

Looked After Children Can existing services ever succeed? A different view

In a reply to the preceding article, **Ian Sinclair** examines the four main arguments put forward in Michael Little's challenge to current social care provision: the care system is not ethical, it is out of date and arbitrary, and too little is known about it. Furthermore, there is an alternative.

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Introduction

Michael Little has written a challenging article. In his view, care is unjust, arbitrary in its allocation, economically unviable and bad for those who receive it. A small number of children may still need something like care, either because their families offer them for adoption, or because they have no homes or are unsafe in those they have. In the main, however, the system is maintained by inertia, the result of a failure to rethink something devised for an earlier age, rather than a response to need. In short, the care system must be radically rethought and the numbers in care drastically reduced.

Michael's hope, I think, is as much to stimulate debate as it is to set down a position of his own. As in any debate, however, there are at least two sides to this one. So if we are to gain as much as we should from his article we need to look at his argument with some care. There are four main planks to this, which he helpfully sets out.

Argument 1: the care system is not ethical

Michael's first main charge is the nub of his argument. As he sees it, the care system is an experiment without an 'ethics committee', it is likely to do harm and unlikely to do good, it is reserved for the poor who are less able to fight back, some authorities make more use of it than others, and no responsible person would wish it for their child. The part of this argument

that relates to the differential use of care by different authorities is best considered later under the heading of 'haphazard selection'. What of the rest?

Clearly, Michael is right in saying that care has no ethics committee. Instead, there are the courts. They do have to balance the interests of child and family, are required to intervene only when the risks of not doing so outweigh those of making an order, and allow for argument and review of individual cases. At present, children are almost always taken into care for one of four reasons: they have no family; they are abused, neglected or in danger in their family; family relations have broken down so that they cannot live at home; or their families are temporarily or permanently unable to care for them adequately for reasons of mental illness, disability or other extreme disadvantage. These reasons are neither arbitrary nor necessarily unjust. An attack on the care system as 'unethical' must involve an argument against the system of law that underpins it and this Michael has so far not provided.

A key part of Michael's attack stems from his belief that the system does harm. He gives no documented evidence for this but perhaps he does not need to do so. The care system is often attacked for its poor outcomes in terms of education, mental health and stability, and the way in which these disadvantages persist into adult life. Disadvantage does persist but *the attacks are not based on a comparison of like to like*. Young children selected for care have major disadvantages in terms of heredity and early experience. Those who come in at a late age are often 'out of control', in trouble at school and with the law. It is not surprising that their 'outcomes' are, on average, poor. What the critics have to produce is evidence that these outcomes are caused or exacerbated by the care

system rather than simply by what went before it.

In practice, the care system seems, on average, to do better than the current alternatives. Children who are adopted seem to do particularly well. Children who return to their families after spending some time in the care system seem to do worse than apparently similar children who stay on in care. Thus, there is evidence that they are worse behaved, more likely to fail to thrive, more likely to be re-abused and more disturbed (Hensey *et al*, 1983; King and Taitz, 1985; Minty, 1987; Taussig *et al*, 2001; Sinclair *et al*, 2005; Biehal, 2006).

Clearly, the system serves the poor – the rich find other ways of giving their children sanctuary from their homes – but it does not follow that it serves the poor badly. Around half the admissions are short term and thus probably ‘proportionate’ to the risks posed – certainly all local authorities try to return children home if they think this possible and safe (Sinclair *et al*, 2007). Most admissions are voluntary. There is often relief for both parent and child that an intolerable situation has been brought to an end. Children in care almost always wish that things could have been otherwise, often they can point to aspects of their care that could be better, but this does not mean that most of them do not acknowledge that the basic decision was right.

So what of the ‘my child’ argument? Most of us can empathise with that. But then most of us are not struggling with addiction, domestic violence and the ghosts of past abuse. These are severe, intractable and frightening. For some children care is the only way out.

Arguments 2 and 3: the care system is out of date and arbitrary

These two assertions are most easily considered together. At their root is the belief that the care system is irrational, ill-thought out and ill-adapted to modern needs. In more detail, Michael argues that the care system was devised as a safety net, before aspirations to universal provision. It persists, unmodified, as a service to the hapless and persistent, and a temptation to the misuse of state power. It is, in the main, an accident that selects a child for attention by the care system rather than special education, or the health or criminal justice services, and in some authorities many more children are taken into care than they are in others.¹ Intervention should be based on the needs of the child rather than those of the systems that allegedly serve them. For this to happen, a drastic change is required.

