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Looking after children: transforming data into management information - report from the first year of data collection

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Looking After Children: Transforming data into management information

Report from First Year of Data Collection

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Part One: Introduction

Introduction

The 'Looking After Children: Using Data as Management Information Study' is designed to help local authorities explore how data gathered in the course of social work interactions with individual children can be aggregated and used at a more strategic level. The stated aim of the study is to discover what information local authorities need to monitor the effectiveness of services for looked after children, identify where improvements can be made and decide how scarce resources can be better deployed. Because the Looking After Children materials have been designed for this specific purpose, a secondary aim is to discover how data gathered through their implementation can be used to address this issue.

As part of this study, two databases of information from samples of children looked after away from home in six local authorities are being established. The first database will eventually comprise information gathered from two snapshot samples of children looked after in the authorities on 1st April 1998 and 30 September 2000. The purpose of the exercise is to explore how local authorities can tailor their services better to meet children's needs. A benchmarking group, composed of senior staff from the participating authorities, has been set up to provide a forum that allows them to compare information and to share ideas on how outcome data can be used within the inter and intra agency planning process.

Data-collection for the first round of this study is now complete and presented in this report, which focuses specifically on the question of how information from a range of variables might be used to assist local authorities in meeting the Government's Objectives for Children's Social Services established under the Quality Protects initiative (Department of Health, 1999a).

The three objectives for children's services which relate specifically to children looked after away from home are :

Objective One: to ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood

Objective Four: to ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care

and

Objective Five: to ensure that young people leaving care, as they enter adulthood, are not isolated and participate socially and economically as citizens.

These objectives are largely concerned with children's progress or developmental outcomes; the related performance indicators on which local authorities are required to provide data (Department of Health, 1999a), will demonstrate *whether* and *to what extent* the objectives are being met. They will not, however, help managers understand *why* they are succeeding (or failing) to meet targets or indicate *what* they can do to improve performance. In order to answer these latter questions, managers need access to a range of contextual information concerning children's vulnerability or unmet need, the extent to which the service meets those needs, and the risk factors that impede satisfactory service delivery. This report therefore seeks to identify variables within these three contextual areas, which produce information that shows a significant relationship to the data on outcome.

For children looked after away from home, a key performance indicator for Objective One is the stability of placements. Children who move rapidly from one placement to another have little opportunity to develop strong attachments, or indeed any sense of security. Unless a reasonable degree of stability can be achieved, it will be difficult to meet the other objectives. Carers who are unfamiliar with a child will find it harder to provide adequate health care: it takes time for health records to catch up, and new carers may not be aware of outpatient appointments or courses of treatment. Children who move frequently are more likely to have a disrupted education and to fail to reach their academic potential. Movement also makes it difficult to sustain friendships; moreover, it is harder to develop skills or the confidence that comes from being an accepted member of a group when one is constantly having to renegotiate entry to a football team, for instance, or membership of a club. Because stability is so central to children's development, this report gives particular attention to the reasons for frequent changes of placement and their relationship to the other objectives for children's services.

The second database will be composed of information gathered from a three-year follow-up of those children included in the first snapshot sample. This study is designed to explore the care careers and psycho-social development of children who enter long-term care in relation to their individual needs and circumstances. The study will be used both to examine further the relationship between needs, services and outcome and to test out a number of theoretical concepts. Amongst these will be the various taxonomies of need currently under discussion: the study will explore

relationships between categories of need or developmental attribute, circumstance and outcome. Longitudinal data gathered from records taken at children's entry to care or accommodation (Time 1) and 12-24 months later (on 1st April 1998; Time 2) have now been collected; although they will be used to inform certain issues in this report, they will be given greater emphasis in subsequent papers, after the third round of collection begins to provide data concerning children's progress within the system.

Construction of sample

Criteria for entry to the sample were chosen to ensure that children identified in each authority were selected on identical grounds, to maximise the chances of the requisite data being available, and to reduce to a minimum disparities in the length of time the group had been looked after. All children looked after within the six participating authorities were included in the study if: they had entered their current care episode on or after 1 April 1996; they had been looked after for twelve months or more; and they were still looked after on 1 April 1998. Although in subsequent years they will diverge, in this first year, at 1.4.98, the snapshot and the longitudinal samples are identical.

A total of 249 cases were included in the sample. The breakdown by local authorities is given below:

Authority A	13
Authority B	25
Authority C	38
Authority D	25
Authority E	87
Authority F	61
Total sample	249

The authorities include inner and outer London boroughs, shire counties, a metropolitan district and a new unitary; they are also spread across the country. The sample is likely to be representative of the national population of children looked after away from home. However, a representative sample of this nature will inevitably produce more children in some local authorities than others. Although well over 10% of looked after children in Authority A were selected for the sample, the numbers are so small that they cannot be relied upon to provide a valid picture of the situation in that authority; they are, nevertheless, an important component of the sample as a whole. In the following analysis, as far as possible, care has been taken to ensure that

any comparisons between authorities take account of the disparity in numbers of children in each sub-sample.

While it is evident that there were differences in levels of deprivation and standards of care experienced by children from each of the authorities studied, it should, nevertheless, be noted that much of the variation in the findings is related to other, extraneous factors. Differences in threshold mean that some authorities are more ready than others to place children in care or accommodation (see Packman & Hall, 1998). Differences in available services mean that some authorities are more likely to place certain groups of children, such as those with severe disabilities, away from home. Differences in interpretation are also likely to account for some of the variance, for instance in the prevalence of learning disability or experience of abuse. Finally, authorities differed in the extent of data that they had available: variations in the accuracy with which placement histories were recorded or the availability of files of children subsequently placed for adoption may well have affected some of the findings.

Factors such as those identified above have inevitably influenced the composition of the sample; they will need to be taken into account in determining how far authorities genuinely differ in the extent to which they are able to match services to needs for this population.

