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Eight-year-olds identified in infancy as at risk of harm: report of a prospective longitudinal study

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Department for Education

Eight-year-olds identified in infancy as at risk of harm: report of a prospective longitudinal study

Research report

July 2016

Rebecca Brown, Harriet Ward, Jenny Blackmore, Caroline Thomas and Georgia Hyde-Dryden: Loughborough University

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GOVERNMENT SOCIAL RESEARCH
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Executive Summary

Introduction

Over the last ten years the Centre for Child and Family Research (CCFR) at Loughborough University has been following the professional decision-making processes that have affected the life pathways of a sample of very young children who were assessed as suffering, or likely to suffer, significant harm before they reached their first birthdays. The overall aim of the study is to inform future professional decision-making about whether abused and neglected children can safely remain living with their birth parent(s) or need permanent out-of-home placements, such as long-term foster care, adoption or special guardianship.

The study began by recruiting from ten local authorities a sample of babies who had been the subjects of a core assessment or a Section 47 enquiry triggered by concerns about abuse or neglect before their first birthdays. Difficulties in gaining access and obtaining parents' informed consent to participate significantly restricted recruitment. However 57 infants were recruited before they were one and 43 of them were traced until they were three years old.[1] Thirty-seven of the original 57 children were then traced up to their fifth birthdays. This second stage of the study focused on the children's experiences of starting school.[2]

Further funding was then made available to follow up the sample when the majority of the children were aged seven and eight. This third stage of the study is the focus of this report and explores the experiences and progress of 36 of the original 57 children. It includes the children's own perspective for the first time. Its objectives were to:

- understand how decisions made in the early years (0-5) continue to affect the lives of abused and neglected children;
- identify the competing considerations of the professionals originally involved with the children when making decisions about assessments and interventions, and explore those which had long-term influence;

[1] See *Safeguarding Babies and Very Young Children from Abuse and Neglect* (Ward, Brown and Westlake, 2012a)
[2] See *Young Children Suffering, or Likely to Suffer, Significant Harm: Experiences on Entering Education* (Ward, Brown and Maskell Graham, 2012b)

- identify the role of primary school teachers and SENCOs in recognising and responding to abuse and neglect; and,
- explore the children's experiences and perceptions of the ways in which they are supported at home and at school.

Methodology

Data have been collected from a number of sources relating to each child in the study. These include:

- Children's social care files (where cases have remained open and/or been reopened).
- Annual in-depth interviews with children's birth parents and/or carers.
- Interviews with professionals including social workers (where cases have remained open and/or been reopened) and teachers (where parental permission has been given).
- Strengths and Difficulties Questionnaire (parent and teacher versions).
- Interviews with the children (from age seven).
- National Pupil Database.

The small numbers involved in the study mean that findings should be approached with caution: more evidence is needed concerning their reliability and generalisability to a wider population. In addition, the composition of the sample has been skewed by underlying sets of circumstances which include:

- The original sample of 57 children was skewed towards those who were *more likely* to suffer significant harm than the eligible population of children who met the selection criteria but whose parents *chose not* to participate.
- Attrition has affected certain groups of children more than others. There were particular difficulties in tracing children after they had been placed for adoption as most adoptive parents were unwilling to participate.

Other factors which have contributed to the limitations of the study include the accessibility of data. Over the course of the study, the number of children in receipt of ongoing services from children's social care has reduced and case files closed. In addition less than half of the parents/carers gave permission for the research team to interview staff from their child's school. We are therefore increasingly more reliant on the views of birth parents and carers. These are undoubtedly biased - the reader should take this into account.

Nevertheless, this study presents a unique opportunity to learn about these vulnerable children and their families, including parents' experiences with mental health problems, domestic abuse and substance misuse; their own experience of abuse as children; their responses to the permanent removal of other children; their expectations of their social worker; and their capacity to change the behaviour which undermines their parenting capability. These types of subjective experiences cannot be generalised to the wider population, but they can provide insights into the inner lives of parents who abuse or neglect their children and improve understanding of ways to help them effectively engage with services. The findings from the study also shed light on the agonising decision-making processes in complex child protection cases, and show their long-term impact on the welfare of the children concerned.

Ethical issues

The study focusses on an exceptionally vulnerable, hard to reach population. Particular care has been taken to ensure that the research processes have received appropriate ethical approval, that informed consent has been given to all interviews and collection of case file data, and that the limits of confidentiality have been understood by all participants. On those few occasions where the research team has become aware that a child is at increased risk of significant harm, a senior local authority manager has been confidentially informed.

Particular care was also taken in the write-up of this report to ensure that the anonymity of the participants was protected. Identifying information has not been included, or has been altered.

The children's experiences and their families' circumstances: birth to age eight years

All the children in the original sample had been identified as suffering or likely to suffer significant harm before their first birthdays. By the time they were eight over two thirds of them had experienced maltreatment at some point, and eleven (31%) had continued to be neglected or abused throughout their lives. However there is no evidence that eleven (31%) of the sample had ever been neglected or abused.

Nevertheless, the circumstances of the sample as a whole deteriorated as the children grew older. The research team had designed a risk classification framework to facilitate analysis of the interplay between risk factors such as parental substance misuse or domestic abuse, and protective factors such as the presence of a supportive partner or relative or evidence of parental capacity to change, that are known to increase or reduce the likelihood of children suffering significant harm. Case file and interview data were searched for evidence of such factors and the

framework used to classify each child according to the risk of significant harm, at entry to the sample and subsequently at ages three, five and eight. The proportion of children living with birth parents at low risk[3] of significant harm decreased from 50% (18/36) at age three to 36% (13/36) at age five to 25% (9/36) at age eight. By the time the children were eight, only nine of the birth parents who had overcome factors that placed their children at risk of harm had succeeded in sustaining the changes they had made (*sustained parental change* group). Nine others, who had made similar changes for the first three years of their children's lives had not succeeded in sustaining them (*unsustained parental change* group), and eighteen parents (or sets of parents) had made only minimal changes (*minimal parental change* group) throughout the eight years of the study. The most common reasons for deteriorating parental circumstances were recurrent domestic abuse and maternal mental health problems, which often occurred in combination. Secondary risk factors such as long-term poverty, poor housing, living in a hostile neighbourhood, and poor physical health exacerbated the challenges parents faced in making and maintaining positive changes.

Nearly half the children (16/36: 44%) were living apart from birth parents by the time they were eight. Professional decisions to separate children from birth parents were in line with research evidence concerning risk and protective factors and the likelihood of significant harm, and by the time the children were eight all those whom the research team had classified before their first birthdays as at severe[4] risk of harm had been permanently placed away from home. However three children who had been the subject of significant concerns throughout their lives were not permanently separated until after their fifth birthdays. Four other children were also separated after the age of five, from birth parents who had initially overcome the adversities that placed their infants at risk of harm, but whose problems had re-emerged after the child was three.

Although, when they entered care, the intention had been to place all but three of the separated children away from birth parents on a long-term basis, some had not yet found a stable home by the time they were eight. One 'permanent' placement had already disrupted and others were approaching crisis point. Children's emotional and behavioural difficulties were a major cause of stress for carers. Kinship placements, now supported by special guardianship or residence orders, were particularly vulnerable, and all were under considerable strain. Kinship carers were often facing the same challenges of poverty, unemployment, inadequate housing and poor health

[3] Children were classified as being at low risk of future harm if risk factors were not (or no longer) present, and there was evidence both of protective factors and of parental capacity to change
[4] Children were classified as being at severe risk of future harm if risk factors were present, and there was no evidence either of protective factors or of parental capacity to change

as birth parents. They had usually been asked to intervene at a time of crisis, without having had the opportunity to fully consider the implications of providing long-term care for a child who had been maltreated, or to understand the impact on the wider family dynamics of taking in a relative's child. They needed professional support to help them understand the children's earlier adverse experiences and to cope with their emotional and behavioural problems. They needed support in enabling the children to come to terms with their experiences and to help them understand their place in the family. This was rarely forthcoming.

Although most parents felt angry and resentful if their children had been placed away from home, at least two of those whose children had been permanently removed thought that separation had been beneficial for their children.

The children's emotional and behavioural development

Children's emotional and behavioural development was assessed using the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). This was completed by primary carers for 31 of the sample children at ages six to eight. Comparative data, collected through SDQs completed at ages four to five, were available for 23 of these children. The findings show a high prevalence of emotional and behavioural difficulties. Interviews with parents, adoptive parents, foster carers and special guardians show that all were finding it difficult to deal with children's challenging behaviour.

SDQ scores for sample children when aged six to eight years show that ten (32%) fell within the 'close to average' range, five (16%) within the 'slightly raised' range; four (13%) within the 'high' range and 12 (39%) within the 'very high' range. The percentage of children with scores in the 'very high' range is almost eight times as great as one would expect to find in a normative population.

The longitudinal data show that both the prevalence and the severity of children's emotional and behavioural difficulties had increased since they were five. Seven of the fourteen children whose scores had been 'close to average' or 'slightly raised' at ages four to five had moved to the 'high' or 'very high' range by ages six to eight. Three children whose scores had been in the 'high' or 'very high' range at ages four to five had moved in a positive direction by the time they were eight, but were still showing evidence of emotional or behavioural difficulties. Positive change was associated with both a change of circumstances (mother's separation from an abusive partner; placement in a supportive adoptive family) and specialist psychotherapeutic support at school and at home.

The fifteen children whose SDQ scores were in the 'close to average' or 'slightly raised' range were either living with birth parents who had made and sustained

changes (six children), living with birth parents with fluctuating but persistent mental health problems (four children) or living with kinship or unrelated foster carers or adoptive parents, most of whom could access additional support (five children). Fourteen of the sixteen children whose SDQ scores were in the 'high' or 'very high' ranges were either living with birth parents who had made minimal changes (seven children) or living apart from birth parents who had made minimal or unsustained changes (seven children) to behaviour patterns that placed them at risk of significant harm.

Parents, carers and schools were all struggling to help the seven children who scored in the 'very high' ranges in terms of both emotional and behavioural difficulties and their impact. These difficulties tended to be displayed in very aggressive behaviour patterns. However specialist support for these troubled children and their parents or carers was at best sporadic, and often inadequate.

Schools and their role in supporting the children

Our report of the children's position at age five had found that other professionals had sometimes held unrealistic expectations concerning the extent to which schools might be able to address children's emotional and behavioural problems and safeguard them from harm (Ward, Brown and Maskell Graham, 2012b). Many of the schools attended by the sample children were in high deprivation areas. An analysis of Ofsted reports for 2014 indicates that while nationally 81% of primary schools were rated as good or outstanding, only 54% of the 26 schools attended by sample children received such a high rating. The children's schools were also more likely to be larger than average (15/26: 58%); and have above average numbers of children with SEN (18/26: 69%) and/or eligible for pupil premium funding (21/26: 81%). The high proportion of children with additional support needs made the task of teaching more complex in these schools, and some achieved this task more successfully than others.

Twenty five child-specific interviews were carried out across 16 schools, with nine SENCOs, 13 class teachers and three head or deputy head teachers. Birth parents who had made substantial changes to their lifestyles early in their child's life, and had had no further involvement from children's social care were less likely to give the research team permission to approach their children's school. Children in this group, who tended to have fewer or less profound difficulties, are therefore under-represented in the data concerning behaviour in school and educational performance.

The 16 SDQs completed by teachers for sample children between the ages of six and eight years show that nine (56.2%) fell within the 'close to average' range; three

(18.8%) within the ‘slightly raised’ range; and four (30%) within the ‘high’ or ‘very high’ ranges. These scores are lower than those for SDQs completed by parents/carers, who scored half of the same 16 children as being within the ‘high’ or ‘very high’ ranges. Put together, the scores from parents and teachers for these children show that: six were displaying no substantial difficulties at home or at school and were considered by their teachers to be progressing well; six were displaying severe emotional and behavioural difficulties at home, but the problems identified by their parents or carers were not apparent to their teachers during school time; conversely, one child who appeared to display significant emotional and behavioural difficulties at school, was not displaying them at home; and three children were displaying severe difficulties both at home and at school.

The children whose emotional and behavioural difficulties were only evident at home were all displaying highly aggressive behaviours to parents, carers and/or siblings. These behaviours should be a specific cause of concern as they appear to indicate poor or deteriorating child/parent relationships. Teachers were often aware of these children’s difficult home circumstances and acknowledged that school could be a safe haven for them (Grayson, 2013).

All of the children in the sample were eligible for pupil premium plus or pupil premium funding either because they were looked after by the local authority, or had been adopted or left care with a Special Guardianship Order or Residence Order, or because they were in receipt of free school meals. There were two approaches to utilising this funding: some schools tailored the additional resources to the individual child; and some schools combined all pupil premium funding to provide whole-class/whole-school interventions. Pupil premium funding tended to be most successful when used to fund specialist evidence-based interventions, either for individual children, small groups or whole classes.

Schools provided a wide range of resources both to help children overcome emotional and behavioural difficulties and also to help them achieve the expected levels of academic progress for their age group. For instance, all but two of the children who were progressing well had previously been identified as having catch up needs and had benefited from additional support with reading, writing and numeracy; one of them had also benefited from expert support to manage behavioural difficulties and to build self-esteem.

However, some schools found that pupil premium funding was not enough to provide adequate support for children with complex emotional and behavioural needs. Currently, entitlement to the enhanced pupil premium is based on status rather than need, so that children who have previously experienced abuse and neglect but have remained with birth parents are not entitled to the same level of services as those who have been adopted. Moreover, children with challenging behaviours did not

always reach the high thresholds for education, health and care plans. As a result, schools had limited access to child mental health services, and were often left to support children whose difficulties related to past (and sometimes current) experiences of maltreatment, without an adequate budget or specialist skills to do so.

It is not, therefore, surprising that schools met these very vulnerable children's complex emotional and behavioural needs with varying degrees of success. The more successful schools promoted strong links between teachers and parents; conducted ongoing assessments of children's needs and attainment and used the results to inform the development of appropriate and tailored support. They used their pupil premium funding in a structured way to support specialist evidence-based interventions; used teaching assistants to provide focused support that promoted integration and inclusion; and understood that additional support was necessary to meet children's exceptional needs, rather than as an additional resource to reward disruptive behaviour. Less successful schools did not offer such an enabling environment. The table below shows enabling features of the children's schools' environments contrasted with those features which were less successful in supporting the children.

Table 1: Enabling and disabling school environments

Enabling	Disabling
Strong home-school links.	Schools and parents/carers working separately, contrasting views and lack of consistency.
Pupil premium funding used for specialist evidence-based interventions (individual children, small groups or whole class).	Pupil premium funding not used in a tailored or structured way.
Assessment of children's needs and attainment ongoing. Assessment of needs used to implement appropriate and tailored support.	Assessments of children's needs and attainment static and not used to inform appropriate and tailored support.
Teaching assistants used to provide evidence based interventions to individual children or within small groups.	Teaching assistants used to separate individual children from the class and provide instructions for tasks.
Children with emotional and behavioural difficulties provided with evidence based interventions.	Reluctance to reward disruptive children with additional resources/attention.

Children's perceptions of support at home and school

The children had experienced numerous adversities, and it was important to explore their perceptions of the ways in which they were supported at home and school, by their families and friends. The 26 children who were interviewed had an average age of just over eight years. Seventeen were living at home (including nine with ongoing concerns about the risk of significant harm) and nine were in kinship care, foster care or adoptive placements. Parents and carers were concerned about allowing children with very disruptive behaviour patterns to participate in the interviews and so this group is skewed towards those children who were less likely to have severe emotional and behavioural difficulties.

Most children had extremely complex family relationships, many of them with kinship carers and adoptive parents as well as birth parents. These were evident in the extensive eco-maps that they created. Eco-maps often included family pets, which

many children regarded as significant family members. However, five children created relatively small eco-maps, indicating considerable social isolation.

Generally, the children who were living with at least one birth parent were clearer about the nature of their *close* family relationships and conveyed a stronger sense of belonging than children separated from both birth parents. Five of the children living with kinship carers, special guardians and adopters expressed uncertainty, confusion and/or discomfort about their close family relationships, use of names and life histories. It is of concern that life story work had not been undertaken with any of the children in kinship care or special guardianship, despite carers expressing a need for professional support in facilitating openness with them about identity issues. It seems likely that, for some children, confusion about their place in their families contributed to emotional and behavioural difficulties.

When asked who they would turn to if they were worried about something, 13 (of 22) children conveyed a clear sense that they had people in their lives to whom they could turn. However nine children expressed uncertainty about potential confidants.

The children were shown pictures of professionals who work with children and were asked to identify those whose job it was to help them. On average they were able to identify fourteen professionals. About a third of the children were aware of children's social care involvement in their lives. Those who talked about social workers and foster carers were generally positive about them, and suggested their lives had benefited from their involvement.

The children expressed a wide range of views about their experiences of school, from not wanting to go, to 'loving it'. Nevertheless, all of them selected teachers as important sources of help, and most (70%) put them in the 'most helpful' category (i.e. teachers help me a lot). Other school staff, such as dinner ladies, playground helpers, and sports coaches were also regarded as important sources of help. Children who said they enjoyed school valued the help they received with challenging academic work, and also talked positively about extra support they received for emotional and behavioural issues.

Over three quarters of the children identified doctors, nurses and dentists as being helpful in their lives, and about half of them identified police and ambulance people as having helped them. Six of the children had witnessed or been aware of the involvement of the emergency services, such as when police had responded to incidents of domestic abuse.

Finally, the children were asked to complete a simple visual analogue measure of overall life satisfaction (Cantrill's Ladder), positioning themselves between 'the worst possible life' and 'the best possible life' (Cantrill, 1963). Despite the adversities that

many had experienced, their distribution of scores was surprisingly similar to those of eight and nine year olds who participated in a Children's Society national survey (Rees 2011), and was skewed towards high life satisfaction. This finding could, however, have been influenced by the presence of children's parents and carers during the interviews.

Given the children's life experiences, it is understandable that some thought that they were relatively far from living 'the best possible life', and surprising that these were so few in number. Children in a sample such as this need to be resilient and this will depend, to some extent, on their sense of belonging and their perceptions of the support they receive. It is therefore of concern that some children were confused about their identities. Moreover, although experiences of professional help were usually very positive, there were, nevertheless, some children who lacked an appropriate confidant, or who had had negative experiences of support from adults in caring roles. It is of particular importance that these very vulnerable children feel adequately supported, for their early experiences are likely to influence their ability to seek help in the future.

With the benefit of hindsight: what were the factors that influenced children's and parents' life trajectories?

The longitudinal data collected from interviews and case papers over the previous eight years suggests that there were six significant factors that influenced children's and parents' life trajectories: primary risk factors, such as parental substance misuse, domestic abuse and mental health problems that increased the likelihood of abuse and neglect; secondary risk factors such as poverty, ill health and poor housing that exacerbated the challenges they faced; the stage that parents had reached in the process of change; the availability and nature of informal support networks; professional relationships, assessments and decision-making; and the availability of both personal and public resources.

All parents in the study were facing issues such as poverty, poor housing, isolation and/or the stress of living in a hostile or violent neighbourhood. As children and parents grew older, and families increased in size, these factors became more significant. Parents' physical health problems also became more prominent and increased the challenges they faced. Their daily lived experiences reveal complex struggles to cope in an extremely harsh environment. It is not surprising that many found it impossible to overcome the problems that placed their children at risk of significant harm. The continuing challenges of bringing up children in impoverished circumstances also meant that those parents who did succeed in making and sustaining significant changes remained relatively vulnerable.

The concept of a process of change (see Prochaska et al.,1992; 2002), marked out in specific stages, provided a useful framework for exploring how far parents were likely to overcome, within an appropriate timeframe, problems that placed their children at risk of significant harm. Most parents in the *minimal parental change* group had not yet acknowledged that a problem existed, or had not reached the point at which they felt able to overcome it. Parents in the *unsustained parental change* group had taken action to instigate change and engage with services, but change was not yet sufficiently embedded to avoid relapse. Those in the *sustained parental change* group had been through the full process of change, and had not relapsed for at least seven years. All parents were determined to keep their children, but only those in the sustained change group appeared determined to overcome the problems that might prevent them from doing so.

There are notable differences in the extent and quality of informal support received by parents in these three groups. Parents in the sustained change group tended to have more supportive and long-standing relationships with partners and stronger support networks than parents in the other groups. They also had at least one highly supportive family member who was able to put the child's needs before their own. Support from extended families for parents in the other groups was notably less constructive, and less centred on the needs of the children or their birth parents.

Parents in the sustained change group were perceived as determined to overcome their difficulties and often found a professional who acted as their champion, going the extra mile to help. Their willingness to engage drew in professionals from several services, so that a strong team around the child emerged and was energised by evidence of positive change. Although all parents should have had equal opportunities to access publicly available services, those in the sustained change group appear to have been more fortunate than others: they were more likely to be rehoused into less impoverished locations, and they appeared more likely to access services which they found to be effective, such as intensive parenting support or school-based psychotherapeutic support for their children.

The converse was true of parents in the other groups. There is less evidence of them finding a champion who was willing to fight their cause; less evidence of inter-agency cooperation or of their being offered accessible or effective services that would support them and their children through the process of change; and more evidence of them continuing to live in (or being moved to) hostile environments where they were socially isolated. While chance undoubtedly played a part, it seems more likely that a symbiotic relationship developed in which parents' willingness to engage promoted effective practice, close inter-agency working and access to effective services and resources, while the converse was also true.

All parents were mindful that social workers had the power to remove their children, and were cautious in their relationships with them. Even when parents had overcome their difficulties, fears still persisted that children could be removed. In the unsustained and minimal parental change groups caution was closer to distrust, which could come to characterise the approach of both parent and social worker and sometimes resulted in a complete standoff. Parents in the unsustained and minimal change groups tended to be reluctant to ask for much needed help for fear of losing their children, one reason why they appeared to have less access to effective services.

Now that the children were eight, it was clear that many of them had benefitted from careful decisions made in their early years that were based on thorough assessments and analysis of evidence that informed how they might best be safeguarded from harm. However, while social work support had often been timely and effective, some early decisions had been marred by common errors of intuitive thinking (see Munro; 1999; 2005) such as inadequate or inaccurate information; a tendency for decision-makers to become attached to their initial impression in spite of subsequent, contradictory evidence; a tendency to ignore the child's point of view and allow decisions to be influenced by emotion; and a tendency to postpone difficult decisions, especially where neglect or emotional abuse were the key issues. Little use had been made of objective, standardised measures that might act as a counterbalance.

A longitudinal perspective threw into sharp relief some of the consequences of the mistaken optimism that had supported some of the less successful decisions made for children in the early years. It also showed how other, current issues, could only be properly understood in the light of a thorough knowledge of the past. For instance, the extreme stress experienced by birth parents (and some children) when violent parents made formal applications for contact a few years after they had been served with injunctions banning them from entering the home or the neighbourhood could not be fully appreciated without an understanding of what had gone before. A longitudinal perspective made it clear how organisational factors such as rapid turnover of social workers, re-organisation and frequent opening and closing of cases made it difficult for practitioners to develop a clear understanding of the long-term, entrenched problems that many of the parents faced.

Conclusion: Implications for policy and practice

The findings from the study raise particular issues concerning the extensive emotional and behavioural problems of this population of children and the support given to birth parents, adoptive parents, special guardians, foster carers and teachers to help them meet their needs. They have implications for the development

of policy and practice that might both prevent abuse and neglect from occurring or recurring and protect children from its long-term consequences.

The findings indicate that attention should be paid to the challenges parents face when bringing up children in impoverished circumstances. Policies designed to reduce child poverty and inequality, to strengthen communities and improve access to supportive services can improve the context of parenting for families such as these. This is why the impact of austerity measures and welfare reforms on the wellbeing of vulnerable families should be carefully monitored and action taken to protect children from unlooked for adverse consequences. Broader policies designed to address child poverty need to be integrated with more targeted safeguarding policies.

Effective preventive measures might include population-level initiatives to disseminate recent research messages on positive parenting that is sensitive to children's needs. These could shift the norms of parenting behaviour and influence those who show extreme, abusive behaviour patterns to change in the same positive direction.

Policies designed to keep very vulnerable families together need to be supported with adequate material resources and probably long-term professional support provided to both parents and children for as long as required. At present parents tend to receive short-term, sporadic support from social workers and other agencies, with cases being closed as quickly as possible both because resources are short and also because of concerns about growing dependency. Yet expecting parents to progress within a few months from a position where they might have their children permanently removed to one in which they provide adequate parental care without support is unrealistic. These families have extensive needs and some degree of dependency on services may well be inevitable if children are to be safeguarded from harm.

Inter-agency working is a major issue, and safeguarding policies need to focus on closer collaboration, particularly between adult and children's services. There is a need for better support for those children whose parents' mental health problems fluctuate over time or who face their own mental health issues.

Members of the extended family who support very vulnerable birth parents and/or who become kinship carers and special guardians may well be struggling with a similar degree of impoverishment as the birth parents. They require more extensive material resources if they are to undertake the task of providing a permanent home for a child who might otherwise be looked after by local authority carers. They also need better professional support to help them to: support a child who may have complex needs arising from previous experiences of abuse and neglect; undertake

life story work with a child who may become confused about their identity; and address complex family dynamics arising from their decision to offer kinship care.

Some children flourished in care, special guardianship or adoptive placements, particularly when there was communicative openness and well-functioning contact arrangements with birth parents. However not all substitute care was of high standard and the findings provide further evidence that careful selection and assessment of both stranger and kinship carers is fundamental to ensuring that children's needs are met.

The most significant findings from this study concern the prevalence of severe emotional and behavioural problems by the time the children were eight. These are indicative of incipient and possibly long-term mental health problems as well as a range of adverse outcomes in adolescence and adulthood. They should be treated with the same gravity as incipient long-term physical health conditions. Systems need to be in place to flag up children who are known to be at risk of significant harm, and their emotional and behavioural development as well as their physical development should be monitored regularly until it is clear that there is no continuing impairment. It should be of concern that many of the children's problems went unnoticed until they started school. Simple, standardised measures, such as the Strengths and Difficulties Questionnaire are currently only used routinely for looked-after children; their wider use for other children at risk of significant harm might alert practitioners earlier to indications of serious behavioural difficulties and encourage swift referral to specialist services.

The persistence and prevalence of children's emotional and behavioural problems indicate that birth parents, adoptive parents, special guardians and schools, as well as the children themselves, all needed high levels of timely, skilled support. The findings suggest that specialist psychotherapeutic services should be developed and made available to children at a much earlier age than is currently the case. Schools should also have better access to children's mental health services, and teachers and SENCOs should have access to initial training and further professional development concerning supporting children with these needs.

The study found that some parents, whose children showed the greatest level of need, mistrusted and avoided social work interventions for fear that their children might be removed. Social workers may need more support in understanding the power dynamics of their role and in engaging and supporting such parents through the process of change. However such parents also need greater access to support that would help them improve parenting practices and address children's emotional and behavioural needs. At present children who are looked after, in special guardianship, or adopted, can access higher levels of support through the elevated pupil premium than those children with similar needs who remain with birth parents.

Policies which aim to ensure that very vulnerable children remain with or return to birth parents cannot be implemented without ensuring that high quality, specialist packages of support for children at risk of significant harm are made available according to need rather than status, and are continuous, following the child whether they are living with birth parents, foster parents or adoptive parents and supporting all carers to meet children's needs for as long as required.

Chapter One: Background, aims, methodology and policy context

Aims and objectives

Over the last ten years the Centre for Child and Family Research (CCFR) at Loughborough University has been following the professional decision-making processes that have affected the life pathways of a sample of very young children who were assessed as suffering, or likely to suffer, significant harm before they reached their first birthdays. The overall aim of the study is to inform future professional decision-making about whether children can safely stay living with their birth parent(s) or need permanent out-of-home placements, such as adoption or special guardianship.

Background

The study began by recruiting a sample of infants who were deemed to be at risk of 'suffering or likely to suffer significant harm' from ten local authorities. Criteria for entry were that all infants had been the subjects of a core assessment or a Section 47 enquiry, triggered by concerns about abuse or neglect, before their first birthdays.

Fifty-seven babies were recruited to the sample, and 43 of them were traced from birth until they were three years old. The first stage of the study was reported in *Safeguarding Babies and Very Young Children from Abuse and Neglect* (Ward, Brown and Westlake, 2012a). It considered several key issues:

- the process by which professional decisions concerning whether or not very vulnerable infants could safely remain with birth parents were made;
- the extent to which the families and professionals were involved in the decision-making processes;
- the nature of the services that were provided to address difficulties in family functioning;
- the extent to which decisions made by parents and professionals promoted or inhibited children's opportunities and influenced their life pathways; and,
- whether and how parents can come to terms with professionals' painful decisions to place their children away from home.

The findings revealed that, for the 43 children at age three:

- just over a third of the sample were living with birth parents who had managed to make sufficient changes to look after them satisfactorily;
- just under a third of the sample (and nearly half of those who remained at home) were considered to be at continuing risk of being harmed by parents whose situation had remained unchanged or had deteriorated;
- about a third of the sample were permanently separated from their birth parents. However, the wellbeing of over half of these children had been doubly jeopardised, by late separation from abusive birth families followed by the disruption of a close attachment with an interim carer when they entered a permanent placement;
- several long-term kinship placements were on the verge of breakdown;
- just over half of those children who did not have a recognised medical condition were displaying developmental problems or showing signs of significant behavioural difficulties; and,
- the aggression, frustration and delayed language and communication skills displayed by some of the children were likely to cause significant problems as they entered school.

Thirty-seven of the 57 children were then traced up to their fifth birthday. This second stage of the study had a focus on the children's experiences of starting school. Professionals had increasingly begun to suggest that social workers would be able to withdraw their support for the children and their families because the children would be adequately safeguarded at school. The report *Young children suffering, or likely to suffer, significant harm: Experiences on entering education* (Ward, Brown and Maskell Graham, 2012b) was published in 2012. The key findings were:

- By the time the children were five, the home circumstances had deteriorated for almost half those children whose parents had previously seemed to address issues that undermined their parenting capacity. In all these cases the mothers had started new, or re-established old, violent relationships which increased the likelihood that their children would suffer significant harm.
- There was clear evidence that about one third of the children had suffered, or were likely to suffer, significant harm at some stage between their third and fifth birthdays, but none of them had become the subjects of care proceedings during this period, and none were newly accommodated by the local authority.

- Just under one third of the children had been permanently separated from their birth parents by the age of three. At least four placements, however, were showing signs of considerable strain and were on the verge of breaking down at around the time of their fifth birthdays.
- By the time they were five, almost half the children were showing signs of emotional and behavioural difficulties which were undermining their progress at school. At least four of the children were displaying very severe behavioural disturbance, such as self-harm. One child had been excluded from pre-school.
- The majority of the children's nurseries or schools had adopted a *child and family welfare* approach in relation to safeguarding children both at home and at school. Those that adopted an *educational attainment* approach focused more on achieving high academic standards and safeguarding children within school.
- Some children were receiving exceptionally high levels of support from their primary schools, but this was not integrated into an inter-agency plan and was unlikely to be maintained when they moved to a new class or a different school.

Further funding was then made available to follow up the children when the majority of them were aged seven and eight. This third stage of the study is the focus of this report. It includes the children's own perspective for the first time. Its objectives were to:

- Understand how decisions made in the early years (0-5) continue to affect the lives of abused and neglected children, reflecting on evidence of good and poor quality assessments and interventions.
- Identify the competing considerations of the professionals originally involved with the children when making decisions about assessments and interventions, and explore those which had long-term influence.
- Identify the role of primary school teachers and SENCOs in recognising and responding to abuse and neglect, with a focus on how children's needs are understood as being driven by perceptions/assessments of (in) adequate parenting and/or special educational needs.

- Explore the children's experiences and perceptions of the ways in which they are supported at home and school.

Methodology

Phase One: Birth (or pre-birth) to age three years

During the first phase of the study, from birth (or pre-birth) to age three years, data were initially collected on 57 infants at the point of identification by children's social care, for most this was *in utero* or during the very early months of their lives and for all before their first birthdays. Data were collected from:

- case files to explore life experiences, reasons for referral and evidence of need.

These were supplemented with:

- extensive in-depth interviews with birth parents, carers (where relevant), social workers and social work team leaders.

Data collections were repeated annually until the children's third birthdays wherever possible; because of the challenges associated with maintaining the sample, in-depth data were obtained on 43 children[5], the *third year follow-up sample*. Case specific interviews were complemented by generic interviews with judges, magistrates, senior managers in children's social care, local authority solicitors and health visitors, carried out towards the end of this phase of the study. This allowed for a comprehensive analysis of factors and decisions influencing the children's life pathways from birth until age three (see Ward, Brown and Westlake, 2012a).

Phase Two: Three to five years – the fifth year follow-up sample

The second phase of the study traced the children for a further two years, until their fifth birthdays. At the start of this phase of the study, efforts were made to maximise the sample by tracing some of the children who had been lost between the first round of data collection and their third birthdays. The research team contacted all parents who had originally expressed a wish to participate but had not pursued this further or had dropped out at some stage. It proved possible to re-introduce seven children to the sample. However, there was further attrition from the third year follow-

[5] See Appendix One for an overview of the challenges associated with maintaining the sample.

up sample of 43, and 13 of these children were inaccessible at Phase Two. These were mostly children who had been permanently separated from their birth parents (see Table Two for an overview). Therefore the fifth year follow-up sample comprised 37 children: 30 whose parents had participated throughout the study and seven who had intermittently taken part in the research programme over the previous five years. In this phase of the study:

- Annual in-depth interviews with birth parents and/or the children's current carers continued.
- Where there had been children's social care involvement, data were collected from the children's case files.
- During their fourth and fifth years, the children began to engage in formal education, therefore, where parental consent was provided, the children's class teachers, pre-school workers and head teachers were interviewed.
- The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), was completed by the children's parents/carers and, where consent was provided, their teachers.