As is quite common in Michael’s argument, one feels here that although wise and true things are being said, the conclusion does not follow. In the first place, universal provision is good but this does not mean that specialist or targeted provision is bad. Any decent system of care must try to serve the needs of the many without neglecting the few who have more complex and expensive needs. These twin needs lead to a dilemma over how much money to spend on ‘prevention’ or universal provision and how much to spend on ‘high-end need’. Michael argues that we cannot afford to go on spending on high-end need. Maybe so. But if we restrict spending in this way we are unlikely to reduce costs in the short run. In the long run we may reduce expenditure, but more probably through a failure to meet

¹ This part of the argument is slightly overstated. There are differences between, for example, adolescents who are subject to special education and those in care. The second group are much more likely to have suffered abuse and to be unsafe at home, and these differences are logically related to provision (eg to whether children are able to go home ‘in the holidays’). Similarly, authorities that have high rates of children in care have proportionately more families living on benefits and more lone parents. That said, much of Michael’s point holds. There are big differences which are not explained by need and there are similarities between children who are served by different systems.

need rather than successful prevention.²

On the wider point of 'irrationality', it is clear that the system is complex and has grown haphazardly. So much is also true of the British constitution and its system of law. Like these, the care system may need to change over time. At the same time, its fundamental principles – the stress, for example, on the need to treat the welfare of the child as paramount – are sufficiently abstract to allow for organic change, for example, in the definition of what constitutes a child's best interests. Its purpose and rationale are set not by some godlike sage but by a myriad of particular decisions taken case by case and finally subject to legal oversight. This may lead to an untidy system in which, for example, different authorities have very different policies. It also leads to one where the initial decisions are taken by people close to those who have to live with the consequences and subject to appeal. As in other areas of life, a postcode lottery is the price we pay for local control.

If and when we are clearer about 'what works' in care and able to fund it, there may be a case for greater central control. At the moment, the government has limited resources, limited expertise and limited ability to impose its will. This allows for variety and we need to learn from it. Development, however, should be incremental. Drastic change would almost certainly breach Michael's injunction that 'we do no harm'.

Argument 4: we know too little and there is an alternative

As a researcher, I can only agree with Michael's assertion that we know too little about the care system. In my view, however, we know something. So I would like to spend this last part of my

reply on what positive steps could be made in this position of 'semi-ignorance'. In doing this, I will hope to put some flesh on the bones of the arguments I have made above.

In brief, my argument is that change in the care system should be piecemeal and organic, not that it is not needed at all. It is, for example, true that some residential homes and probably some foster carers are much better than others at promoting education. Michael's challenge is to look at all these issues and then ensure that practice and research move forward together. If we are to do this, where might the priorities be? The following is a personal list, written from the point of view of someone who has been primarily involved in research on the care system.

First, we need to become better at providing genuine permanence for those children who need it. This would involve authorities increasing their use of adoption and kinship care, particularly if they make little use of them. It also means making sure that other long-stay foster care becomes more genuinely permanent in the sense that foster carers can exercise the responsibilities of parents (eg over the notorious 'sleep-overs'), that difficulties in the placement (eg on transfers to secondary school) are handled as they would be if the child was with his or her family (ie with the assumption that the family should be kept together if possible and certainly not separated in a final way) and that the foster children can stay on beyond 18 and leave home at their own pace. Two lessons need to be taken from research: (a) the earlier the decision is taken to place a child in one of these provisions the more likely it is to last; and (b) ideally, decisions (on, say, adoption as against fostering) should reflect the

² An essential part of a more sophisticated approach to the costs of care is a recognition that prevention does not necessarily save money. The costs of the drastic switch Michael proposes would be considerable in the short run, since it would mean continuing with one system while building up another. For the switch to save money in the long run, it is necessary (a) to identify a high proportion of those at risk of going into care, (b) not to provide services to many people who will not go into care, and (c) to ensure that the services are effective in preventing those who receive them from entering care. Current community services have not shown that they can meet any of these tests.

particular situation and preferences of a child and not, as too often happens, the financial and other support that will be available should the carer (say) adopt a foster child, take out a residence order or continue to foster them.

Second, we need to get better at listening to children. Practitioners have looked to research for definite messages on whether, for example, siblings should be placed together, or children are better placed with other children or on their own. On these matters, research can give information on the most common response – most children, for example, want more contact with their families than they get. Where this is the case, there is a *prima facie* ethical case that they should have it. However, not all children want more contact, some want less and many want more with one family member, none or less with another, or some control over the conditions in which contact occurs. So in many ways the message is that there are no rules of thumb. Social workers and carers have to listen to the individual child, if they are to take wise decisions on whether children should move placement, whom they should see, with whom they should be placed and whether or not they should be put up for adoption.