Availability of data

An earlier report to the Research Advisory Group (Ward, Skuse & Pinnock, 1998) has drawn attention to the difficulties in gathering comprehensive and accurate information both from local authority computer systems and from files. Although the researchers searched exhaustively through files for answers to key questions such as date of birth, gender and number of placements, much of the other data were only available if the Looking After Children forms had been completed. As Table 1 shows, there are weaknesses in implementation, and these have affected the extent and quality of the data available.

Table 1: Percentage of forms filled in by each authority

Authority	EIR1	EIR2	AAR	RF	CP	PP1	PP2
A	85	92	23	100	77	69	69
B	92	92	68	96	84	72	48
C	95	66	29	76	40	58	42
D	68	64	28	36	60	40	40
E	83	78	53	90	76	53	41
F	90	72	33	77	74	71	57
Key:							

EIR1: Essential Information Record, Part One	CP: Care Plan
EIR2: Essential Information Record, Part Two	PP1: Placement Plan, Part One
AAR: Assessment and Action Record	PP2: Placement Plan, Part Two
RF: Review Form	

The vast majority of data gathered by the research team comes from questions on the Essential Information Records (EIR1 and EIR2) and the Assessment and Action Record (AAR). While completion of EIRs is relatively high, poor implementation of Assessment and Action Records accounts for a considerable amount of missing data on some questions. Further analysis has, however, shown that there are no significant differences in age, placement history or gender between those children for whom an AAR has been completed and those for whom one has not.

It should be noted, however, that missing data do cause some difficulties in the analysis. Efforts have been made to maximize the number of cases in each calculation and a result of this is that the number of children included varies across the analyses. Wherever it was reasonable to do so valid percentages (which exclude cases where data are missing) have been used.

Part Two: Background information

Age at entry to care or accommodation

It should be remembered that by the time they were eligible for entry to the sample, all the children had been looked after for between twelve and 24 months. While the mean age at entry to care or accommodation was 7.00 (sd 5.26) the most common ages were under one (38 children:15.3% of the total sample), 15 (20: 8%) and 14 (19: 7.6%); only three young people (1.2%) had been aged 16 at entry to care/accommodation. The predominance of very young children in the sample is likely to reflect the slow pace both of decisions to adopt and the process itself: while at entry adoption was the plan for 16% of under ones, by 1.4.98 this was the objective for 53% of this group. The relatively high number of young people aged fourteen and fifteen at entry is likely to reflect the extensive needs of adolescents; the much lower proportion of sixteen-year olds will either reflect the transience of adolescent difficulties or, more probably, the difficulties of providing and sustaining an appropriate service as young people approach adulthood. The longitudinal data will shed further light on the amount of independence given to young people looked after when they reach sixteen and the consequences for their long-term well-being.

Table 2 shows the ages of sample children broken down into the groupings used in the Assessment and Action Records. It will be remembered that these age-groups have been chosen to represent different stages in children's psycho-social development and are therefore not of even chronological span. The extent to which policy rather than need has influenced the composition of this sample may be reflected in the considerable differences between authorities in the age-groups of children looked after for a year or more. Authority E had the highest percentage of children aged under one at admission to care/accommodation who were still looked after a year later, although this difference did not reach statistical significance¹. This authority also had a substantially lower percentage (less than 20%) of young people admitted over the age of ten than did others.

Table 2: Age at entry into current episode of care/accommodation

Age groups	A	B	C	D	E	F	Total Sample
Under1	7.7%	8%	7.9%	16%	24.1%	11.5%	15.3%
1 yr	7.7%	12%	21.1%	16%	13.8%	8.2%	13.2%
3-4 yrs	7.7%	12%	10.5%	8%	11.5%	8.2%	10.0%
5-9 yrs	23.1%	24%	26.3%	24%	31.0%	23.0%	26.4%
10-14 yrs	30.8%	32%	26.3%	24%	18.4%	32.8%	25.6%
15 yrs+	23.1%	12%	7.9%	12%	1.5%	16.4%	9.2%
N	13	25	38	25	87	61	249

¹ This could be a skewed finding in that in this authority the researchers had greater access to files of children placed with prospective adoptive parents than elsewhere.

Gender

Fifty-six per cent (n=139) of the children in the total sample were male and 44% (n=110) were female. The relationship between gender and other variables will be considered later in this report.

Ethnicity

The Looking After Children materials gather information concerning the ethnicity of both birth parents. Table 3 uses this information to calculate the ethnicity of the children in the sample.

Table 3: Ethnicity of sample children

Ethnicity	Frequency	Percentage
White British	168	67.5%
Black Caribbean	3	1.2%
Black African	4	1.6%
Asian	4	1.6%
Irish	3	1.2%
Mixed parentage	45	18.1%
Other	1	.4%
Blank/Inadequate information	21	8.4%
Total	249	100%

It is worth noting that there were a number of problems with the classification of ethnicity. Twenty-two of the 168 'White British' cases had been recorded as 'White', 'White European', 'British' or 'Caucasian'. For the purposes of this analysis the decision was made to classify this group as 'White British', although it is possible that a number of other interpretations could be made from such descriptions.

As can be seen, 67.5% of sample children were White British, and 18% were of mixed parentage. The mixed parentage classification was composed of a wide range of racial combinations, including White British and any other ethnicity (32); non-white plus non-white (3); Irish and White British (1); and Irish and any other ethnicity (9). The very small numbers of children from Black African, Asian or African-Caribbean families will make it difficult to ascertain the consequences of transracial placements, though this is an issue that we will monitor for mixed parentage children when the longitudinal data become available.

As Table 4 shows, there were considerable differences between the ethnic profile of looked after children from different local authorities. As one might expect, shire counties had fewer children from minority ethnic groups than inner London or Metropolitan boroughs. The high proportion of children of mixed parentage found in the looked after population of many authorities reflects findings from other studies (Rowe, Hundleby & Garnett, 1989). The over-representation of these children in the care system could reflect discriminatory policies or a paucity of family support services for mixed race families; however, it is more likely to reflect the particular vulnerability of children living in families whose supportive networks may be weakened by an ambiguous cultural or ethnic identity.

