus Model?

Barnahus is a Scandinavian word which literally means 'Children's House', and is an interdisciplinary, child-friendly multi-agency centre where child victims and witnesses can be interviewed, assessed and medically examined as well as receiving all relevant therapeutic services in one place. It originates in Child Advocacy Models from the USA in the 1980s, was firstly implemented in 1998 by Iceland.

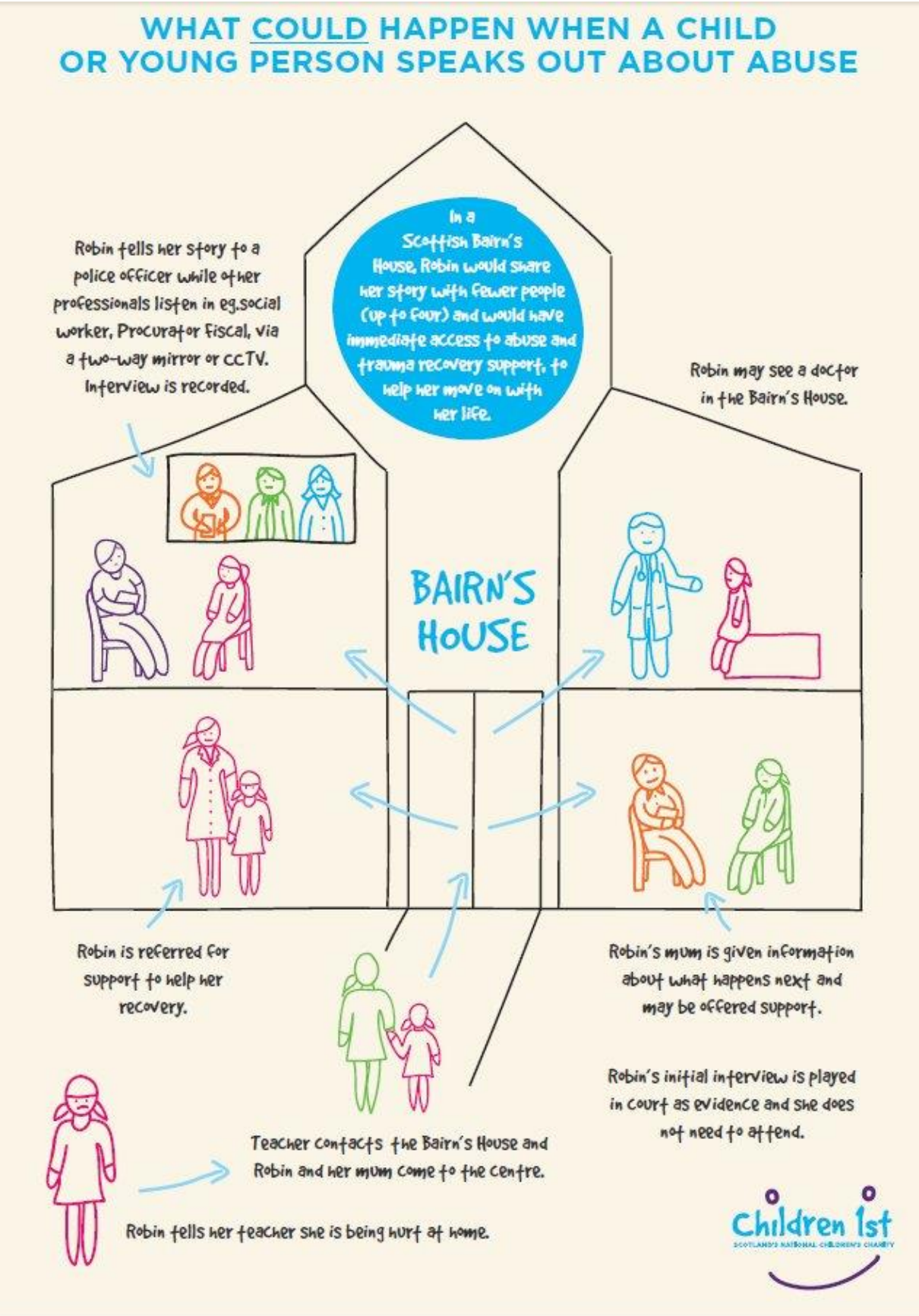
The model recognises that the needs of children in cases where they have been subjected to abuse or violence, are totally different from the needs of adults under the same circumstances. It puts the rights of the child, their wellbeing and participation at the forefront of service design.