Phase Three: Six to eight years – the eighth year follow-up sample

The third phase of the study – the focus of this report - includes data on 36 children, the majority of whom were aged seven and eight and had completed Key Stage One at school at the time of data collection. Over the years, some parents and carers have tended to opt into and out of the research programme, and others have taken an active interest and have been highly committed to taking part in the study throughout. Efforts have continually been made by the research team to maximise the number of children in the sample; these include searching online directories of residential records, using social media, and re-contacting families who have previously not been contactable. Of those for whom contact information was maintained or re-established, only one parent has ever actively withdrawn their participation. Therefore, the eighth year follow-up sample comprises 28 children whose parents/carers have been highly committed to taking part in the study throughout, and eight children whose parents/carers have intermittently participated. For the eighth year follow-up, data were collected from:

- ongoing annual in-depth interviews with birth parents and/or the children's current carers;
- where the children's cases had been open to children's social care, case file records and interviews held with their social workers;

- where parental consent was provided, interviews with the children's current class teachers, and where involved, their SENCO. Only about half of the parents or carers gave their consent for these interviews, therefore, to supplement this, data were also collected from the National Pupil Database on the children's attainment, school absences, exclusions and SEN status.
- The Strengths and Difficulties Questionnaire completed by parents/carers and, where consent was provided, an SDQ completed by the children's teachers.
- For the first time in this study so far, where parental consent was given, interviews were carried out with the children themselves.

Table 2: Summary of methodology

Source of data	Sample	Data collected
Children's social care files.	**Third year follow-up sample (n=43):** Data from case files were collected relating to all 43 children up to case closure or their third birthday. **Fifth year follow-up (n-37) and Eighth year follow-up (n-36) samples:** Where cases had remained open, or had been re-referred, data were collected. Case activity was checked on most cases[6].	Details of referrals, decision-making, assessments, services, court involvement.
In-depth case specific interviews with birth parents or current carers.	Ongoing annual interviews: At entry to the study (pre-birth up to age one year): 53 children Age 1-3 years: Interviews in relation to 31 children Age 3-5 years: Interviews in relation to 35 children Age 6-8 years: Interviews in relation to 31 children	The children's home environments and any changes, new or re-emerging risk and/or protective factors, parents'/carers' perceptions of the children's progress, views about services and interventions, including those provided by children's social care.

[6] Access to case files was not always granted by local authorities, despite parents having given their written consent for the files to be accessed. Two local authorities denied access during the fifth year follow-up; and two (different) local authorities denied access for the eighth year follow-up.

Interviews with children (see Appendix Two for an overview of the methodology used for interviewing the children).	**Eighth year follow-up sample (n=36):** 26 children were interviewed	The children's views of their relationships at home and school, and the support and help they receive at home and school, and their life satisfaction.
Case specific interviews with professionals.	**Third year follow-up:** Social workers: 73[7] interviews Social work team leaders: 61[8] interviews **Fifth year follow-up[9]:** Pre-school workers: 5 interviews Class teachers: 11 interviews Head teachers/child protection liaison staff: 17 interviews **Eighth year follow-up:** Social workers: 3 interviews Class teachers: 15 interviews SENCOs: 12 interviews	Social worker and team leader interviews focused on their assessments and decision-making, as well as evidence of risk and parenting capacity. Interviews with class teachers, head teachers and SENCOs covered the children's progress and their educational needs, as well as the schools' safeguarding agendas.
Strengths and Difficulties Questionnaires (SDQs) completed by parents and teachers.	**Fifth year follow-up:** 31 completed by parents/carers 17 completed by teachers **Eighth year follow-up:** 31 completed by parents/carers 15 completed by teachers	Completed to gain an indication of emotional and behavioural problems, including parents/carers' and teachers' perceptions of children's positive qualities as well as difficulties.

[7] More than one interview with social workers occurred in 25 cases.
[8] More than one interview with team leaders occurred in 21 cases.
[9] Interviews with social workers not included during the fifth year follow-up phase of the study.

Ethical issues

The study focusses on an exceptionally vulnerable, hard to reach population. Ethical approval has been sought at each stage from the Loughborough University Ethics Committee, research governance liaison officers in all participating authorities, and other ethics committees responsible for specific professional groups, such as CAFCASS, when staff have been interviewed. Particular care has been taken to ensure that the research processes have received appropriate ethical approval, that informed consent has been given to all interviews and collection of case file data, and that the limits of confidentiality have been understood by all participants. On those few occasions where the research team has become aware that a child is at increased risk of significant harm, a senior local authority manager has been confidentially informed.

Particular care has also been taken in the write-up of this report to ensure that the anonymity of the participants is protected. The following guiding principles were followed:

- Participants, including children, parents, carers and professionals have not been referred to by using pseudonyms or case identification numbers.
- In the presentation of case studies, identifying information has not been included, or it has been altered.
- Case studies and quotes are accompanied with a description of the circumstances of the child they relate to rather than pseudonyms or case identification numbers.
- Permanent carers such as, kinship carers, long term foster carers and adoptive parents are referred to as *permanent carers*.
- Birth parents are referred to as either *birth mother* or *birth father*.
- Staff from the children's schools such as class teachers, SENCOs and head/deputy head teachers are referred to as *school staff members.*

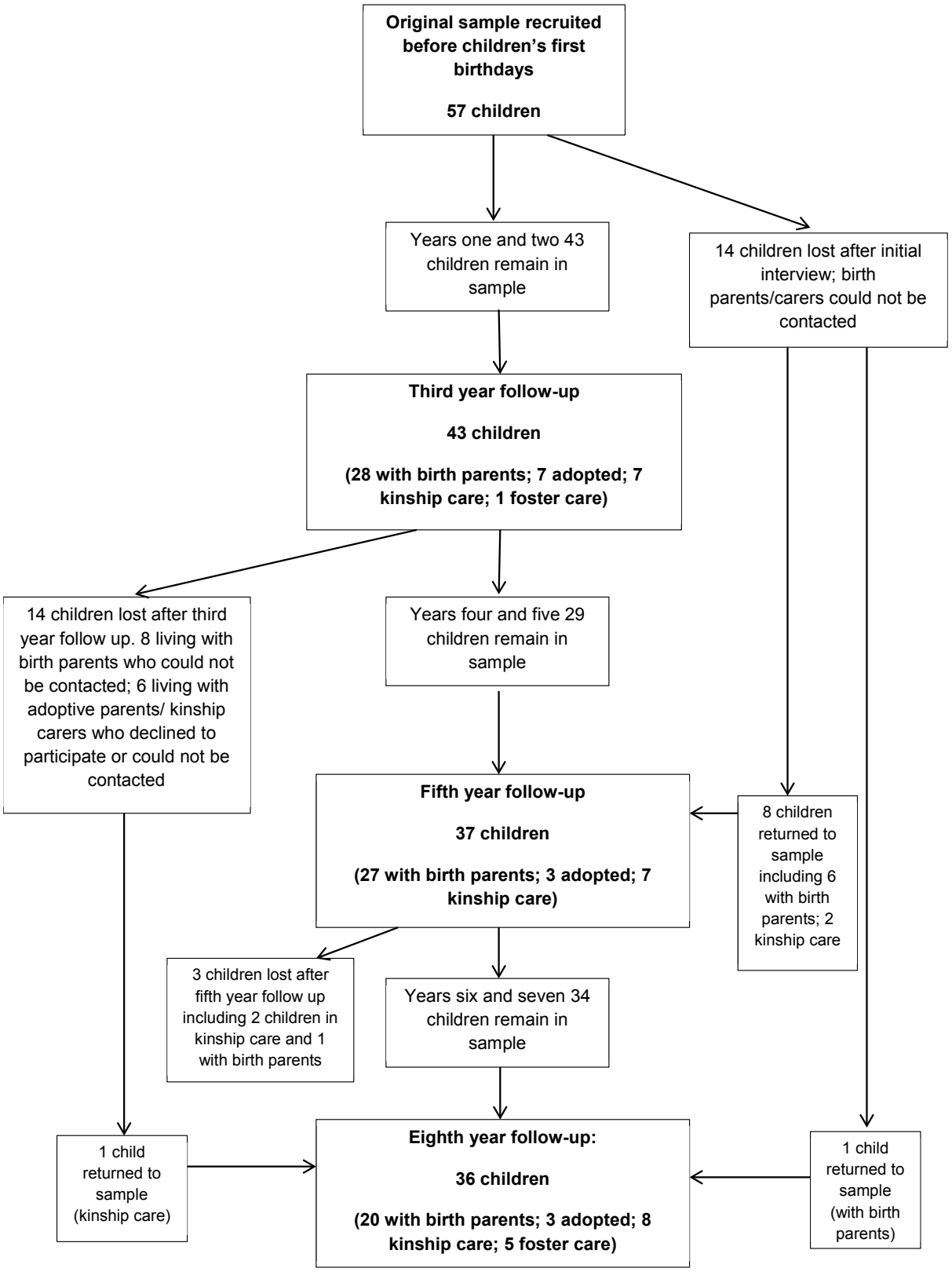
Sample bias and limitations

Over the ten years of the study, accessing, securing, and maintaining the engagement of the parents of the children who were identified as suffering, or likely to suffer, significant harm has involved many challenges (see Appendix One for an overview). The parents of only 84 eligible children from the 10 local authorities responded to the original recruitment drive for the study, only 57 of these children could be included in the initial sample. Table Three below summarises the longitudinal sample, and the rate children have been lost from it over the years.

Table 3: Summary of the longitudinal cohort and attrition

Longitudinal sample group	Number	Attrition from original sample at each follow-up (not sequential)
Original sample The study team were able to collect some initial data concerning 57 children whose parents formally agreed to participate in the study.	57	
Third year follow-up The research team were able to maintain 43 of the original 57 children in the sample until their third birthdays. The research team lost contact with 14 sets of parents/carers during this phase, most commonly because parents/carers chose not to respond to letters/calls/texts etc, or because they changed mobile numbers/addresses.	43	25%
Fifth year follow-up The fifth year follow-up cohort comprises 29 children who had been traced from birth, and eight who had been lost to the study after the initial interview, but were then re-recruited. The research team lost contact with 14 sets of parents/carers during this phase. The majority of attrition at this point was in relation to children being placed with adoptive parents or kinship carers who declined to participate in the study or could not be contacted (six children), or parents/carers who could not be contacted because their mobile numbers/addresses had changed (eight children).	37	35%
Eighth year follow-up The seven/eight year follow-up comprises 34 children whose parents/carers have taken part in the study over prolonged periods and two children whose parents/carers have intermittently participated. Three children were lost to the sample between the ages of five and eight.	36	37%

Figure 1: Diagrammatic representation of the cohort composition and attrition



The small numbers involved in the study mean that findings should be approached with caution: more evidence is needed concerning their reliability and generalisability to a wider population. In addition, the composition of the sample has been skewed by two underlying sets of circumstances.

The first is in relation to the parents who were likely to take part in the study. Letters were sent to over 1000 parents of children who had been the subjects of a core assessment or section 47 enquiry before their first birthday. Although 84 parents responded, only 57 took part in at least an initial interview with the research team. To explore bias within this sample of 57 children, anonymised management information for *all children who met the sample criteria* from four of the ten participating local authorities was scrutinised. This showed that the sample children, whose parents *chose* to participate in the study, were significantly more likely, than those who did not participate, to have been referred before birth, to have received services following a core assessment, and to have become looked after before their first birthdays (see Ward, 2012, p.222). This indicates that the original sample of children was skewed towards those who were *more likely* to suffer significant harm than the eligible population of children whose parents *chose not* to participate. Our qualitative data corroborates this, suggesting that at around the time of the children's birth, the parents were in receipt of high level intervention from children's social care and the courts. Parents wanted to share their experiences; either because they had had their baby removed from them, and were feeling isolated and disempowered; or because they were able to overcome substantial difficulties in their lives and were providing a nurturing and safe environment for their new-born baby. These parents were very proud of what they had achieved and wanted to share this.

The second set of circumstances contributing to bias within the sample relate to attrition, and how it has affected certain groups of children more than others. This includes the following factors:

- Of the original sample of 57 children, by the age of eight, 26 (46%) were separated from their birth parents, including 19 who were removed before they were three, and seven children who were separated at around the ages of six to seven years. Of the 26 separated children, 12 were adopted, nine were in kinship care, and five (of the late separated children) were in foster care. Ten (38%) of these children have been lost from the sample, including nine who were adopted and one child in kinship care. Therefore, only three adopted children were accessible for the eighth year follow-up, in contrast to children in kinship care, where all but one were accessible. Adoptive parents have chosen, by and large, not to take part, whereas kinship carers have

shown a keen interest in the study, and have mostly all remained extremely committed to participating.

- The dynamic whereby parents and carers have opted in and out of the study: some parents have been inaccessible at times when their personal difficulties have overwhelmed them, and have then re-joined the sample when their circumstances have improved (in some cases years later). Other parents however, have shown a greater willingness to participate when their personal difficulties have deteriorated, and they therefore have been under heightened surveillance from children's social care and the courts.
- Kinship carers and parents who have overcome substantial personal difficulties in their lives and have been able to sustain such changes have remained relatively accessible throughout the study.

Other factors which have contributed to the limitations of the study include the accessibility of data. At the outset ten local authorities were recruited to the study, all agreed to participate, and provide the research team with access to data held on their social care case files about the children in the study (where parental consent was provided). However, over the years, accessing data held by local authorities has become increasingly problematic, despite having continued consent from those with parental responsibilities for the children. Delays often arise because of impromptu inspections or changes to senior personnel. For this phase of the study, all ten local authorities agreed to continue their participation in the study, and provided the research team with written confirmation of this. However, despite having parental consent and following 18 months of negotiation, attempts to collect data from two local authorities had to be aborted because there was no longer time left within the study parameters. On one occasion, the researcher arrived at a local authority's offices on an agreed day and time and with all relevant consents in hand. However, the local authority denied access on the grounds that the matter would need to be confirmed (again) by senior management. Local authority staff were particularly nervous about allowing the research team access to children's case files.

Occasionally parents also found that there were barriers to participating in the research, as one birth mother described:

> *My social worker didn't like me talking to you lot…Yeah, he didn't, he didn't want me talking, because he didn't want me to talk to you. I thought, Why not? He's scared because they'll find out the truth what you all are like, that's what, that's what I said to him.*
>
> Birth mother of study child: at entry interview

As one might expect, over the course of the study, the number of children in receipt of ongoing services from children's social care has reduced. Therefore case files have been closed and increasingly we are more reliant on the views of birth parents and carers. These are undoubtedly biased - the reader should take this into account.

The findings from this study should be approached with caution and more evidence is needed concerning their reliability and generalisability. Nevertheless, this study presents a unique opportunity to learn about these vulnerable families, including the challenges they face in bringing up children with inadequate material resources and in an often hostile environment as well as their experiences with mental health problems, domestic abuse, substance misuse, their own experiences of childhood abuse, and the permanent removal of children; their expectations of their social worker; and their capacity to change the behaviour which undermines their parenting capability. The children in the sample are now mostly all in their seventh or eighth year, the study for the first time can provide an even rarer opportunity to capture their own views and expectations. Furthermore, because this study is prospective, it follows these seldom heard experiences and perspectives forward in time and can therefore provide reliable information on what factors have changed and what has influenced the life trajectories and developmental progress of each child.

Qualitative enquiry of this nature can provide rich insights into the lives of these families with whom social workers are involved and help us to understand their subjective experiences. This study is reliable in demonstrating child safeguarding scenarios and investigating them reflexively in detail by triangulating data from different sources over prolonged time periods. While the study cannot show the prevalence of any situation nor be certain about its cause and effect, the prospective research can provide hypotheses, theories and raise important new understandings which can then be further explored in larger, less detailed, quantitative studies. These types of subjective experiences cannot be generalised to the wider population, but they can provide an insight into the inner lives of parents who abuse or neglect their children, and improved understandings of ways to effectively engage them with services, the agonising decision-making processes in complex child protection cases, and how these can affect the welfare of the children involved.

Parenting capacity (or capability) and parental capacity to change

Assessments needed to take account of parents' capacity (or capability) to meet their children's needs, and parental capacity to change. Parenting capability (the term used in this report in order to avoid confusion) refers to the parent's ability to meet their children's needs. In England and Wales, although there have been recent moves to introduce greater flexibility of timescales and processes, the core

assessment task nevertheless still involves assessing parents' ability to meet their children's needs across six dimensions (basic care, safety, emotional warmth, stimulation, guidance and boundaries and stability) within the context of their wider family, community and environmental circumstances (Department for Education, 2013).

Assessing parental capacity to change focusses on a different issue – the extent to which parents are able to overcome those factors within themselves and their environment that undermine their parenting capability. These include factors such as parental substance misuse, mental health problems, domestic abuse and experience of abuse in childhood. Many of these factors occur in combination and interact with one another, presenting a complex web of problems in families where there is an elevated risk of significant harm to children. It should also be noted that while the majority of poor families provide nurturing homes for their children, nevertheless factors such as poverty, poor housing, debt and material deprivation increase the stressors in families and make the task of parenting more challenging. All the families in our study were living in extremely poor material circumstances, and their poverty added to the challenge of overcoming the behaviour patterns that were more directly related to abuse and neglect.

Prochaska and colleagues (1992; 2002) argue that individuals who are overcoming problematic behaviours and lifestyles move through a series of psychological processes as they first deny that a problem exists (*pre-contemplation*); come to accept that there are issues that need addressing (*contemplation*); become motivated and make some small behavioural and cognitive changes (*preparation*); make modifications to their behaviour, experiences or environment to overcome their problems (*action*); consolidate the gains they have made and work towards preventing relapse (*maintenance*). They also argue that change follows a spiral rather than a linear course, in that *relapse*, followed by a return to an earlier stage in the process is the rule rather than the exception (for further discussion, see Ward, Brown and Hyde-Dryden, 2014). Prochaska and colleagues' Transtheoretical Model of Change (1992; 2002) may have limited practical applicability in children's social care cases (see Girvin, 2004; Littell and Girvin, 2005; Hegarty et al., 2008); nevertheless it provides a conceptual framework that offers some valuable insights into the position of the parents in this study. Behavioural change can be a lengthy process. In attempting to assess whether parents are likely to be able to make sufficient changes within a child's timeframe, it may be helpful for practitioners to consider what stage they have reached on the process of change, in particular whether they have not yet accepted that a problem exists, are motivated to change, but not yet ready to take significant action, or thoroughly engaged in the change process.

Policy context

Major changes to national economic and social policy during the research period have had and/or are likely to have a significant impact on the family lives and education of the very vulnerable children involved in the study.

Bradshaw and Main (2014) argue that the improvements in the UK in relation to child poverty and wellbeing gained during the first decade of the 2000s have been threatened by the global financial crisis. They suggest that the subsequent austerity measures and the burden of austerity have fallen particularly heavily on children. The office of the Children's Commissioner for England (2013) has studied the impact of austerity measures on children in detail and concluded:

> *The analysis of the tax, benefit and tax credit systems has shown that successive policies have led to families with children losing a greater share of their income than those without children. It is also of great concern that some of the most vulnerable families with children are losing proportionately the most (p.6).*

During this period of austerity, however, the Coalition government has protected day-to-day spending on schools (Lupton and Thomson, 2015). Total expenditure has risen by 1% from £46.1bn in 2009/2010 to £46.6 bn (in real terms in 2009/2010 prices). This has allowed pupil-teacher and pupil-adult ratios to be maintained, although capital expenditure has fallen dramatically by 57%.

The introduction of the pupil premium has directed more money to schools with intakes from disadvantaged groups. In 2015-16 the premium was set at £1320 per eligible primary school pupil. All types of primary schools have gained, especially the most deprived. While eligible looked-after children previously attracted the same pupil premium as deprived children, in 2014-15 the pupil premium plus was introduced, meaning that all current and some former looked-after children are to attract £1900 additional funding. The pupil premium plus has also been extended to adopted children.

In July 2014 Ofsted (Ofsted, 2014a) published its view on the progress schools have made in using the pupil premium funding to raise the achievements of those pupils who are eligible to receive it. It concluded that:

> *There are encouraging signs from inspection that the concerted efforts of good leaders and teachers are helping to increase outcomes for pupils eligible for the pupil premium. However, it will take time to establish whether this increased focus will lead to a narrowing of the attainment gap between those eligible for the premium and other pupils.*

Lupton and Thomson (2015) argue that the pupil premium has 'shifted more resources to schools serving children from disadvantaged families in a way that has become more pronounced as its value has increased.' They also concluded that, 'at a time when other spending cuts have disproportionately affected poorer households, these policies stand out for their progressive intent.'

The Education Act 2011 is also in the early stages of implementation. The Act broke up local authority responsibilities for the state school system and by 2014; one in ten primary schools had become Academies. However, there is no clear research evidence available yet to determine whether pupils in Academies perform better or worse than those in the local-authority managed schools they replaced. It is also too early to assess the full impact of other reforms to the curriculum, assessment and teacher training. Lupton and Thomson conclude the school system is in 'flux' and that the key issues of equity and achievement remain 'unresolved'.

The impact of changes relating to children with special educational needs and their families that were introduced by the Children and Families Act 2014 are also too recent to assess. However, the proposed changes were piloted and evaluated for the Department for Education under the Special Educational Needs Pathfinder Programme (Spivack et al. 2014). The evaluation found that areas appeared to retain their previous approaches to eligibility. Therefore the children who had been expected to be eligible for a Special Educational Needs (SEN) Statement were similarly expected to be eligible for a new Education, Health and Care (EHC) plan. However, the EHC planning pathway was found to be different from that for the SEN statement process:

- the family was much more involved through the coordinated assessment and planning stages;
- children's social care professionals were involved *throughout* the Education, Health and Care (EHC) planning process, while their involvement in the SEN statement process had generally been limited to completion of a form during Statutory Assessment; and,
- the new process produced a plan which was more family and outcome focused and resulted in a more comprehensive understanding of the child.

However, challenges still remained in relation to coordination/cooperation between agencies and ensuring that the EHC plan coordinator had sufficient time to deliver a meaningful plan for each family.

In March 2013 the Department for Education published significant changes to the statutory guidance, Working Together to Safeguard Children (Department for

Education, 2013). This reaffirmed that safeguarding children is everyone's responsibility, and all professionals and organisations involved in children's lives need to play their full part. It restated that for services to be effective they must adopt a child-centred approach and be based on a clear understanding of the need and views of children. However, the revised guidance - condensing 700 pages into 95 - aimed to reduce the bureaucracy involved in child protection procedures and give social workers a greater role in every-day decision-making. There was a new emphasis within the guidance on the need to provide intensive early help to address children and families' problems. More specifically, the changes included the removal of the statutory distinction between initial and core assessments and began a process of removing statutory timescales for assessments to allow cases to be driven by children's needs rather than arbitrary timeframes.

The government has also introduced radical changes to the Family Justice System which, Sir James Munby, President of the Family Division, has described as '... the largest reform of the family justice system any of us have seen or will see in our professional lifetimes' (Muller, 2014). The changes are a response to the recommendations of the independent Family Justice Review (Ministry of Justice, Department for Education and the Welsh Government, 2011). They aim to cut delays and improve the overall functioning of the system.

A new Family Court has been introduced in England and Wales, replacing a three-tier system with a single court. Most judges now sit in the same building and there is a more thorough allocation process. These changes should help to reduce the delays previously caused by the transfer of cases between the different levels of court. The reforms also introduced a 26 week time limit for care proceedings to further reduce the delays in these cases. Expert evidence in family proceedings concerning children is now only permitted when necessary to resolve the case justly, taking account of factors including the impact on the welfare of the child.

Chapter Two: The children's experiences and their families' circumstances: birth to age eight years

Introduction

All the 36 children included in the eight year follow-up had been the subjects of a core assessment or Section 47 enquiry and identified before their first birthdays as suffering, or likely to suffer, significant harm. Our first report (Ward, Brown and Westlake, 2012a) traced professional decisions and their impact on the children's experiences and progress from birth until they were three; a second report (Ward, Brown and Maskell Graham, 2012b) explored the children's circumstances at age five and discussed how they had changed in the previous two years. It also considered how the children's experiences may have affected their developmental progress at around their fifth birthdays, when they had begun to engage in formal education. This current report explores how the children's circumstances have altered since their fifth birthdays, and the impact of their past experiences on their progress in school and through Key Stage One. This chapter explores the children's current circumstances and how they have changed since birth.

Background: the children and their families

The original sample included 57 children; however 14 were lost in the early stages as parents who had originally agreed to take part decided not to participate further, or the children were placed for adoption. Nevertheless, 43 children were followed until they were three, 37 until they were five, and 36 children are included in this eight year follow-up. There are some slight differences in the characteristics of the children at each follow-up point, as a small number of parents and carers have moved in and out of the follow-up sample (see Chapter One). The eight year follow-up comprises 26 boys (72%) and 10 girls (28%), an imbalance which has always been evident in this sample, and was replicated in summary data from 639 children who met the study criteria but did not participate (see Ward, Brown and Westlake, 2012a, p.221). Three quarters (27/36: 75%) of these children are White British; nine (25%) are from Black and Minority Ethnic groups. The eight year follow-up comprises 34 lone children and one sibling pair.

Six (17%) of the children have disabilities or special health care needs, including hereditary conditions that can impair sight and gross and fine motor control; cerebral palsy; epilepsy; global developmental delay; and childhood cancer.

Table 4: Comparison of original full sample and the five year follow-up with the eight year follow-up sample

	Original full sample (n=57)	Five year follow-up (n=37)	Seven/eight year follow-up (n=36)
Gender:			
Male	36 (63%)	28 (76%)	26 (72%)
Female	20 (35%)	9 (24%)	10 (28%)
Ethnicity:			
African – Black/Black British	3 (6%)	3 (8%)	3 (8%)
Any other Black – Black/Black British	1 (2%)	--	--
Any other mixed – Mixed	3 (6%)	--	--
British – White	35 (69%)	28 (76%)	27 (75%)
Not stated – Other ethnic groups	1 (2%)	--	--
White and Asian Mixed	5 (10%)	3 (8%)	3 (8%)
White and Black African – Mixed	3 (6%)	3 (8%)	3 (8%)

Evidence of maltreatment

All the children in the original sample were identified as suffering, or likely to suffer, significant harm before their first birthdays. Of the 36 children included in the age eight follow-up, 25 (69%) were maltreated in the first three years of their lives, including 13 (36%) who were maltreated *in utero*, through their mother's continuing misuse of alcohol or drugs and/or through her partner's violent behaviour. Seven of these babies continued to be maltreated following their birth, as well as a further 12 babies who did not experience abuse or neglect until after they were born. As the children grew older and at around the time they started school, there was evidence that 13 (36%) continued to be maltreated. These include 10 children (28%) who had been exposed to maltreatment throughout their lives, and a further three children whose experiences of maltreatment had begun at some stage between the ages of three and five. Beyond the children's fifth birthdays and as they progressed through Key Stage One, there was evidence that 11 (31%) continued to be abused or neglected.

The children experienced a wide range of different types of maltreatment. Of the 25 children who experienced abuse following their birth and before the age of three years, four experienced physical abuse. These children include one, whose parents had inflicted a series of non-accidental injuries on him during his infancy; another, whose mother suffered from mental ill health and had physically assaulted him during infancy; a third, who as a baby had been shaken by his father until he was unconscious and suffered a subdural haematoma; and lastly, a child, who

experienced a complex pattern of physical abuse and neglect, including instances of severe nappy rash requiring hospital treatment. Once physical abuse was identified, it led more swiftly to removal than other forms of maltreatment experienced by the sample children.

The most common form of maltreatment experienced by the sample children was neglect, which often occurred in combination with exposure to domestic abuse and emotional abuse. Twelve (75%) of the 16 children who experienced maltreatment following birth and prior to their third birthday experienced a complex pattern of neglect and emotional abuse; for six children this also included exposure to domestic abuse. Indicators of neglect and emotional abuse rarely led to swift removal, and the children remained at home whilst professionals worked with their parents to address the underlying difficulties that were causing the complex pattern of maltreatment they were experiencing. However, at around the time the children started school, neglect and emotional abuse continued to be a concern for 11 (69%) of this group.

Indicators of neglect are not always difficult to recognise. For instance, professionals may become concerned if children arrive at school dirty or hungry, or they visit homes that are extremely dirty or unsafe (Brandon et al. 2014). Similarly, in the current study, professionals identified, for instance, when health appointments were continually missed, when children were left alone in their homes, or were being looked after by adults who were under the influence of alcohol or drugs. However, as numerous Serious Case Reviews show, professionals may individually have concerns about a neglected child, but these concerns do not always trigger effective action. Brandon and colleagues (2014) identify factors which may cause obstacles for effective action. These include, firstly, a lack sufficient knowledge and training for practitioners of the impact of neglect on the children's social, emotional and behavioural development. Secondly, there may be resource constraints which dictate what practitioners perceive can be achieved when they have concerns about neglect, and thirdly, a number of 'mind-sets' can impede a professional's confidence in taking effective action.

Brandon and colleagues (2014) identify these mind-sets as including: fears about being considered judgemental; a focus on the parent rather than the child; failure to consider the child's lived experience or understand the child's world; a fixed view of the family, such as a professional's first impressions which are difficult to change; parents' superficial or false compliance; practitioners lacking the confidence to take responsibility for an assessment of the impact of neglect on child development; and a reluctance to refer concerns to children's social care. Many of these issues were identified in the earlier stages of the study when, for instance, practitioners in adult services were reluctant to share their concerns with children's social care, or when professionals in all services focused on the parent rather than the child (see Ward,

Brown and Westlake, 2012a). Further discussion on the barriers to effective action as children grew older can be found in Chapter Six.

Importantly, however, there has been no evidence that 11 (31%) children in the age eight follow-up group have ever experienced maltreatment. Two of these were children who were placed with kinship carers at birth because their mothers had significant learning disabilities; one child was placed with his mother in a mother and baby foster placement for two years until she left him and he went on to be adopted; seven were children whose parents had succeeded in making changes to address the underlying problems that placed their children at risk of significant harm before they could be exposed to them. We do not have enough evidence to substantiate whether one additional child, who was at risk of sexual abuse, ever experienced maltreatment, although she was exposed to a convicted child sex offender for a number of years prior to being placed in foster care. The following sections explore and compare in more detail the different life trajectories of children who at the outset were in similar circumstances, but whose parents showed different capacity to address their adversities and safeguard them from harm.

Classifying families where children are suffering, or likely to suffer, significant harm: The Risk Classification Framework

Before their first birthdays all but one of the children were assessed as suffering, or likely to suffer, significant harm and were in receipt of statutory interventions to safeguard and promote their welfare as a consequence. At around this time, birth parents were not only dealing with the usual emotional stress of pregnancy and child birth, but were also experiencing substantial difficulties including: domestic abuse, problem alcohol and drug use, mental health problems, learning disabilities, consequences of abuse in their own childhood, experiences of trauma and loss following the permanent removal of older children (see Neil et al., 2010). Most were experiencing complex combinations of these problems. They were also living with the day to day stresses of housing problems including homelessness, financial problems including bankruptcy, and the problems of living in impoverished and sometimes violent neighbourhoods (see Ward et al., 2012a).

Making decisions concerning which children can safely remain at home and which require temporary or permanent out of home placements is complex, involving an exploration of the children's needs, their parents' circumstances and an assessment of parental capacity to change. There is often a complicated interplay between the presence of risk factors such as domestic abuse, substance misuse and mental health problems, and protective factors such as a supportive partner or relatives, effective professional support and interventions and parental capacity for change.

The research team designed a risk classification framework to facilitate an analysis of this interplay and to aid an understanding of the varying trajectories that the children have followed over a prolonged period. The Risk Classification Framework (Brown, forthcoming) is currently being piloted as a practice tool by the NSPCC (Hyde-Dryden et al., 2014).

The Risk Classification Framework makes extensive use of Hindley, Ramchandani and Jones' (2006) and White, Hindley and Jones' (2014) systematic reviews of empirical studies investigating factors associated with maltreatment recurrence in children. The 2006 review examined sixteen studies which were published prior to December 2002 and met strict inclusion criteria. The 2014 review updated the original review to include empirical studies published between 2003 and 2009, and widened the original scope by including unsubstantiated as well as substantiated cases of child maltreatment. Fifteen studies met the rigorous inclusion criteria of this review, all of which were from the USA. Factors which increased the likelihood of recurrent maltreatment and harm to the child were identified from each study.

The table below sets out 'those factors which were found to be associated with an increased likelihood of future harm, contrasted with those where the likelihood is decreased following identification of significant harm to an index child' (Jones, Hindley and Ramchandani, 2006). The table combines the results from both the reviews. Items in italics were most strongly associated with recurrent maltreatment; the other factors were identified by the studies in the reviews but were less strongly associated with recurrence.