Third, we need to be much more explicit about three aspects of our care system which we prefer at the moment to gloss over. These are:

- *Costs* – it seems to some that it is almost immoral to mention these where children's needs are at stake. Yet money spent on one child is money not spent on another. Similarly, money spent at one point in a child's career is money not spent later on. How often would a parent with £200,000 to spend on their children allocate all of it to two years' residential care for one of them? And if they decided to favour one child over the others, would they spend all of it at this point, rather than provide at least some of it in a trust fund for later?

- *Authority* – there is a reluctance to give social workers the authority they need to

exercise the responsibilities they have. If Michael's vision of a reduced care system is to hold good, social workers must be able to demand that children at risk fulfil the plans that are made for them – for instance, they must receive care at which they are openly and explicitly monitored. An understandable wish for voluntary agreement means that children are at risk unnecessarily and social workers may find that they switch suddenly from the role of benign helper to authoritarian enforcer.

- *The differences between early prevention and late intervention* – clearly, prevention is better than cure, but it is too easily assumed that it is cheaper (this is not necessarily so) and that it operates according to the same principles. Prevention typically offers help that others can use as they choose, when they choose and for the purposes they choose. By contrast, later interventions are most effective when they are targeted at individuals at risk, and seek to achieve ends determined by professionals and in a way that professionals have found most effective. It is by no means obvious that the same organisation or group or individuals can be effectively deployed to do both.

Fourth, and exactly as Michael says, we need to be much clearer about the diversity of needs served by the care system. What children in care need varies with the length of time they have been in the system, their age both at entry and currently, and the reason for entry. To give a trivial example, a 16-year-old from Somalia who is seeking asylum and has just arrived, does not have the same needs as a five-year-old who has already been in care for three years and who is hopefully recovering from the effects of horrendous early abuse. We need to document this variety and work out the kinds of help that these different groups may need.

Fifth, we need to be much clearer that what is often amiss is not the type of service offered but the quality of its practitioners. Some residential homes

are dens of iniquity, places of low morale where only the bully, the racist and the criminal thrive. Others are benign and friendly. Most foster carers are committed, warm, sensitive and kind adults who are willing to go the extra mile for the children they serve. A few are cold, or bad tempered, uncommitted or even abusive. The day-to-day well-being of children depends on the qualities of the carers who look after them, not on the procedures, goals and organisational behaviour of the departments in which they do so. Until we learn to be much clearer about the crucial importance of practice and the difficulties of ensuring that it is uniformly good, we will not do as well by children in care as we might.

Finally, we need to be better at applying the research that we have. There is, for example, evidence that long-stay care is probably better and more cheaply provided in adoption or in kin care than it is in ordinary foster or residential care. Neither is better in all cases, and kinship care in particular is not 'a free lunch' and needs to be used with caution. Yet there are widespread variations between authorities in their use of both adoption and care by family and friends. Some make much more use of one or both of these options than do others. This might be defensible if the authorities that made low use of them were also those who sent most children home. In practice, however, it is still possible to find authorities that send relatively few children home, make much more use than others of long-stay care, but also make very low use of adoption and kinship care. Such a policy is very expensive and seems to have very little to commend it at all.

In conclusion

The fundamental truth in this field is that some children are better off not living with their families. The ways in which this problem is handled will vary over time, between societies and between groups. The rich may make more use of private education or clinics. In societies with strong extended families,

children may be brought up by their relatives. In some European societies it will be easier to use the resources of voluntary agencies or the church. None of this variation, however, can hide the need to deal with this problem in some way.

Given this need, certain key questions arise. Which children are best away from home? Can we reduce the numbers who need to be removed? How do we best deal with them once they are removed? For example, can we make more use of relatives or of adoption, should we consider using boarding schools or combining boarding schools with foster care, which models of residential care should we offer, how far can we blur the line between home and care through respite, and so on? It is in this context that Michael Little's article should be read. He has provided a challenging and useful critique of the care system. It is time to consider different ways of providing care, the different approaches appropriate for different groups and changes in the balance of what is provided.

At the same time, it would be a mistake if Michael's article was taken to imply that the care system requires Draconian change. The care system and the carers who work in it have achievements of which they can be proud. Neither Michael nor anyone else has a convincing blueprint for what we should put in their place. What we need now is a willingness to act on what we already know, incremental research on how care can be improved, and steady change that builds on research, good practice and the insights of all those involved.

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