Table 4: Child's ethnicity - percentage by local authority.

Ethnicity	A	B	C	D	E	F	Total Sample
White British	61.5%	32%	60.5%	76%	59.8%	95.1%	67.5%
Black Caribbean		8%			1.1%		1.2%
Black African		16%					1.6%
Asian	7.7%	4%			2.2%		1.6%
Irish			7.9%				1.2%
Mixed Parentage	15.4%	32%	10.5%	4%	31.0%	4.9%	18.1%
Other		4%					.4%
Missing	15.4%	4%	21.1%	20%	5.7%		8.4%
Totals							100%

Type of placement

Most children, at both admission and as of 1st April 1998, were placed with a local authority foster carer (see Table 5). The percentage of children placed with parents or with relatives increased between admission and April 1998.

Table 5: Type of placement

Type of placement	At admission	As of 1st April 1998
Placement with parents	5.2%	10.0%
Foster care with relatives	4.4%	9.2%
Foster care with others	68.7%	53.8%
Residential unit	12.4%	18.5%
Independent living		.4%
Other	5.6%	5.2%
Missing	3.7%	2.9%
Total	100%	100%

There was a significant difference between the authorities in the types of placement offered. At entry, Authority C and Authority E placed a smaller proportion of children in residential care (0% and 2.4% respectively).than Authority A (30%), Authority B (46%) Authority D (46%) and Authority F (21%). The same pattern emerged for placements current as of 1st April 1998. Few authorities are able to offer much in the way of placement choice, and the variance is more likely to reflect the availability of specific types of provision than a careful matching of service to need; in some authorities virtually all the residential provision has been discontinued, thus making foster care placements the only viable option for most children.

Stability of placements

Objective One: 'to ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood' is linked to the National Priorities Guidance target: to 'reduce to no more than 16% in all authorities, by 2001, the number of children looked after who have three or more placements in one year'. As already noted, stability of placement is fundamental to the achievement of successful welfare outcomes. Moreover, instability is one of the major features that distinguishes the experiences of children looked after from those of their peers in the community: an earlier study by the Looking After Children research team found that children living within their own families had experienced an average of one move during their lifetime, while those looked after had experienced an average of three moves during the period in which they had been looked after (Moyers & Mason, 1995).

Table 6 indicates the frequency of placement change for children within their first year of the care episode. (Children who were living at home but receiving regular respite care from foster carers were coded as having only one placement. Information about whether children always went to the same respite carers was largely unavailable.) While 44% of children remained in the same placement throughout the year, at least 26% had two placements, and 28% had three or more. Although there is considerable evidence of instability, the percentage of children remaining in one placement was substantially higher than in the similar sample studies in *Lost in Care* for which data were gathered in 1984 (Millham, Bullock, Hosie & Haak, 1986). The *Lost in Care* study found that only 23% of the sample children were in the same placement twelve months after first being looked after, suggesting that, although movement is still distressingly frequent, stability may have considerably increased over the last fourteen years.

Table 6: Number of placements in first 12 months of episode

Number of placements	Frequency	Percentage
1	110	44.2%
2	65	26.2%
3	30	12.0%
4	25	10.0%
5	8	3.2%
6 or more	7	2.8%
Missing	4	1.6%
	249	100

Of the six authorities, significantly more children in Authority F had experienced three or more placements in their first year (46%, n=26) (chi sq=20.83, df=5 p=.001). This authority was, however, the one in which records were most carefully kept, and at least some of the difference could be due to a more accurate recording of placement history.

The National Priorities Guidance target relates to placements of all children looked after by the authority over a twelve month period. This will therefore include children who have been looked after in stable placements for several years as well as those who are at the start of a care episode. On this basis, many of the participating authorities have been able to meet the target. However, the findings suggest that movement during the first twelve months of an episode may be substantially higher than at a later date. For instance, Authority F, which had such a high proportion of multiple placements during children's first year of a care episode, nevertheless was only 5% off the target with 21% of its total care population experiencing three or more placements in the previous year, and Authority B where 36% of children moved 3 or more times met the target for its total population.

If local authorities are genuinely to meet the Government Objectives for Children's Services, they will need to take particular note of the extent of movement experienced by children and young people in the first year of being looked after away from home. Reducing the frequency of movement during this period is likely to have benefits for all children, and this is an issue that will be examined in greater detail when further longitudinal data become available. The finding that a high proportion of very young children now remain looked after for lengthy periods suggest that there may be a population of young children who are denied the opportunity of forming stable attachments with carers at this critical stage of their development. It is worth noting

that, when the sample is broken down into age-categories according to the Assessment and Action Record groupings, children who were one year or under at admission showed the second highest mean number of placements (2.26, sd=1.1, range=1-5, n=38). Many of these children had experienced changes of primary carer before they became looked after, with the result that there was a small but important group who had reached the age of two without having ever spent more than six months with one carer.

The purpose of setting objectives is to improve the quality and effectiveness of services for children in need. However, if performance indicators are to be used to monitor and improve services rather than as ends in themselves, then agencies will need to develop a clear understanding of those factors which are associated with successful (and unsuccessful) outcomes. In analysing the data we have therefore attempted to identify a number of variables which correlate with stability and instability of placement. These may provide additional, contextual information that agencies may wish to monitor on a routine basis in order to develop strategies for improving outcomes.

Part Three: Factors associated with frequent placement changes: vulnerability

Firstly, it seems clear that successful outcomes will bear some relationship to children's previous experience and the extent of their vulnerability at the start of a care episode. We therefore considered whether some children displayed certain characteristics that contributed to the instability of placements.