Table 5: Factors associated with future harm[10] [11]

Factors	Future significant harm more likely	Future significant harm less likely
Abuse	Severe physical abuse including burns/scalds *Neglect* Severe growth failure Mixed abuse *Previous maltreatment* Sexual abuse with penetration of a long duration Fabricated/induced illness Sadistic abuse High continuing perpetrator access	Less severe forms of abuse If severe, yet compliance and lack of denial, success still possible
Child	Developmental delay with special needs Mental illness *Very young – requiring rapid parental change* Low child visibility	Healthy child Attributions (in sexual abuse) Later age of onset One good adult corrective relationship
Parent	*Personality disorder* (anti-social, sadistic, aggressive) Lack of compliance Denial of problem Learning disabilities *plus mental illness* *Parental mental health difficulties* *Substance misuse* *Paranoid psychosis* Abuse in childhood – not recognised as a problem Parental stress History of assaultive behavior	Non-abusive partner Willingness to engage with services Recognition of problem Responsibility taken Mental disorder, responsive to treatment Adaption to childhood abuse

[10] Table adapted from: Jones, Hindley and Ramchandani (2006) White, Hindley and Jones (2014) Reproduced following discussion with David Jones (david.jones@psych.ox.ac.uk).
[11] Items in italics most strongly associated with recurrent maltreatment.

Parenting and parent/child interaction	Disordered attachment Lack of empathy for child Own needs before child's *Impaired positive interaction between parents and children*	Normal attachment Empathy for child Competence in some areas
Family	*Inter-parental conflict and violence* *Family stress* Power problems: poor negotiation, autonomy and affect expression Large family size Poor home conditions Housing instability	Absence of domestic violence Non-abusive partner Capacity for change Supportive extended family
Professional	Lack of resources Ineptitude	Therapeutic relationship with child Outreach to family Partnership with parents
Social setting	Social isolation *Lack of social and family support networks and lone parenthood* Violent, unsupportive neighbourhood	Social support More local child care facilities Volunteer network Involvement of legal or medical services

The Risk Classification Framework is a very simple methodology which utilises evidence concerning the risk and protective factors shown in the table above to distinguish between those families where the likelihood of children suffering harm appears to be higher or lower, with particular weight given to evidence of parental capacity for change. The framework consists of four groups:

Severe Risk: Families showing risk factors, no protective factors and no evidence of capacity to change.

High Risk: Families showing risk factors and at least one protective factor but no evidence of capacity to change.

Medium Risk: Families showing risk factors and at least one protective factor including evidence of capacity to change.

Low Risk: Families showing no risk factors (or families whose earlier risk factors had now been addressed), protective factors including evidence of capacity to change.

Data collected from case files and interviews with birth parents and social workers at identification were scrutinised for evidence of these factors. Two members of the research team then independently allocated each of the sample children to one of four groups according to the evidence concerning these factors. Their independent judgements agreed in the majority of cases, but where they did not, the data were further scrutinised and discussed until a consensus was reached. The classification was undertaken at identification and then repeated at ages three, five and eight. Where children had re-entered the study, and thus had not always been included in each of the follow-up samples, the classification was made retrospectively using children's social care case file data.

Likelihood of significant harm: age eight follow-up

Birth to age three years

Table Six below shows the risk classification of the 36 children included in the age eight follow-up sample at around the time of their birth, and at three, five, and eight years old. At birth, 18 (50%) of them were classified as being at medium risk of future harm, nine (25%) at high risk and seven (19%) at severe risk. Two children were not considered to be at significant risk of future harm. At this point, most parents were experiencing multiple difficulties in their lives, including complex combinations of domestic violence, substance misuse and mental health difficulties.

By the age of three, the children's positions had substantially changed. There was evidence that half of the children (18/36: 50%) were now adequately safeguarded whilst remaining at home[12], living with parents who had been able to achieve substantial improvements to their parenting, behaviour and lifestyles, including becoming abstinent from alcohol and drugs, and/or extricating themselves from abusive relationships. However, half (18/36: 50%) of the parents had been unable to achieve such changes. Nine children were now permanently separated from parents who had been unable to change, and nine had remained at home where they appeared to be at medium (three), high (five) or severe (one) risk of suffering significant harm.

[12] The high proportion of parents who showed positive change reflects the nature of the sample (see Chapter One) and is not generalisable to all parents whose children are likely to suffer significant harm.

Three to five years

On the whole, by the time the children had reached their fifth birthdays, their position appeared to be less positive than when they were three:

- The proportion of children remaining at home living with birth parents who had addressed risk factors and sustained their positive changes reduced; from half (18/36: 50%) of the children at the age of three; to just over one third (13/36: 36%) at the age of five.
- Children living at home with parents who had been unable to make positive changes or had not sustained changes they had previously made increased from a quarter (9/36: 25%) at the age of three to just over a third (14/36: 39%) at the age of five. The home circumstances of five children had deteriorated, as parents who had successfully made positive changes earlier in their children's lives had been unable to sustain them up to their child's fifth birthday.
- Although there had been a deterioration of home circumstances for a number of the children between the ages of three and five years, no new legal orders were made, and no more children were placed away from home. The proportion of children who were permanently separated at age five remained the same as at age three (9/36: 25%).

Five to eight years

By the age of eight years, the position of children had changed further from the previous time points:

- The proportion of parents who had addressed their difficulties and had sustained these changes had decreased over the course of the study. The proportion of children who met the criteria for being at low risk of significant harm fell from half the sample at the age of three (18/36: 50%), to just over one third at age five (13/36: 36%), to a quarter by the time they had reached their eighth birthdays (9/36: 25%).
- The proportion of children living at home at continued risk of harm, with parents who had been unable to make positive changes, or who had not been

able to sustain changes made earlier, also decreased, from 14 (39%) at age five, to 11 (31%) at age eight.

- By the age of eight, the proportion of children who were now separated from their birth parents had almost doubled, from 9 (25%) at around the time of the children's fifth birthdays; to 16 (44%) at age eight. This increase in separated children includes three of those who had been living at home at continuing risk of harm throughout their lives, and four children whose parents had made initial positive changes to their lifestyles and behaviour to adequately safeguard their children, but who had been unable to sustain these changes. By the time they were eight all of the children who had been identified as at severe risk of significant harm before they were one were now permanently placed away from home – the last one was 5yrs 8 months old when he was admitted to foster care.

Table 6: Risk classification of eight year follow-up at birth, age three years, age five years and age seven-eight years

Likelihood of significant harm	Birth	Age 3 years	Age 5 years	Age 8 years
Low risk	2 (6%)	18 (50%)	13 (36%)	9 (25%)
Medium risk	18 (50%)	3 (8%)	5 (14%)	9 (25%)
High risk	9 (25%)	5 (14%)	8 (22%)	2 (6%)
Severe risk	7 (19%)	1 (3%)	1 (3%)	0
Separated		9 (25%)	9 (25%)	16 (44%)
Total	36 (100%)	36 (100%)	36 (100%)	36 (100%)

Changes to the children's trajectories according to the likelihood of significant harm

By the age of eight, approximately half of the children remained with birth parents and half were separated. Over the course of the children's lives so far, this proportion had substantially changed. The number of children who were separated from birth parents who had been unable to overcome problematic parenting, or sustain positive changes in the longer term had almost doubled, from a quarter of the children at around the time of their fifth birthdays, to almost half of them by the age of

eight. A closer exploration of the data shows the trajectories the children's lives have taken can be divided into the following groups:

Children who remained at home:

- Remained consistently low risk since the age of three years – sustained parental change (n=9).
- Increased risk since the age of three years: low risk at age three, medium, high, severe risk by age eight – initial parental change but not sustained since age three (n=5).
- Consistently medium, high or severe risk since the age of three years – no/minimal parental change (n=6).

There were no instances where the risk decreased from medium, high or severe risk at age three years, to low risk at age eight years. However by the time they were eight the majority of children who had remained with their birth parents were either at low (nine) or medium (nine) risk of significant harm. Only two were at high risk and none at severe risk.

Separated children:

- Parents who were unable to change and the children separated before their first birthday (n=7).
- Parents who were unable to change and the children separated between ages two and three years (n=2).
- Parents who were unable to make and/or sustain change and their children separated between ages five and eight years (n=3).
- Parents who were successful in making initial changes but were unable to sustain them and their children were separated between ages five to eight years (n=4).

Children's trajectories and parents' capacity to change

The children's trajectories were shaped both by their parents' eventual capacity to overcome the risk factors that threatened their safety and welfare, supported by appropriate services, and by professionals' perceptions and predictions of their ability to do so within an appropriate timescale.

It is evident that, over the eight years since their children were first identified as suffering or likely to suffer significant harm, the parents followed three contrasting pathways - about half of those who remained in the sample showed little or no capacity to change and were consistently unable to meet their children's needs; about one in four made substantial changes in the first three years but were unable to sustain them; and about one in four made significant and sustained changes before the children's first birthdays and developed the capacity to provide nurturing homes throughout the following seven or eight years.

Before exploring the evidence concerning children's emotional and behavioural development (Chapter Three), their school performance (Chapter Four), children's views of their circumstances (Chapter Five) and the professional decisions made and the rationale behind them (Chapter Six), it may be helpful to look more closely at the parents and children who followed each of the following trajectories.

- Parents who were able to meet their children's needs within an appropriate timeframe, by making and sustaining significant changes to adverse behaviour patterns, avoiding relapse and developing their parenting capacity. Their children remained consistently at low risk of significant harm from before the age of three (**the sustained parental change group:** nine children).
- Parents who made substantial changes in the first three years of their children's lives, but were unable to sustain them (**the unsustained parental change group:** nine children). Most of these parents acknowledged that a problem existed and had taken action and engaged with services to overcome it, but had not been able to maintain the changes they had achieved. Their children were all at low risk of significant harm at age three, but were either permanently separated (four children) or at medium, or high risk by the time they were eight (five children).
- Parents who showed little or no capacity to change and were consistently unable to meet their children's needs (**the minimal parental change group:** 18 children). Most of these parents had not yet acknowledged that a problem existed or had not reached the point at which they felt able to address it. Their children had either been permanently removed by the time they were eight (12 children including all those at severe risk) or had remained with them at medium or high risk of significant harm (six children).

Children and parents in the sustained parental change group: consistently low risk between three and eight years old

There were nine parents in the **sustained parental change group;** at age eight all their children were classified as at low risk of significant harm. However, at the start of the study, three of these children had been classified as at high risk of significant harm because their parents had shown substantial risk factors and no evidence of capacity to change: one child's mother had misused drugs throughout the pregnancy; the second child's mother was still in a violent relationship, although she had repeatedly told the social worker that it had ended; and the third child's father, who had claimed to be able to protect his daughter from her violent mother had just been found to have lied to children's services about his previous relationship with another partner who had been convicted of cruelty to her children. Five other parents in this group had already made substantial changes before the start of the study, and their children had originally been classified as at medium risk. One parent had never displayed any significant risk factors and claimed, possibly rightly, that the original assessment by social services had been an over-reaction to a minor, isolated accident.

Only one parent in this group had had children's social care involvement since the child's third birthday; most of them had not seen a social worker since their child was a baby. Fewer children in this group showed evidence of extensive emotional or behavioural difficulties than those in other groups, although two of them nevertheless had high or very high SDQ scores at age eight (see Chapter Three).

Parents in this group had overcome substantial difficulties in their lives and made extensive changes to their lifestyles, behaviours and relationships to effectively parent and safeguard their children. There were two fundamental ways in which they had succeeded in doing so: the first was to overcome addiction, and the second was to extricate themselves from an abusive relationship or, as was the case with so many families with complex needs, a combination of the two.

Four parents (or sets of parents) overcame addictions. All four of these parents had begun to address their addictions during pregnancy, or at the point of the birth of their child, and all were successful in becoming abstinent within six months of the birth of their baby. There is no evidence that any of these parents had relapsed between then and their child's eighth birthdays. An example of the progress made by this group of parents is presented in the case below:

> Prior to his birth, the study child's mother and father experienced substantial difficulties including alcoholism and domestic abuse. These had led to the neglect and physical abuse of his older siblings, who consequently were

permanently placed away from home. During the time between the abuse and subsequent removal of their older children, and the birth of the study child, his mother and father had become committed to engaging with children's social care and addressing the difficulties which led to the separation. He was placed on a child protection plan for the first seven months of his life, but it then ceased and when he was just over a year old the case was closed because of the progress his parents had made. By the time he was three, he had remained with his parents who had succeeded in sustaining their changes; they had also had another two babies.

At the age of five years, this study child remained with his parents and there had been no further children's social care involvement. He was now the eldest of four children living at home. However, their home had become overcrowded, and both parents were experiencing physical health problems. Nevertheless, his mother remained positive about her parenting role and determined to sustain the changes.

At eight, the study child was now the eldest of five children, all of whom were living at home. The family were experiencing some difficulties, including unsuitable and overcrowded accommodation, financial problems and the deteriorating physical health of both parents. There were issues also in relation to the child himself who had been refusing to go to school. However, despite these problems and the challenges of raising five children, his mother remained positive about her parenting role and highly committed to sustaining the changes she had made.

(Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

The second way that parents succeeded in minimising the likelihood that their child would suffer significant harm was by extricating themselves from an abusive relationship, or protecting them from an emotionally abusive parent who had mental health problems. Four parents successfully addressed the risks of maltreatment in this way, including two mothers who ended a relationship with a partner who was physically and emotionally violent towards them and two fathers who ended a relationship with a mother who had a long standing history of abuse and neglect towards older children who had been permanently separated from them. Both fathers in these cases became the primary carers for their babies. The case presented below is one such example:

This study child's parents had only had a very brief relationship with one another when her mother became pregnant. Her father knew very little about her mother's history, which had included the removal of her two older children because she had physically abused and neglected them. The study child's father had arrived from Iraq as a teenager. He did not understand the role of children's social care and did not therefore question why his partner's children were cared for by their paternal grandparents. The study child was placed in foster care following her birth whilst parenting assessments were completed.

However, the pressures of these assessments combined with the experience of their child's removal and the stress of only seeing her in a contact centre for many months led to the couple separating, and at this point only the study child's father 's assessment was continued. This was positive, and at around the age of six months, she was placed in his care permanently. However, the child and her father lived at a considerable distance from their other relations, and soon after reunification, they moved to be closer to them. The extended family were extremely supportive, particularly during the first three years of her life, when her father found life as a young single dad very isolating.

At around the time of the study child's third birthday, she was thriving, and described by her father as a well-balanced, loving and out-going little girl with plenty of friends. The extended family continued to play an extremely important and supportive role in her life, particularly in helping her father with childcare so that he could return to work. She also had regular phone contact with her mother.

The study child continued to thrive and progressed well as she started school; she was described as an intelligent and loving girl who could speak several languages. Her relatives continued to play an important role in helping her father with childcare. Her mother had maintained regular phone contact, although she rarely saw her daughter, as neither parent could afford to travel the long distance.

At the age of eight, the study child was still living with her father, and there had been no further involvement from children's social care since she was a baby. Her mother had continued to maintain regular phone contact, however the support the child and her father had been receiving from her wider family had diminished because her grandmother had recently begun to suffer from a degenerative health condition. She had been extremely close to her grandmother, and found her increasing disability very upsetting. Her father had sought advice from her school and a local support service to help her come to terms with her grandmother's illness. She had recently started an after school club which she was enjoying. Her father is very proud of her, and believes that her life should not just be about getting good grades; it should also be about having fun.

(Girl: medium risk of significant harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

While the major changes for these parents had been externally focused on protecting themselves and their children from an abusive partner, they had also had to make substantial internally focused changes both to their self-perceptions and to their lifestyles.

One father, for instance, who had given up his job to care for his new baby and an older child had until then 'been escaping the kid side of things'. He found the change:

> *Quite daunting, I'll tell you, going from oil and water to nappy changing, I mean, it was pretty scary at the beginning, and I thought I've got to do it 'cos I couldn't see 'em going into care or nothing, so I decided if you're man enough to have them [babies] you're man enough to look after 'em, so what I got, got here, and I ain't regretted it…. I never thought in a million years I'd have ever done it, but I have done it and I'm quite pleased I have.*
>
> (Birth father of study child: age two interview)
> (Girl: medium risk of significant harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

As we shall see, the majority of mothers who had extricated themselves from abusive relationships with violent men by the child's third birthday had either re-established them or moved on to another equally abusive partner by the time the children were eight. However two mothers both succeeded in developing the inner confidence and sense of self-efficacy needed to withstand the pressures that led to this common trajectory (see Stanley, 2011). By the time their children were eight they were also both in long-term relationships with non-abusive partners.

These are illustrations of some of the success stories, but at the age of eight, there are fewer than at the age of five, and only half of the number that appeared successful at the age of three. The cases illustrated above show the significant changes that can be made to improve parenting ability when parents are determined to succeed. However, the circumstances of many of these families are fragile. The interviews with birth parents suggest that the presence of secondary risk factors including poverty, unsuitable and overcrowded housing, financial difficulties, and poor mental and physical health are making it increasingly harder for them to cope and sustain the improvements they have made. Their support networks are also diminishing in strength as grandparents begin to age.

The experiences of the following group of children, those whose parents had made extensive improvements to their parenting during their infancy, but had been unable to sustain them beyond their third birthdays, can provide some useful insight into the impact of secondary risk factors and the vulnerabilities these families face.

Unsustained parental change group: children who were no longer safeguarded at home

There were nine parents (and ten children) in the unsustained parental change group. At the start of the study one of these children was classified as at low risk of significant harm – children's social care had primarily been involved because the child had a disability requiring intensive care which the mother was finding it difficult to engage with because she was suffering from post natal depression. The other children in this group were all classified as at medium risk because their parents had already made substantial changes before their first birthdays. By the time they were three, the major problems had apparently been overcome, and, as with the *sustained parental change* group, all children in this group were classified as at low risk of significant harm. However, by the time they were eight, the circumstances of children in the *unsustained parental change* group had deteriorated (or more evidence of parents' problems had become apparent), and four of them had been placed away from home, while five were living with birth parents, four at medium and one at high risk of harm.

The most common reasons for the deteriorating circumstances of families in this group were recurrent domestic abuse and the mother's mental health problems. These were often combined, although in two families (three children) domestic abuse was more prominent and in four families fluctuating parental mental health problems played a greater part. In the other three families, new evidence came to light that indicated that previous assessments of parental change had been over-optimistic (see below). The case, illustrated below, is an example of deteriorating circumstances relating to abusive relationships:

> This study child's father had a history of perpetrating domestic abuse and had mental health problems. His mother had also been severely neglected as a child, resulting in the prosecution and conviction of his grandmother.
>
> When he was five months old he suffered a non-accidental head injury, caused by his father shaking him. Subsequently the study child was placed in foster care whilst parenting assessments were completed. Both these were positive, but by the time the father's was completed, the study child's mother had extricated herself from the relationship and, at 11 months old he was rehabilitated to her care. Around the time of the study child's first birthday, the case was closed to children's social care.
>
> Before the study child's third birthday, his mother had formed a relationship with a new partner. However, her new partner also had a history of perpetrating domestic abuse and by his fourth birthday there had been several episodes of violence in his home, and his mother was struggling to look after herself, her children and their home. At around this time, the study child became the subject of a child protection plan, his behaviour had become

increasingly aggressive and his speech and language development was delayed.

When the study child was five, the police were called to the house by neighbours who could hear a loud argument. The police report expressed concerns that he and his siblings were being severely neglected. From about this time, children's social care intensified their involvement because of further incidents of domestic abuse and concerns in relation to the neglect and emotional abuse of the study child and his siblings. Under pressure from children's social care, his mother ended the relationship; however she now had two children by this partner and he maintained contact. By the age of eight years, the study child had substantial emotional and behavioural difficulties, which had recently included hearing the imaginary voice of his mother's ex-partner telling him to stab her with a kitchen knife and he was in receipt of intensive support services from school to help him come to terms with these difficulties.

(Boy: medium risk of significant harm at birth; low risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

The other issue which notably affected parents' ability to maintain initial positive changes was the re-emergence of long-standing mental health problems. For instance, one child's mother succeeded in overcoming her mental health problems as well as her addiction to heroin for the first five years of his life. However, her mental health then began to deteriorate, and she had several admissions to psychiatric hospital within a year, the last one because she had threatened to kill herself and her child. As a result, he went to live with his maternal grandmother. Other parents' mental health issues were not so dramatic: the case presented below is of a child who experienced a more nuanced trajectory:

During the early months of this study child's life, his mother suffered from post natal depression. She had suicidal feelings and felt she might harm her baby. The study child consequently became the subject of a child protection plan. He and his mother moved into his grandmother's home, and three months later, following a family group conference, children's social care involvement ceased. However, his mother and grandmother's relationship was not always supportive and could at times be volatile. When the study child was about 18 months old, he and his mother were evicted from his grandmother's home. They were rehoused into a one bedroom flat, but the conditions were very cramped.

By the study child's third birthday, he and his mother had moved to alternative accommodation, but it was still very cramped. He was displaying emerging emotional and behavioural difficulties. However his mother was in a new relationship and she was not showing signs of mental health problems. By the study child's sixth birthday, children's social care had become involved again and he was offered services as a child in need. His mother was experiencing several difficulties including poor housing, social isolation, hostility from the

neighbourhood within which they lived and deteriorating physical and mental health. The study child's emotional and behavioural difficulties had also become more severe. By the age of eight these circumstances had deteriorated further and his mother's physical and mental health had severely worsened. The child had at least twice been physically attacked by other children on the estate, on one occasion so severely that the police had been called. Further support for his mother and her children was not forthcoming.

(Boy: medium risk of significant harm at birth; low risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

The presence of secondary risk factors, including social isolation, long-term poverty, poor housing, hostile neighbourhoods, and poor physical health is very evident amongst parents in the unsustained change group, and exacerbated the challenges they faced in maintaining the positive changes they had previously made. The birth of more children from new relationships and the problems of maintaining complicated contact arrangements also increased the vulnerability of these parents, who also often had to cope with increasing emotional and behavioural difficulties displayed by their older children. For instance, one mother was caring on her own for four children, one of whom was severely disabled, and two of whom had significant behavioural problems. She was also trying to juggle contact arrangements with two birth fathers, one of whom was forbidden any form of contact with two of the children in the household. She was struggling to manage on a minimal income that did not allow for any savings to cover emergency expenses. However the family had recently been helped to move to accommodation that was in better condition than their previous home.

The following chapter explores evidence of emotional and behavioural difficulties amongst the sample children; it shows that the prevalence of difficulties is greater amongst children in the unsustained parental change group than those who were living with parents who were able to sustain improvements to parental capability. Some children in the unsustained change group were showing evidence of extremely challenging behaviour: for instance, one child had been excluded from school three times by the time he was eight, and the volunteer who had been found to act as his mentor was recorded as being 'frightened of him'. His mother had successfully extricated herself from a violent relationship by the time he was three, but had then become increasingly dependent on alcohol.

A key finding from our previous reports (see Ward, Brown and Westlake, 2012a; Ward, Brown and Maskell Graham, 2012b) was that there was often a premature withdrawal of services, particularly when parents had succeeded in overcoming their difficulties. These cases were often closed abruptly and with no further monitoring or support. Parents were also highly unlikely to contact children's social care themselves if they experienced further difficulties, because understandably they

were fearful that evidence of further problems would be interpreted as grounds for judging them to be incapable of looking after their children. The cases illustrated above highlight these issues.

However some parents' apparent inability to maintain changes is only part of the picture. In some families new information came to light after the children's third birthdays that made it clear that the changes that appeared to have been made in the first three years were largely illusory. For instance, one child, was thought to have been adequately safeguarded because she and her siblings had been made the subjects of care orders and placed with their mother with the stipulation that all contact with the father, who was considered to pose a danger to children, should cease. However, although it was now concealed, the relationship continued. Finally, after two and a half more years the parents were 'caught out' when one of the children 'let slip' at school that she was seeing her father. He explained:

> *Would you blame the girl [child's older sibling], do you blame her... all she's had is fright and fear whenever somebody comes to the door, she comes and shouts 'Daddy social services are here' I can't blame the girl at all from saying that, she's had a horrible life, and the social worker would say 'Have you seen your Dad?' and the girl would have to lie... it was a horrible experience.*
>
> (Birth father of study child: age eight interview)
> (Girl: medium risk of suffering harm at birth; low risk at age three; high risk at age five; permanently separated at age eight – unsustained parental change)

It could be argued that this child's parents, as well as another mother, whose longstanding alcohol dependency did not come to light for more than three years, should have been re-classified as parents who had shown little or no capacity to change and placed in the minimal change group. However we have not done so because this is a prospective study, our data are collected and analysed in *real time*, as and when events in the children's lives are occurring and their circumstances changing. We therefore have not used the benefit of hindsight in our analysis of these cases; instead we used only the evidence that was available for each child at each time point. This has facilitated greater understanding of the reasoning and evidence which formed the basis of key social work decisions for these children (see Chapter Six for further exploration).

Three of the four children in the unsustained parental change group who were placed away from home after their fifth birthdays were removed at least partly because new evidence had come to light that identified long-standing problems that had previously passed unnoticed: one child and her siblings had been made subjects of care orders since she was 12 months old, but had continued to live at home with their birth mother. Four and a half years later they were removed and placed with local authority foster carers when it became apparent that they had been secretly

seeing their father; a second child was removed from his birth mother when the alcoholism which had been a problem since she was fifteen, came to light; and a third child was abruptly removed from his birth father because he was thought to have been subject to physical abuse for many years - an issue that was hotly denied. Only child in this group was placed away from home because his parents had genuinely changed: this child was placed with his grandmother at six years old because his mother's mental health problems re-emerged.

Persistent concerns about the children's welfare: minimal parental change group

There are eighteen children whose parents were classified as being in the minimal change group. Parents in this group tended to display more complex combinations of adversities than parents in other groups. At least a third of them had lifestyles that were described in social work assessments as 'chaotic', with a combination of factors such as drugs, prostitution and homelessness featuring heavily. Domestic violence was also a factor in at least a third of families in this group. The group also includes two mothers who had learning disabilities that were linked with additional concerns relating to sexual vulnerability and domestic abuse. Neither of these mothers had shown an interest in caring for the baby either before or after the birth. At around the time they were born, seven children in this group were classified as being at severe risk of significant harm, six at high risk and five at medium risk.

All but three of the children in the minimal change group experienced abuse or neglect in early childhood. The exceptions are one child, who was placed at birth with his young mother in a mother and baby foster home and was abandoned by her at the age of two, and the two children of learning disabled mothers, who were placed with relatives at birth.

The prevalence of emotional and behavioural difficulties in children in the group showing minimal parental change is striking. At least ten of the eighteen children in this group were showing signs of emotional or behavioural difficulties at the end of the study, according to their scores on the Strengths and Difficulties Questionnaire. By the time they were eight, these children's emotional and behavioural difficulties were having a negative impact on their relationships with parents, carers and teachers, as well as with other children. Parents who were still labouring under their own problems were finding it difficult to look after them without additional support, and in some instances a vicious circle of increasingly negative inter-relationships was becoming established. For instance, at the eighth birthday interview, one mother described her daughter as defiant, aggressive and confrontational. She was unkind towards her brother and had poured cold water on him. She had also hit a support worker at school, who had had two weeks off as a result of the incident. According

to her mother, this child would hit family members and ‘make your life hell' if she did not ‘get her way’. At this interview, the mother struggled to find anything positive to say about the child at all.

> *She will hit you... she will throw herself on the floor, she’ll scream, she’ll shout, she’ll have paddies, she’ll do what she wants, she don’t care... it’s very tricky at the moment, the way that she is.*
>
> (Birth mother of study: age eight interview)
> (Girl: medium risk of suffering harm at birth; high risk at age three; high risk at age five; high risk at age eight – minimal parental change)

The emotional and behavioural development of the sample children as a whole is discussed further in Chapter Three.

Children in minimal change group who remained with birth parents

By the time they were eight, two thirds (12/18) of the children in the minimal change group, including all of those who were classified as being at severe risk of significant harm, had been permanently placed away from birth parents. However a third of them (6/18) continued to live at home. Concerns about the parents’ ability to safeguard these six children, and to meet their social, emotional and physical needs, have persisted throughout their lives. At eight, four were classified as being at medium risk and two at high risk of significant harm, but the risk classification has tended to fluctuate between medium and high as parents have temporarily shown some evidence of positive change, but have then been unable to progress further or persist. These parents differ from those in the unsustained change group in that so far they have never, even temporarily, completely overcome the problems that placed their children at risk of significant harm. Substance misuse was not a strong feature of parents in the minimal change group whose children remained at home. However domestic abuse and/or parental mental illness which have fluctuated in severity over time have created this pattern of increased and decreased risk and created ongoing concerns about emotional abuse and neglect. The case presented below illustrates these circumstances:

> This study child’s father suffered from mental illness as well as a number of physical health problems at the time of her birth. Her mother had had an abusive childhood and appeared to be very depressed throughout the study, although she refused counselling or other forms of support. Both parents’ mental health problems appeared to be exacerbated by unresolved feelings of loss related to the removal of five older siblings because of concerns about emotional and physical abuse. The study child was placed in foster care at birth, and her parents had daily contact, and subsequently completed a residential assessment when she was seven months old. The outcome of this assessment was positive, and at nine months she was reunited with her parents, under the protection of a care order and with a substantial level of

support from both children's social care and health visitors. By the time she was three, the professional support for the family had reduced, but the care order remained in place. The study child had by then been diagnosed with global developmental delay and related illnesses. When she was five years old, the care order was rescinded against the wishes of the school; she was still at home with her parents and she now had a younger sibling who also had extensive health care needs. At around this time however, the family were experiencing substantial stress, and her father, who had originally been identified as the main carer, spent most of his time in bed leaving the majority of child care to her mother. The family lived on an extremely hostile estate, the children could not play outside because of local drug users and resulting paraphernalia and the presence of aggressive dogs.

By the study child's eighth birthday, her family were under immense strain. Her father, continued to spend most of his time in bed, and her mother was struggling to cope with the hostility of their neighbourhood, financial problems, tensions within the extended family, her children's health needs and the difficulty in travelling a long distance on the bus each day to get her children to school. In addition to her health needs, the study child had also developed severe emotional and behavioural difficulties, and could be very aggressive towards her parents. Children's services had closed the case when the child was six; although there had been three subsequent referrals for suspected physical abuse and neglect, none of these had led to further professional support. The mother would not approach children's social care or the school for help for fear that the children would be separated from them. The family's circumstances were extremely fragile and at the brink of crisis.

(Girl: medium risk of suffering significant harm at birth; medium risk at age three; high risk at age five; high risk at age eight – minimal parental change)

The child described above remained with her birth parents, with inadequate and sporadic support, just below the threshold for further social work involvement and possible entry to care. Chapter Six looks more closely at the implications of social work decisions in cases such as this.

Children in the minimal parental change group who entered long-term care

Twelve children in the minimal parental change group had entered long-term care by the time they were eight. Two, had experienced extensive parental substance misuse *in utero* and were immediately separated at birth, as were the two children of learning disabled parents who lacked the capacity to care for them, and were placed with family members, described above. Four more were initially cared for by their birth parents, but were placed away relatively early: three before they were six months old and one at 14 months. Extensive attempts were made to help another child's mother successfully parent him, but she left their shared foster placement when he was two, because she could no longer cope with parental responsibilities.

At least seven of these children had substantial experiences of abuse and neglect. They include one child who suffered a series of non-accidental injuries, another who was neglected by his mother and often either left home alone or cared for by groups of young people who had been drinking and taking drugs; and a third, who was considered to be at severe risk of harm at around the time of his birth, and who went on to experience chronic neglect and physical abuse.

Three older children in the minimal parental change group, who remained with birth parents until they were six or seven, had been exposed to domestic abuse, parental substance misuse, neglect, abandonment and had very poor school attendance throughout their lives, giving rise to continuing concerns about their safety and wellbeing. For instance, before being placed in long-term care aged seven, one child had been placed with temporary kin carers on three occasions, following incidents of domestic abuse or, on one occasion, being left alone overnight. He was finally placed away from home to safeguard him from exposure to domestic abuse.

The case presented below illustrates in greater detail the trajectories of these late-separated children:

> Both parents were drug users, and the study child's mother continued to misuse substances during pregnancy. Both parents had experienced abuse in their own childhoods and did not have any support from their extended family. The study child was separated from her parents at birth, whilst assessments were carried out concerning their ability to care for her. These assessments were positive and, at three months old, she was reunited with her parents, initially with the protection of an interim care order, and then from just before her first birthday for a further twelve months on a supervision order. Her parents had succeeded in reducing their drug intake during this time, but had not achieved abstinence. Over the next two years the quality of care her parents were providing to her and her young sibling fluctuated, and there were incidents of domestic abuse. Her parents' drug use then increased, and they were using heroin within their family home. When the study child was five, her school teacher was extremely concerned for her welfare, and she often seemed withdrawn at school. Her attendance was also very poor. There were further concerns that her mother was using their home for prostitution and that she had re-established a relationship with a convicted paedophile and therefore that the study child and her sibling were at risk of sexual abuse. Children's social care became re-involved and at around the time of her seventh birthday she and her sibling were moved to foster care.
>
> (Girl: medium risk of suffering harm at birth; medium risk at age three; medium risk at age five; medium risk at age eight – minimal parental change)

The trajectory of this child as well as those of others in this group raise serious concerns about the reliability of the assessments of parental capability that were completed during the children's early years; the adequacy of the analysis relating to evidence concerning the likelihood of significant harm; and the appropriateness of

the decisions that were made that would go on to have a long-term impact on the lives and wellbeing of these children.

Permanent separation

Three of the nine children in the minimal parental change group who were separated from their birth parents before their third birthdays were placed with adoptive parents, and six were placed in kinship care with Special Guardianship or Residence Orders. The three children from this group who were separated after five were placed with unrelated foster carers. Two of the four children in the unsustained parental change group who were separated from their birth parents after the age of five were placed permanently with unrelated foster carers; the other two were placed with relatives until their parents were able to resume care. Table Seven gives brief details of these children, and the timeframes for intervention in order to facilitate understanding of their experiences.