Aims of Barnahus Standards in Scotland

Having to tell their story to multiple people on multiple occasions when they give evidence, can be detrimental to their wellbeing and prevent recovery by repeatedly making them relive their traumatic experiences. Furthermore, having to repeat their stories may reduce the quality of the evidence they give, reducing their effectiveness as a witness and putting them through an unnecessary ordeal.

By introducing Barnahus standards, the intention is to lay the foundations for developing a Barnahus model in Scotland, aiming to establish standards which improve recovery, reduce trauma, and shape services around the needs and rights of children and young people.

Children 1st created a briefing about the Barnahus model and standards which can be accessed here. The picture below is taken from that Children 1st report (pg. 10) and shows how the Scottish 'Bairn's House' could work using the Barnahus model.


WHAT COULD HAPPEN WHEN A CHILD OR YOUNG PERSON SPEAKS OUT ABOUT ABUSE
In a Scottish Bairn's House, Robin would share her story with fewer people (up to four) and would have immediate access to abuse and trauma recovery support, to help her move on with her life.
Robin tells her story to a police officer while other professionals listen in eg.social worker, Procurator Fiscal, via a two-way mirror or CCTV. Interview is recorded.
Robin may see a doctor in the Bairn's House.
BAIRN'S HOUSE
Robin is referred for support to help her recovery.
Robin's mum is given information about what happens next and may be offered support.
Robin's initial interview is played in court as evidence and she does not need to attend.
Teacher contacts the Bairn's House and Robin and her mum come to the centre.
Robin tells her teacher she is being hurt at home.
Children 1st
SCOTLAND'S NATIONAL CHILDREN'S CHARITY

2. Model for improvement

Care Inspectors can take regulatory action where care is failing, but in Scotland this is viewed as a last resort, with the preferred approach being to support improvement where possible.

The Model for Improvement is a structured methodology for improvement support which is being used by The Care Inspectorate across Scotland. It is underpinned by what the Institute for Healthcare Improvement (IHI) calls the 'science of improvement', which is an approach to quality assurance that goes further than traditional methods which are about setting targets, identifying areas for improvements and requirements, using a more systematic approach instead, bringing diverse groups of people together to identify, plan and make the changes collaboratively. A key principle of this approach is that in order to improve, something must fundamentally change but that not all change is for the better, therefore careful consideration and exploration of how and if change will result in improvement is required. Changes may come from testing new and innovative approaches, but they may be informed by existing good practice.

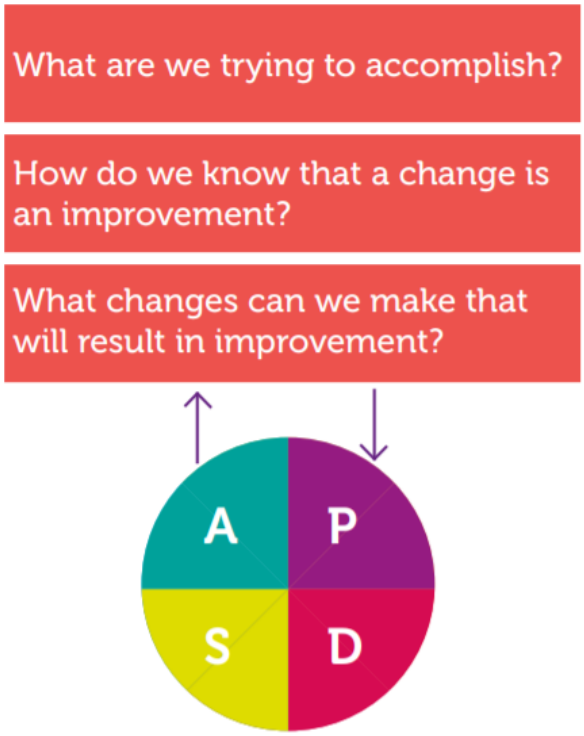
Key principles of improvement science are:

- understand and recognise where and why improvement is required – self-evaluation
- prioritise and plan improvements
- develop or identify a change idea to test, which may result in an improvement
- have a system in place that will evidence improvement has taken place.

The Model for Improvement is summarised in the diagram below. It guides the user through three fundamental improvement questions, which help

to define the improvement aim, intended outcome and change idea and a system for planning and running small tests of change – Plan, Do, Study, Act (PDSA). The IHI has found that the process is effective and efficient in supporting sustainable change and providing learning that organisations and individuals can use to further improve their interventions.