Antecedents

At entry to care or accommodation, children were categorised according to several different taxonomies currently being developed. (A later paper will consider this issue in depth). The MORI taxonomy (Sinclair & Carr Hill, 1996) classifies children according to causation of need, using a precise series of definitions. Table 7 uses this methodology in relation to the current sample:

Table 7: Causation of Need using MORI taxonomy

Causal factor	Frequency	%
Intrinsic physical condition	22	9
Deprivation	0	0
Parental illness	36	14
Abuse/ Neglect	123	49
Family under stress	13	5
Offending	3	1
Rejection, estrangement from or collapse of own family	40	16
Other behavioural problem in child	6	2
Other	4	2
Don't know	2	1
Total	249	100

These factors were influential in the decision to place children away from home. As can be seen, for nearly half of the children the major precipitating factor had been experience of abuse or neglect. However, for 16% of the children, a key factor had been their rejection or estrangement from their own family; for 14% it had been parental illness, disability or addiction, and for 9% their own physical or mental ill-health or learning disability.

Although these data indicate considerable areas of vulnerability within the sample group, only some categories were associated with frequent placement change. Children who were rejected or estranged from their families or who had exhibited offending or other behavioural problems, experienced significantly² more placements than those

² There was some concern about heterogeneity of variance within the MORI groups, which will increase the risk of Type 1 errors. However, ANOVA was considered to be a sufficiently robust statistical test to accommodate this. Moreover, the results were highly significant, which suggests that

admitted because of intrinsic ill-health, neglect or abuse or who had ill, disabled or addicted parents.

Although parental ill-health or addiction was a precipitating factor in the decision to admit 14% of children; the prevalence of drug or alcohol problems among birth parents was considerably higher overall. The extent to which difficulties such as these inhibit parental capacity to meet children's needs is increasingly well-recognised (see Cleaver, Unell & Aldgate, 1999; Department of Health, 1999b). At least 22.6% of birth mothers and 11.4% of birth fathers were known to have drug or alcohol problems (the lower incidence among birth fathers is more likely to be due to lack of information than to a genuine gender difference). There was a significant difference between the authorities in the proportions of birth mothers who had substance dependency problems ($\chi^2=15.497$, $df=5$, $p=.008$); 40.3% of birth mothers in Authority E had drug or alcohol problems compared with 25% in Authority A, 17.6% in Authority B, 16.1% in Authority C, none in Authority D and 25.5% in Authority F. Although some of this variation may relate to demographic factors - the authority with the highest incidence was a metropolitan borough with extensive evidence of deprivation - much of the disparity between authorities will be occasioned more by differential thresholds in admission to care or accommodation and/or differences in provision of adult services.

Possibly as a result of local policy, children of substance abusing parents experienced their first episode of care or accommodation at an earlier age than the rest of the sample. It may be that the early separation of these children protects them from the effects of their parent's difficulties: substance misuse amongst birth parents was not associated with children's behavioural problems, and these children were significantly less likely to have a conduct disorder than others. An alternative explanation may be that many of these children were still very young at Time 2, and the behaviour of younger children is less likely to be perceived as conduct disordered.

Unmet need

There is evidence of widespread unmet need amongst the group of children looked after away from home, much of it related to the factors which had precipitated them into the care system. As Table 8 shows, nearly one in five children had unmet needs in each of the seven dimensions of development at admission, with just over

the findings are indeed real. The available compensatory measures were not considered appropriate for use with this sample.

one in two having health and/or behavioural needs and with nearly three out of four having difficulties in their family and social relationships.

Table 8: Evidence of vulnerability

	Frequency	% (groups not discrete)
Health	134	54
Education	102	41
Identity	57	23
Family and Social Relationships	183	74
Social Presentation	60	24
Emotional and Behavioural Development	126	51
Self Care Skills	47	19

Health conditions and disabilities

The data provide more specific indications of children's vulnerability in some of these dimensions. For instance, the sample children showed a number of ongoing health conditions, although these were not necessarily a precipitating factor in the admission.

Table 9: Ongoing health conditions for total sample

Health condition	Valid percentage (groups not discrete)
Asthma	17.8%
Coeliac disease	.5%
Epilepsy	8.5%
Hayfever	1.9%
Thalassaemia	.5%
Hearing impairment	8.9%
Learning disability	18.3%
Cerebral palsy	4.2%
Cystic fibrosis	.5%
Eczema	9.3%
Glue ear	2.8%
Visual impairment	9.3%
Physical disability or mobility problems	8.0%
Other chronic condition requiring outpatient appts	19.5%

The incidence of asthma is similar to that found in the general population . However, as Table 9 shows, there was also a high incidence of learning disability, epilepsy and hearing and visual impairment within the sample. Up to a point this will reflect policies to provide accommodation for children with disabilities, or possibly the lack of other resources available within the community to support their families rather than demographic factors.

The high percentage of children with 'other chronic conditions requiring outpatient appointments' reflected an extensive range of different health conditions that did not fit preconceived categories. Moreover, many children had more than one condition (27% of children had two conditions and 14% three or more). We know that many of those looked after away from home will have experienced poverty, and that poverty and morbidity are closely related. It is anticipated that the longitudinal data will show a relationship between ongoing health conditions and developmental outcome. At this stage it is sufficient to note that children with chronic health conditions may be more likely to perform less well at school than healthy children; they may also need specialist support from carers and other professionals

There is, however, some evidence to suggest that local authority policies or lack of clarity concerning definitions may have skewed the distribution of some conditions. There were, for example, a particularly high proportion of sample children with learning disabilities in two authorities, as Table 10 shows. This could be due to demography, local policies or, more probably, differences in the way such a condition is defined.

Table 10: Incidence of learning disability by local authority

Local Authority	Percentage of children with learning disabilities
Authority A	50%
Authority B	23.8%
Authority C	17.2%
Authority D	77.8%
Authority E	6.3%
Authority F	12.7%

Further work is currently being undertaken to establish the extent of variation in social workers' use of the term 'learning disability'. It is particularly important to identify an agreed definition in this area, as the prevalence of learning disability within their care population will affect the ability of local authorities to meet National Priorities Guidance targets concerning educational outcomes for children looked after away from home.