Table 7: Timeframes for separation

Child	Reason for separation	Age at separation	Age at entry to permanent/long-term placement	Permanent placement	Emotional and behavioural development at 8 based on parent/carer completed SDQ
Girl	Learning disabled mother unable to cope	0 months	0 months	Kinship care/Special guardianship	Total difficulties: very high Impact[13]: missing Interview with carer suggests impact of EBD is very high EBD data at age 5 missing
Boy	Learning disabled mother unable to cope	0 months	0 months	Kinship care/Special guardianship	Total difficulties: very high Impact: very high Remained the same since age 5 Global developmental delay
Boy	Repeated non-accidental injuries	5 months	5 months	Kinship care/Special guardianship	Total difficulties: very high Impact: very high Remained the same since age 5

[13] The SDQ includes an impact score, reflecting whether the informant considers the child to experience distress or social impairment as a result of any of the emotional or behavioural difficulties it covers.

Boy	Substance misuse in utero	0 months	9 months	Kinship care/Residence order	Total difficulties: high Impact: close to average Deteriorated since age 5
Boy	Neglect of older siblings	1 month	11 months	Adoption	Total difficulties: very high Impact: very high EBD deteriorated since age 5
Boy	Substance misuse in utero	0 months	15 months	Kinship care/Residence order	Total difficulties: slightly raised Impact: close to average Deteriorated slightly since age 5
Boy	Neglect	6 months	18 months	Adoption	Total difficulties: close to average Impact: close to average Diagnosed with Autistic Spectrum Disorder EBD data at age 5 missing
Boy	Physical abuse and neglect	18 months	18 months	Kinship care/Special guardianship	Total difficulties: very high Impact: very high Remained the same since age 5
Boy	Birth mother left mother and baby foster placement because she was unable to cope	2 years	4 years 11 months	Adoption	Total difficulties: slightly raised Impact: very high Improved since age 5

Girl	Risk of sexual harm from father	5 years	5 years	Foster care	Total difficulties: very high Impact: missing EBD deteriorated since age 5
Boy	Neglect	7 years	7 approx.	Foster care	Total difficulties: close to average Impact: close to average Remained the same since age 5
Boy	Substance misuse by birth mother	4 -5 years 7 years	7 years	Kinship care	EBD data missing
Girl	Risk of sexual harm (also neglect and domestic violence)	6 years	8 years	Foster care	Total difficulties: close to average Impact: close to average Remained the same since age 5
Boy	Mental health of birth mother	6 years	Care not permanent plan	Kinship care	EBD data missing
Boy	Domestic violence	6 years	Care not permanent plan	Foster care	EDB data missing
Boy	Physical abuse by birth father	6 years	Not yet permanent	Foster care	EBD data missing

Although at entry to care the intention had been to place all but three of these children away from birth parents on a long-term basis, some, at age eight, had not yet found a stable, permanent home. As the following chapter shows, many of the children were displaying extensive emotional and behavioural problems, and these were placing a strain on placements; one placement had already broken down, and others were approaching crisis point.

We know that 12 children from the original sample were placed with adoptive parents. However adopters have been reluctant to take part in the study and we were only able to access three adopted children at around their eighth birthdays. There is insufficient data to show how representative their experiences are of other children placed for adoption. However we do know that all three of these children were displaying emotional or behavioural difficulties at age eight; that these were of varying concern to their carers; and that at least one of them was displaying the type of extreme child to parent violence identified as prevalent amongst adopted children with challenging behaviour patterns in Selwyn and colleagues (2014) study of adoption disruptions (see Selwyn et al., 2014, p.148-150).

Our report on the children's progress at age three (Ward, Brown and Westlake, 2012a) had identified the double jeopardy experienced by many children who are placed for adoption, in that they first experience abuse and neglect before removal from their birth parents and then trauma and loss when a close relationship developed over many months with a temporary carer is broken as they enter their adoptive home. The experiences of some of the adopted children in the sample appear to have followed this pattern.

Our previous reports have highlighted the difficulties experienced by the children in kinship care placements, and the increasing strain the placements were having on family life. When the children were eight, these placements appeared no more positive and all six permanent kinship placements, supported now by special guardianship or residence orders, were under considerable strain. All the children placed permanently with relatives were displaying troubling behaviour, and all were experiencing difficulties at school. For instance, one carer described how their child was regularly trashing the classroom:

> *Tables go flying, chairs go flying. They have little pots with pencils and pens, they go flying. He'll destroy everybody's work, writing, ripping it up, you know, like he's so frustrated about something.*
>
> (Permanent carer for study child: age eight interview)
> (Boy: severe risk of suffering harm at birth; permanently separated by age three)

Another child, also placed permanently with relatives, was refusing to go to school, and would not be in a room alone at home. He had been placed with his before his first birthday, and they linked his escalating difficulties with him starting to question his identity, and asking about issues which they felt ill-equipped to discuss. This child's carer had contacted children's services for help with life story work over a year before, but

none had been forthcoming. At eight, he was still unaware that his 'mother' was, in fact, his kinship carer: She commented that she needed:

> *Someone to help me how to tell him, if you see what I mean, because I haven't got a clue what to say... because he's so sensitive I don't know how he takes it, you see what I mean. I think he'll take it well that he's got another mum and a dad, but I think the bit that won't get through [child's] head is that I'm not his real mum, if you see what I mean. It's like he won't stay out anywhere still...That's the reason he says he doesn't want to go to school and stuff like that because it's all that he's going to miss me... [uncle] is quite an anxious person as well so I think [child] winds him up so then you've got both of them ... but no, it's just me really, yes and the school said because I'm the primary carer ...you know a trip to the Co-op for them can end up in a huge row where [child] will kick off, or something, and then [uncle] will get anxious and he just can't take it, so he'll bring him home, 'I'm never going back'.*
>
> (Permanent carer for study child: age eight interview)
> (Boy: severe risk of suffering harm at birth; permanently separated by age three)

When the children were five years old we reported that at least two of these placements were on the verge of breakdown. We now know that one placement, has disrupted:

> This child was placed with his maternal aunt and her partner at the age of five months following a series of non-accidental injuries, including a broken arm. Because of the nature of the circumstances they did not have the opportunity to fully consider the implication of caring for him as well as their own children who were of a similar age. A Special Guardianship Order was granted when this child had just turned one year. However, by the time he was three, his relatives found caring for him extremely challenging. He was described by them as having a very short attention span and high pain threshold: for instance he had not responded when he burnt himself on an iron. He would also bite the other children living in the home. His aunt had to leave her employment so that she could care for him, and consequently his uncle worked away so that he could earn more to cover the loss of household income. The family had not received or been offered any support to help them deal with the strain of the placement.
>
> By the time he was five, his placement had become increasingly fraught, and his aunt and uncle had temporarily separated. This child's behaviour was highly challenging and the family, including the other children in the home, reported feeling scared of him. The family blamed much of their anxiety and stress on the child's presence; neighbours and the school had expressed concerns about the treatment he was receiving , and a number of neighbours and professionals had expressed concerns that his carers treated him less favourably than their own children, and had been heard telling him that he would have to leave. His aunt recognised that with hindsight the family would not have offered the child a permanent placement, had they known the difficulties involved. Support was also not forthcoming.
>
> The circumstances did not improve, and just after his ninth birthday, his placement disrupted and he was placed with alternative kinship carers. The whole family

were upset by the placement breakdown, particularly the cousins he had lived with, who began to soil and wet the bed.

(Boy: severe risk of suffering harm at birth; permanently separated by age three)

A number of factors contributed to the difficulties the children and carers experienced in kinship care or special guardianship. Firstly, the placements raise concerns about unrealistic expectations of kinship carers who are asked to look after an extra child on a long-term basis. Relatives were often struggling with the same issues of unemployment, poverty, poor housing and poor health as birth parents (see Chapter Six). The two children living with relatives on residence orders were both living in extremely impoverished circumstances: one, had shared a bedroom with four of his uncles (all minors) for many years; his aunt and her child had also lived in the 'parlour room' of the house for some years, leaving the family unit of ten with only one downstairs room and a galley kitchen, the other was living in a neighbourhood where the family were bullied and he was frightened to go out. Bringing up a vulnerable child in these circumstances requires resources which were often not forthcoming.

Secondly, the data show how the kin carers were more likely to have been asked to intervene at points of crisis, and were therefore given very little opportunity to fully consider and understand the implications of providing long-term permanent care for the children, particularly those who had experienced maltreatment. There was also little evidence of professionals acknowledging to the kinship carers that social, emotional and behavioural problems are more likely to occur in young children who have been removed from very abusive situations. One of the kinship carers explained:

I assumed he'd fit in, especially as he came as a baby. I assumed he'd fit in with the rest of them [birth children]. I'd never heard of attachment disorder. But I think a lot of children who go into care get it. I think we should have been warned of it before we went for a SGO [Special Guardianship Order]. We were told nothing. I think Social Services have fallen short there. We didn't have any information or counselling, I think we should have been given counselling, saying 'he could have this when he gets older.' It's no good a social worker coming to me now, one came in December saying 'you do realise when he's a teenager he probably won't be living with you anymore because the percentage of children like [child] who ruin their home life and end up back in care is very high – I went 'thanks for the vote of confidence, you've really helped me.' We had no idea in the beginning that he wouldn't go back to his mum and dad. We were just asked if we could take him on. We had no idea what we were taking on. We were just told to take him or he'd have to go into foster care. We had no idea what had happened. Had no idea about the non-accidental injuries –we just thought they [birth mother and father] were not coping. When you're told a year down the line 'oh he's not going back' ... here's this baby we should have had a lot more information and family counselling.

(Permanent carer for study child: age eight interview)
(Boy: severe risk of suffering harm at birth; permanently separated by age three)

Thirdly, and further compounding the issues outlined above, the data raise questions about the adequacy of support for kinship carers. The carers in this study needed professional support: to help them understand the children's earlier adverse experiences; to help them cope with the children's extensive emotional and behavioural difficulties; to help the children themselves come to terms with their experiences; to facilitate the children's own understanding of their place within their family; and to understand the impact of providing a home for a relative's child on the wider family dynamics. This was rarely forthcoming.

Three children were permanently separated from their parents between the ages of five and eight, and placed in mainstream foster care. Whilst one of them was reported to be angry and challenging to care for, the other two were not. Both these children had experienced gross neglect throughout their childhoods: at five, each of them respectively had been described by their teacher as the child about whom the school was most concerned. One of them had also been repeatedly exposed to domestic abuse. Although both had very troubled siblings, these two children showed great resilience in the face of adversity. They had been described by their parents as cheerful, placid, 'deep-thinking' children who were very caring and 'easy.' This resonated with the experience of their foster carers, who noted that they were a 'delight' to care for, able to get on with other people well; 'very likeable'. One had found it easier to relate to adults than children when first placed, but that had soon changed. The other, who had often protected her mother from her violent father, was unusually caring and sensitive towards other people's feelings, her foster parents noticed.

Parents' views of current circumstances

Many parents in the study, including the majority of those in the minimal change group, reported experiencing abusive and often very unhappy childhoods.

> *My mum and dad never said they loved me, they never put their arms round me, never gave me love.*
>
> (Birth mother of study child: age eight interview)
> (Boy: high risk at birth of suffering; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Some were conscious of the need to change the pattern of their own childhood for their children, for whom they desperately wanted something better:

> *We enjoy spending our time as a family, you know, us three. Because it's something I didn't really have as a kid, you know. Mum were a drinker when I were a kid. I were moved. I went to six different first schools, it wrecked my school years, did that, maybe even led to all the years of drugs, you know, because I had a bad start in life. We knew both of us had had unstable childhoods and we knew that she [daughter] needed a stable childhood. I hated school, me. I hated school more than prison. But I enjoyed prison - more like sitting in a Jacuzzi, school like being electrocuted, you know, in comparison. School terrified me. Jail were like a walk in the park, it were totally easy.*
>
> (Birth father of study child: age three interview)
> (Girl: severe risk at birth of suffering harm; high risk at age three; high risk at age five; permanently separated at age eight – minimal parental change)

Although most parents in both the unsustained and minimal change groups were angry and resentful if their children had been placed in care, this was not true of all of them. Two parents of children (unrelated) who entered care following their fifth birthdays felt that their children had benefited from the fact that they were no longer living at home. One of these parents described their child as now happy; feeling more secure, content and comfortable with himself. She recognised that he had not had much adult attention whilst in her care, and was enjoying that now. The other child's parent had similar experiences:

I'm really annoyed now I can see how me and [child's mother] weren't good for those kids, it really bugs me, it really annoys me, that I were too busy hating [mother], to understand that I should've been protecting them maybe more, you know, and I shouldn't have been calling [mother] names in front of them, cos at the end of day she's their mum, isn't she?

They're [child and sibling] thriving [in care]... a little bit of me... it's hard for me to see, that, but I know my kids are doing well and ultimately that's what I want , me kids to do well – I want them to grow up and want to have a job, you know – when I were a kid I can't remember ever being encouraged and that, and I wish I had've been – I really want my kids to grow up and have an ambition, cos I didn't, me... at 14 I already felt the world were against me.

(Birth father of study child: age eight interview)
(Girl: severe risk at birth; high risk at age three; high risk at age five; permanently separated at age eight – minimal parental change)

Conclusion

This chapter has considered in some detail the children's experiences from birth until they reached their eighth birthdays. The picture should give rise to concern: the circumstances of the sample as a whole deteriorated as the children grew older, and one in three children were abused or neglected throughout their lives. While nine (25%) of the children remained with parents who had been able to overcome adversity and maintain significant changes, another nine remained with parents who had been unable to make or unable to sustain changes; many of these parents had fluctuating problems with mental health and/or domestic abuse, but were unwilling or unable to access the support they needed. By the time they were eight, almost half the sample were permanently placed away from home, including all those who had been identified as at severe risk of significant harm before their first birthdays. Although some children flourished in care or with adoptive families, some placements were very fragile, including all six placements with special guardians who needed far more support than they received to respond appropriately to children's emotional and behavioural problems and to help them understand their place in the family.

Key points from Chapter Two

- By the time the children were eight over two thirds of them had experienced maltreatment at some point, and eleven (31%) had continued to be neglected or abused throughout their lives. However there is no evidence that a further eleven (31%) of the sample had been neglected or abused.
- The circumstances of the sample as a whole deteriorated as the children grew older. The proportion of children living with birth parents at low risk of significant

harm decreased from 50% (18/36) at age three to 36% (13/36) at age five to 25% (9/36) at age eight.

- By the time the children were eight all those who had been classified as at severe risk of harm before their first birthdays had been permanently placed away from home.
- Children's wellbeing was associated with parents' capacity to overcome the difficulties that had placed them at risk of significant harm. By the eighth birthdays, nine birth parents (or sets of parents) had made changes in the first three years of their children's lives and succeeded in sustaining them; nine parents had made similar changes but not succeeded in sustaining them; and eighteen parents had made only minimal changes.
- Nearly half the sample (16/36: 44%) were permanently separated by the time they were eight.
- Parents, adoptive parents, foster carers and special guardians were all finding it difficult to deal with children's challenging behaviour. Kinship carers felt particularly ill-prepared and unsupported.

Chapter Three: The children's emotional and behavioural development

Introduction

The report so far has shown the different trajectories the children's lives have taken based on their parents' capacity to overcome adversity and maintain changes over time. By their eighth birthdays, approximately half (16/36: 44%) of the children had been separated from birth parents who had been unable to change or to sustain changes to their lifestyles and approximately half of them remained at home. Nine (9/36: 25%) of this latter group of children were living with parents who had overcome considerable adversity to safeguard their children. However, 11 (31%) children remained at home where concerns about their welfare persisted. In addition, six placements were showing signs of considerable strain. Several parents and kinship carers were also living under immense stress relating to the challenges of bringing up children with inadequate resources in an impoverished environment. This chapter explores the children's emotional and behavioural development and the impact of problematic behaviours on family life within this context.

Evidence of emotional and behavioural difficulties: Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a behavioural screening measure that can be administered by parents or carers of children between the ages of four to 16. It covers common areas of emotional and behavioural difficulties and asks parents or carers to respond to a total of 25 statements in relation to their child. The scale covers five domains. Four of these capture difficulties in the child's behaviour and relationships, emotional symptoms or difficulties, conduct problems, hyperactivity and peer problems. The fifth domain captures the positive attributes and strengths of the child: the pro-social score. The four difficulties scores are added together to make a total score with a maximum of 40. The pro-social score has a maximum of ten and is reported separately from the difficulties score. The SDQ also explores whether the informant thinks that the child has a problem in these areas, and if so, whether the child experiences any resultant distress and social impairment. This impact score is graded out of a total of ten. In addition to the parent or carer reported SDQ , there is a teacher report version and a version for children and young people, between the ages of 11 to 16, to complete about themselves (Green et al., 2005).

The British Office of National Statistics carried out two extensive surveys of child and adolescent mental health in 1999 and 2004 (see Meltzer et al., 2000; and Green et al., 2005). One of the primary measures of psychopathology for these surveys was the SDQ. Both of these surveys obtained SDQ information from a normative sample of nearly 6000

children aged between 5 to ten years old, as well as similarly comprehensive data for older children and young people. These datasets allow for comparison of the prevalence of emotional and behavioural difficulties amongst the normative population of children in Britain compared with the prevalence of difficulties amongst the children in the current study.

The SDQ was completed by primary carers of sample children during the course of in-depth interviews, which have been carried out at around the time of the children's fourth, fifth, sixth, seventh and in some cases eight birthdays. Because of the floating nature of this sample (see Chapter One for further discussion), SDQ information is not available for all children at every time point. Therefore primary carer completed SDQ data have been analysed in the following way:

- Age five SDQ: the most recent SDQ completed for each child up to their fifth birthday (i.e. an age four SDQ or an age five SDQ; where both were available the age five SDQ was used).
- Age eight SDQ: the most recent SDQ completed for each child up to their eighth birthday (i.e. an age six, seven or eight SDQ, where more than one SDQ was available then the most recent was used).

An SDQ carried out between the ages of six and eight years was available for 31 of the 36 cohort children; and for 23 of the same children an age four or five SDQ was also available. It was not always possible or appropriate to ask the parents or carers to complete an SDQ during the in-depth interviews.

A four-fold classification for SDQ scores has been developed based on cut off points in the 2004 British community sample (Green et al., 2005). These groups include; 'close to average', 'slightly raised', 'high' and 'very high'. For SDQs completed by parents or carers, total difficulties scores of up to 13 out of 40 are considered within the 'close to average' band; scores of between 14 and 16 are considered within the 'slightly raised' category; scores between 17 and 19 are considered 'high'; and scores of 20 or more are categorised as 'very high'. About 80% of children in the general population are expected to score within the 'close to average' category; 10% within the 'slightly raised' group; 5% are expected to be classified as 'high'; and 5% classified as 'very high'. The table below shows the SDQ total difficulties scores for sample children compared with the scores of those from the 2004 British survey.

Table 8: Strengths and Difficulties Questionnaire scores for sample children compared with a representative community sample

Total difficulties	Age 4 or 5 years	Age 6, 7 or 8 years	2004 British community survey
Close to average	10: 43%	10: 32%	80%
Slightly raised	4: 17%	5: 16%	10%
High	4: 17%	4: 13%	5%
Very high	5: 22%	12: 39%	5%
Total	23: 100%	31: 100%	
Missing	8 (of 31 children with an age 8 SDQ also)	5	

The SDQs completed for sample children between the ages of six and eight years show that 10 (32%) of them fell within the 'close to average' range; five (16%) within the 'slightly raised' range; four (13%) within the 'high' range; and 12 (39%) within the 'very high' range. It is important to note that this sample is not representative of all children for whom a core assessment or Section 47 enquiry is completed before the age of one year (see Chapter One). Nevertheless, the finding that, by the age of eight years, 7.8 times as many of these children scored within the 'very high' range as would be expected from a normative population is extremely concerning. The SDQ can be a reliable screening instrument for mental disorder in children. When the SDQ is compared with clinical assessments it has been found to be over 90% effective in detecting children with a disorder (Goodman et al., 2009). Higher scores predict much greater rates of mental disorder than lower scores (Goodman and Goodman, 2011). It is therefore likely that many of the 16 children who scored within the 'very high' and 'high' ranges have or will develop a mental disorder that will require clinical intervention.

Ford and colleagues (2007) examined psychiatric disorder among British looked-after children (n=1453) compared with children living in private households (n=10428). They found that 41.1% of 5-10 year old looked-after children were categorised as having a psychiatric diagnosis according to ICD-10 definitions, compared to 7.6% of children of the same age living in private households. They concluded:

> *Our study suggests that British children who are looked after by the local authority have higher prevalence of both psychosocial adversity and psychiatric disorder than the most socio-economically disadvantaged children living in private households, and that care-related variables are strongly related to mental health* (Ford et al., 2007 p.323).

The SDQ scores for sample children indicate that both the prevalence and severity of the children's emotional and behavioural difficulties had increased from when they were four

or five years old. SDQ scores were available at ages four or five for 23 of the 31 children who also had an SDQ between the ages of six and eight years. Of these 23 children:

- At age four or five, 10 (43%) fell within the 'close to average' range. By the age of eight, four remained within the 'close to average' range, however emotional and behavioural difficulties had emerged for six of them: two of these children now scored within the 'slightly raised' range, two within the 'high' range and two within the 'very high' range.
- At age four or five, four (17%) of the 23 children scored within the 'slightly raised' range. One of these children remained 'slightly raised' at age eight, and emotional and behavioural difficulties increased for the other three: one now scored 'high' and two scored 'very high'.
- Four (17%) children fell within the 'high' range on their SDQ at ages four or five. By the age of eight, two of these children's emotional and behavioural development had improved, and they now fell within the 'slightly raised' range. However the other two children's difficulties increased, and they now scored within the 'very high' range.
- At the age of four or five, five (22%) children scored within the 'very high' range, indicating a substantial risk of clinically significant problems. Four of these children remained in this category at age eight, and one child made slight improvements, and now fell within the 'high' range.

Of the 23 children, for whom an SDQ was available at ages four or five as well as at between six and eight, 19 were displaying emotional and behavioural difficulties at the later time point. For 13 children these had been present from before they were five years old. For all but three of these children, their difficulties increased between the ages of five and eight. Although three children moved in a positive direction, there are no examples of any children being able to overcome emotional and behavioural difficulties that were present at age five, moving from the 'slightly raised', 'high' or 'very high' categories to within the 'close to average' range by the age of eight years.

The following sections explore these findings further in relation to the children's experiences and circumstances.

Children in the 'close to average' group

Ten (36%) children in the age eight follow-up scored within the 'close to average' range on their parent/carer completed SDQ. Seven of these children were living with birth parents, of whom three had been classified as at low risk of suffering significant harm.

The parents (or sets of parents) of these children had made substantial changes to overcome adversity and to make improvements to their parenting capability. These include two children whose fathers had ended their relationship with their abusive mothers to become the children's sole carers; and one whose mother had extricated herself from a violent partner. The changes these parents made to safeguard their children as well as their commitment to meeting their needs had been successful in ensuring that their children's wellbeing was promoted. The quote below, from the father of one of these children, is a typical example of the progress made by these children and their families:

> *Interviewer: What are [child's] biggest achievements?*
>
> *Father: So in a sense she's been good all round…Everything, I mean as I was saying, her being part of the school council, part of the ambassador. She's quite helpful at the school, she helps out the younger children, that's what I've known about her and basically she seems to get on very well with everybody. I can't just pick one item, there's so many things, just her daily life.*
>
> (Birth father of study child: age eight interview)
> (Girl: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

An additional four children who were living at home and scored within the 'close to average range' on their SDQ were classified as at medium risk. The parents of these children had also made substantial changes to their lifestyles to overcome adversity and to improve their parenting capability. They include; one child who was born with special heath care needs and whose mother suffered from mental health problems during his early years; a second child whose mother also suffered from mental health problems and had extricated herself from a violent relationship; a third child whose father became his sole carer when he had extricated himself from an abusive relationship with the child's mother; and a fourth child whose mother had been facing multiple, traumatic issues around the time she became pregnant and had subsequently experienced mental health difficulties. Whilst the parents of these four children had made substantial improvements to their parenting capability, mental health problems persisted, and the children therefore continued to be considered as at medium risk of harm. However it is important to note that these children appear to be thriving, and this is indicative of their parents' success in providing them with a loving and nurturing home, and overcoming adversity. It is however, also significant that the circumstances of these children are fragile and their parents may require additional support in the future to ensure that they can continue to progress so well. The quote below is from one of these children's parents, describing day to day life together:

> *Oh, I love it. I wouldn't give it up for anything. Don't get me wrong, there are days where - I don't know, I suppose it's because of my - I wouldn't say it's an illness, but mental state, there are days where you don't even want to get up in a morning, but then as soon as your head wakes up and it's like oh [child]! He's my world. I'd*

be lost without him, I really would be lost, but yes, now he's getting a bit older and a bit cheeky and yes, it's like oh my God, I used to be like this! …I've started letting him, obviously supervised, making cups of tea, doing toast, using the microwave for beans on toast, because I don't want him to get to 16 and, be like' tie my shoe laces, wipe my bum' …it's like, 'No, you're big enough now. Providing you act responsibly, I'll stand and watch you and you can do things on your own, so you're learning.'

(Birth father of study child: age eight interview)
(Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Three other children who scored within the 'close to average' range were separated from their birth parents. One of these children spent six months with his birth mother, who neglected him, and then was placed with his permanent carers just before he was three years old. His placement was very stable and progressing well. He had recently been diagnosed with autism, however the impact of this had been very low and his carers who were committed to ensuring his needs were met.

We approached our [paediatrician] to have [child] assessed for ASD/Asperger's and that's what they diagnosed. We only did that because we felt from our experience that would account for his behaviours. They didn't diagnose anything we weren't aware of ourselves, just put the label on it. It was helpful to have the diagnosis to explain [child's] behaviour to give insights into his quirky annoying behaviour! Most of time he's lovely, though he has quirks. Things have to be exactly the way he wants them. If he has things on his mind it can be quite difficult. He gets sent to his room and blows up but it is short lived and he calms himself down, as if nothing's happened the next day. He was having a lot of anger before we went to the doctor's but it is less and less over the last 6 months. Maybe we're coping better. He'll always think certain things are a bit of an entitlement. Like time on his computer. He thinks rules are variable. So we need to explain that. We have to be very specific in how we explain things and give time frames and give reasons behind our decisions. Until you know there's a reason for that you could think he's just being stubborn – when you know he sees the world a bit differently it helps – you have to cue things more.

(Permanent carer for study child: age eight interview)
(Boy: high risk of suffering harm at birth; permanently separated by age three)

The other two separated children, who were classified as in the 'close to average' range on their SDQ, had both moved from their birth parents to long-term foster care at around the age of six. By the age of eight they were both settled in long-term foster placements, where they appeared to be thriving and with foster carers who were committed to meeting their needs until they reached adulthood and independence. All three of these children, experienced considerable adversity in their early years including extensive and extended exposure to neglect and disrupted attachments. Their SDQ scores are counter-intuitive. It is therefore worthwhile considering what factors may have contributed to mitigating some of the consequences of their early experiences and in building their

resilience. Firstly, we know that, at around eight, all three of these children were in stable, long-term placements where they were receiving high quality, sensitive care, and this will have been a significant positive factor.

In addition, one of these children has a severe disability, and therefore has a Statement of Special Educational Needs. He has received extensive support from school both before and after entering care. In addition to the formal support he has received in relation to his SEN, whilst he was living at home his teacher went to extraordinary lengths to mitigate the consequences of his home circumstances, including washing his uniform daily to ensure he was not dirty or smelly and therefore not bullied by his peers, and ensuring he received a hot meal each day regardless of the time he came into school because it was likely to be the only one he would get. He was also supported by a specialist charity for children with his disability. All of these factors may have contributed to his wellbeing. The quote below is from his permanent carer describing the help he was receiving and the progress he was making:

> *He will work with you. Yes, he loves rewards, he loves being good. He does his homework. They've got him like a little laptop thing, not as big as the one he had and it's for him to do his work, and he's at the front of the class. When he was at the back of the class he was doing anything rather than doing his work. So, he's brought to the front of the class now so he's monitored. That seems to be working with him. I think like all kids, they try it on, and we don't know, with his disability, is that making him frustrated? But he's a very likeable boy, plenty of friends, yes, very popular in class.*
>
> (Permanent carer for study child: age eight interview)
> (Boy: severe risk of suffering harm at birth; severe risk at age three; severe risk at age five; permanently separated at age eight – minimal parental change)

Another child in long-term foster care who scored within the ‘close to average’ range on the SDQ had also experienced extensive adversity in her life, including long-term neglect and violence between her parents. Prior to entering care there were also concerns that she was being groomed by a known sex offender. Following three placement changes, by the age of eight she was settled in a long-term foster placement, which appeared to be going very well. In the past there had been concerns that she had an eating disorder, was unable to concentrate in class and constantly needed reassurance that she was ‘good’. Since entering care, her eating habits had improved and she was making better progress in school. Although her SDQ rated in the ‘close to average’ range it is important to note that as a measure of psychiatric diagnoses the SDQ is less reliable in predicting children with specific phobias, separation anxiety and eating disorders than children with conduct, hyperactivity, depressive and some anxiety disorders (Goodman et al., 2000). Nevertheless, she appeared to make good progress in her placement:

> *She's very helpful. She does show a lot of concerns for other people's feelings Yes, she's nice. She's bright in a lot of ways, a little bit behind still with her maths,*

but she's quite bright in a lot of ways. She's a bubbly, lively girl always singing and dancing. She likes doing her clubs at school. She loves doing them.

(Permanent carer for study child: age eight interview)
(Girl: medium risk of suffering harm at birth; high risk at age three; high risk at age five; permanently separated at age eight – minimal parental change)

At eight years old, the three children described above were safe. They were no longer neglected and had now reached permanency in adoption or long-term foster care. Furthermore, they appeared to be progressing extremely well, particularly given their experiences of adversity. Perhaps these children were particularly resilient; perhaps the adversity they had experienced had been overestimated; perhaps their problems were internalised rather than externalised and therefore less likely to be recognised. It is noteworthy that the siblings of two of these children had extremely poor outcomes: one of their younger siblings had been placed in residential care because their emotional and behavioural difficulties were so severe they could not be accommodated in foster care. Similarly one of their older siblings was in a separate placement with behaviour that was highly aggressive and sexualised. The needs of these three children were being met at age eight; however it was also important to ensure that they continued to be met in the longer term to make certain they maintained the progress they had made. Their carers were committed to this and the future for these children looked hopeful.

Children in the ‘slightly raised’ group

Five (16%) children scored in the ‘slightly raised’ range on their parent/carer completed SDQ, including three children living at home who were classified as at low risk of suffering significant harm at around the time of their eighth birthdays; one adopted child; and one child living with kinship carers. There is some possibility that SDQ scores within the ‘slightly raised’ range reflect clinically significant problems; however, when their impact score is also taken into account, the difficulties of four of these five children seem less concerning, falling within the ‘close to average’ range and indicating that their parents or carers did not believe that they experienced resultant distress or social impairment from their difficulties. Conversely however, one of these children’s impact score was within the ‘very high’ range.

This child was permanently placed at around the age of five. He had experienced substantial emotional and behavioural difficulties prior to his placement and the SDQ that was completed by his previous carers at around the time of his fifth birthday scored within the ‘high’ range. It is a positive indicator that this child’s behavioural problems appeared to have improved since he entered his permanent placement, from an SDQ score of ‘high’ at the age of five to ‘slightly raised’ more recently, although the impact of his difficulties remained very high. His permanent carers had support both at home and at school to help them cope with his difficulties and to help him overcome them himself. The quote below from his permanent carer is illustrative of the improvements he had made:

He went through an unsettled stage. I think it might have been grief coming to the surface, the loss of his foster mum, unresolved grief because he was chewing his socks. I had to go and buy new socks for school. He was getting through socks quite rapidly and for a while he had quite a nervous cough which occasionally comes back now, but I took him to the doctors and there was nothing wrong with him. I think it was just an anxiety thing, more grief coming out in a physical way but that seems to have settled down now, but generally certainly at home when we're in a normal routine and familiar people are around he's much, much calmer, much more settled, much more able to occupy himself, much more able to focus on things. We've been away on holiday a couple of times. We've always been away. It was much better this time. He was much calmer with the whole process of going away and coming back.

(Permanent carer for study child: age six interview)
(Boy: high risk of suffering harm at birth; permanently separated by age three)

Children in the 'high' or 'very high' groups

Sixteen (52%) of the children scored within the 'high' (four) or 'very high' (12) ranges of total difficulties according to their parent/carer completed SDQ, suggesting that their problems were likely to be clinically significant. Eleven had experienced maltreatment at some point in their lives so far; for seven this included substantial violence within their homes, either through witnessing domestic abuse between their parents or step-parents, because they themselves had been physically abused, or a combination of the two. All but one of these children fell within the 'very high' range of the SDQ. An additional three children's experiences of maltreatment included extensive exposure to their mother's heroin or crack cocaine use *in utero* and chronic neglect. There was also some evidence that one further child may have experienced sexual grooming.

Only two of the sixteen children who fell within the 'high'/'very high' ranges of total difficulties in their SDQ were cared for by parents who had been able to address the problems that were undermining their parenting capability and had sustained these changes. One of these children had been diagnosed with ADHD, and had been exposed to extensive crack cocaine *in utero,* before his mother overcame her addiction. The other children in this group had parents who had been unable to address those difficulties that were undermining their ability to parent effectively. These include seven children who were living at home with ongoing concerns and seven children who had been separated from their parents. These findings indicate that children whose parents had been unable to overcome difficulties were more likely to develop substantial emotional and behavioural difficulties than children whose parents were able to do so.