More information about the Model for Improvement, developed by the IHI, along with resources and tools can be accessed here.



The Care Inspectorate has an Improvement Support Team (IST), who are all qualified improvement advisers. Their role has two main elements:

- Supporting inspection staff through advice, learning and development, and mentoring to build confidence in using improvement science tools.
- Providing improvement support to care providers and local partnerships in collaboration with local networks and other organisations.

The Inspectorate also has a dedicated website, designed to give advice and support to care professionals called 'The Hub' which can be accessed here.

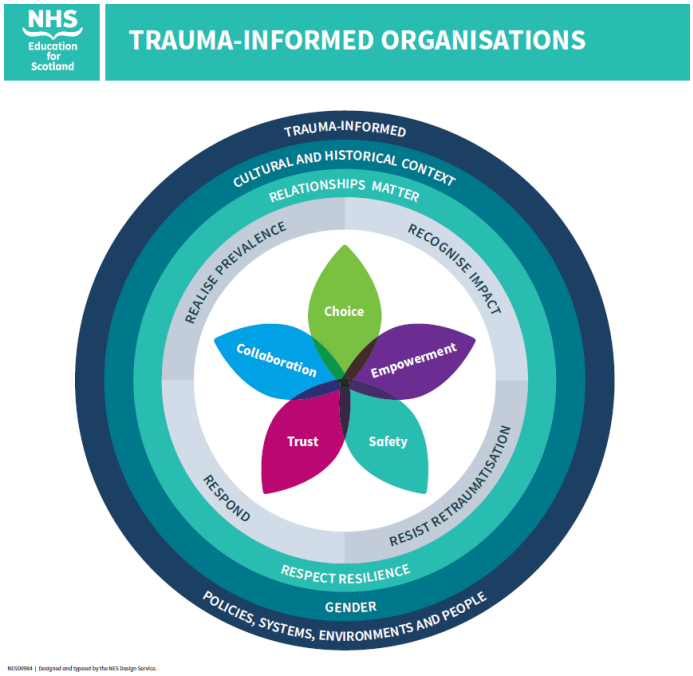
The Care Inspectorate's most recent improvement strategy gives more detailed information about their approach to improvement and can be found here.

3. National Trauma Training Programme

The detrimental impacts of trauma, and the need for a workforce that understands and is properly equipped to deal with them have been highlighted throughout the Care Review.

The Scottish Government have invested £1.35 million in the National Trauma Training Programme, which is intended to enable workers to recognise and respond to psychological trauma, with plans to expand the programme over the coming two years.

SNHS Education for Scotland was commissioned to deliver the National Trauma Training Project, intended to support the strategic planning and delivery of training for those who have contact with survivors of trauma across all parts of the Scottish Workforce, as part of the Scottish Government Survivor Scotland Strategic Outcomes and Priorities 2015-2017. The resulting document 'Transforming Psychological Trauma: A Skills and Knowledge Framework for The Scottish Workforce' was published in May 2017 and can be found here.



Since then, the project has produced a range of materials, accessible online, to support all parts of the Scottish workforce in developing and delivering training that is tailored to the specific needs of their organisation. All of these, including a list of key contacts for the lead training team, as well as area

coordinators, e-learning module, event listings, a video series, animations, infographics, background and definitions can be found on the website here.

One of the animations developed as a resource for training is called 'Sowing Seeds': Trauma Informed Practice for Anyone Working with Children and Young People' and is particularly aimed at workers who support children and young people. That animation can be found here.

4. Proportionate universalism

Proportionate universalism is an approach to tackling health inequality by aiming to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest.

NHS Scotland have advocated for the use of proportionate universalism, recognising the social determinants of health rather than focusing solely on improving the health of individuals. The Health Inequalities Action Framework was published in 2013 and sets out guidelines for assessing plans against theoretical concepts that explain the link between social factors and inequalities in health outcomes, and encourages consideration of the range of actions that might be taken.

'The framework aimed to establish a generic approach for partnerships to address health inequalities, which used a common theory base and indicators of progress, but could be adapted to the diversity of need in different neighbourhoods and to different planning levels from local practice to national policy.'(p.1, Health Inequalities Action Framework 2013).

The document is intended to guide action planning, by leading planners through a process of considering a specific set principles and asking how it relates to their own work programme or topic by asking a series of questions. A briefing which explains the principles of Proportionate Universalism as a way of addressing health inequalities in more detail, is available here: Macdonald W, Beeston C, McCullough S. *Proportionate Universalism and Health Inequalities*. Edinburgh: NHS Health Scotland; 2014.