Emotional and behavioural difficulties

Social work records indicate that a high number of children in the sample displayed some kind of behavioural problem; by 1 April 1998 social workers indicated that 95

children had displayed a behaviour pattern 'that had been of concern to current or previous carers'. In addition to social workers' reports, the research team also made an assessment of children's mental health following their reading of the case file. Table 11 illustrates the types of difficult behaviour noted by the research team at Time 2 (12-24 months post admission). According to this analysis, 119 children (50.4% of those for whom data were available) were showing some kind of behavioural disturbance. Many displayed more than one problem behaviour. As can be seen, almost a third of them displayed conduct problems; these included temper tantrums, aggressiveness, offending, absconding and defiance. In addition, a relatively high proportion of children displayed self-harming or inappropriate sexual behaviour.

Table 11: Type and prevalence of behaviour problems (119 children)

Problem behaviour	Frequency	Percentage noted at 1.4.98 (not discrete)
Conduct disorder (not related to ongoing health condition)	78	33.1%
Conduct disorder (related to health condition)	4	1.7%
Conduct disorder (unclear if related to health)	1	0.4%
Self harming behaviour	19	8.1%
Inappropriate sexual behaviour	19	8.1%
Relationship problems	18	7.6%
Anxiety	14	5.9%
Bedwetting (related to anxiety)	14	5.9%
Bedwetting (related to health)	4	1.6%
Concentration problems	7	3.0%
Other problem	8	3.4%

These data come from the researchers' reading of the case files. In 1996, McCann, James, Wilson & Dunn assessed the prevalence of psychiatric disorders by interviewing young people looked after by Oxfordshire. Although their sample is not entirely comparable with ours, it is interesting to note that each identify a similar level of conduct disorder (28% and 33%); however, other disorders such as depression and anxiety which were prominent in the Oxfordshire study are much less evident in the sample under discussion. The difference is more likely to be due to poor recording or lack of awareness than to genuine differences in behaviour patterns: while conduct disorders are hard to ignore, less obtrusive difficulties may be more easily overlooked.

Much of the data concerning behavioural disorders was identified by researchers searching through case files, there is some evidence to suggest that it was not always

adequately acknowledged by social workers. The Placement Plan handed to carers at admission frequently gave no indication of apparent difficulties, as the following examples demonstrate:

Example 1 Girl, aged 7

No information had been recorded in the Placement Plan at entry. However, the review form prior to Time 2 noted:

"_very extreme and bizarre behaviour. Imagines something touching her and shouts 'Bloody keep off me'. Makes animal noises and body shakes uncontrollably." Will urinate publicly and in inappropriate places (living room, playing field). Obsession with death. Attempts to stab people. Very insecure. Needs constant reassurance.

Example 2 Girl aged 13

The Placement Plans indicated that there were no concerns, despite the fact that this young woman had previously shaved her head and plucked out all her eyebrows and eyelashes. By Time 2 she had been involved in truancy, self harming behaviours and had attempted suicide. Whilst she was no longer self harming by April 1998 she was still seeing a psychiatrist.

In some instances, problem behaviour will have only become apparent during the course of the care episode. Nevertheless, these findings reiterate those of other studies which have also found that social workers often fail to appreciate or acknowledge the difficulties with which carers have to contend (see Ward, 1995).

It was anticipated that the presence of behavioural difficulties would be strongly associated with placement breakdown and hence instability, and that the likelihood of this would be exacerbated if, as we have seen, carers were often ill-prepared. Although this was the case in some areas, it was by no means universal. For example, children with conduct disorders (lying, defiance, absconding, temper tantrums) had a significantly higher number of placements during the first year of their care episode than children who showed no evidence of this difficulty (Fisher's Exact = 0.011). Children who displayed self harming behaviours (cutting, scratching, substance abuse, suicide attempts, severe eating disorders) also had a significantly higher number of placements in the first year than those who did not (Fisher's Exact = .000). However, there was no relationship between inappropriate sexual behaviours (precocious sexual behaviour, prostitution, promiscuity) and the number of placements in the first year of the care episode.

Offending behaviour

Thirty per cent of children (24 out of the 81 over ten year olds for whom information is available) are known to have had had a criminal conviction or caution. Most of the offences were for loss or damage to property, such as shoplifting or other types of

theft. By 1.4.98, 43% of these children had received convictions or cautions, clearly suggesting that some young people (n=11) had begun offending whilst they were in the care of the local authority. Young people who had started offending whilst looked after had significantly more placements in the first year than young people who did not offend ($t=2.45$, $df 54$, $p=.018$), although at this stage we do not know the direction of the relationship - more criminal activity may lead to more placements or more placements may lead to more criminal activity. For young people who had no convictions at admission there was a significant association between their living in a residential unit at some point during the episode and their acquiring a criminal record (Fisher's Exact = .005). This supports the findings of Sinclair & Gibbs (1998), who suggested that criminal activity amongst looked after young people was linked to being placed in residential care.

One final vulnerability factor was the age of the children concerned. There was a significant correlation between age at entry and the number of placements experienced in the first year of the current episode ($r =.145$, $p = 0.023$). Possibly because behavioural difficulties tend to be exacerbated by adolescence, the older children were when admitted, the higher the number of placements. It should, however, be noted that, notwithstanding the above, children aged under one at admission were also particularly liable to instability. Frequent changes of placement for very young children may reflect the administrative processes of adoption and have important implications for policy. An apparent gender difference, suggesting that girls had significantly more placements than boys in the first year, proved to be an artefact, brought about by a greater incidence of reported learning disability in the latter group (see Part 4).

Who is most vulnerable?

Although many of the children in the sample may be regarded as having extensive unmet needs, it appears that certain sub-groups may be at greater risk of placement instability than others. From this analysis children aged one year or under at admission, teenagers and those with conduct disorders or self harming behaviours are more likely to experience a higher number of placements in the first year of care/accommodation. A particularly vulnerable group are those who have experienced rejection or estrangement from their own families. These children were significantly more likely than others to be moved from their first placement at the carers' request (Fisher's Exact = .022). This supports findings from Quinton, Rushton, Dance & Mayes (1998) which demonstrated that prospective adopters had the greatest

difficulties in forming attachments with children placed over the age of five who had previously experienced rejection.