The emotional and behavioural difficulties the children were displaying were placing extensive strains on their home lives. Impact scores were available for 14 of the 16 children who fell within this category. Eight of these children had impact scores in the 'high' or 'very high' range and a further two within the 'slightly raised' range. This is

particularly concerning and shows the extent to which the children's difficulties were causing additional stress for their parents and carers who were struggling to deal with the daily challenges they caused.

The majority of the children's emotional and behavioural difficulties were displayed in very aggressive behaviour patterns including attacks on classmates, teachers, parents/carers and pets. For instance, one carer described how her child's anger and aggression had been displayed in attacks on her:

> *He's [child] pushed me down the stairs, yes, given me black eyes, threatened me with all sorts of cutlery. I didn't go to the doctor. It's not the sort of thing you would need to go to the doctor for, so they [doctors] probably weren't aware of the full extent of injuries that we've all sustained. Perhaps if they'd realised, they might have taken me a bit more seriously, I don't know.*
>
> (Permanent carer for study child: age seven interview)
> (Boy: severe risk of suffering harm at birth; permanently separated by age three – minimal parental change)

Similarly the quote below describes how another of the children in this group could be aggressive towards his sibling and the difficulties this behaviour had caused his mother:

> *Well, there can be times when they [child and sibling] get on, but there's times when they can't get on. He can be a bit rough with her and does hit her sometimes, so I'm more or less trying to get her away from him. Just say, 'Go in your bedroom [sibling] please and calm down', or try and get him [child] into his bedroom so he can calm down. Then get her [sibling] in here with me and try and get her to calm down herself, because she can get a bit upset if it's just him shouting and screaming. That can tend to set her off crying, so I try and get her to stay with me to try and calm her down, and obviously, with the stress of me it can make my IBS [Irritable Bowel Syndrome] flare up as well.*
>
> (Birth mother of study child: age seven interview)
> (Boy: medium risk of suffering harm at birth; medium risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

In addition to the very aggressive behaviour displayed by some children, at least one child in this group was displaying sexualised behaviour:

> *She'd [child] want to sit right next to him [foster father], and she'd link arms with him, which was fine, but then she'd start stroking his legs, stroking his hair, and when that started happening my husband was extremely uncomfortable… They [child and siblings] used to talk about sexy time. I said, 'What is sexy time, because you keep going on about it?' 'Let's do sexy time.' They used to do a lot of dances when they first came here like lap dancers, those sort of movements, quite provocative.*
>
> (Temporary carer for study child: age eight interview)

(Girl: medium risk of suffering harm at birth; low risk at age three; high risk at age five; permanently separated at age eight – unsustained parental change)

Three of the children with severe emotional and behavioural difficulties had also been formally diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and were consequently medicated. Another child's school had also recently requested a clinical assessment to test for ADHD but this had been rejected. All four of these children scored within the 'very high' total difficulties range.

Symptoms of ADHD can be suppressed with stimulant medication which can improve children's compliance, peer relationships, family relationships and learning ability (Goodman and Scott, 2012). However this needs to be part of an integrated approach whereby family members join with professionals to treat the child's disorder. For instance, the child's school will need to take account of the child's limited attention span. Parent-training programmes can also be useful and improve parents' child management skills which can reduce family stress and the child's negative behaviours. Parents can also try dietary treatment, such as the removal of certain food colours (Goodman and Scott, 2012).

However, there is limited evidence that the parents of the children with ADHD were in receipt of such support. For instance, the mother of one of these children had found much of what she knew about ADHD from the internet and based on this information had made a decision to stop his medication, without support or advice from a professional:

> *He's been diagnosed with ADHD, and slight Oppositional Deficit Disorder. Yes, he's been diagnosed with that. Last year, for example, at school he was put on medication, and I put him on medication because I was advised, you know, it suggested that it would be good, der, der, der…but had I done my research - I was probably naive, and said, 'Okay'. Then after he was on medication I did some reading, I actually picked up the computer, opened it and did some research, and if I'd read the things that I'd read I would never have put him on it…Well, basically, there's no research, that I saw, to show what happens to somebody that's been on it for a long period of time, the medicines. I just got information from all over the place, and seeing videos, informative videos…so they - to cut a long story short, if children don't conform we medicate them. So since my mind's open, since I've looked, I've found information. I was going, 'Yes, okay', trying to please the teacher, trying to listen and obey and please the doctor, because they know what they're talking about, they must be right, do you know what I mean? So anyway, he came off the medicine. So he's developed ticks. He developed a tick where - it changes, his tick changes. What was it before? He used to be flicking his hair. Now it's something else.*
>
> (Birth mother of study child: age eight interview)
> (Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

This mother had however joined a support group for parents of children with disabilities which she found helpful:

I've been going to parent meetings every Thursday, and I've been on ADHD courses through them, its parent support meetings for parents with children with disabilities, and so it's like a circle, we'll sit and talk on how we've been getting on, blah, blah, blah, and they put on courses, so I've done an ADHD course through them. Just knowing what you do and what to expect. So I've learnt a lot.

(Birth mother of study child: age eight interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

The formal diagnosis of ADHD seemed to have enabled this child's mother to access some support to help manage his behaviour. However, although his school SENCO believed this condition might explain his behaviours, another child had not formally been diagnosed with ADHD, and so his mother had not been able to access additional support:

The school have tried to put in for CAMHS to come into the school, because they think he could be autistic and ADHD but CAMHS, because they're so overloaded with applications for things, they've rejected it basically but they've not given us an actual reason why they've rejected it, so I've told the school about that. I had to wait until the holidays were over to let them know about it because I received it in the holidays. They're going to try and chase up to find out why they've rejected it without a reason. What they may have to do is keep sending in new applications to make them see that we need help, we need someone to come in and look at him. Try and figure out whether definitely that's what he's got or if it's something else.

(Birth mother of study child: age eight interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Two further children had been formally recognised as having global developmental delay and both also suffered with epilepsy. These children also scored within the 'very high' range of total difficulties. The example below is a quote from the mother of one of these children describing how her daughter's behaviour had deteriorated since being medicated with an anti-epileptic drug:

It's since they increased the Keppra. It causes aggression. So, they're trying to bring it down, but they can only bring it down at half a ml at a time and it's got to be every fortnight. She got hold of that kid in the playground and was just smacking his head on the floor. You've got to laugh because if you don't, you go insane, because I couldn't believe it.

(Birth mother of study child: age eight interview)
(Girl: medium risk of suffering harm at birth; high risk at age three; high risk at age five; high risk at age eight – minimal parental change)

Some of the most concerning behaviours were being displayed by sample children who scored within the very high ranges on both difficulties and impact. Seven children fit this criterion, including three children who were living at home with ongoing concerns with

parents in the minimal change group. These parents had not shown any capacity to overcome the difficulties that were increasing the likelihood that their children would be exposed to maltreatment. Their children had remained at medium or high risk of harm throughout their lives so far.

For instance, one of these children had global developmental delay and epilepsy and was extremely aggressive both at home and at school. At the most recent interview her mother could not find anything positive to say about her, describing her as defiant, aggressive and confrontational, making her life 'hell'.

Another of these children, had been exposed to domestic abuse as an infant, and had then been subjected to physical abuse by his older teenage brother. At around the age of six his mother described him as being:

> *Not like any other child I've had. I can control him at home though cos I haven't got 20 odd other children to manage. He has to have one to one attention. He can get very aggressive, has thrown tables and chairs and smacked children, spat at teachers.*
>
> (Birth mother of study child: age six interview)
> (Boy: high risk of suffering harm at birth; high risk at age three; high risk at age five; high risk at age eight – minimal parental change)

At this time this child's school were funding one to one classroom support for him for three days a week, and were also seeking funding to support him during break times. He remained at home for the other two days, in his mother's care, as his behaviour in school was so challenging that teachers felt that he was a danger to other children without one to one support in place. By six, he had been diagnosed with ADHD and soon after was placed in specialist educational provision.

A third child had also been exposed to domestic abuse during infancy. His mother then ended this relationship and the perpetrator, his father, went to prison. However shortly after this, his mother formed a new relationship which was also abusive and he was subjected to further incidents of violence within his home. Whilst the violence was occurring he was made to go to his bedroom. His mother described him as:

> *…very boisterous, uncontrollable. He was upset, he wouldn't give out hugs, kisses, wouldn't say I love you, wouldn't come near me. Didn't want anyone touching him or anyone near him, wouldn't talk to us, wouldn't tell us about simple things like school days or dreams or whatever. We just couldn't get through to him at all.*
>
> (Birth mother of study child: age seven interview)
> (Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

This child's behaviour had deteriorated since he had been having contact with his (violent) birth father. However, he had been able to access specialist therapeutic counselling through his school, which his mother believed had helped him:

> *He was seeing [birth father] at that time, he was going to [specialist counselling] talking to them. The point of their counselling sessions is it's child led, they let the child speak, they won't ask any questions, won't get them to do anything or say anything they don't want to do. It's all done through play and arts and crafts. They said from monitoring his play and his arts and crafts and whatever he wasn't emotionally scarred, he wasn't keeping secrets, he wasn't angry or upset or anything like that. He was just holding a lot of things back. It [improvements in child's behaviour] was about two or three sessions going to [specialist counselling]. Then he stopped going and it all starts again.*
>
> (Birth mother of study child: age seven interview)
> (Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Four additional children who scored within the 'very high' category on both difficulties and impact were separated from their birth parents. Brief descriptions of the impact of some of these children's emotional and behavioural difficulties on family life in their placements are given below.

One child was permanently placed at around the time of his first birthday. However, by the age of five, he was extremely aggressive towards his carers and siblings. His carers found his behaviour very difficult to cope with and took parenting in turns. By his eighth birthday, his carers and siblings felt they needed a break from him, and had advised children's social care that if they did not receive the help they needed the placement would disrupt.

Another child was placed with his permanent carers at around the age of 18 months. Prior to his placement he had been living with his father where he had experienced high levels of neglect and physical abuse. By the age of six this child was also extremely violent and had attempted to harm a family member's new born baby. His behaviour had caused a great deal of stress within his placement. His carers' relationship was on the verge of breaking down, and they attributed this to the strain caused by this child's behaviour. He was formally diagnosed with ADHD, but support to help him and his carers was not forthcoming. They had been told by a psychiatrist that, '*he'll need a lot of counselling when he's older*', and that they should return when he reached adolescence because they would then be able to access help. The child's carers felt that they had not been made fully aware either of the adversity he had experienced prior to being placed with them or the additional support he was likely to need to help him to overcome these experiences.

An additional child in this group had global developmental delay and epilepsy and was permanently placed with his carers from birth. He was attending a specialist school by

the time he was eight and he had been excluded from his previous school. His carer described:

> *Life itself has been stressful with [child]. He's gone to a special school now, thought it would improve his behaviour but he keeps slipping back into his little habits. He has good days and bad days at the school. They haven't excluded him like the other school did, so he's doing all right. It's full-time education. He seems to be enjoying it but he does have his outbursts. I'm trying to see now what's the root of his outbursts. Trying to see if there's something triggering it. So, I've kept [child] off E numbers for about over a year now because of his behaviour, because he was hyperactive, he wouldn't keep still. He still can't keep still but he seems to be, not a lot calmer, but less bouncy everywhere, do you know what I mean? Banging off doors, sort of thing…he does what he wants to do. He won't sit down to do his work, he won't do this, he won't do that, he just wants to do what he wants to do.*
>
> (Permanent carer for study child: age eight interview)
> (Boy: outlier case)

One of the key concerns raised by the families of children with severe emotional and behavioural difficulties was that adequate support to help them overcome their difficulties as well as help for their parents and carers to cope with them on a day to day basis was not forthcoming. These children were extremely vulnerable and the behaviour they displayed was highly disturbed. They could well require extensive support throughout the rest of their childhood if they were to overcome the consequences of their adversity.

Conclusion

The high prevalence of emotional and behavioural problems amongst this sample of very vulnerable children, and their increasing severity, are matters of some concern. The apparent lack of support either for parents or carers who were trying to help children deal with these problems on a day to day basis was particularly worrying. Although existing behavioural issues became more apparent and new ones began to emerge as children grew older, we know from earlier reports that many of the children had begun to display challenging behaviour patterns from at least their third birthdays (see Ward, Brown and Westlake, 2012a). They had an impact on their families, their placements and on their readiness to learn and cope with school.

Schools had a major role to play in ensuring these children's needs were met. The following chapter discusses how their emotional and behavioural problems played out in the school environment, and how they impacted on both the children's ability to learn and to develop social networks. It also discusses the degree to which schools were able to manage the children's behaviour within the classroom environment and the resources they were able to use to help them.

Key points from Chapter Three

- At ages 6-8 years, over half of the sample children were displaying SDQ scores in the ‘high’ or ‘very high’ range. Twelve (39%) were in the very high range, almost eight times as many as one would expect to find in a normative population.
- Both the prevalence and the severity of children’s emotional and behavioural difficulties had increased since they were five.
- Ten of the thirteen children who had been showing emotional and behavioural difficulties before they were five were showing increased difficulties by the time they were eight; only three had moved in a positive direction.
- The fifteen children in the ‘close to average’ or ‘slightly raised’ groups were either living with birth parents who had made and sustained changes (six children), living with birth parents with fluctuating but persistent mental health problems (four children) or living with kinship or unrelated foster carers or adoptive parents, most of whom could access additional support (five children).
- The children in the ‘high’ or ‘very high’ groups were living with birth parents who had made sustained changes (two children); living at home with birth parents who had made minimal changes (seven children) or living apart from birth parents who had made minimal or unsustained changes (seven children).
- Seven children scored in ‘very high’ ranges in terms of both difficulties and impact. Parents, carers and schools were all struggling to help these children with inadequate, or at best sporadic support.

Chapter Four: The effectiveness of the schools in supporting the children to achieve their full potential

Introduction

The previous chapters have explored the trajectories the children's lives have taken so far, the presence of emotional and behavioural difficulties and the impact of the children's problematic behaviour and extensive emotional and psychological needs on their family life. By the time they were eight, over half of the children in the sample were displaying emotional and behavioural difficulties, and 12 children scored within the 'very high' range on the SDQ: almost 8 times as many as would be expected in a normative population. This chapter explores how the children were progressing in school and considers how far their schools were equipped to work with children and families such as those from this sample.

During this phase of the longitudinal study the children were mostly all in primary school years three or four and were approaching the time that their parents, carers and teachers would be considering their transition to secondary school. Permission was given by the parents or carers of 17 of the sample children to interview their class teacher and school SENCO. One school declined to participate in the study, therefore interview data from 16 schools were available. A total of 25 interviews were carried out, including nine with SENCOs, 13 with class teachers and three with head or deputy head teachers. It is important to note that the birth parents who had made substantial changes to their lifestyles early in their child's life, and had had no further involvement from children's social care were much less likely to give permission for the research team to approach their child's school. Understandably, these parents were concerned that doing so could alert their child's school to their past difficulties, and could result in their child being treated differently by their teachers. Therefore this group is underrepresented in interview data used in the following sections.

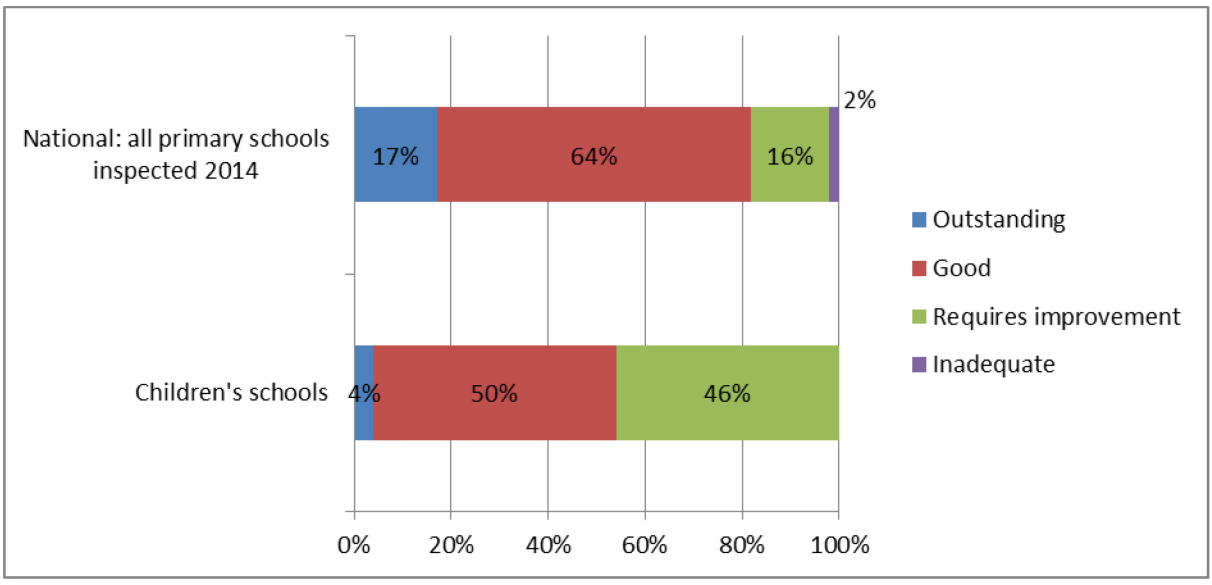
The schools and the communities they serve

All of the parents or carers were asked the name of their child's school so that summary information could be collated from the latest Ofsted reports. This was available for 26 of the children's schools, which were all mainstream schools.[14] Some parents were unwilling to disclose this to the research team, and in some instances it was inappropriate to ask. The figure below compares the overall effectiveness judgement by

[14] The research team were aware that one child attended a non-mainstream school, however this child's parents did not disclose the name of the school, therefore this school has not been included in the Ofsted analysis.

Ofsted for the children's schools with all inspections of primary schools that were completed by Ofsted during 2014 (see Ofsted, 2014b). Eighty one per cent of all primary schools that were inspected during 2014 were judged to be good or outstanding, compared with 54% of the sample children's schools. Therefore, overall the sample children were more likely to attend less effective schools, according to Ofsted, than would be expected nationally. The children's schools were also more likely to be larger than average (15/26:58%); have above average numbers of children with SEN (18/26: 69%); and have above average numbers of children eligible for pupil premium funding (21/26: 81%).

Figure 2: Ofsted overall effectiveness judgements



The high level of deprivation in the surrounding areas of many of the schools and the high proportion of children with additional support needs undoubtedly made the task of teaching more complex. However, some schools achieved this task more successfully than others. There were a number of factors which contributed to or inhibited the schools' effectiveness. These are outlined in further detail below.

The prevalence of emotional and behavioural difficulties in school

So far, in this report, we have only explored the data concerning the children at home. Where permission was granted, the children's class teachers were asked to complete the Strengths and Difficulties Questionnaire (Goodman, 1997). Teachers tend to assess children's behaviour less severely than parents (Goodman, 1997), therefore the four-fold classification for teacher completed SDQs differs from the parent version (Green et al., 2005). For SDQs completed by teachers, total difficulties scores of up to 11 out of 40 are considered to be within the 'close to average' band; scores between 12 and 15 are considered within the 'slightly raised' category; scores between 16 and 18 are considered

within the ‘high’ category; and scores of more than 19 are categorised as ‘very high’. Teacher completed SDQs were available for 16 of the sample children. These are displayed in the table below, compared with the scores for parent/carer completed SDQs for the same 16 children.

Table 9: Strengths and Difficulties Questionnaire scores completed by teachers compared to those completed by parents/carers

Total difficulties	Parent completed SDQ (ages 6, 7 or 8)	Teacher completed SDQ (ages 6, 7 or 8)
Close to average	4: 25%	9: 56.2%
Slightly raised	4: 25%	3: 18.8%
High	2: 12.5%	2: 12.5%
Very high	6: 37.5%	2: 12.5%
Total	16: 100%	16: 100%

The SDQs completed by teachers for sample children between the ages of six and eight years show that nine (56.2%) fell within the ‘close to average’ range; three (18.8%) within the ‘slightly raised’ range; and four (30%) within the ‘high’ or ‘very high’ ranges. These scores differ from those SDQs completed by parents/carers for the same children. Half of the children scored within the ‘high’ or ‘very high’ ranges according to the parent/carer completed SDQs compared with a third of children who scored within these ranges according to their class teachers.

The sample children for whom both teacher and parent completed SDQ scores were available (n=16) can be grouped in the following way:

- Children who did not present with emotional and behavioural difficulties at school or home (n=6).
- Children who presented with emotional and behavioural difficulties at school and at home (n=3).
- Children who presented with emotional and behavioural difficulties at home according to their parent/carer completed SDQ, but not at school according to their teacher rated SDQ (n=6).

- Children who did not present with emotional and behavioural difficulties at home according to their parent/carer completed SDQ, but difficulties were displayed at school according to their teacher rated SDQ (n=1).

Children progressing well in school

Six of the 16 children whose schools engaged with this study were progressing well in school and were also not displaying substantial difficulties at home. These children include four children who were living with their birth parents; and two who were permanently separated from birth parents.

The children in this group who remained at home were living with birth parents who had overcome substantial difficulties including substance misuse and domestic abuse. One of these children was considered low risk of being exposed to maltreatment at the age of eight, and two were classified to be at medium risk. Whilst the parents of these two children had made substantial improvements to their parenting, and both had extricated themselves from violent and manipulative relationships, mental health problems persisted, and the children therefore continued to be considered at medium risk of harm. In addition, the fourth child was the only child in the sample who was considered to be at low risk at the outset, and had remained low risk throughout.

Of the two separated children who were progressing well in school, one was living with relatives and the other was one of the late entrants to care in the study, and had been placed with foster carers at the age of six years.

All six of these children were considered by their current class teachers to be progressing well in school both academically and behaviourally and their parents or carers also had not identified any emotional or behavioural difficulties at home. The quote below from a school staff member for one of these children, who was living with birth parents in the sustained change group, describes his achievements:

> *He's polite, well mannered, helpful, kind. I actually use him as a role model in terms of keeping focused and on task…I actually say to the other children he's a good role model in that respect. He's known for being curious, he's known for being creative, he's known for being able to use his thinking skills and problem-solving skills. So he has a good relationship with the other boys in the class, with myself and with the other adults, we just adore him.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Throughout his school life so far, the child described above had always made exceptional progress and had not needed any additional provision to aid his progress. Conversely, however, the other four children who were progressing well at school and home had

required additional support with reading, writing and/or numeracy to ensure that they were able to achieve the expected levels in these areas for their age. The schools for all four of these children identified these additional needs and were able to implement relevant support, to enable the children to progress to the expected levels. For example, one of these children had moved schools within the past year, his new school had assessed his functioning immediately, and used evidence from his past school to understand what his needs were and to implement the support where it was required:

> *His reading ability was really, really strong although we did have to do quite a bit of work with comprehension to make sure that his understanding of what he was reading matched his ability to read the text. We made that a real target for him and worked hard to increase his understanding of what he was reading. That was achieved; he did well in our Year 4 SATS tests and left Year 4 as a 4B which is a very strong achievement for Year 4….There were times when perhaps his presentation in his work wasn't exactly as we would expect. However we chatted about that and he knew himself that he was so keen to get everything written down that often the presentation wasn't the first thing that he was prioritising if you like. He worked hard on that and improved throughout the year as well and was just really keen to learn and really keen to make progress. He was a delight to teach.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: medium risk of suffering harm at birth; high risk at age three; medium risk at age five; low risk at age eight)

Similarly, another child had recently moved schools when she had been placed with her current foster carers, and was slightly behind with her attainment. However, the school were able to implement additional teaching assistant support using Pupil Premium funding to ensure that she was able to achieve the expected levels for her age. This additional support had also improved her confidence, particularly in group situations:

> *Attainment-wise it's [teaching assistant support] certainly helping. From my point of view it allows me to direct the teaching assistant to the specific areas that she does struggle with and it's quite nice she's in a group with four or five [other children] that have very similar catch-up needs, so attainment-wise certainly. Confidence-wise I'd say it's helped a little bit as well. She, when I work with her table in a full class situation, she certainly seems more confident when, immediately after she's had the extra support so that clearly helps. Then her confidence goes back down when we move onto a new topic then. Then we try and build it up again with the teaching assistant support.*
>
> (Staff member at study child's school: age eight interview)
> (Girl: medium risk of suffering harm at birth; high risk at age three; high risk at age five; permanently separated at age eight – minimal parental change)

Another child in this group had made more substantial improvements to his progress at school. The previous year, this child had been excluded from school because of several aggressive outbursts towards his peers and teachers. The school was able to access additional behavioural support through the local authority. A 'behavioural expert' visited

the school to monitor and observe him and two other children in his class. They then helped the class teacher implement strategies to address the issues. He had since moved to a different class with a new class teacher. His behaviour had vastly improved, and he had also made good progress academically:

> *He [child] was a very high category child last year, very bad behaviour. He's more controllable now. He just acts silly more than bad behaviour.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: severe risk of suffering harm at birth; permanently separated by age three)

This school staff member continued to explain:

> *He's got a lot of confidence, he's a happy boy at the moment, he knows he's doing well in terms of his handwriting. His hand writing is beautiful now. He's very, very proud of his work. I think if he keeps his confidence up, and obviously if he can do extra work with his parents or if he can build on his reading. There's still obviously a long, long way to go for him to be where he should be but he is the one child in my class that I could see has made the biggest progress.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: severe risk of suffering harm at birth; permanently separated by age three)

Children displaying fewer difficulties at school than at home

Six of the 16 children whose parents or carers had granted access for the research team to interview their child's teachers, were displaying severe emotional and behavioural difficulties at home, but the difficulties identified by their parents or carers were not apparent to their teachers during school time.

Four of these children were permanently separated from their birth parents; and two were living with their birth parents and were both considered to be at medium risk of being exposed to maltreatment.

Five of these children had scored within the 'very high' range of total difficulties according to their parent completed SDQ, and one scored within the 'high' range. The behaviours that their parents and carers described were of particular concern. For instance, one described instances of severe child to parent violence, another spoke of their other children being afraid of the study child, and another described her child as defiant, aggressive and confrontational.

However, interviews with staff members at these children's schools reveal very contrasting information about the children's behaviour. Four of these children, scored within the 'close to average' range according to their teacher completed SDQ, and two of them, within the 'slightly raised' category. The class teachers for these children did not experience the same levels of difficulties that their parents or carers reported.

For instance, one of these children's class teacher described how school seemed a 'safe environment' for him and that she did not 'see evidence of that [child's behaviour experienced at home] in the classroom'. She also described how he had a 'few good buddies', and that academically he was 'where he should be'. This child's class teacher was aware of the difficulties that were experienced at home relating to his aggression. However, she found it hard to understand and provide support because it was different from her experience of this child at school. She did however raise concerns that he seemed anxious at home time.

Similarly, another child's class teacher had identified that he was treated much more negatively by his carers than their own birth children. The experience of one child being singled out from their siblings for negative parental attention is under researched in relation to adoption (Rushton and Dance, 2003). However, Rohner (1986) examined this dynamic within birth families and concluded that the effects for the child can include emotional unresponsiveness, hostility or aggression, poor self-esteem and emotional instability.

Other children in this category, where emotional and behavioural difficulties were substantially more prevalent at home than at school, were also experiencing problems at home. For instance; one child and her sibling were living in a home in which the father spent most of his time in bed, leaving all child care to the mother who was struggling to cope with these demands; another child was living in a home in which the relationship between the adults was described as turbulent.

The problems experienced by the children at home most likely contributed to their emotional and behavioural difficulties and, as we have seen, could be indicative of poor or deteriorating parent-child relationships. School can be a safe place for children who experience problems at home. Close partnerships between schools and parents can help teachers understand to a greater extent the children's home life. Grayson's (2013) review of literature of parental engagement with schools found that successful school-home links can improve outcomes for disadvantaged children. Good practice involves schools valuing parents' opinions, meeting their needs, and helping them to support their children's learning. Grayson emphasises the importance of schools engaging with parents in a variety of ways, rather than restricting contact to formal parent-teacher meetings.

Children displaying more difficulties at school than at home

In contrast to the group of children described above, one child, appeared to display significant emotional and behavioural difficulties at school, whereas his carers did not identify these concerns.

This child had experienced chronic neglect whilst living with his birth mother until the age of six, when he was placed in foster care. His foster carers described him as a delightful

child and did not raise any concerns about his behaviour. They were very experienced carers and had fostered numerous children in the past, particularly those, such as this child, who had disabilities. However he was described by staff at his school, as the pupil in her class who took up most resources:

> *He can be quite rude and say things to hurt other people. He does that quite a lot. He'll say things that are hurtful, and not be very nice.*
>
> (Staff member at study child's school: age eight interview)
>
> (Boy: severe risk of suffering harm at birth; severe risk at age three; severe risk at age five; permanently separated at age eight – minimal parental change)

It was rare for a looked after child to attend this school, and this class teacher, despite her long-standing career, had had very little experience of working with children in care.

Children displaying severe difficulties at home and at school

Three children were displaying severe difficulties both at home and at school. One was permanently separated from birth parents and the other two had remained with birth parents with ongoing mental health and domestic violence issues and were considered to be at medium risk of harm.

To meet the high levels of emotional and behavioural need for these three children, their schools were required to implement intensive support programmes. The three schools for these children approached this in different ways and with different degrees of success. These are described in further detail below.

Insufficient home-school links

One of the three children in this group attended a school which was smaller than average and the proportion of children with SEN and supported with pupil premium was also below the national average. The most recent Ofsted report judged the school as good. This child's mother reported the difficulties she experienced at home with him, which included severe aggression towards her and his sibling. He had undergone an assessment for autism or ADHD, but had not been formally diagnosed. He scored within the 'very high' range on the SDQ according to both his mother and class teacher. However, support implemented by the school to help address these difficulties was minimal; instead he would be removed from the class when he became angry and disruptive. His class teacher felt that his home circumstances were the cause of his difficulties:

> *He's [child] timid but he's an extremely bright little boy, and that with very minimal assistance at home in terms of reading and everything. He's very bright, but it's his attitude that keeps him back. He's achieving good scores in Maths and reading, and his writing is of very good quality, but it's the quantity that's limited. He has great diversion techniques. He does get cross quite quickly; he's beginning to*

manage that better, but that's the issue that holds him back. He is extremely bright. He's attaining generally well, however you feel had he started off in a different environment, he would be just flying, I think. He is doing well in that his level is above average, but you just think given another home to live in and different support, he would be extremely bright

(Staff member at study child's school: age eight interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

The school also had not built a positive partnership with his mother. She felt herself unable to express herself directly with her child's class teacher. Other parents also had difficulties in communicating their concerns with the schools, for instance, one parent explained:

If I feel there's something that I want to say to a teacher but I can't, then I either speak to her [Home School Link worker] or I can write it in - they send home a green Home School contact book so if there's anything the teachers want to say to the parents without saying it in front of other parents they write it in there, or say with me, I can write it in there as well so the other parents don't have to listen or things like that. It works quite well, it just depends on how you - I'm trying to think what the word is - how strong you feel about having to put it in writing. [Speaking with the teacher] at the start of the school day or at the end of the school day it can be quite difficult, because obviously they're trying to make sure the children are going to the right people and making sure they're not going off with somebody they shouldn't be.

(Birth other of study child: age seven interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

The unease experienced by parents about working with the school and approaching them with difficulties was also noticed by some of the schools, for instance, one class teacher explained:

She [mother] does come to Parents' Evening but she doesn't write notes in the book. We have very little communication with mum. She's frequently late with the children and barely makes eye contact. I don't think she finds the school environment very easy to come into, really.

(Staff member at study child's school: age eight interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

More positive relationships between the school and the parents might have helped address some of the difficulties being experienced, and provided the school with further information and context. For instance, one child's mother was experiencing severe financial hardship, there were difficulties in receiving her benefits and she continually worried that she did not have enough resources to clothe and feed her children.

However, these circumstances were not fully understood by this child's school. The school had placed the expectation on his mother to provide money for additional activities; because she was unable to do so, he could not therefore take part, a staff member at his school stated:

> *We have a [school activity], where the children bring in a few pounds. He [child] said to me this afternoon: 'Do we have to do [school activity]?' I don't know whether he'll have money given to him or not. He doesn't participate in an awful lot of things.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: medium risk of suffering harm at birth; low risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

Close supervision

Another of the three children in this group attended a school which was larger than average, with a high proportion of children eligible for pupil premium funding. The school also had a higher than average proportion of children who speak English as a second language. This child had started at the school at around the time he moved to his permanent placement. A staff member at his school described how his behaviour could be extremely challenging:

> *Academically, I wouldn't say he really was progressing since I've known him. There have been little bits of progress, but in terms of what we would expect of the age he is, he's not made as much progress as his peers by any stretch of the imagination. Socially, there has been some progress in the last year. He is coping better with situations, but he's finding it very, very difficult in school. He pushes his boundaries constantly; it's almost become a bit of a game, the way he sees it. He's testing his boundaries to see if he's safe, but it's also 'how far can I push it?'. In terms of how others see him, I would say they'd say there wasn't a great deal of change in him since this time last year, because they still see him out of the classroom a lot. I would say that when he's out of the classroom it's more controlled in terms of the fact he's not racing around the school, he's actually with somebody, but the perception is he's outside playing when we know he's outside having a break because he can't actually cope with the classroom anymore so we give him a break. How we're dealing with him is allowing him to make some progress but it's very, very limited.*
>
> (Staff member at study child's school: age seven interview)
> (Boy: high risk of suffering harm at birth; permanently separated by age three)

This child's school had implemented substantial one to one support to help him with his behavioural needs and he was closely supervised at school, his teaching assistant was with him at all times, including break and dinnertimes. During class time, he was also often withdrawn from the activities set for the rest of the class so that he could take part in an activity more appropriate for his level of attainment.