5. Values Based Recruitment

Values Based Recruitment has been adopted by NHS Scotland as Part of Project Lift, to appoint senior level staff. It is based on the premise that the values those in leadership positions should be upheld as being of equal importance to recruiting a person as their experience and skills.

Project Lift is a collaboration between the Scottish Government, NHS Education for Scotland, the Golden Jubilee Foundation and NHS National Services Scotland, intended to support transformation in health and care in Scotland and the development of leadership capacity. It recognises that the challenges facing the public sector today are unprecedented, and that to meet these challenges, a different type of leadership is required. Values Based Recruitment is one of four key elements which are being implemented to achieve the aims of Project Lift, alongside talent management, leadership development and performance management and appraisal.

The NHS Scotland values that all leadership roles are expected to be committed to are:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork

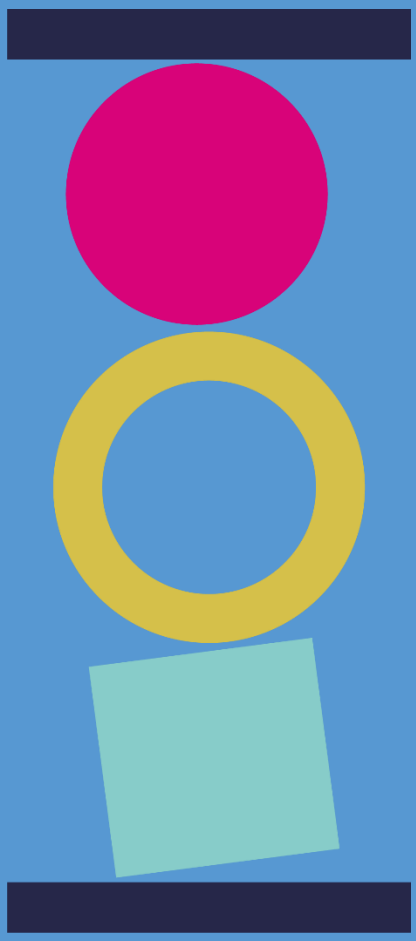
A very brief summary of the process is as follows, however a copy of the full Values Based Recruitment Process, including an overview of the process, paperwork and guidance can be found here.

1. Prior to interview, candidate undergo three Psychometric tests which have been developed for leadership appointments which measuring values and behaviour.
    - NEO-PI-R - a general personality questionnaire
    - HDS - identifies behaviour under pressure
    - MVPI - identifies motives, values and preferences.
2. A 30 minute meeting with the existing Executive Team, designed to assess the candidate's fit with the team as well as insight into managerial competencies, skills and leadership.
3. A profession specific assessment in the form of a focussed interview, used to assess the candidates key capabilities against the person specification, clinical or managerial competencies and training. This is scored against the NHS Scotland Values by an interview panel including external panellists and a chair.
4. A role play exercise based on a true to life scenarios, and designed to assess values under pressure, particularly how they work as part of a team, their respect for other's roles and responsibilities, and, their views of those that they engage with, scored against all of the NHS Scotland values and a number of aligned core competencies.
5. Candidates are asked to give a presentation on a subject specific to the role in order to explore current Board/NHS Scotland priorities, enabling assessment of the extent of the candidates preparation vision, communication skills, innovation and creativity and values.
6. A Values Based Competency Interview which looks at the interviewee as a "whole person", maximising opportunities to understand candidates' strengths and areas for future development in order to enable a fair and robust assessment of the candidate against the essential criteria for the role and NHS Scotland values.

The guidance also advises that a Values Based Recruitment Process requires professional HR leadership to ensure the integrity of the process

and to co-ordinate and organise each stage and advise panel members of what is expected from them.

Stop:Go



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1. Introduction

The Care Review repeated the evidence methodology outlined at the start of this resource many times between 2017 and 2020. Constantly running iterations of processes designed to hear the voices of those who told their story then using their experiences to build the evidence base meant that voice remained at the heart of the Care Review and close attention could be paid to identifying and filling the gaps in evidence that emerged.

The methodology worked. The evidence base built by the Care Review is extensive and comprehensive, building on existing literature and knowledge while constantly redirecting readers back to the experiences of those who have lived and worked in the 'care system'.