***Part Four: Factors associated with frequent placement
change: quality of service***

How far does the service meet children's needs?

Where data are available, they show that, up to a point, authorities make use of universal services for their children looked after away from home. At Time 2, 69% (n=182) of children and young people had received all their routine immunisations, and 72% of those aged three or over had seen a dentist within the preceding six months (n=79). Almost all children of school age were in school (91%; n=119).

However, it should be noted that these figures are generally below those found for the general population; for instance over 90% of children and young people now receive their immunisations. Moreover, there is little evidence of authorities taking compensatory action to address past deficits: the proportion of children who had received all immunisations only rose by 4% between entry to care or accommodation and 1 April 1998. The percentage of children seeing a dentist in the preceding six months is much the same as that found in the general population (Moyers & Mason, 1995), and yet the likelihood is that many members of this very vulnerable group will have a previous history of poor diet and dental neglect.

Similarly, not only is the figure of 91% receiving education below the percentage for the total population, but this drops still further when one considers the length of time spent at school: only 80% of the looked after sample were receiving full-time education, the remaining 20% were either receiving part-time tuition or had no school place.

When it comes to the provision of specialist services, there are a number of effective actions that local authorities can and do take to mitigate the vulnerability of children looked after away from home. By Time 2, 80% of those children for whom data were available (n=100) had received a statutory medical within the preceding year. By this time also, 81% of children identified as having learning disabilities had statements of special educational need either extant or pending. However, although by this stage a few more learning disabled children had been identified, the percentage of those receiving or awaiting additional educational support had remained the same, suggesting that again, compensatory action is not always being taken.

It is, of course, possible that apparent inactivity in some of these areas is due to a failure to update files rather than to take action, and indeed, the above findings are likely to be an under-estimate of the extent to which services are provided to meet needs. However, this report has to assume that unless actions are recorded they have not taken place, because the files provide the only source of information. In this, the

research activity is likely to mirror practice, for with frequent changes of carer and social worker (see below) the written record has to be regarded as providing the most reliable data.

While adequate compensatory actions to mitigate the effects of past deficits may not always be taken, we did find that children with health conditions or learning disabilities tended to experience greater stability of placement in their first year of being looked after than others. This was contrary to our expectation that placements might be jeopardised by the exceptional demands made on carers by looking after a child with disabilities. There was a significant correlation between the number of placements and the number of ongoing health conditions ($r = -.147$, $p=.032$), with a higher number of conditions being associated with fewer placements in the first year. In addition, children with learning difficulties also experienced fewer placements than others (Fisher's Exact=.001).

The reason for the greater stability of these children is unclear. It may well be that carers are better prepared and trained to meet the needs of disabled children. Alternatively - and less encouragingly - disabled children may be left in unsatisfactory placements because they are less able to articulate their distress.

As we have seen earlier in this report, the case files suggest that 50% of the children in the study were exhibiting some degree of behavioural disturbance. It was evident that, in many instances, action was being taken to address the needs of this group. A sizeable percentage of children (35.6%, $n=89$) for whom information was available had been seen by a mental health professional at some stage in their lives. As one might hope, those with current behavioural problems were significantly more likely to be receiving specialist assistance than those who were now free from such difficulties (Fisher's Exact=0.000). However, as Table 12 illustrates, 62.2% of children who were displaying problem behaviours did not currently have access to mental health support.

Table 12: Access to mental health professionals for children with behavioural problems as noted by the research team (n=119)

Type of professional	Percentage being seen by a MH professional as of 1 st April 1998
Has not seen/not seeing MH professional	62.2%
Psychiatrist	9.8%
Educational psychologist	3.7%
Psychotherapist	1.2%
Clinical psychologist	8.5%
Family therapist	1.2%
Counsellor	2.4%
Waiting for an appointment	2.4%
Other type of MH professional or combination of above	8.5%
	100%

Some children were significantly more likely to receive specialist interventions than others. Children with conduct disorders were more likely to be seen by a mental health worker at Time 2 than children with other problems (Fisher's Exact=.004). Children who demonstrated inappropriate sexual behaviours were also more likely to be receiving mental health interventions than those who were not (Fisher's Exact=0.036). Although the numbers are small it should nevertheless be noted that 57.1% (8) of children with these behaviour patterns were not receiving any kind of support. Similarly, while children who displayed self harming behaviours were more likely to be seeing a mental health worker at Time 2 than those who were not (Fisher's Exact =0.001), 36.4% (4) of them were not receiving any support from mental health services.

*Part Five: Factors associated with frequent placement
change: organisational risks*

Risk factors associated with local authority provision

More effective provision of both universal and specialist services might serve to mitigate some of the disadvantage experienced by this very vulnerable group of children: for instance, better access to mental health services might not only help more children overcome emotional or behavioural disorders, it might also provide additional support to carers and thereby improve the stability of placements. However, there may also be a number of organisational factors within the care system itself which serve to enhance or inhibit satisfactory service delivery.

If children are to receive a satisfactory service they need to have an advocate within the organisation whose role is to ensure that their needs are being met. At 1.4.98, almost all the sample children (97.5%) had an allocated social worker, with responsibility to fulfil this role. However, social workers rarely stay for long in the same post (Ward 1995): 54% of sample children had kept the same social worker for the 12-23 months they had been looked after so far, but 34% had experienced two social workers, and nearly 10% three or more. One sixteen year old boy had already been the responsibility of seven social workers, while six children had never been allocated to anyone. As yet the data show no significant correlation between frequency of social worker change and placement stability, but the relationship between this risk factor and all outcome data will be closely monitored in the longitudinal study.