He had begun to make some progress. However this was not as significant as the school had hoped:

> *He has made some progress and I think what's been slightly frustrating for a lot of staff is that he's not making progress as quickly as they'd like him to make progress but the problem is that the issues are more historical and they are perhaps things we can't change. We could sit here doing Maths and English intervention until we're blue in the face, but at the moment he's not ready for that, so we're not putting in a great deal of extra intervention with him in terms of his academic learning. All our intervention is social. The staff he's got is very well qualified to do what they do, but I think they need additional support themselves. I also think that he needs different faces because his TA is with him all day long. For one person, that is an incredible stress on them. He is hard work, like having a petulant toddler with you all the time and I think, by the time she gets to the end of the week, she is absolutely exhausted. Though you try your best the whole time to be very fair, even, and persistent, by the time you get to Friday it's getting to be hard work.*
>
> (Staff member at study child's school: age seven interview)
> (Boy: high risk of suffering harm at birth; permanently separated by age three)

Research findings on the impact of teaching assistants for one to one support in class to help with behaviour are varied. For instance, Blatchford and colleagues (2012) found that assigning teaching assistants to specific children for individual support related to learning, behaviour or attention can help them develop confidence and motivation, good working habits and a willingness to complete a task. However, concerns have also been raised that assigning a teaching assistant to individual children can encourage dependency and discourage them from thinking for themselves. Over reliance on one to one teaching assistant support can have detrimental effects, including limiting ownership and responsibility for learning, and separation from classmates (Giangreco, 2010).

Guidance from the Educational Endowment Foundation on making the best use of teaching assistants recommends that where teaching assistants are assigned to individual children, this should be with the purpose of delivering high quality evidence base structured interventions. Teaching assistants should not be deployed in informal, unsupported, instructional roles; because this can negatively impact on children's learning outcomes (Sharples, Webster and Blatchford, 2015).

Nurture and wellbeing

The third child who had extremely complex emotional and behavioural needs both at home and at school had experienced a violent home as an infant and at six months old was physically abused by his father. After his father had left the family home, his mother formed a new relationship with another violent man who had lived with this child and his family whilst he was between the ages of three and five and a half years. Staff at his school described this child as:

> *…aggressive verbally and physically. He had complex emotional needs of where he didn't understand his emotions and feelings, and an appropriate way of expressing them. [He] struggled with reading social clues from other children, and from adults following instructions, around friendships. He was continually plagued with a voice in his head, and so he had all sorts of mental issues going on as well, and he clearly didn't know himself - we were dealing with a child that he was a child, but he had all the adult feelings in his head, and adult actions, but yet it was in the body of a child, so he was a very, very complex little boy. He'd outright tell us as well that somebody was telling him to behave in a certain way inside his mind, and struggled a lot with that.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

However, this child's school had made exceptional progress in addressing his high level of needs. This school's approach was to provide intensive nurture programmes to enable him to remain in school and to come to terms with his past adverse experiences. Below staff at his school described the support that was implemented:

When he came to us in the beginning of year three, he had immense emotional needs. There was a great deal of work put around [child] in terms of nurture provision, and support within the classroom, and because of the continued structured support to meet his individual needs he has made amazing progress. There was quite a comprehensive report that we did for him, and he was supported through the behaviour support team, and that was followed up with a MEP, a multi-educational plan around him, to ensure that all individuals within the school were buying into the needs of him, and that's had a massive impact because it's been a whole-school inclusive response to it, the outcome has been as we would want, because now [child] is still in school, and he's managing his social and emotional needs. He's moved on incredibly, and this is now not impacting on his learning.

(Staff member at study child's school: age eight interview)
(Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

School staff continued to describe the resources that were used to help address his needs:

There were massive attachment issues around [child], which then had an impact on his emotional needs. He'd been subject to lots of problems at home; it was problems from family, and situations and relationships. Mum was clearly doing her best, but it was having a big impact on [child], and we knew when [child] came to our school that there would need to be some very comprehensive support around the nurture, to ensure that we met those needs before the learning could take place. So he did have a very intensive nurture programme, behaviour support programme around him, and that involved our nurture, positive play, and a whole-school SEAL [Social and Emotional Aspects of Learning], because we're quite hot on all of that. Because of the area that we're in, that support is essential in our school.

(Staff member at study child's school: age eight interview)
(Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

This school was in an area of high economic and social deprivation. The proportion of children in receipt of pupil premium and with SEN was well above that found nationally. The latest Ofsted report for the school judged that it required improvement. Since then the school had undergone a complete senior leadership change, including the SENCO who was relatively new to post. As a result the ethos of the school changed, from a school where exclusions were common place, to a school that prioritised a nurturing environment to address the emotional needs of the children. A school staff member explained:

We communicate positive behaviour at all times. It's about there is a reason why there's a behaviour happening. So we look very much at the reasons, the functions, and we do have a lot of work around behaviour management in terms of ensuring that we deliver that positive communication message

(Staff member at study child's school: age eight interview)
(Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

This child had a SEN in relation to emotional regulation, following instructions, understanding school rules around boundaries, social interaction, expressive and receptive language, attention and concentration, learning skills, and gross motor skills. He was provided with a SEN teaching assistant to support him in class with his behaviours and learning. However the approach to the use of a teaching assistant resource in class differed from the approach adopted by the schools of other study children. A school staff member explained:

[Chid] has a SEN teaching assistant who is there to support him with his behaviours and with his learning, but she's not, Velcro'd (sic) to him, she doesn't work one-to-one with him, she works with supporting him in group situations, and other children in the class. He knows that he has a TA that he can go to, if he has his emotional needs or behavioural needs where he's just struggling and needing support, but she's there to support him one-to-one, in group situations, and from afar in the classroom.

(Staff member at study child's school: age eight interview)
(Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

In addition, and in contrast to the approach of other schools described above, staff at this child's school were able to develop a positive partnership with his mother. They felt that this was a crucial aspect of the progress that he had made. His mother had also noticed improvements to his behaviour at home:

[Child] would have been completely excluded and the school's SENCO fought for him to stay in that school because she didn't want him to leave and then, all of a sudden, he's changed. He is amazing, absolutely. He still has his moments like an ordinary seven-year-old child does, having paddy fits and tantrums and that, but he's not half as bad as he was.

(Birth mother: age eight interview)
(Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

The school viewed partnership working with parents as vitally important to their approach:

[We] make sure that the parents realise that they are the ones that know the children, and their ideas and opinions are the ones that are most valued, and knowing that they can have an open door policy. And they're part of putting together the passport of the child, so it's the parents' voice. We've got very child-friendly reviews, allowing the voice of the parent, because they know their child the best, so what they want for their child, so it's much more than a team around the table; it's about the child's voice, the parents' voice. But we also have opportunities for drop-in, and another way, we have six weekly coffee mornings, where we invite the parents in for children who are on SEN support, and we have a speaker. So it might be a speaker from the multi-agency team, it might be another mother out there who's got a child with ASD, and it's just like trying to get the parents in. When we get the parents in through the door we can build those relationships with them.

(Staff member at study child's school: age eight interview)
(Boy: high risk of suffering harm at birth; medium risk at age three; high risk at age five; medium risk at age eight – unsustained parental change)

Although, this child scored within the 'high' range of the SDQ according to both his teacher and mother, in contrast to the other two children described above with difficulties both at home and at school, it is clear that, after his mother's violent partner left the home, this child was making exceptional progress in coming to terms with his past adverse experiences and in addressing his emotional needs with the intensive support implemented by his school.

Entitlement to additional school resources

All of the children in the sample were eligible for pupil premium plus or pupil premium funding; either because they were a looked after child, or had been adopted or had left care with a Special Guardianship Order or Residence Order; or because they were in receipt of free school meals. Pupil premium funding is for eligible children to improve their educational and personal outcomes. It is not intended that the additional funding should be used to back-fill the general school budget nor is it intended that the funding should be used to support other groups of pupils, such as those with special educational needs or those who are low attaining (Department for Education, 2014).

On the whole, there were two approaches to utilising the additional funding from pupil premium: there were those schools which tailored the additional resources to the individual child; and those which combined all pupil premium funding to provide whole-class/whole-school interventions. The quotation from a school staff member below refers to a child who benefitted from the individual child approach. Her school paid for her to attend extra-curricular activities such as dance classes outside of school to help her increase her confidence:

[Child] is one of the children that finds it quite difficult to make friends, so using the pupil premium money we've actually enrolled her in an off-site dance school, so

that she can actually take part, and do dancing and different things. I was speaking to the dance school a couple of weeks ago, and they said that now she's starting to talk to them and to the other children, so her confidence and interaction is starting to come on.

(Staff member at study child's school: age eight interview)
(Girl: medium risk at of suffering harm at birth; low risk at age three; high risk at age five; permanently separated at age eight – unsustained parental change)

In contrast, another school combined their entire pupil premium funding to pay for specific whole-school or whole-class interventions:

We've got an awful lot of children funded through pupil premium, so we're very clever with that, and even though the pupil premium is attached around that child, what we do is, we're very, very careful to look to see what other children would benefit from that intervention. So we've got a very tight entry onto an intervention programme, and any intervention we're running is very, very clearly written down what it is, who's doing it, where's it happening, when's it happening, when's it starting, entry and exit data, because we need to know, we're coming up to the end of this term in December, and we need to measure the impact of that intervention. If that intervention doesn't impact, I don't want it, we don't want it in school, because it's a waste of money, it's a waste of time, it's a waste of the children's time. So it is about being really smart.

(Staff member at study child's school)

However, although the schools welcomed the additional funding from pupil premium, for some it was not enough to adequately meet the needs of individual children. For instance a staff member at a child's school who had substantial emotional and behavioural needs explained:

He [child] would not get a statement, or education healthcare plans as they are now known, because the thresholds are so high and all the top up money that we used to apply for children like him is gone as well, so we're meeting his teaching assistant out of our school budget. Obviously he gets the enhanced pupil premium money, but it doesn't go anywhere near to cover that. It has a huge impact on our budget, because it's not just the teaching assistant time, it's the time the class teacher's spending with him, and the learning mentor's time as well and as a school we've made the decision to fund those things, but it costs us a huge amount, and we're not getting any funding for him.

(Staff member at study child's school: age eight interview)
(Boy: high risk of suffering harm at birth; permanently separated by age three)

The majority of the teachers and SENCOs interviewed expressed concerns that they did not feel sufficiently knowledgeable about the most effective ways of supporting children with severe emotional and behavioural difficulties, particularly where they had experienced historical abuse or neglect. The schools had limited access to child mental health services, so they were often left to support these very vulnerable children without

adequate budget or specialist skills to do so. For instance a school staff member explained:

> *Because of his [child's] needs, we don't know where to go to get support. Dealing with it on a day-to-day basis and not knowing if you're doing the right thing and not knowing what the current kind of best practice is makes it harder.*
>
> (Staff member at study child's school: age eight interview)
> (Boy: high risk of suffering harm at birth; permanently separated by age three)

In addition, the enhanced pupil premium funding does not entitle children who have remained with their birth parents, but may have experienced difficulties in the past similar to those children who have been adopted, to the same level of services. Therefore entitlement to services should be based on the individual needs of the children, rather than their legal status.

Conclusion

The children's schools were able to meet their complex emotional and behavioural needs with varying degrees of success. The table below shows enabling features of the children's schools' environments contrasted with those features which were less successful in supporting the children.

Table 10: Enabling and disabling school environments

Enabling	Disabling
Strong home-school links.	Schools and parents/carers working separately, contrasting views and lack of consistency.
Pupil premium funding used for specialist evidence-based interventions (individual children, small groups or whole class).	Pupil premium funding not used in a tailored or structured way.
Assessment of children's needs and attainment ongoing. Assessment of needs used to implement appropriate and tailored support.	Assessments of children's needs and attainment static and not used to inform appropriate and tailored support.
Teaching assistants used to provide evidence based interventions to individual children or within small groups.	Teaching assistants used to separate individual children from the class and provide instructions for tasks.
Children with emotional and behavioural difficulties provided with evidence based interventions.	Reluctance to reward disruptive children with additional resources/attention.

Key points from Chapter Four

- The children were more likely to attend less effective schools, as reflected in Ofsted judgements, than would be expected nationally. The children's schools were also more likely to be larger than average (15/26:58%); have above average numbers of children with SEN (18/26: 69%); and have above average numbers of children eligible for pupil premium funding (21/26: 81%).
- The high level of deprivation in the surrounding areas of many of the schools and the high number of children with additional support needs made the task of teaching more complex. Some schools achieved this task more successfully than others.
- A total of 25 interviews were carried out across 16 schools, with nine SENCOs; 13 class teachers; and three head or deputy head teachers.

- Children whose birth parents made substantial changes to their lifestyles early in their child's life, and had had no further involvement from children's social care are under-represented in the schools interview data.
- The SDQs completed by teachers for sample children (n=16) between the ages of six and eight years show that nine (56.2%) fell within the 'close to average' range; three (18.8%) within the 'slightly raised' range; and four (30%) within the 'high' or 'very high' ranges. These scores differ from those SDQs completed by parents/carers for the same children. Half of the children scored within the high or very high ranges according to the parent/carer completed SDQs compared with a third of children who scored within these ranges according to their class teachers.
- Six (out of 16) children were progressing well in school and were also not displaying substantial difficulties at home.
- Six (out of 16) children were displaying severe emotional and behavioural difficulties at home, but the difficulties identified by their parents or carers were not apparent to their teachers during school time.
- One child appeared to display significant emotional and behavioural difficulties at school, whereas his carers did not identify these concerns.
- Three children (out of 16) were displaying severe difficulties both at home and at school.
- All of the children in the sample were eligible for pupil premium plus or pupil premium funding, either because they were a looked after child, or had been adopted or had left care with a Special Guardianship Order or Residence Order or because they were in receipt of free school meals.
- There were two approaches to utilising the additional funding from pupil premium: some schools tailored the additional resources to the individual child; and some schools combined all pupil premium funding to provide whole-class/whole-school interventions.
- Pupil premium funding tended to be most successful when used to fund specialist evidence-based interventions, either for individual children, small groups or whole classes.
- For some schools pupil premium funding was not enough to meet the needs of children with complex emotional and behavioural needs.

- Schools were not always sufficiently knowledgeable about the most effective ways of supporting children with severe emotional and behavioural difficulties, particularly where they had experienced historical abuse or neglect.
- Schools had limited access to child mental health services, so they were often left to support these very vulnerable children without an adequate budget or sufficient specialist skills to do so.

Chapter Five: Children's perspectives of support at home and school

Introduction

The previous chapters have shown the children's experiences and changes to their circumstances over the course of their lives so far. By the age of eight the trajectories the children's lives had taken could be split into three groups shaped by their parents' capacity to overcome the risk factors that threatened their safety and wellbeing. These were the nine children who had remained with parents who had been successful in overcoming substantial difficulties to provide and sustain a safe and nurturing home environment (the sustained parental change group); the nine children who were either living at home (five children) or were separated from parents (four) who had made initial improvements to their parenting capabilities but had been unsuccessful in sustaining them (the unsustained parental change group); and the 18 children whose birth parents had not been successful in addressing risk factors, of whom six remained at home and twelve were permanently separated (the minimal parental change group).

Over two thirds of the children had been maltreated at some stage in their lives, and at least 11 (31%) were continuing to suffer neglect and abuse at the age of eight. It is not surprising that the prevalence of emotional and behavioural problems was high. Analysis of evidence relating to children's behaviour patterns indicates that those in the unsustained and minimal parental change groups were substantially more likely to have developed emotional and behavioural difficulties. The behaviours that many of these children were displaying were particularly disturbed, and high levels of aggression were common. However some children were displaying behaviours which were more internalised and/or sexualised.

The children's schools therefore had to undertake a substantial task in helping the children overcome their difficulties and in managing their behaviour in a classroom environment. Some schools were able to use additional resources, such as the provision of nurture rooms, and were making good progress in meeting the children's needs. However, some of the children's schools were ill equipped to help children with such significant difficulties, and the children's ability to learn was substantially compromised.

However, so far, we have only heard about the children from the adults in their lives. We therefore now turn to hear from the children themselves; about their perceptions of the ways in which they were supported at home and school, by their families and friends as well as professionals such as teachers, social workers and other professionals. We particularly wanted to find out whether the children themselves felt they had 'sufficient support of the right kind' which might promote their resilience and help them to withstand some of the impact of the adversities they had experienced (Gilligan, 2003). Given that resilience and growth also depend in part on a strong sense of belonging, the chapter

also examines the children's own views of the nature of their relationships with adults and other children. The chapter finishes with an exploration of their personal sense of their emotional wellbeing.

Interviews with the children

26 (72%) of the 36 children included in the age eight follow-up sample were interviewed. Eight of these children were girls and 18 were boys. The children's average (mean) age at interview was eight years and one month. With the exception of one child who was five years and nine months, all the children were over seven years old when interviewed. The oldest child was aged nine years and six months.

Seventeen of them were living at home, and these included eight who were living at home where concerns about their welfare no longer persisted, and who were classified as at low risk of being exposed to maltreatment; and nine children who were living at home where concerns were ongoing and were therefore either classified as at medium or high risk of significant harm. Nine of the children who were interviewed were separated from their birth parents, and were either adopted (three children), in kinship care (four children), or with foster carers (two children).

Five of the children who were interviewed had a disability, including hereditary conditions which impair sight and gross and fine motor control, cerebral palsy, global developmental delay as well as epilepsy, and Autistic Spectrum Disorder.

There were a number of reasons why ten of the children in the sample were not interviewed: one parent refused permission because she was concerned about her child's behaviour; a further five parents or kin carers took part in the study by telephone. All these parents and carers had previously taken part in face-to-face interviews in the study, but were unable to do so for this phase due to circumstances such as severe health difficulties, or acute difficulties managing their child's behaviour. These parents and carers were not approached about the possibility of their children being interviewed to ensure that the research team did not add to the stresses they were already experiencing. Three children were in mainstream foster care and their carers could not be accessed within the time frame of the study, and one additional child had recently moved to kinship care.

The subset of children who were interviewed is skewed towards those without or with less severe emotional and behavioural difficulties than the sample of children overall. The table below compares the prevalence of emotional and behavioural difficulties amongst the subset of children who were interviewed with the full age eight follow-up group.

Table 2: Comparison of the prevalence of emotional and behaviour difficulties amongst children who were interviewed with the full age eight follow-up sample

SDQ range	Age eight interview sample	Age eight full follow-up sample
Close to average	9: 35%	10: 32%
Slightly raised	5: 19%	5: 16%
High	4: 15%	4: 13%
Very high	6: 23%	12: 39%
Total	24[15]: 100%	31[16]: 100%

It was only possible to interview half (six out of 12) of the children with severe emotional and behavioural difficulties. The parents and carers of these children were particularly concerned about allowing them to participate in an interview because of their disruptive behaviour.

In conducting research with young children it is important to take account of their attention spans; the need for careful pacing; the use of clear, cognitively appropriate language; the provision of simple explanations; and confirmation that the child understands (Ford, Sankey and Crisp, 2007). These issues were particularly pertinent for sample children. Consequently, extensive thought, sensitivity, planning, and consideration of the most appropriate methodologies was required in conducting interviews with the children; in ensuring that their wellbeing was not compromised further by the research process; and to fully understand the limitations of the interview data.

The limitations of the interview data firstly relate to the exceptionally vulnerable population of children in this study. As described above, the children with the more severe emotional and behavioural difficulties were less likely to participate, therefore the children's interview data is skewed towards those who were progressing *relatively* better. Nevertheless, the sample of children who were interviewed was exceptionally vulnerable with a higher prevalence of emotional and behavioural difficulties than would have been expected from a normative population. Therefore their chronological age was likely to be higher than their emotional and/or reading age. Secondly, there were a number of practicalities that affected the interview process. For instance, many of their homes were overcrowded, and most children lived with siblings including babies and toddlers. It was therefore difficult to find a calm, private space in which to conduct the interview.

[15] No parent or carer completed SDQ was available for two of the 26 children who were interviewed.
[16] No parent or carer completed SDQ was available for five of the children included in the age eight follow-up sample.

Maintaining concentration in such circumstances was difficult for the children, and was a particular issue for those with emotional or behavioural difficulties. In addition, only three of the interviews with children took place without an adult present. A further six children were interviewed alone but with adults entering the room from time to time to check to see how the children were feeling. The interviewer had a strong sense that some children chose to share, or not to share, important information that might have upset the adult who was with them (see Appendix Two for further information about the children's interviews).

The interviews with children involved four sections. During the first part children were asked to use stickers depicting abstract human and animal forms to create 'eco maps' of their family and friends on large sheets of coloured paper. The maps were then used to explore the supportive nature of their relationships with adults and other children in their home lives. More particularly, the children were then asked who in the picture they would turn to if they were worried about something. During the second part of the interview the children were given a set of 'helping people' cards, showing pictures of professionals who work with children such as a teacher, social worker, doctor and police officer (Cossar et al., 2013). The children used the cards to identify adults in their lives whose job it was to help them. Thirdly, the children were asked to complete *Cantril's Ladder* (Cantril, 1963), a simple visual analogue measure of the child's global assessment of his or her life satisfaction. Lastly, the children were asked to write a message that grown-ups should think about when helping children, and put their message in the *really useful envelope*. The children were also provided with a *Stop* and *Go* sign which they could use to indicate whether they were happy, or not, to proceed with the questions they were being asked (see Appendix Two for a full overview of the methodologies used for interviewing the children).

The children's views and understanding of their familial relationships

As seen throughout the report so far, the children's familial relationships are were extremely complex, often involving a multitude of members, such as step-parents, half siblings, absent birth parents, absent siblings, and grandparents or aunts and uncles who had taken on a parental role and who some children thought were their birth parents. Many of the children had experienced permanent separation from one or both birth parents, and were living either with a non-abusing birth parent, or with kinship carers, foster carers or adopters. These complexities are illustrated by the eco-maps the children created. Most of the children enthusiastically created pictures of often large and complex immediate families and households, extended families, and networks of friends.

For instance, one of the children who was permanently separated from his birth parents created a picture of members of his family, including his current carers, and his family pet, as well as school friends and members of his extended family. He left his birth

mother when he was six months old, but he also chose to include her in the picture, and his three birth half siblings. He appeared relaxed about including his birth family in his picture, which his current carer, who was present during the interview, and was very open in her communication about his life story, had predicted. He also spoke openly about his previous foster carers with whom he lived until he was almost three years old. Below is an image of this child's eco-map.

Study child's eco map: Boy – permanently living with substitute carers



In contrast to the example above and most other children who were interviewed, five children created relatively small eco-maps. For instance, one of these children created a picture of social isolation. Included in this child's picture were his mother and sister with whom he lived; however, others he chose to include were his father, with whom he rarely had contact, four imaginary friends, an imaginary cat and dog, and three members of his extended family, two of whom had moved away. This child's home circumstances were extremely strained. His mother was labouring under immense stress, causing her to have periods of being hospitalised, which she associated with being the victim of intimidation from her neighbourhood as well as with trying to cope with her child's severe emotional and behavioural difficulties. An image of this child's eco-map is shown below.

Study child's eco-map: Boy – living with birth parents (unsustained parental change group)



Generally, the children who were living with at least one birth parent were clearer about the biological and social nature of their *close* family relationships – their relationships to their parents, grandparents and siblings – and were more likely to convey a clear sense of their place within the family, than children who were separated from both birth parents. In most instances the children who were living with either their birth mother or father communicated that they were aware of their absent parent even if they did not include them in their map.

Additionally the two children who were living with foster carers were also very clear about their relationships with their birth and foster families. Both of these children had been separated from their birth parents and placed with foster carers at the age of six, following extensive, chronic neglect. Both children were well settled in their placements and enjoyed regular contact with some members of their birth families.

They seemed to know exactly 'who was who'. One called her foster carers by their first names and whilst the other called his foster parents 'Nana' and 'Granddad', he neatly categorised the members of each family and placed himself within his birth family on his eco-map. He also included a younger brother who had been adopted by another family.

However, not all children expressed a clear understanding of their familial relationships. These included some of those children who were separated from one abusive birth parent, and were living with the other non-abusive parent; some of those living with birth parents who had been permanently separated from older children; and some children separated from both parents These children expressed uncertainty, confusion and/or unease about their close family relationships.

For instance, one child's mother had extricated herself from her relationship with his father who had been violent towards her during pregnancy and the first few months of this child's life. This child chose not to include his birth father on his eco-map. He did not have contact with him, however he did occasionally ask his mother about him. His mother had indicated in her own interview that her son knew she found his questions uncomfortable. During his interview this child referred to his mother's new partner as 'Dad' for the first time. After the interview the mother commented that she felt 'choked' by this.

Occasionally, the children also made references to absent siblings, including children permanently removed from their parents' care, adult siblings no longer living at home, and those living with another parent. Some of the children were confused about the role these siblings played in their lives. This is of concern given that relationships with siblings are usually the longest in a person's lifetime and can promote positive developmental outcomes. They often provide important sources of support through late adolescence, adulthood and old age (Hegar, 2005).

Some children living with kinship carers or special guardians expressed uncertainty, confusion and/or unease about their close family relationships, their use of names within their families and their own life histories. Research suggests that children's feelings of belonging can be reinforced by the names they use to describe members of the kinship care family, and other members of the birth family, especially birth parents (Wade et al., 2014). This particular issue, however, seemed to cause the children living with kinship carers much discomfort. For instance, one child living in a kinship care placement called his carer 'Mum'. During his interview he clearly identified his carer as someone he would turn to at home if he was feeling upset about something but then queried his relationship with her, saying, 'You're my mother. You're everyone's mum. Are you my Mum?' Another child, also referred to his kinship carer as his 'Dad' but did not mention his deceased birth mother or his birth father at any point during the interview.

Another child placed with kinship carers had been living with them with the protection of a residence order from toddlerhood, and they had been heavily involved in his life from birth. He had been separated from his birth parents at birth because of their continued heroin use and chaotic lifestyle. Prior to his placement with his kinship carers he had spent time in unrelated foster care. He called his kinship carers 'Mum' and 'Dad' and his birth parents by their first names unless his birth parents were present, in which case he called them 'Mum' and 'Dad'. He also viewed the other children in his household as his

siblings although they were his uncles and aunts. He implied a strong desire to have more contact with his birth father. He also seemed desperate to know why he was unable to live with his birth parents. During the interview there was a brief but poignant exchange between this child and his kinship carer:

> Child*: I live down here. When I was little I used to live up there with them [my birth parents] didn't I? I got kicked out didn't I?*
>
> Kinship carer: *No you didn't.*
>
> Child: *What?*
>
> Kinship carer: *No you didn't.*
>
> Child: *I got sent down.*
>
> Kinship carer: *No you didn't.*
>
> Child: *What?*
>
> Kinship carer: *When you're a bit bigger we'll explain.*
>
> (Interview with study child: Boy, living with permanent substitute carers, age eight)

Adoption research over the last 40 years provides a strong body of evidence of the need for adopted children to know why they were separated from their birth parents (see Treseliotis, 1973; McRoy et al., 1990; Howe, Feast and Coster, 2003; Neil, 2012). It is reasonable to assume that children in kinship care and special guardianship are likely to have very similar needs. While there have been few formal evaluations of the efficacy of specific types of life story work with children (McKeown, Clarke and Repper, 2005), reports based on the views of looked-after children and young people stress the importance of helping them to develop a clear sense of identity through preserving consistent accurate information about their history and family relationships and the reasons for their being looked after away from home (see NICE, 2010). However, life story work of this nature had not been undertaken for any of the children in kinship care or special guardianship in this sample; support for their carers to facilitate this had also not been forthcoming.

Other children who were permanently separated from their birth parents also expressed confusion and unease about their own place within their family. For instance, towards the end of his eco mapping one child said 'I was going to put my sisters in that I'm not living with ... but there's too many'. He did not include them or elaborate any further.

Another child had been permanently placed shortly before his fifth birthday. On his eco-map he included a sticker for a 'big brother' but said 'I don't know his name'. Presumably he was referring to the older teenage son of his previous foster carers, as he was the first

child born to his mother. He also expressed confusion and anxiety about his own identity. Towards the end of his interview he suddenly said, ‘Don’t call me [child’s name] anymore. I’m not [child’s name].’

All of the five children mentioned above who were permanently separated from their birth parents were displaying significant emotional and behavioural difficulties. One had been excluded from school on the day of his interview, and another was refusing to go to school. It seems likely that the children’s bewilderment about their place in their families and their life histories was contributing to some of their difficulties.

Friends

Most children included numerous friends, including several particularly close friends in their maps. Overall they spoke very positively about the fun and supportive nature of their friendships. Very few of them openly talked about or alluded to any difficulties within them.

One child, who was living with his birth parents where there were ongoing concerns relating to mental ill health, physical ill health and ongoing financial difficulties and housing problems, however, only had imaginary friends and seemed to be socially isolated. He mentioned one boy saying, ‘I’m not going to include him because he’s not like a friend. Sometimes he’s mean to me’ and also referred to other people at school being mean to him. His social isolation may have been related to his mother’s mental health problems and the bullying the family had experienced on its housing estate for over five years.

Another child, who was also living with her birth parents where there were ongoing concerns relating to mental and physical ill health and housing and financial difficulties, also seemed socially isolated, naming just one friend with whom she seemed to have an ambivalent relationship. When she first mentioned the friend she was described as her ‘best friend’, but she then repeatedly said that she and her friend often disagree and fight with each other.

Pets

Many of the children regarded animals as significant members of their families and very real friends. Their pets were valued as confidants, and offered the children important sources of support, comfort, cuddles, company and continuity. Animals that lived with extended family members were also occasionally included in the children’s ‘eco maps’.

Sadness and loss was expressed about pets that had died and others that had moved to be looked after by others. One child mentioned Brody, ‘... my dog who ran away. I miss her ... Brody is my favourite dog.’ Another child talked particularly fondly and sadly of a

pet - his cat Ruby who had often allowed him to stroke her and tickle her under her chin. Mum explained that Ruby had '... unfortunately decided to live with someone else'.

Pets can be important in promoting resilience for vulnerable children, particularly those who are separated from their birth families. Gilligan describes:

> An animal may be warm, cuddly, responsive, loyal, non-judgemental, sensitive, reliable and constant. It can contain the secrets and stresses confided within it. This "listening ear" which an animal may provide may be very therapeutic for a child who finds it hard to access what he or she regards as a trustworthy human ear . . . The animal can represent a comforting, precious and supportive constancy. It may signal very clearly its affection for the child, a child who may have been starved of such affection at many points in the past. The purring of a cat, the nuzzling by a horse, the wagging tail of a dog directed in recognition of a child familiar to the animal may prove healing gifts for the child craving acceptance and affection. This sense of "lovability" conveyed to the child by the animal may help to improve self-esteem. (Gilligan, 2009, p. 70)

Who would you turn to if you were worried about something?

Twenty-two children were asked who they would turn to if they were worried about something. Thirteen of them conveyed a strong and positive sense that they had people in their lives at home with whom they could confide if they had a worry. These children were able to identify at least one of their primary carers from whom they would seek help and support. For instance, two children suggested that they felt that they could take a worry to any of those they had included on their maps. As one explained, 'I've got loads of people – loads and loads and loads' and 'everyone' helped him. Another also stressed that 'lots of people help me'.

However, the responses from nine children were ambivalent. Two children identified a teacher, and not a primary carer as their confidant, and five children chose only their siblings or peers. For instance, one child said that he would turn to a friend who would write a note to his mother. He did not want to elaborate further with this, choosing instead to use the *Stop* sign. Similarly, another of these children chose a friend from school, however she had also mentioned that she and her friend often fall out. It is important to note, however, that this child has global developmental delay and may not have fully understood the question. An additional three children chose not to mention anybody specifically. For instance, one explained that he went to 'different people at different times' depending on the nature of his problem. Perhaps this indicated that he felt confident in turning to several people in his life with whom he had a strong bond. However, conversely, perhaps it is indicative that he felt he did not have a strong sense of closeness with anybody in particular. This child was permanently placed away from home, and had severe emotional and behavioural difficulties that were threatening the stability of his placement. A further two children, both living with birth parents and classified as at high or medium risk, did not identify anybody who they could turn to. For

instance, one found the question uncomfortable, she pointed to several people on her eco-map, but said, ‘I don’t want to say’.