Many of the voices shared negative, often traumatic, previous experiences that remained a current issue for the children still living within Scotland's 'care system', and for the adults who were experiencing the life-long impacts of having spent their childhood in care. Others spoke of positive experiences and good practice which could benefit care experienced children and adults if rolled out. It was clear from the outset that the three years it would take the Care Review to conclude was too long for the care community to wait for change; what could be changed within the lifetime of the Care Review, must be.

2. The stop:go work programme

At the end of the Discovery stage, everything the Care Review had heard was collated and analysed. The learning from this formed the evidence base for a programme of work called stop:go which captured 34 areas of practice; a combination of practice having a negative impact and should therefore stop, and good practice which required acceleration.

This evidence base was the main stimulus to focus the change that was possible within the lifetime of the Care Review. In time, these change areas were further developed and aligned with the wider Care Review work programmes to create the stop:go list:

The Promise foundation: Voice When children speak, adults must really listen to them. Adults must make sure that children are included in decisions about their lives.	
Stop	**Go**
Not explaining why decisions were taken Writing lengthy inaccessible reports Having lengthy meetings about me Not explaining to me what meetings are about and who will be there	Optional attendance at review meetings for young people if they cannot cope with the meeting – think of other ways to run meetings

The Promise foundation: Family

If children are living with their family and are safe and feel loved, they should stay there. Their family should be given all the help they need to stay together. If they need extra help when things get difficult, they should get it.

Stop	Go
Taking too long to make decisions	Developing flexible solutions for individual children and groups
Lengthy waits for mental health support	Right support at the right time for as long as it is needed

The Promise foundation: Care

If children cannot stay with the adults in their family, they will stay with their brothers and sisters. The home they live in together will be a place where they feel safe and loved. It should be their home as long as they want and need it to be.

Stop	Go
Care placement moves	Creating ways to work to develop ambition and confidence
School moves	More nurture
Having low expectations and ambitions	More care

Separating brothers and sisters unless there are safeguarding reasons to do so	• More love • Maintaining young people's relationships with their carers when they move for a job or to go to university/ college/ etc. • Giving choices when leaving care • Supporting me into adulthood and beyond • Creating homely warm and welcoming care places • Parallel planning for asylum seeking young people

The Promise foundation: People

Relationships are important. Adults must make sure children are able to stay close to the people they want to and keep contact with them. Adults must also help children make new relationships as they grow up. Sometimes adults also need some help too. The adults who are close to children must get the help they need to make sure they can do their best for children.

Stop	Go
Not explaining what words mean e.g. 'in care'	Keep having positive attachments – maintaining these
Changing social workers	Challenging poor practice
• Tolerating poor practice • Cancelling meetings with me due to crisis and workload issues	More reliable relationships

The Promise foundation: Scaffolding Help and support must be there for children and their families whenever they need it. It must also be there for the adults who are close to children and families. It is important everyone knows where to go for help and that it is ready when it is asked for.	
Stop	**Go**
• Stigma from the public • Short sentences which make it impossible to care for children • Services working in silos • Making me wait forever for a passport, a bank account, to stay overnight with my friends	Help the general public understand why children are in care

Throughout the Journey stage of the Care Review, the stop:go team worked across Scotland to support and increase the pace of change across each of the identified areas. The work programme was further supported by the stop:go Workgroup, who provided oversight and ensured the progress made, and any associated bridges and barriers to change, were understood across the entirety of the Care Review's work, and externally communicated to stakeholders and individuals. The work undertaken to identify the bridges and barriers was collated and analysed to provide a high level thematic list applicable across Scotland (not exhaustive):

Key Elements of Change	Bridges	Barriers
Leadership	Collective vision	Lack of clarity, ambition and pace
	Creativity and imagination	
Culture	Shared values and language	Risk aversion
	Strengths and evidenced based approach	
	Positive relationships	
	Reflective learning	
Legislation	Supported implementation, e.g.	Complex and cluttered

and Policy	GIRFEC	landscape requiring coherence
		Scottish Government Directorates working in silos
Structure	Chief Social Work Officer in position of influence and in relation to Children's Social Work Service	Lack of clear planning, evaluation and attachment of resources
Workforce	Committed, dedicated staff	Recruitment and retention issues
	Learning and development opportunities	Capacity
		Low morale and sense of feeling undervalued
Finance	Lack of funding and short-term budgeting	Commissioning bureaucracy which can seem to lack humanity
Voice	Highly aware and active Corporate Parenting Boards	Tokenistic Corporate Parenting Boards lacking collective responsibility
	Embedded structures and methodologies to listen to voice, e.g. effective Champions Boards	Lack of succession planning
System change	Well-resourced early intervention and family support services	Inconsistency of approach across services, including thresholds
	Multi-agency collaboration and integration	Access deprivation within rural and island communities
	Whole systems partnership approach	Issues of IT systems not communicating, including data sharing confusion

Implementing change successfully with maximum impact was dependent not only on working with organisations to put in place the right conditions, but also working to eradicate the things that would get in the way either initially or in the future, and bolster the things which could speed up the pace of change. Key to this was a primary focus on implementation gaps – all links between good intent and on the ground practice were fully considered and actioned to mitigate against the risk of unintended consequences which could have a detrimental effect.