Not only do children experience a lack of continuity because social workers move on to new jobs, but in some authorities services are organised in such a way that change is built into the system. The creation of specialist teams for children under the age of eight, or for long-term cases or young people leaving care may offer opportunities to develop much needed expertise in certain areas, but it brings with it the disadvantage that children may move through a system in which the pattern of instability is reinforced as no one appears to have long-term responsibility for their future. The suggestion that services might be organised in such a way that social workers continue to carry responsibilities for long-stay children wherever they themselves are in the organisation is worth considering (House of Commons, 1998).

Changes of placement

However, nowhere is the process by which the system reinforces patterns of instability more apparent than in the frequency with which children move from one placement to another. We have already seen (Table 6, p.15) that less than 50% of the sample children

Table 13: Reasons for leaving each placement

	1 move in first year (2 placements)	2 moves in first year (3 placements)	3 moves in first year (4 placements)
Reason for leaving 1st placement			
Placement time limited			10%
Unit closed	1.6%		
Carer retired	1.6%		
Planned transition	70.5%	40.7%	35%
Disruption at child's request	3.3%	3.7%	
Disruption at carer's request	11.5%	29.6%	30%
Child absconded		3.7%	
Other	11.5%	22.2%	25%
Total n	61	27	20

Reason for leaving 2nd placement			
Planned transition		53.6%	50%
Disruption at carer's request		17.9%	11.1%
Death of carer		3.6%	
Child absconded		3.6%	
Other		21.4%	38.9%
Total n		28	18

Reason for leaving 3rd placement			
Unit closed			5%
Planned transition			20%
Disruption at child's request			5%
Disruption at carer's request			30%
Other			40%
Total n			20

remained in the same placement for the first twelve months that they were looked after. Table 13 gives details of the reasons for leaving placements. Just over one in ten (11.5%) of those children who moved once in the first year of the care episode did so at the request of a carer. For children who moved twice, 29.6% of first moves and 17.9% of second moves were of this nature, as were 30% of first moves, 11.1% of second moves and 30% of third moves for children who moved three times.

The above data refers specifically to children who experienced 2, 3 or 4 placements in the first year. Owing to small cell sizes it was not statistically reliable to present percentages for data beyond the third move. However, when all cases are included (except those with missing data) it appears that 16.3% of children (37) experienced a disruption at carer's request within the first year of their care episode.

When we compare all children who have moved at least once, we find that those who had experienced a disruption at a carer's request had passed through significantly more placements within the first year than those who had not ($t=4.617$, $df=46$, $p=.000$). Children who had experienced such a disruption had a mean of 3.7 placements in the first year compared with 2.5 placements for those who had not.

Placements break down for a number of reasons, not by any means all to do with the children concerned. Carers may ask for a child to be moved because they had not anticipated that a placement would last so long, or extraneous circumstances may make it impossible for them to continue. Nevertheless, children's characteristics, and particularly their behaviour patterns, are frequently contributory factors in a placement disruption. The data show that there was no gender difference, with 51% of disruptions occurring to males and 49% to females. Age, however, appeared to be an important factor in determining whether children experienced a disruption at the request of their carer during the first year: 24.3% ($n=9$) of this group were aged between 0-4 years at admission; 21.6% ($n=8$) were aged 5-9 years; and 54% ($n=20$) 10-15 years. Children who experienced disruptions were significantly older (mean age = 9.22, sd 5.34) than those who did not (mean age = 6.32, sd 5.15), $t=3.11$, $df=225$, $p=.002$.

A high proportion of children whose placements disrupted (43%; $n=16$) had been categorised at entry as having been rejected or estranged from their family; a further 32.4% ($n=12$) had been abused or neglected. Children who had been rejected or estranged from their families were significantly more likely to experience a placement disruption in the first year than those who were not (Fisher's Exact=0.000). It is

unclear whether the disruption is a result of the continuation of behaviours which led to these children being rejected in the first place, or whether the experience makes it difficult for them to form relationships with their new carers. Either way, such children are a vulnerable group for whom particular care needs to be taken to reduce the likelihood of their encountering further experiences of rejection and instability.

Factors such as these within children's past history may have contributed to a number of behaviour patterns that may have jeopardised placement stability. Of the 37 children whose placements broke down, 78.4% (n=29) had at least one behaviour problem as identified by the research team at Time 2. The most common difficulties were conduct disorders, displayed by 67.6% (n=25) of children, but in addition, 13.5% (n=5) manifested inappropriate sexual behaviour and 18.9% (n=7) were demonstrating self harming behaviour. 64% (16) of those children whose behaviour patterns may have contributed to a placement disruption were apparently not receiving mental health support.

We have already seen that carers were not always given adequate information about children's behavioural patterns prior to placement; no doubt, in a number of instances this will have contributed to a decision to ask for the child to be moved. In other cases, the absence of specialist support from mental health services might not only have meant that challenging behaviour was not addressed, but might also have left carers feeling inadequately supported and hence contributed to an eventual disruption.

There is, however, some evidence to suggest that when the first placement breaks down extra efforts are made to ensure that subsequent placements are more secure. Certainly there was a trend for those children whose first placement had disrupted at a carer's request to have fewer subsequent moves than those whose disruption occurred later in the first year ($t=1.998$, $df=33$, $p=.054$). Disruptions are likely to have an adverse effect on long-term outcomes for children and young people; their impact will be examined more closely as the longitudinal study progresses.

However, as Table 13 demonstrates, disruptions are by no means the most common reason why children move from one placement to another. Not only is 'planned transition' the most frequent reason given for first moves, from what are often temporary or emergency to more secure, longer term placements, but this is also a common reason given for second and even third moves. If we separate the sample into children who moved once, twice or three times in the first year of being looked after, in the first group, 70.5% of moves were planned transitions; in the second group

(children who moved twice) 40.7% of first moves and 53.6% of second moves were planned transitions. For children who moved three times, 35% of first moves, 50% of second moves and 20% of third moves were planned transitions. As we have already argued, it is difficult for children to achieve satisfactory welfare outcomes if they constantly have to readjust to a changing home environment. These findings reinforce concerns that the care system itself may obstruct the necessary development of attachment in very young children: the 38 children aged one or under at admission to care or accommodation had, between them, experienced 62 moves by 1.4.98 (four of the children had each experienced five placements). Only four moves (6.5%) were due to placement disruptions; 41 (66.1%) were 'planned transitions' and the remaining 17 (27.4%) were due to other reasons. Even when children were moving from third to fourth placements, the majority of transitions were categorised as planned.