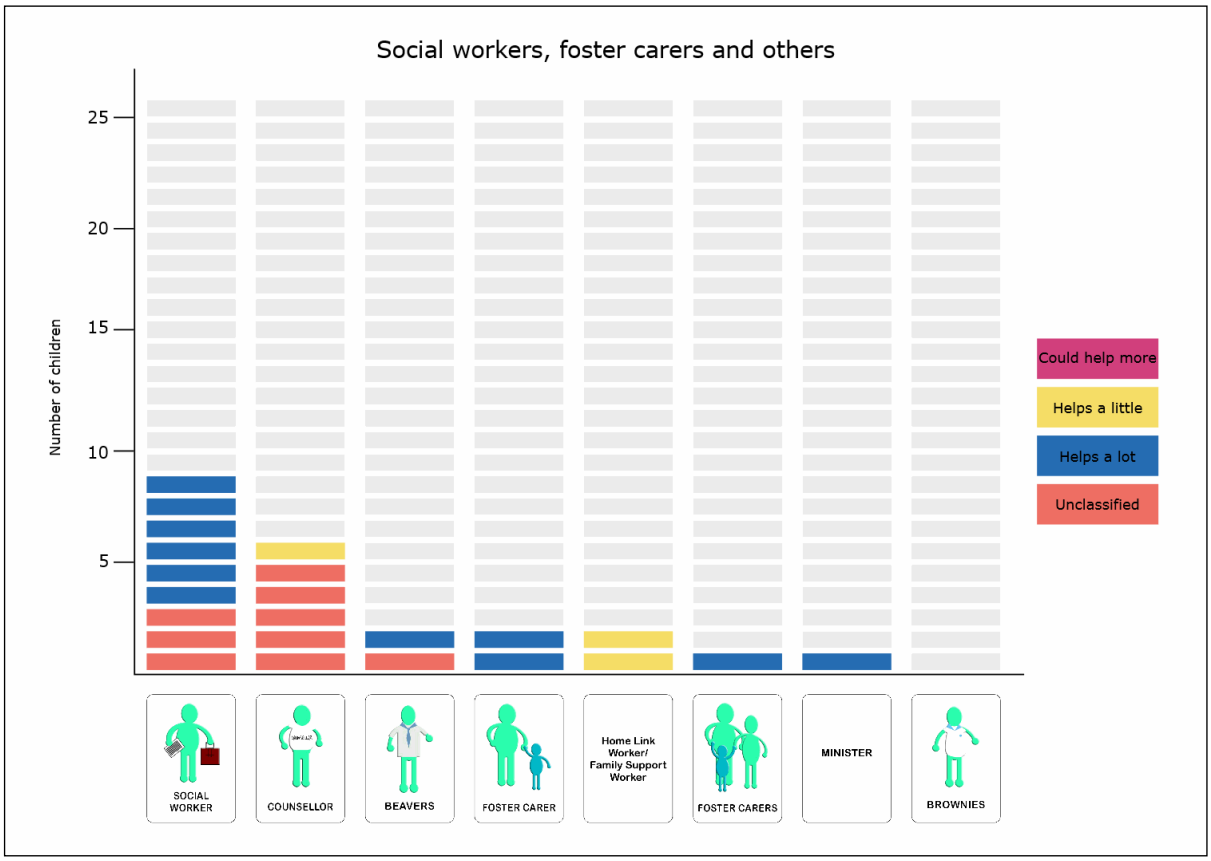
Helping people cards

The children were then given a set of ‘helping people’ cards, showing pictures of professionals who work with children e.g. a teacher, social worker, doctor and police officer. They added dentists, opticians, ministers, specialist school based counselling services, and school care takers to the set of 26 cards that were provided.

Using the cards, the children identified an average of 14 adults in their lives whose job it was to help them. The number of adults identified ranged from 10 to 18. The children were then asked to classify the ‘helping people’ they had in their lives into those that ‘help a lot’, ‘help a little’ and ‘could help more’. Twenty-four of the 26 children were able to use the cards in this way. If possible, the children then described ways in which the professionals in their lives had been supportive. Some children made judgements according to the quality of their contact with the professionals, others judged them according to the quantity.

Social workers, foster carers and others who work for children's services

Figure 3: The children's selection of helping people cards for social workers, foster carers and others who work for children's social care



About a third of the children within the sample were aware of children's social care involvement in their lives. These children generally described social care interventions positively and, in some instances, suggested that the services had significantly improved their lives.

Nine children noted that they had at the time of the interview or previously had social workers. For example, one child described phoning a social worker to report that she had been hurt by her mother's violent and aggressive partner, and that the partner had subsequently and helpfully been removed from her home. She explained:

> *... I told them to get the social worker. So the police was on our door – knock, knock, knock. Where's M? He was hiding behind me – proper hiding. So I said "Get in front of me ... There. Have him". Because Mum couldn't cope, really couldn't cope... And the next day all was calm.*
>
> (Interview with study child: Girl, living with birth parents; unsustained parental change, age eight)

The same child also described help she had received from a family resource worker saying:

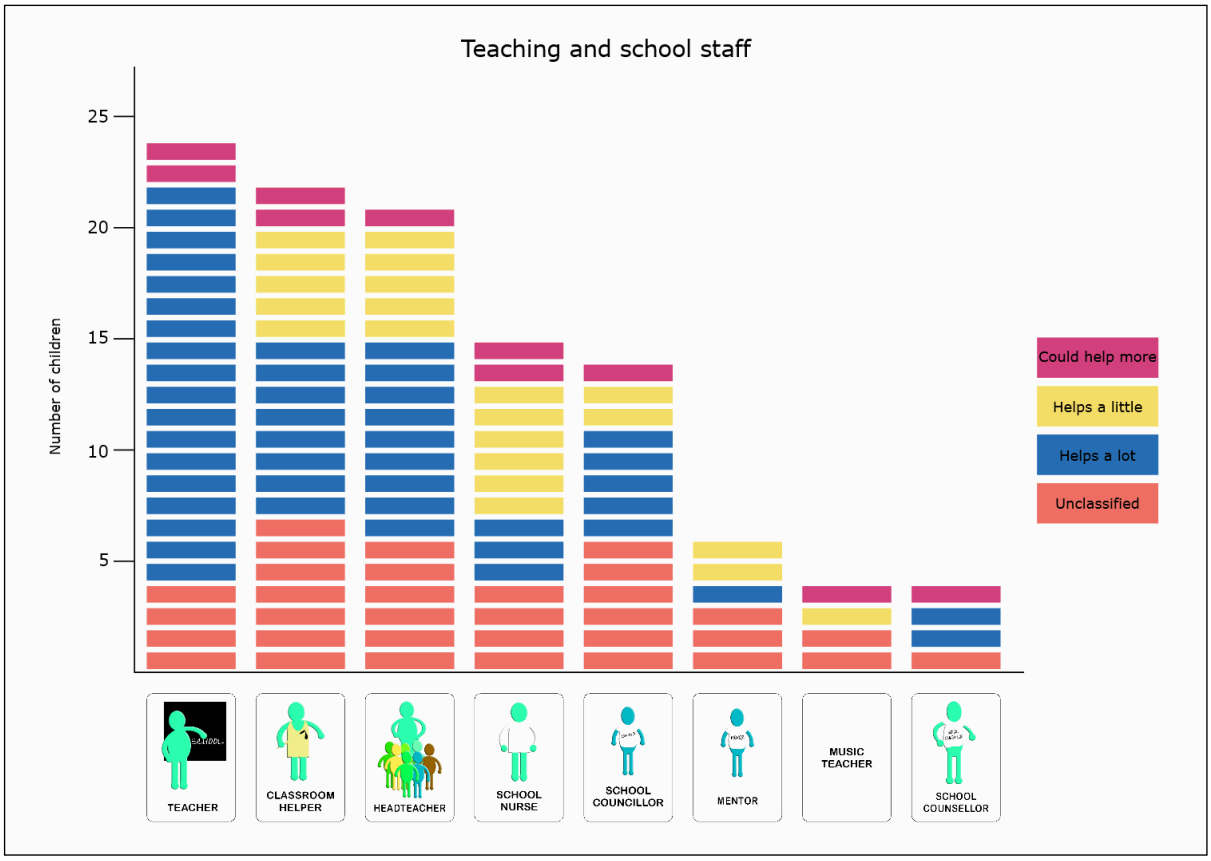
> *... She helped me very, very a lot ... She looked after me. She bought toys. She helped my Mum ... She looked after me if I was a bit poorly or a bit upset, or if I was angry and wanted to get the anger out of me.*

Two of the children who were interviewed had become looked after since the previous phase of the study. They were also both complimentary about their social workers and valued the contact arrangements with their birth family that had been put in place. One of them described how he appreciated the support he received from the worker who organised his contact. It was particularly important to him that the worker offered him a choice of activities for his contact sessions and respected the choices he made.
These two children seemed settled and happy, and were bonding with their new carers and their carers' extended families. The carers' grandchildren had become part of their friendship groups. The children excitedly described enjoying holidaying, riding scooters, and having regular healthy meals with their foster carers.

One additional child powerfully communicated the significance of his relationship with his previous foster carer. This child had been very close to her and found the separation, extremely difficult. He indicated that it was simply too painful to discuss her during the interview. When asked by the interviewer whether he had had a foster carer he replied, 'No, no, no, no!' His current carer then said, 'But what about [name of previous carer]?' The child then replied emphatically, 'No!'

Teaching and school staff

Figure 4: The children's selection of helping people cards for teaching and school staff



Teachers were extremely important sources of help in the lives of the children who were interviewed. All the 24 children who were interviewed selected their teachers as people who helped them and the majority (70%) put them in the most helpful category (i.e. teachers helped them 'a lot'). One child however explained that his teacher was unhelpful when other children were mean to him and would not let him play with a particular toy.

Similarly high numbers of children selected cards for classroom helpers and head teachers. However, about a third of the children regarded them as being 'a little' helpful or needing to 'help more' rather than helping them 'a lot' (the remainder were unclassified). This in part reflected, however, more limited levels of contact that some of the children had with these school staff compared with their teachers rather than dissatisfaction with the help they had provided. However, at least three of these children were in receipt of substantial support at school, either in relation to a disability, or because of their behavioural needs.

The children expressed a wide range of views about their experiences of school from not wanting to go to school to 'loving' it. Those who said they enjoyed school valued the help they received with the academic work they found challenging, particularly literacy and mathematics. They talked positively about extra support they received at school for

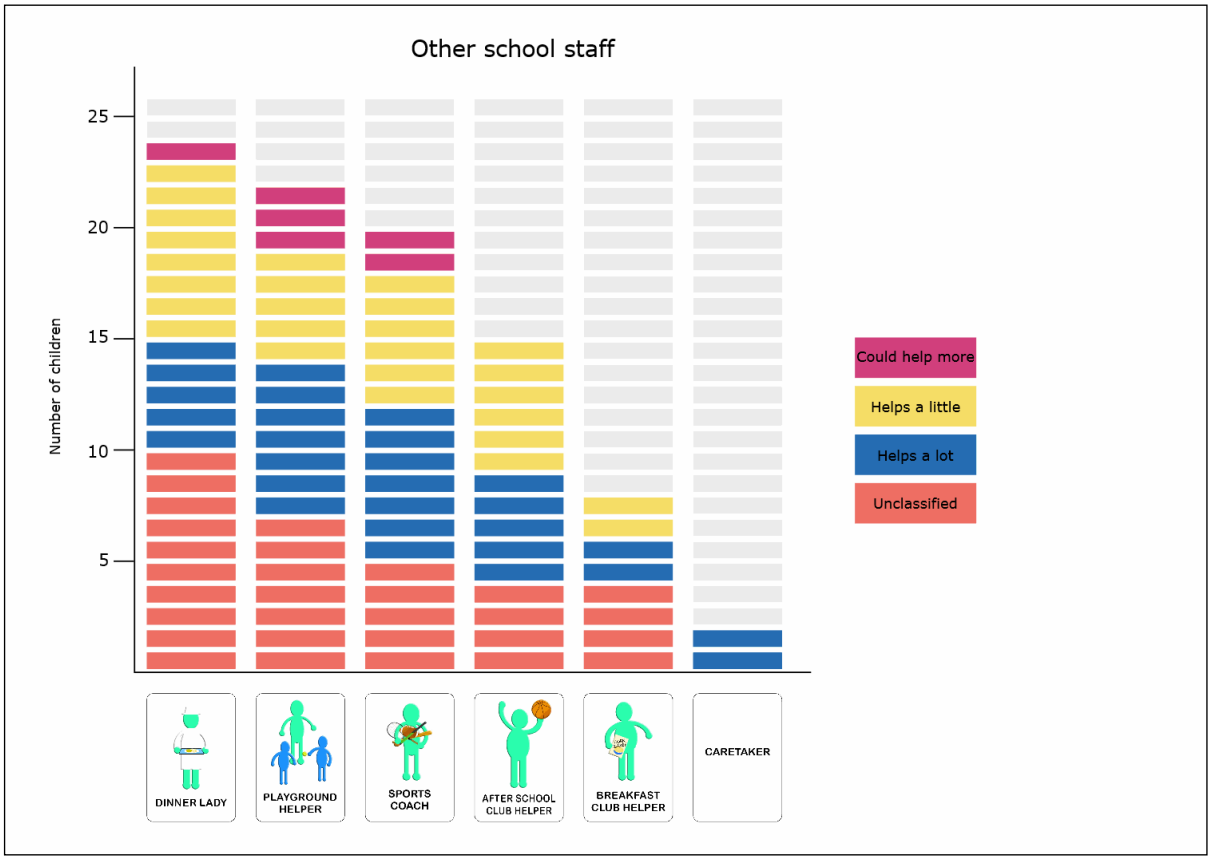
emotional and behavioural issues, appreciating the discipline and clear behavioural boundaries that were set in school.

One child, who has until recently been living with an abusive step parent was especially enthusiastic about the support he had received at school the previous year from his teacher, classroom assistant and SENCO, particularly in relation to controlling his anger. He was aware that his mother and various school staff had worked together to help him. He said he found it reassuring that if he told his mother about a problem she would discuss it with his teacher and ‘they would sort it out’. His special relationship with his classroom helper had made a difference to how he felt about attending. He described her as his ‘best friend’ and that he had been very upset when she had been on sick leave. He also linked his improved ability to regulate his emotions with his recent academic progress. He said he no longer needed to talk to the SENCO very often because he was ‘doing well by myself and I’m doing great writing, great writing’.

Other children were less positive about school. Some expressed dislike and fear of particular school staff and/or subjects. For instance, one child said her classroom helper made her ‘shiver’, while another described his as having a ‘right temper when she’s angry’, often giving children detentions.

School staff who work outside of the classroom

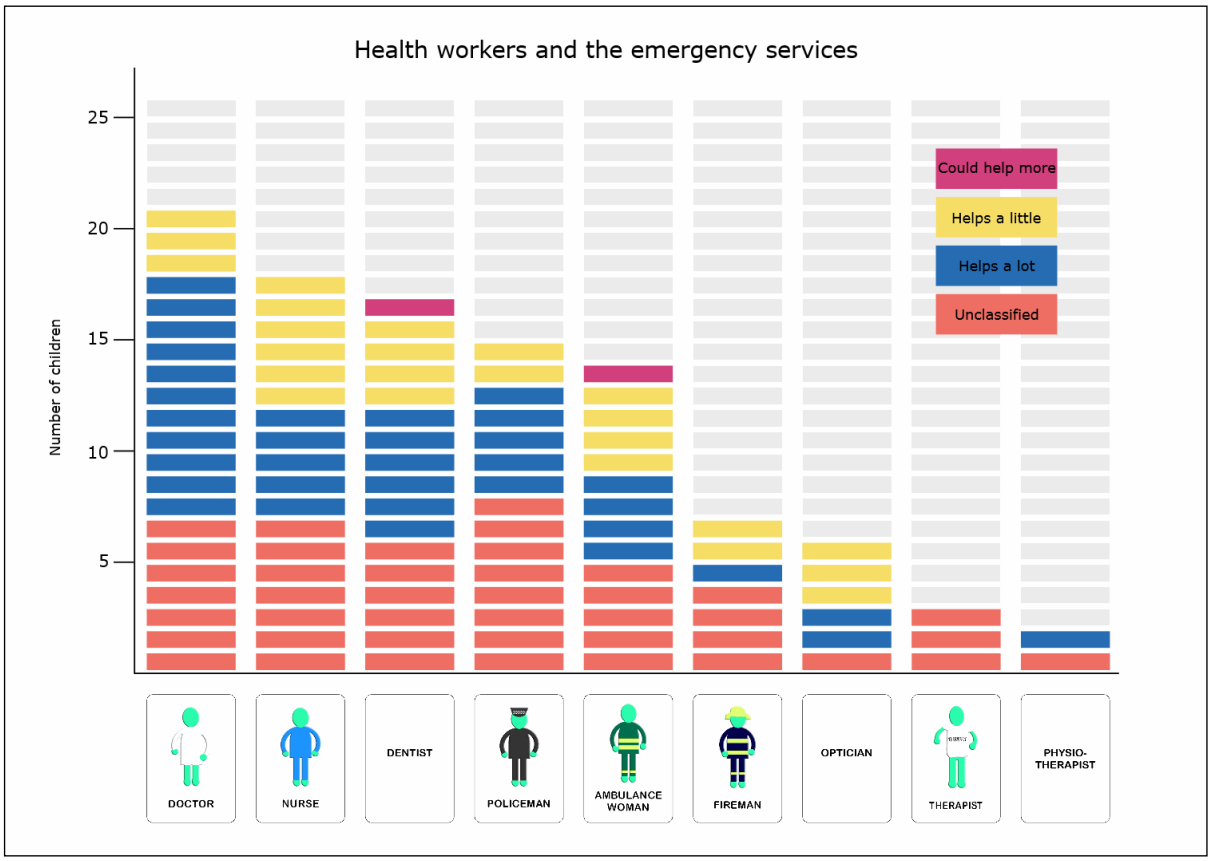
Figure 5: The children's selection of helping people cards for school staff who work outside of the classroom



Other school staff who work outside the classroom, particularly the dinner ladies, playground helpers and sports coaches, were also important sources of help in the lives of the children who were interviewed. These people were especially helpful if the children were physically hurt, being bullied and/or enjoyed sport. Only very small numbers of the children suggested that there was scope for these particular staff to be more helpful.

Health workers and the emergency services

Figure 6: The children's selection of helping people cards for health workers and emergency services



Over three-quarters of the children identified doctors, nurses and dentists as being helpful in their lives. The one child who made a suggestion as to how his dentist could help more was clear that he simply wanted his treatments to be 'less painful'. The children who had received hospital or regular GP treatment for acute or chronic illnesses were generally positive about the support they had received. One child was particularly complimentary about her specialist nurse, who she felt had treated her as an individual, and arranged celebratory parties when children were well enough to leave the ward. Another child also mentioned a nurse who had helped him 'a lot' by dressing the wounds on his toes after surgery.

About half the children identified police and ambulance people as having helped them, or being available to help them, at some point in their lives. Six of the children had witnessed or been aware of a range of incidents involving the emergency services. For instance, one child knew that his mother had contacted the police after his brother reported that he had been sexually abused by another child. Another child mentioned the local use of police surveillance related to incidents of young men riding motorbikes without crash helmets and the fire brigade attending frequent fires on the estate where he

lived with his carers. The police had also visited another child's home very recently to investigate her mother's stolen purse.

One child spoke particularly positively about the police's responses to incidents of domestic abuse between his father and his father's partner:

> *I had to go home in the police car because T gets really drunk and then me and Dad have to go home 'cos she causes arguments. So, we have to ring the police and then we have a ride in a police car and the police have a word with T ...They're nice... They help sort your problems out.*
>
> (Interview with study child: Boy, living with birth parents; sustained parental change, age eight)

Messages for 'what people or grown-ups should think about when trying to help children'

The *really useful envelope* exercise was quite a challenge for most of the sample children. Very few of them could think of a message about 'what people/grown-ups should think about when trying to help children.' However, most of the messages that were written related to specific problems the children had mentioned earlier in the interview. For instance, one child expressed concern that her school nurse occasionally forgot to record incidents of children hurting themselves, saying 'Sometimes she forgets to put in our book that we, when we get hurt, sometimes she forgets to do that ... I know when I bashed my head she forgot to write it in the book ... I reminded her.' This child bruised easily as a result of ongoing medical treatment and any bruising needed careful monitoring. Her short but powerful message related to the importance of adults 'remembering things'.

One of the older children in the sample wrote a succinct and clear message for grown-ups suggesting that, 'People at school should think about what children's lives are like at home.' Earlier in the interview he had described having experienced significant behavioural difficulties. He said that at one point in his life he had been 'very, very, very, bad ...' and attributed this to his contact with his father which he said 'made me worry and made me act strange'. He also suggested it was linked to sadness he had been feeling about his lack of contact with his step-father. He also described having been referred to a therapist at this time but that as a result of social work intervention in his family life and a change of school '... they stopped the therapist coming because my behaviour got better and better.' A member of staff at his school also supported this view:

He [child] settled really well. We'd read his notes from his previous school and his reports and we were expecting [child] to be a particular [kind of] child when he first arrived based on all the evidence we'd had from his previous school. However he settled incredibly well and made friends really quickly.

(Staff member at study child's school: age nine interview)
(Boy: medium risk of suffering harm at birth; high risk at age three; medium risk at age five; medium risk at age eight – unsustained parental change)

Measure of life satisfaction

The study aimed to explore the children's subjective life satisfaction because this can be another important indicator of underlying issues, and has been found to be significantly related to children and young people's mental health problems. The choice of measure was guided by the Children's Society's and University of York's extensive work on understanding children's wellbeing led by Gwyther Rees and Jonathan Bradshaw (Rees et al., 2011). However, it was constrained by the lack of widely used measures for children under eight and the very limited availability of measures suitable for children aged eight and nine.

We selected Cantril's Ladder (Cantril, 1963) used by the Children's Society for children aged eight and over. It is a simple visual analogue measure of the child's global assessment of his or her life satisfaction. It consists of an image of a 'self-anchoring' ladder with 10 rungs with its base at '0' (relating to the 'worst possible life') and the top rung at '10' (relating to the 'best possible life'). Children are asked where on the ladder they would position themselves at the moment (see Appendix Two for an overview).

Eleven of the 12 children in the interview sample who were aged eight or over at the time of their interview completed Cantril's Ladder. Six children indicated they were having the 'best possible life' (two permanently separated; two living with birth parents at low risk of harm, and two at medium risk); three children scored their life satisfaction as above average (7-8) one living with birth parents at low risk and two at medium risk; and two scored their life satisfaction as below average (both living with birth parents at low risk).The scores need to be interpreted with caution given that most of the children completed the ladder with their parent or carer present. However, the distribution is similar to that of the eight and nine-year olds in a Children's Society national survey, with scores skewed towards the top of the ladder. The mean and mode are also the same, eight and ten respectively (Rees, 2011). Most of the children assessed themselves as having a positive level of life satisfaction.[17]

[17] Scores of 6 or more have been defined as a 'positive level of life satisfaction' (Currie et al., 2004 p.56).

Given the adversities in the lives of the sample children, we expected them to score themselves more negatively. Rees and colleagues (2011) have found that individual and family factors, such as age, gender, poverty and family structure, explain less than 7% of the variation in the children and young people's broader wellbeing. Nevertheless, factors such as life events (including recent experiences of bullying) and the quality of relationships play a more significant part in explaining variations. Also, groups such as disabled children and those not living with their parents have 'substantially lower than average levels of wellbeing' and also the 'cumulative effect of multiple disadvantages can also have a significant negative impact' (Rees, 2011 p.9).

The interviews with the two children who scored the ladder negatively indicating that they had 'low life satisfaction' were not particularly remarkable. However, in terms of life events one noted during his interview that he had needed support with bullying. Also, he had been reprimanded twice at home earlier in the day of the interview. In relation to the quality of relationships, another child was a little unusual in that, compared with other children, he identified significantly more people he felt could be more helpful to him. He wanted more help from his classroom helper, who he described as angry and giving detentions; his school counsellor who 'pushed in'; his music teacher who could teach more instruments, and his dentist who could make treatments less painful.

Another child very clearly related her low and high scores to life events and the quality of her relationships. She explained that her position on the ladder was determined by the presence of her mother's ex-partner, who was also the father of her younger siblings, and had been removed from her home after incidents of domestic violence. She indicated that she would position herself at '0' if he was living with the family and at '10' if he was not.

Conclusion

Children's resilience and growth depend in part on their sense of belonging and having enough of the right kind of support in their lives. It is therefore of great concern that some of the extremely vulnerable children in the interview sample felt confusion and unease about their family relationships and/or described needing more and/or different help and support.

The interviews with the children in kinship care and adoptive placements revealed and confirmed some of the unanswered questions they had about the nature of their family relationships and why they had not been able to live with their birth parents. The carers and adoptive parents of these children had particularly difficult stories to tell and may have needed tailored professional advice about how to talk to their children sensitively about their pasts and their birth parents' problems (Selwyn et al., 2013). The children themselves might have benefited from life-story work. More generally, kinship carers needed the kind of advice adopters routinely receive about telling their children's stories.

Carers need this advice to support the children into their placements and through their later stages of development.

Thirteen of 22 children in the sample identified an adult at home they could turn to if they had a worry. Children were very positive about social care interventions if they remembered having had them. The majority valued the help they received from their teachers and school staff in relation to their academic work but also emotional and behavioural issues. There were, however, children who lacked an appropriate confidant. There were also children who said they did not enjoy school and others who did not want to attend. Some children identified staff at school as needing to provide more or different kinds of support. The data suggests that, with the exception of teaching assistants, these problems were related to specific staff rather than whole staff groups. They are therefore extremely difficult problems to address through continuing professional development and may be more responsive to improvements in individual management and supervision. Nevertheless, a lack of, and negative experiences of, help and support matter to these vulnerable children now, and worryingly may also discourage help-seeking behaviour later in their childhoods and adolescence (Cossar et al., 2013).

Key points from Chapter Five

- Twenty-six children were interviewed, aged on average just over eight years. Eight were living at home. Nine were in kinship care, foster care or adoptive placements. The sample was skewed towards the children in the overall sample without or with less severe emotional and behavioural difficulties.
- Most children created pictures of large and complex eco-maps, but five created relatively small eco-maps.
- Generally, the children who were living with at least one birth parent were clearer about the nature of their *close* family relationships and conveyed a clearer sense of belonging than children separated from both birth parents.
- Five of the children living with kinship carers, special guardians and adopters expressed uncertainty, confusion and/or discomfort about their close family relationships, use of names and life histories.
- Animals were significant members of the children's families and real friends.
- Thirteen of 22 children conveyed a clear sense that they had people in their lives they could turn to if they had a problem. Nine children, however, expressed uncertainty about potential confidants.
- On average the children identified 14 adults whose job it was to help them.

- Those children who talked about social workers and foster carers were generally positive about them, and suggested they had improved their lives.
- Teachers were identified as extremely important sources of help with most of the children suggesting that they helped them ‘a lot’.
- The children expressed a wide range of views about their experiences of school from not wanting to go to ‘loving it’.
- Surprisingly, and perhaps because the adults were present, the distribution of 11 Cantril’s Ladder scores was similar to that of eight and nine year olds who participated in a Children’s Society national survey, and was skewed towards high life satisfaction.
- Two of 11 children whose Cantril’s Ladder scores suggested they had ‘low life satisfaction’ may have reflected their awareness of difficult recent life events and/or poor quality relationships.

Chapter Six: With the benefit of hindsight: what were the factors that influenced children's and parents' life trajectories?

Introduction

All but one of the children in this study was born into a household where parents and other adults were displaying complex combinations of factors such as mental health problems, domestic abuse and substance misuse, learning disabilities and experience of maltreatment in their own childhood that are known to be associated with an elevated risk of child abuse and neglect (Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, 2014). The one exception was a family that were going through an intense period of stress, but showed no other major risk factors, and there was an investigation concerning a single (disputed) incident of physical abuse. The preceding chapters have traced the trajectories of this cohort of highly vulnerable families until the children were aged eight. Just under half (16: 44%) of the children appear to have been adequately protected from abuse and neglect for all or almost all of their lives, either through timely separation (seven) or through sustained and significant parental change (nine). However twenty went on to experience further maltreatment: ten of these were eventually separated, though the majority only after they were five years old, and ten remained with birth parents who were frequently unable to meet their needs, although their problems could fluctuate.

Adverse experiences in their early years are reflected in the high prevalence of emotional and behavioural problems and the delayed development of the sample children. While these features were more apparent amongst children who had long-term experience of abuse and neglect, they were also evident in a small number of those who had been adequately safeguarded from an early age, and may be linked to factors including abuse *in utero* and the first few months of life as well as the limited support available to parents who were struggling with the challenging task of bringing up children in impoverished environments. Attempts to safeguard some children by placing them permanently away from their birth parents were also not always successful: some carers did not have the capacity to meet their needs, and some supposedly permanent placements were very fragile; one had broken down by the time of the interview.

Hindsight is a wonderful thing, and it is easy to explore these children's case histories and offer glib explanations as to how they could have been better safeguarded from harm. However it is also easy to ignore the complex realities of child protection work. The wealth of longitudinal data collected for this study offers a rare opportunity to explore in some depth the factors that influenced the trajectories of these children and their families. The data suggest that there were a number of interlocking factors, and that there were notable differences between the sustained, unsustained and minimal parental change

groups. However the reader should note that the small numbers in this sample mean that these findings are indicative of issues that should be further researched rather than definitive evidence of difference.

The data suggest that there were six significant factors that influenced children's life chances: primary risk factors such as parental substance misuse, domestic abuse and mental health problems that increased the likelihood of abuse and neglect; secondary risk factors such as poverty, ill health and poor housing that exacerbated the challenges with which parents were faced; the stage that parents had reached in the process of change, which influenced their determination; the availability and nature of informal support networks of partners, extended family and friends; professional relationships, assessments and decision-making; and the availability of both personal and public resources.

Parenting children in a challenging environment

While substance misuse, mental health problems and domestic abuse placed the children at risk of significant harm, it should also be noted that all the families in the study were struggling to bring up children in a challenging environment. Poverty, unemployment, poor housing, isolation, living in a dangerous or hostile neighbourhood, and parents' physical or mental health problems all increased the stressors in families and made the recurrence of primary risk factors more likely. They also made the task of parenting much more challenging.

Employment and money

During the initial phase of social services intervention in the children's lives, only one child out of the 36 in the study was living in a household where one or more parent was [known to be] in paid employment. At age eight, only five of the twenty children who continued to live with one or more of their birth parents lived in a household where at least one parent was in paid employment.

Those parents who did work were low paid, and financial hardship remained an issue for children in families with or without paid employment. Parents and carers often reported feeling saddened because they could not afford to buy birthday or Christmas presents and/or because they could not afford quality food, days out or new clothes.

Financial hardship exacerbated the practical difficulties of bringing up children. For instance, several mothers described the difficulties of getting their children to school; one mother walked six miles every day, to drop her children off and collect them. She lived on a bus route, but she could not afford the bus fares; and her application for a bus pass had been turned down because she did not live far enough away from the school. Her younger daughter could not walk fast, and so this mother, who was severely

underweight, regularly ended up carrying her. She had applied for Disability Living Allowance, which would have entitled her to a free bus pass, but had been turned down three times.

Parents often indicated financial vulnerability in their wider families; certainly, few participants' families were in a position to support them financially, or even to provide them with a 'safety net' in times of crisis. Conversely, some parents reported having supported other family members financially when they were barely able to support themselves. Sometimes these loans, occasionally made under pressure to abusive or bullying family members, remained unpaid, creating further difficulties.

Housing

The difficulties faced by families trying to access adequate housing; the lack of choice, inadequacy of provision and inability of families to exercise any control over this aspect of their lives has been a constant theme during the interviews, throughout the eight years of the study. At least 29 of the 36 children in the eight year follow-up had been adversely affected by issues relating to housing for an extended period lasting months or even years. Such issues included overcrowding and homelessness; poor quality housing; living in a hostile environment; bullying, substance misuse and other anti-social behaviour, and social isolation.

At least eleven children lived with a member of their extended family, generally grandparents, for several months during the first year of their lives. This was due to homelessness or, in some cases, the requirement of children's services for grandparents to supervise the parents' care of their children. Often, this had involved living in intensely overcrowded situations:

> *We were actually living at his Mum's house, but we were living on the living-room floor so, you know, we'd be asleep in the morning and people'd come downstairs, walk through and, you know, no privacy for us.*
>
> (Birth mother of study child: at entry interview)
> (Boy: medium risk of suffering harm at birth: low risk at age three; low risk age five; low risk at age eight – sustained parental change)

By the time the children were eight, the nature of some of the housing difficulties faced by families in the study had changed; none of the children lived with grandparents or aunts and uncles, other than those placed in kin care or special guardianship. Nevertheless, by this phase of the study at least eight children had lived in severely overcrowded housing situations, most of them for a large part of their lives. For instance, at age six one little boy was still sharing a bedroom with his sister, who was now in her teens. Every night, his mother put him to bed in his shared bedroom but then moved him into her bed, so that he was not disturbed by his older sister. Parents and carers reported that such arrangements had a profound effect on their family's sleep, privacy and ability to play.

The housing in which the children lived, including private, housing association or local authority owned, was often also of poor quality. At six years old, another child was living with his pregnant mother, her partner and two younger siblings together in one room, as the rest of the small house was too damp to occupy. His younger brother had already been hospitalised with breathing difficulties caused by the damp, and his mother was suffering from regular chest infections. The GP had written five letters to the housing association, and the health visitor, local mayor, Surestart nursery and a midwife had also contacted the housing department on the family's behalf. Environmental health officers had visited, and some cavity wall insulation had been put in, but this had not made a significant difference. The family were finally moved to a suitable property after more than two years.

The parents and carers of around half of the children in the study indicated that their child had nowhere safe to play, as they had no garden or access to safe parkland nearby. This situation has continued for many years.

Several children regularly experienced bullying in the shared areas surrounding the flats in which they lived. At the three year interview, one mother had described how the family's home was surrounded by drug addicts and dealers; the pathway was littered with needles and the man living downstairs kept dogs for dog fights. The maisonette had steep concrete steps which would have been dangerous for any child, but particularly so for her daughter, who had learning disabilities and epilepsy; there was also no garden. The family was eventually rehoused to another area. However, this move did not improve the family's situation significantly; at the eight year interview, this mother described tearfully how abusive names were often shouted at her whilst she stood at the bus stop outside her house, how a neighbour regularly kicked the family's small dogs and how, most upsetting of all, another neighbour had deliberately set his dog upon, and killed, the family cat.