3. Implementation of Change

Stop:go was Scotland wide but sought to make links and connections between learning and activity to deliver a change programme which was as cohesive as possible and did not replicate the existing 'postcode lottery' so often spoken about by those who shared their stories.

The work centred primarily on those who held some degree of responsibility for service design and/or delivery (including local authorities, Scottish Government, the third sector and national bodies), pulling together groups of organisations and sharing learning between areas which may otherwise have remained unconnected. By doing this, new ideas were generated, challenges were shared and overcome and the very best practice could be promoted across Scotland, utilising activities and initiatives not necessarily located within standard organisational practice.

A mapping process was developed and offered as a tool to stakeholders. The mapping tool was used by organisations and bodies across Scotland to understand changes required within their current context. The identified changes were urgent but implementing them in exactly the same way in every locale was impossible and would quickly lead to various unintended consequences. Instead, each organisation and body was engaged directly and supported to translate the stop:go list into a change programme which was meaningful to their local community and, importantly, achievable within their current operating framework.

This did not mean organisations prioritised their own change in isolation. Engagement was sustained over the duration of the Journey stage of the Care Review and into Destination to ensure all change that was possible was carefully worked through and implemented in a way that would work, having the biggest impact on those who would benefit. The voice of those

with care experience threaded right through this process with each organisation and body supported to consider how they would consult with those with experience of care to identify the improvement priorities they should commit to. Many organisations chose to publicly pledge to change their practice within the lifetime of the Care Review providing an added layer of accountability for the work programme.

There are examples of successful change implementation as a result of the stop:go work programme all over Scotland. All are significant and hugely impactful, ensuring those who needed things to change saw this happen as soon as possible, wherever possible:

- All 32 local authorities pledged to make changes
- In total 224 pledges were made by local authorities
- All 34 priorities on the stop:go list were progressed
- In total 17 tests of change were developed demonstrating appetite for improvement
- The 'bridges and barriers' to change both locally and nationally were identified across all organisations engaged
- The voice of care experienced young people was been brought to every conversation
- Intensive work undertaken with statutory bodies to embed change within existing work programmes
- Commitment via umbrella organisations for example; CCCPS from Third Sector to support and work collaboratively with local authorities to effect changes identified in The Promise
- Extensive engagement across Third Sector to progress change areas
- Six announcements contained within 19/20 Programme for Government

4. Maintaining change momentum

The stop:go work programme achieved transactional commitments in relation to change for the care experienced population of Scotland within the Care Review's lifetime; a key aim of the work undertaken.

Just as important was ensuring the momentum built did not end when the Care Review concluded and the change implementation already achieved became the starting point for wider implementation of all asks of The Promise. A key part of this transition was laying the foundations within local and national government, national bodies and the third sector to significantly enhance understanding of the issues and to challenge the current siloed approach and culture in responding to the needs of the care community.

The ambitious engagement programme raised the profile of the Care Review and increased the opportunities to work in partnership to achieve transformational change in the present and future. The wider influencing and engagement work undertaken better places Scotland's organisations and sectors to respond to the implementation of The Promise and ensures change continues to be cohesive and can be made at pace.

By building a strong commitment to, momentum for and understanding of what it will take to deliver transformational change across local authorities, national bodies and the third sector, the stop:go work programme created the foundations on which wider implementation will be built and set the appreciative tone for collaboration in achieving transformational change. A key part of this was shifts in practice towards innovative ways to shape local and national change while simultaneously strengthening the voice of lived experience as vital evidence in influencing and informing improvement. The resulting culture shifts provide the fertile

ground a successful implementation of The Promise requires to ensure Scotland becomes the best place in the world to grow up.

Part Five: Bibliography and Acknowledgements

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“We grow up loved, safe, and respected so that we realise our full potential.”

Scotland’s Ambition for children and young people

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