There appears to be considerable variance in the use made of planned transitions by different authorities. For example, these accounted for 38.5% of the terminations of first placements in Authority F yet only for 26.1% in Authority B. Although it may be that Authority B made less use of temporary placements than did Authority F, there is also some evidence to suggest that at least some of the variance may be due to a differential usage of terminology. An earlier study undertaken in one authority showed that virtually all placement changes were described as planned transitions, and suggested that the term was used to mask the rate of disruption (Ward, 1998). If a placement disrupts at the carer's request, the move may sometimes be categorised as a planned transition if, for instance, the child is allowed to stay until a new placement can be arranged. In preparation for the revisions to the Looking After Children materials, further work is currently being undertaken to examine more closely social workers' understanding and use of this term.

Whatever the reason for the variance it seems clear that in many authorities children move extensively from one planned but temporary placement to another. The reasons for this would merit further scrutiny: we know that in about 80% of cases, children are already known to social services before they become looked after (Packman, Randall & Jacques, 1986), so why are so many given a temporary placement before a more permanent one can be found? Why are second or third placements part of an apparent process of planned transition? Are all planned transitions necessary, and what is their cost in administrative and practitioner time and resources as well as in child welfare outcomes?

Finally, the pattern of continuous change and instability experienced by children within the system is compounded by their experiences in the community. We know from other studies that many children looked after will have experienced frequent changes of both carer and address within their own families prior to being looked after (see for instance Millham *et al*, 1986). Such changes continue both as they move from one placement to another within the system and also, for many children, as they frequently change status from 'being looked after' to 'returned home to live with parents, relatives, or other person with parental responsibility'. A third of the children in the total sample (33.3%) had already been looked after away from home on at least one occasion prior to the current episode; 12% had had at least three admissions including this one. One child had been admitted twelve times. (The sample did not include children who were midway through a planned series of respite placements as these were regarded as part of a single episode). There is no statistically significant association between the number of previous admissions and the number of placements children receive in the first year of the care episode, but the extent to which all indicators of instability correlate with developmental outcomes will be closely monitored as the longitudinal data become available.

Part Six: Conclusions: implications for policy

Conclusions: implications for policy

The above analysis identifies a number of issues that have implications for future policy development. Because the data come from a representative sample of children looked after away from home, they will have relevance not only to the research authorities, but also to other authorities outside the research group and also to policy makers at national level.

At both national and local level, a key issue raised by this analysis relates to the absence or inaccuracy of data. Although we have no reason to believe that there is any bias in the amount of data gathered for any one group of children, it seems probable that findings which relate to children's progress over time will be skewed if information is not updated. Thus the conclusion that past deficits in health care or education are not always remedied when children are looked after, may well relate more closely to the absence of recording than to lack of activity. However, any attempt to monitor the quality of care or assess outcomes is almost bound to rely on written information: if the data are inaccurate, erroneous conclusions will inevitably be drawn.

At a national level, the analysis raises a number of issues concerning the introduction of the new Government Objectives for Social Services and the performance indicators upon which the programme relies. Firstly, the analysis has demonstrated that the extent of need shown by a sample of children looked after away from home will not only be determined by demographic factors, but also by agency policy concerning the provision of services within the community and the threshold at which children enter the care system. Thus the success or failure of authorities to meet the objectives for children looked after can only really be understood in relation to their ability to meet identical objectives for all children in need.

Secondly, it is salutary to note that the ability to meet objectives does not inevitably reflect satisfactory delivery of services to all users: we found, for instance, that agencies can meet the National Priorities Guidance target concerning stability of care and yet still be in a situation where children - including the very young - move frequently from one placement to another.

At a local level, the analysis identifies a number of areas where action might be taken to reduce the numbers of placements experienced by certain children. Not only would this make it easier to achieve the objective to ensure that children are securely attached to carers, but it would also be likely to contribute to the achievement of the

other objectives concerning education, health and social care and the social and economic participation of care leavers.

It might, for instance, be possible to reduce the rate of placement breakdown by targeting certain groups of children who are especially vulnerable: as one might expect, the placements of teenagers are may end prematurely, but the data also show that children and young people who have been rejected or estranged from their families are particularly at risk of disruption. Breakdowns might also be reduced if carers were more aware of the behavioural difficulties that certain children are likely to present; although it is clear that some children will manifest behaviours that are extremely difficult to address, more use of specialist assistance from mental health services might preserve some placements. There is evidence that some of these issues are already being addressed: carers may be better prepared to meet the needs of children with physical or learning disabilities, and a number of children with behavioural difficulties are receiving support from mental health professionals. However, more support could usefully be provided in this area both to children and adults.

The breakdown of a placement can be traumatic for both carers and child, and may well have long-term consequences for future well-being. While it is obviously beneficial to develop strategies to reduce this risk, the greatest increase in stability might be achieved by addressing the use of temporary placements and planned changes. While it is clear that emergency placements must be available for those children who enter the system unexpectedly, the reasons why many children then move from one short-term placement to another need to be examined and addressed. While frequent, administrative moves are likely to create instability and therefore be detrimental to most children, this issue is of particular concern for the group of very young children who remain looked after for lengthy periods pending a decision to place them for adoption, and who may find that the unpredictability created by numerous changes of carer in their early years has a long-term effect on their ability to form attachments. It seems probable that policies which aim to provide a service for children who will be quickly reunited with their families ignore the needs of those who require long-term placements.

Some of these recommendations will be implemented by senior managers in the authorities involved over the next two years. Subsequent rounds of data collection both from a longitudinal follow-up of the current sample group, and from a further

snapshot study, should demonstrate how far new policies affect the delivery of services and subsequently outcomes in this area.

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