Some parents described feeling very socially isolated. At times this appeared due to a combination of factors, such as parenting young children compounded by living in an unfamiliar or hostile area. Some parents had given up their previous friendship group, in an attempt to make necessary lifestyle changes, particularly relating to substance misuse. Sometimes parents had recently left relationships with controlling partners, who had stopped them from seeing friends, and they were then left feeling particularly vulnerable and 'lost.' Parents often found it hard to establish new networks of friends, especially when they were experiencing depression.

One child's mother, for example, described how she had been required by children's services to move out of the area she knew, so that she lived some distance from her abusive partner. She described feeling intensely lonely in the new area, which she found 'racist' and 'gossipy.' Although social services' initial concerns had been solely connected to her ex-partner, within a few years this mother had started reconnecting with her old friendship group, established prior to her child's birth, and was drinking in pubs in the

town centre. By the time her son was aged six this mother's drinking had become such a problem that he had been removed from her care. Desperate for him to return, she commented that now she could no longer risk even trying to move to a new area; she knew that she would be allocated a one-bedroom flat and felt this could further jeopardise her attempts to have her son returned home.

Two other parents had come to live in the UK from another country, to escape political imprisonment and poverty. They had been very young adults when they had arrived in the UK, and neither had a close family member in the country. One had been raped immediately before arriving in the UK. These parents were extremely isolated; they could speak little English for the first few years of their children's lives, and both indicated enormous difficulties in communicating with professionals, understanding cultural and social norms and accessing services or other support. The church was the most important source of support for one of them, and after some years she and her children moved cities to be nearer their religious and ethnic community. However, this was not the end of their troubles: the family moved to a block of flats where they were the only people of their ethnicity. They were subjected to daily verbal, racial and physical abuse from other residents. On one occasion a stone was dropped from a flat above onto one of the children, who is severely disabled, and her mother lived in fear of a similar incident leading to her child being seriously hurt.

Parents' health conditions

During early social service intervention in their lives, at least 22 of the 36 children had one or more parents with a significant health issue which affected their day-to-day life. Little had changed by the current phase of the study. Nine of the twenty children living at home were living with birth parents with mental health difficulties. The parents of at least nine of the children still living at home had on-going significant physical health issues; most of them had been hospitalised in the previous three years due to their health concerns. Between his seventh and eighth birthdays one little boy had seen his mother hospitalised for many months. During this time he was cared for by his older sister, who had had extensive involvement with children's services with her own children. His mother had experienced abuse including neglect in her own childhood. Like many parents in the study, her dental care had been very poor, her early experiences as a child compounded by drug use and other lifestyle choices in her teenage years, affecting her dental care still further. By this child's eighth birthday, his mother was in severe dental pain and had only been able to eat soup for several years. She was struggling to manage depression, linked, she indicated, with her earlier experiences and the physical pain she was in. Around her thirtieth birthday a GP had finally referred her to hospital for full dental extraction and dentures.

Poverty, poor housing, isolation and poor health formed the context within which the parents in the sample struggled to overcome factors that placed their children at risk of

significant harm. As children and parents grew older, these issues increased in significance: parents' physical health problems appeared more prominent and increased the challenges of bringing up children, many of whom had extensive emotional and behavioural needs. Twelve of the children living with birth parents now had younger siblings; one child had four younger siblings living at home, and a further two children had three. Seven of the twelve younger siblings of children living with birth parents had significant health issues which required paediatric referral involving frequent hospital appointments and operations. Increasing family size and complexity inevitably added to the stress of bringing up children in an impoverished environment. Faced with such challenges it is unsurprising that many parents found it impossible to make the necessary changes to lifestyles and behaviour patterns that placed their children at risk. Such challenges could also mean that those families that did succeed in overcoming adversity remained relatively vulnerable despite their strengths.

Parents' determination to change

As noted in Chapter One, Prochaska and colleagues' (1992; 2002) research on human behaviour indicates that individuals who are overcoming problematic behaviours and lifestyles move through a series of recognisable psychological processes. Their research was undertaken with people who were attempting to give up smoking, and it does not always reflect the complexity of child protection work (see Little and Girvin, 2005). Nevertheless, the concept of a process of change, marked out in different stages, provides a useful framework for exploring how far parents are likely to overcome problems that place their children at risk of significant harm within an appropriate timeframe. The concept of a process also provides a positive message – that parents who have not advanced sufficiently at present may nevertheless succeed in doing so in the future, although not necessarily within the timeframe for a particular child. The parents of the children in our study fell into three different groups, each of which appeared to have reached a different stage in the process of change. Most of the parents in the *minimal parental change* group were in the pre-contemplation or contemplation stages of change (see Chapter One), in that they did not acknowledge that a problem existed or they had not reached the point at which they felt able to overcome it. Many of them also had not yet acknowledged that their actions had an impact on their children. Parents in the *unsustained parental change* group had taken action to instigate change and engaged with services, but change was not yet sufficiently embedded to avoid relapse. Parents in the *sustained change group* had been through the full process of change and had not relapsed for at least seven years, although as we have seen, secondary factors such as poverty, poor housing and increasing health problems could mean that their situation was still fragile.

While almost all parents expressed their determination to keep their children, only those in the sustained change group talked about their determination to overcome the problems that might prevent them from doing so. The determination of these parents to prove to

themselves and others that they could provide a nurturing home for a child is a theme that is repeatedly touched on in their interviews.

> *I knew I didn't want to be in that dark place, and that wasn't going to happen, full stop, I knew that, that's not going to happen. I knew where I wanted to be. So that was then. I knew where I didn't want to be as a parent, as a mother, pushing a buggy, where I didn't want to be. So I put my mind set on it, I'm not going to be like that.*
>
> (Birth mother of study child: at entry interview)
> (Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)
>
> *No, it just all changed from there just realised, it's scary what I'm doing, my kids come first, I can't do this to my kids. What will my kids do if I'm dead? ..I couldn't do it, so I think, my kids started to change my life….I got help from no one, just started to do it myself.*
>
> (Birth mother of study child: age five interview)
> (Boy: high risk if suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

This is in contrast to the interview data from parents in the *minimal change group* who often did not understand the need for change.

> *There was no need for the social workers to get involved. I would have looked after her. We had everything, well before she was born, and they didn't need to get involved. It really upset me. I was involved with them when I was younger and I didn't need them in my life... too many bad memories.*
>
> (Birth mother of study child: age three interview)
> (Girl: medium risk of suffering harm at birth; high risk at age three; high risk at age five; permanently separated at age eight – minimal parental change)

This mother's child was neglected, at risk of sexual abuse and repeatedly witnessed domestic abuse – she and her sister used to sit on their mother's knee to try to protect her from being abused by their father - until she was finally placed in long-term care at six years old.

Because they were not yet ready to acknowledge that a problem existed, these parents tended to focus more on 'getting the social worker off my back' than on making the necessary changes to safeguard their children (see Dumbrill, 2006).

Informal support from partners, family and friends

All parents needed considerable support both informally, from partners and family members, and formally from professionals from a wide range of agencies in order to

achieve and maintain change. There is a clear distinction in the different levels of informal support that the three groups received.

Parents in the sustained change group tended to have more supportive and longstanding relationships with partners than those in the unsustained or minimal change groups. Three of the nine children in the sustained change group had lived with both birth parents in what appeared to be relatively harmonious relationships throughout their lives, and two more had lived with a parent in a stable supportive relationship since they were babies. Only one of the children in the minimal change group, and none of those in the unsustained change group had this experience of living with parents in a long-term, mutually supportive relationship. Although at least four children in these groups had lived with parents who had long-term partners, the relationships were acrimonious and/or physically abusive.

Many of the parents in both groups had difficult relationships with extended family members. However parents in the sustained change group had at least one highly supportive family member who was prepared to make considerable changes to their own lives in order to help the parent care for the baby. Almost all parents in this group lived with one of the index child's grandparents for a lengthy period following the initial children's services investigation, and continued to receive ongoing support after they moved into separate accommodation. For instance one mother regarded her own father as grossly unhelpful (he turned up drunk for meetings with social workers) but she received constructive support from her partner's family who agreed to the requirement of the child protection plan that she and her baby would live with them for the first six months, and gave her continuing support after that. By the time the children were eight, the grandparents were less involved and some were no longer capable of looking after them; but by this time their support was no longer so crucial to the families.

Parents in both the unsustained and the minimal change group did receive support from family members, but this was notably less constructive, and often appeared to be begrudging. Two mothers received support from maternal grandfathers who professionals considered to be adults who posed a threat to children; one of them also had a difficult relationship with her own mother because she had in the past had relationships with a number of her daughter's boyfriends. Another mother had mental health problems, including suicidal ideation linked to fears that she might harm the baby. They were both taken in by the maternal grandmother, but the relationship was often hostile. When this child was nearly two the maternal grandmother moved out of the home to start a new relationship some distance away. The tenancy was in her name and there were rent arrears, so both the index child and his mother were evicted. When this child was seven his mother was hospitalised following a mini stroke; the grandmother reluctantly came back to help out, but constantly phoned the mother in hospital to say that she was not really ill and should come home.

Parents found it difficult when children were placed with grandparents as kinship carers, especially if they thought that the same grandparents had not been able to meet their own childhood needs or when they perceived the abuse they had experienced as children as being the source of their own problems as adults. Parents' perceptions could often undoubtedly be one-sided, and there is little information from grandparents to balance their views. However a notable difference between grandparents of children in the sustained and unsustained or minimal parental change groups was that the former were able to put their children's and their grandchildren's needs before their own on a long-term basis – a question that was often asked in assessments of parents.

Many of the parents in the sustained change group had successfully created stable support networks, which helped them care for their child. One mother had extensive support from her partner, the maternal grandmother and the faith community in which they were involved. A father in this group had support from both grandmothers and a wide circle of friends. When his daughter became seriously ill at the age of three, the neighbours came with the father to the hospital to support him when he was given the diagnosis. When she was recovering and returned to nursery, because there were such concerns about her health, the staff were unwilling to let her play outside with the other children unless her father could provide one to one supervision in the playground. He himself was not allowed to spend time in the nursery because of an unspecified past criminal conviction, so he arranged a rota of his friends to provide the supervision on his behalf. Parents in the other groups did have friends, but as with members of the extended family, the relationships tended to be less constructive and more manipulative. The quote below offers an example:

I admit I were quite lonely and so you compromise yourself and you do things that you're not proud of and you're not happy about. But, to feel like you're with the in-crowd, to be like in, you know, be wanted ... I got involved ... crime and drugs and stuff ... Heroin... You know, I managed to shake those people off and everything now ... but obviously, things did, did slip again... People that have professed to be friends and it's turned out they've not been. You know, cos I'm kind-hearted, I'm too generous and I'll help anybody out. You know, and people take kindness for weakness and took advantage.

(Birth mother of study child: age one interview)
(Boy: severe risk of suffering harm at birth; severe risk at age three; severe risk at age five; permanently separated at age eight – minimal parental change)

Social work relationships, assessments and decision-making

As is evident from the research on social work interactions with service users (Dumbrill, 2006), change cannot be imposed; professionals played a role in helping parents through the process of change, but only those parents who accepted the need for change were strongly motivated to do so and succeeded in providing nurturing homes throughout the first eight years of their children's lives. Stable relationships, constructive support from partners, members of their extended families and friends were also key factors in helping parents overcome their difficulties and in supporting children.

However these families had also reached a point where children's social services, and in many instances the courts, had intervened in order to ensure that children were safeguarded from harm. How effective were their interventions and decisions in supporting parents and safeguarding children?

Relationships with social workers and other professionals

Social work research often emphasises the fundamental importance of relationships between professionals and parents in facilitating and sustaining change (see Trevithick, 2003; de Boer and Coady, 2007). The key elements of the social work side of such relationships are well known: honesty about what needs to change and why, sensitivity and a willingness to listen to parents' points of view, respectful uncertainty in the face of dissimulation and supportive rather than bullying use of power (see Forrester et al., 2008; Dumbrill, 2006; Laming 2003). The interviews with parents and social workers in the current study also show the converse, that those parents who had reached the stage in the process of change where they were willing to engage openly and honestly, albeit cautiously, with practitioners found this to be a major contributory factor to practitioners' support of them (see also Quinton, 2012) .

At the time the children were born, all but one of the sets of parents had had recent or current experience of mental health problems, substance misuse, domestic abuse and/or their partner's abuse of a child. Most of them had complex and entrenched problems:

there was no guarantee that, even if they had made significant changes to previous lifestyles, they would be able to maintain them. Decisions about whether or not to keep children at home were often finely balanced; however once practitioners perceived that parents were fully engaged in the change process, they were more willing to take a chance on them.

> *The key thing in this case you know without a manager who is willing to take a little bit of risk [child] wouldn't have gone home with his mum and that, you know you don't know what would have happened but that might have been very discouraging for [child's] mum and maybe things in the end would not have been so positive, so I think it is about the local authorities being clear about where their threshold is and sometime you know it does work out better pushing to the edge of that threshold when you can because the easier and safer thing is to just, would have been just to put [child] into a foster home and we would have all slept easy except [child's mum] and her family and that could have been horribly wrong.*
>
> (Social work team leader for study child: age one interview)
> (Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

However, although professionals were prepared to take a chance, they tended to be cautious, and sceptical about the likelihood of success:

> *I cannot see them managing…because I don't think they'll be prepared to make the major changes to their lifestyle that are going to be needed. Babies are expensive and she can't go out and leave the baby …while she's earning £100 a night.*
>
> (Social work team leader for study child: at entry interview)
> (Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

This cautious approach may well have been at the root of the careful, proactive case management that was also a distinguishing feature of social work involvement in the sustained change group. These parents (including the fathers who became primary carers) received extensive, coordinated support in the early months, followed by gradual withdrawal, with access to less intensive universal or targeted services. Family group conferencing was also evident, and professional support was coordinated with that provided by family members.

We were asking the family, the extended family or the wider family network to be supporting the family. ….. there's a whole range of specifics in the Care Plan about the child's needs and the parent's responsibilities and what the family would do and what the key worker would do –and it's not a rigid Care Plan, the Core Group own it, and that includes the family.

(Social work team leader for study child: at entry interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Parents' willingness to engage might also draw in professionals from other agencies, so that a strong and supportive core group, that took ownership of the plan, enjoyed working with the family and committed time to attend meetings, might also develop into an effective team around the child:

We had actually a very good core group which I think was the biggest factor in the success of this case… both [mum] and [dad] kind of actively embraced the child protection plan and so, just in terms of always in for visits, always, the door was always open, always receptive to people going in, really, sort of quite, quite an enjoyable case to work because people were sort of seeing the progress that [mum] and [dad] were making, in terms of parenting and just seemed to sort of build up some kind of momentum that just came through ... And, as I say, successful outcome for everyone concerned .

(Social work team leader for study child: age two interview)
(Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Success also breeds success, and parents who were perceived as determined to overcome their difficulties against considerable odds often found a practitioner (a social worker, a health visitor or a family support worker) who acted as their champion, and went the extra mile to help. For instance, one child's health visitor gave her father some clothes her own baby had grown out of when she discovered no preparations had been made when his partner had concealed her pregnancy. Similarly, when another child was about two, his mother had another baby who died; the health visitor helped her through this period when she was particularly vulnerable to returning to her previous lifestyle:

She come to see me every day. She were brilliant, she helped, she really helped, she were brilliant. She made sure that everything was going to be all right. Not, it's not, that's going to happen, but not, it's not your fault.

And, she helped me. I think she came really, to see, monitor me with my son. See if I were going to crack up or anything so I think, really, she helped me to, stopped me from neglecting my son, you know what I mean?

(Birth mother of study child: age five interview)
(Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

Parents in the sustained change group had a better relationship with social workers than did parents in the other groups. Nevertheless, they were not so open with them as with other professionals. For several years after the index child was born they remained concerned that their past history could be held against them if there were further concerns about the care of their children:

> *I know it sounds nasty, love, but, I've had them all my life and now I'm scared in case they come back in, and he had that accident, and I was really, really scared they would take my kids off me. Then I thought why would they take the kids off me they're not neglected.*
>
> (Birth mother of study child: age five interview)
> (Boy: high risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

None of the parents in this group had had social work involvement since the children were infants, although there had been a couple of referrals that had been closed without further action. Now that the children were eight they were still proud of their success in managing without social work support.

While parents in the sustained change group continued to be cautious in their relationships with social workers, in the minimal and unsustained change groups caution was closer to outright distrust. Principles of working in partnership with parents tend to mask the fundamental imbalance of power that underlies child protection work (see Forrester and colleagues, 2012 for a careful analysis of this issue). Parents were well aware of this, and the knowledge that a fundamental part of the social worker's role was to assess their parenting capability and decide whether they were able to provide a sufficiently nurturing home for the index child inevitably skewed the relationship and led to suspicion and mistrust. This was particularly true where parents who had not yet accepted the need for change had already seen the removal of older children for reasons that they did not consider justifiable. One consequence, typical of parents in the minimal change group, was that they were determined not to ask for help for fear that their children would be removed. For instance, by the time one child was eight, she had extensive emotional and behavioural difficulties, some of which were associated with her physical disabilities. Her mother had no support from her partner or extended family, and they were living in a hostile community in which they were regularly subject to verbal abuse from neighbours. However her mother had had four older children permanently placed away from home; although children's social care had allowed this little girl to remain at home with the support of a care order for her first five years, her mother vowed that 'hell would have to freeze over' before she asked for help, or risked being involved with social workers again.

Forrester and colleagues (2012) have also pointed out that, because so much is at stake for parents and they have so little power themselves, 'parental lying – whether conscious and systematic or simply minimizing the extent or impact of an issue – is almost

omnipresent in child protection work' (p.123). We have already seen that one set of parents lied about the children's contact with their potentially sexually abusive birth father for several years; parents in both the unsustained and minimal change groups also talked about 'pretending' that everything was well, just to get social workers 'off their backs.' Social workers were also aware that many parents lied, and their relationship with parents could also be characterised by mistrust. When the mutual mistrust reached a certain point the relationship could break down completely as happened in two of the families.

There is less evidence of families in the unsustained, and particularly the minimal change group making a relationship with a specific practitioner who then acted as their champion. Some parents' past history made it difficult for them to engage with any professionals who might have been able to help them: for instance the mother referred to above, whose past history included the removal of four older children, needed extensive support from the school to help address her child's physical and mental health needs, but found it difficult to engage with teachers because she was very wary of anyone in 'a position of power'.

In these families there is also less evidence of professionals working together to form a team around the child: one father's substance misuse worker deliberately undermined the social worker, telling him that he did not think that social services needed to know about his continuing drug consumption; another child's child protection plan was discontinued when he was four because it did not appear to be making a difference - on the understanding that children's social care would continue to remain in contact, other agencies then provided less support in this very complex case. While parents in the sustained change group appeared to develop a mutually reinforcing relationship with professionals, where their willingness to engage promoted effective practice across agencies and *vice versa*, the converse appeared to happen with parents in the unsustained and minimal change groups, where reactive and ineffective case management appeared more common and poor or short-term inter-agency relationships meant that children were less effectively safeguarded.

Private and public resources and services

There also appeared to be differences in both public and private material resources available to parents in the different groups. Although, as Chapter Two has shown, most of the parents in the cohort were struggling with material issues such as poverty, debt and overcrowding, a small number of parents in the sustained change group had access to, usually slender, private material resources. One mother in this group had a boyfriend who was able to pay for the deposit on her new flat; a father in this group had been in full employment for some time before he gave up work to care for his children and he had some savings, although these were quickly spent when his daughter became ill; there are also hints throughout interviews concerning another child in this group that his parents

had access to additional income – possibly from the paternal grandparents who were thought to be drug dealers. Such resources (including those that were illicit) were a substantial asset to these families, and they increased confidence as well as material wellbeing. There is no evidence of families in the unsustained or minimal change groups being able to draw on such resources; although birth parents in these groups sometimes claimed that tensions in their families were exacerbated because they had lent money to relatives and it had not been returned.

While access to private resources was a matter of luck, parents should have had equal opportunities to access publicly available resources and services. However once again, those in the minimal change group appear to have been more unfortunate. Seven of the families in the sustained change group lived in (or had been rehoused to) areas that they would describe as friendly, where there was grass where children could play and a strong sense of community:

> *Well, it's really nice, because you, I mean… the kids can go out in the garden and play and it's all fenced in and you haven't got to worry about anything, like people coming and grabbing them or anything because the fence is up and the gate is locked. Yeah, I'm not moving now. Because I, this is where I, sort of ideal place for me.*
>
> (Birth father of study child: age three interview)
> (Girl: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

The two families in this group who were housed in more impoverished areas nevertheless lived in the localities where they had grown up and had strong, positive social networks. One mother, for instance, had moved to live next door to her maternal grandmother who had always been supportive of her.

In contrast, families in the unsustained and minimal change groups were often socially isolated. For instance, one mother in this group was rehoused in a new area in order to protect herself and her child from a violent partner. However the move meant that her social network was disrupted and she was desperately lonely. She also found the new area hostile and racist. These were all contributory factors to her increasing alcohol abuse. Women without supportive partners who did not have strong social networks could become dependent on their children's companionship, and became particularly lonely and vulnerable when they started school or nursery. Some parents in the minimal change group were also living in hostile environments where they and their children were bullied by neighbours, and sometimes physically attacked.

Parents and children in the sustained change group also appeared more likely to access services when they needed them. In this group, one child and his mother both had intensive behavioural parenting support at home; another mother had had support from the police and Women's Aid to ensure that both she and her child were safe. Parents in

this group also had good relationships with schools which had been very supportive in, for instance, helping one child overcome the emotional consequences of living with domestic abuse; trying to address the issues underlying another child's occasional school refusal; helping a third child catch up with reading and helping a fourth understand her grandmother's dementia.

Parents in the other groups did manage to access some services when they needed them. One family, for instance, had a good and very helpful relationship with a family support worker – so much so that the child asked if she could live with her when it became apparent that she could no longer live with her birth parents. Nevertheless there is a distinctive pattern of these parents stating that the services they were offered were inaccessible or ineffective. One mother, for instance, claimed that when the substance misuse service moved to a new franchise she could no longer get appointments to see a counsellor, the groups were no longer available at a time of day she could attend and she had to walk a long distance to get her methadone prescription; another mother found support for her alcohol abuse unhelpful, and so on.

It is possible that services for these parents were more difficult to access; but it is also possible that parents' perceptions of services related to the position they had reached on the change process, so that those who were further advanced and more willing to engage perceived services as more helpful than those who were still relatively unconvinced of the need for change.

The latter explanation is supported by parents' approaches to parenting classes. A high proportion of parents in the cohort had been abused or neglected in their own childhood, and they needed to learn different ways of parenting their children. Almost all parents were asked to attend parenting courses not only to help them learn practical skills, but also to develop greater understanding of positive and sensitive parenting in response to the children's needs. A number of parents in all groups were initially doubtful about the value of parenting classes. However those in the sustained change group went along to them if only to show willing:

> *They just put me on the parenting class, 'cos I asked for just to keep them quiet, you see.*
>
> (Birth father of study child: age two interview)
> (Girl: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

However such classes came to be valued by parents in the sustained change group, not only for the skills they taught, but also for the confidence they gave. Discovering that they could be good parents was a source of immense pleasure to many of the parents in this group, and gave them the confidence to go on to develop other skills. By the time the index child was eight, those parents in this group who did not have younger children were either at college or in work or actively seeking employment.

Parents in the unsustained and minimal change groups were more likely to be defensive and claim that they did not need to be taught how to parent. Reading through the interview transcripts and case papers, parents in the sustained change group appeared to be extraordinarily lucky in being allocated to effective, proactive professionals and accessing resources that would support them through the process of change. However, while chance undoubtedly played a part, it seems more likely that a symbiotic, mutually reinforcing relationship developed, in which parents' willingness to engage promoted effective practice and *vice versa.*

Assessment and decision-making

Now that we have data concerning children's experiences and outcomes at age eight, we can see that a number of children benefited from thorough assessments and analysis of evidence concerning risk and protective factors and parents' capacity to change, that then formed the basis for carefully argued decisions concerning how they might best be protected from harm. On one child's social services file, for instance, there is a clear analysis of the strengths and weaknesses of the case for agreeing to him living with his mother, who was a Schedule One offender, after she was released from prison. The conclusion that he could safely remain with her proved to be accurate. Other cases, such as the one described below, show social workers taking authoritative and effective action to safeguard a child:

I just felt like they were my backbone at the time. I wouldn't have done anything without them. I don't know if it was the panic that they put in me by saying your kids will be on the at risk register. I knew I wanted to sort it, but I didn't feel brave enough to, so I just feel they were kind of the push that I needed. Yes, I knew it had to be done, but it was just doing it myself, I couldn't. They were just like more supportive than anything, yes, yes, yes.

…We gained our life back quicker I suppose, a decent life, normal life, no shouting, no frightened, no walking on eggshells, we didn't have that any more. Well [child] obviously, being a newborn wouldn't have known, but the other kids especially, yes, yes, having to barricade ourselves in the bedroom, that had all gone, it was great. I was still nervous at night, you listen out for noises, don't you? Is he coming round tonight to bang on the windows? It did give us that, we got our lives back quicker with social services because, like I say, without them, would I have not got rid as quick?

(Birth mother of study child: age seven interview)
(Boy: medium risk of suffering harm at birth; low risk at age three; low risk at age five; low risk at age eight – sustained parental change)

However with hindsight it is now also evident that in a number of cases, the assessments and decisions made by social workers and the courts did not serve the interests of the children and their families as well as they might have done. In some instances the issues were largely procedural, for instance one family waited in limbo for at least three years while care proceedings dragged through the courts, thereby adding to their sense of alienation and resentment. However they could also reveal poor relationships between agencies: the children's guardian in one case formally complained to the court about the social worker's reluctance to take action in the face of multiple indicators of long-term neglect; and in another case the guardian complained that the social worker had withheld evidence that did not suit his assessment.

Decisions shaped by intuitive thinking

In an ideal world, inter-agency conflicts and inefficiencies should not get in the way of court decisions. Decisions about such important issues as whether a child can be adequately safeguarded at home should also be made as objectively as possible after all the available evidence has been drawn together and weighed up against what is known about the likely outcomes of the different options available. However, as Munro (1999; 2005) has convincingly argued, pressure on time and resources, as well as a culture that focuses on relationships and empathy, means that social work decisions tend to rely on faster, intuitive thinking that is informed by experience and heuristics 'rather than face the laborious task of sifting through all the evidence and reaching a rational conclusion' (Kahneman, Slovic and Tversky, 1990; Kahneman, 2011). Research into human behaviour has shown that intuitive thinking and decision-making can be influenced by a number of factors that reduce objectivity and skew the process of assessment, particularly when there are no checks and balances that might act as a counterweight

(see Munro, 1999; 2005; Kirkman and Melrose, 2014). Factors that reduce objectivity include insufficient or inaccurate information; a tendency for decision-makers to become attached to their initial impression in spite of any subsequent evidence that contradicts it; a tendency to rely on the most recent or dramatic evidence rather than take an inclusive, long-term view; emotional and cultural bias; and tendencies to ignore the child's point of view, to postpone difficult decisions and to avoid conflict (see Munro, 1999; 2005).

Decisions in families where neglect was the major issue were particularly influenced by factors that reduced objectivity and skewed perceptions. For instance two children who were living with parents who were misusing substances, involved in prostitution, and had relationships with men who were considered to place their children at risk of sexual abuse, were severely neglected for the first six years of their lives. They moved in and out of child protection plans and their cases were frequently opened, closed and then re-referred until they were finally taken into care at the age of six.

Many of the decisions made in these cases were based on inadequate or erroneous information; the father of one of these children, for instance, told the research team that it had been easy to fool the first social worker into believing that he had reduced his substance misuse because she had no understanding of the issues and he had been able to time his consumption so that he appeared clean when tested – a trick he had learned in prison. First impressions were also a major issue in this case. This child's mother took drugs throughout the pregnancy, but due to an administrative error, it had not been possible to complete a pre-birth assessment and so the baby was initially placed in foster care while parenting assessments were completed. Social workers felt the mother had been poorly treated by the authority – especially as she had previously been a child in their care – and this coloured their perceptions of her ability to parent. Frequent changes of social worker in both these and other cases, meant that the children's long-term experience of neglect was never fully understood. Neither of these two children responded with challenging behaviour patterns and so it was not until they reached school that concerns were raised about the physical neglect of one and the withdrawn behaviour of the other. Finally in both these cases there was a tendency to postpone difficult decisions concerning appropriate responses to long-term corrosive neglect and emotional abuse. In both cases a dramatic incident rather than painstakingly collected evidence of the children's long-term experiences prompted the decision to take them into care: one of the children's mothers re-established a relationship with a convicted sex offender, and the other child set fire to the kitchen. Emergency services were called and found him and his siblings alone in what the police described as ' appalling home conditions' – a typical 'accident waiting to happen' (see Brandon and colleagues' (2013) analysis of serious case reviews in neglect cases); the children were all removed under police protection.

In both these cases intuitive decision-making was not counterbalanced by objective evidence such as that obtainable from standardised tests and scales, or by a learning

culture in which social workers were invited to test out their perceptions in discussion with colleagues. For instance, one of these children had an extremely unhealthy and limited diet. Monitoring her weight gain might have alerted professionals to her incipient eating disorder and led to questions concerning the extent to which she was adequately safeguarded.

Parents' rights vs children's needs

Our previous report on the children's experiences up to the age of three found that in these early years, professional decisions were often informed as much by concepts of parental rights and empowerment as by evidence of parents' ability to meet their children's needs. Professionals gave parents every opportunity to demonstrate that they had the ability to look after a child; the optimism needed to undertake the challenges of child protection work sometimes led practitioners to continue to hope that parents would change in spite of evidence that children were at continuing risk of significant harm. Now that the children are eight, some of the adverse consequences of mistaken optimism are more apparent. For instance, one mother was fifteen when her child was born. She had no support from her extended family. Her own foster carer described her as 'a young girl who had absolutely no life skills whatsoever ... none at all. 'Couldn't look after herself, let alone a young child.' (Second birthday interview). Nevertheless, in spite of repeated indications that even with extensive professional support, the task would prove too challenging for her, the social worker and the children's guardian remained convinced that she would eventually develop the capacity to look after her child until, when he was two and a half, she abandoned him.

Contact

As the children grew older further conflicts between parents' rights and children's needs appeared, focusing particularly around issues concerning contact with non-resident parents or with birth parents and other relatives when children were placed away from home. Contact was often well managed and obviously met children's (and parents') needs. Most birth parents acknowledged that their children needed to know their absent parent, even when that parent had been neglectful or physically abusive: for instance, one father took pains to ensure that his son developed a relationship with both his maternal grandparents and his birth mother, even though for much of his life she was in a secure psychiatric unit, following her assault on him as a baby.

However contact could be problematic. We have already seen in Chapter Five that several children were uncertain of their identity and place in their family because carers had not been transparent about relationships. Several children also did not know that the reason they did not have contact with an absent father was because he had repeatedly assaulted their mother or had committed offences against children. As they grew older they began to ask more questions, and the suspicion that something was being kept

hidden from them may well have contributed to some of their confusion and distress. For instance, one mother had been told by children's social services that, in order to safeguard her child, she would have to leave his father who had been charged with rape of a minor and was violent in this and previous relationships. The father was subject to a restraining order, preventing him from approaching the home or school. But at seven, this little boy kept asking why he could not see his father; he was very aggressive and prone to temper tantrums, and clearly did not believe it when his mother lied that she did not know where he was: 'you've got a sat nav, why can't you find him?' Both carers and birth parents needed support in dealing with issues such as these. They also needed support in understanding children's behaviour around contact, which often reignited feelings of trauma and loss, and could be extremely challenging.

Children's services' response to families where children were exposed to serious domestic abuse was to insist that the violent parent leave the home, in order to prevent the need for the children to come into care. However as the children grew older, a number of parents who had been excluded either through formal arrangements with children's services or through court injunctions, asked for contact to be restored. For at least five families, a violent father's application for contact after several years of absence and often a prison sentence for assault, caused enormous stress and concern. The mothers all resisted attempts to re-establish contact by fathers who had previously been formally excluded from the family home. Not all these children wanted to see absent birth parents, and it might have been beneficial to postpone attempts to re-establish it until they were older. Some decisions about contact made by both the courts and children's services appeared to be framed according to parents' rights rather than children's needs and did not take into account the complexity of the issues involved.

Organisational issues

Decisions by the courts and children's services were also frequently skewed by organisational issues that prevented a measured assessment of all the available evidence. In particular, reorganisation of services, frequent changes of social worker and opening and closing of case files meant that these very vulnerable families received at best a fragmented service in which understanding of their long-term, chronic problems was difficult to achieve. Almost all families in the study had had numerous social workers (a finding replicated in numerous other research studies, see for instance Skuse and Ward, 2003; Ward, Holmes and Soper, 2008; Ward, 2009). Constant turnover not only frustrates any attempt to establish relationships with service users, but also makes it very difficult for any one practitioner to develop a historical understanding of the issues involved. This is particularly important where children are neglected and decisions are necessarily based on the chronicity as well as the severity of the abuse. Our previous report (Ward, Brown and Westlake, 2012a) found that social workers were under pressure to close cases as quickly as possible, both in order to make efficient use of resources and also to discourage unnecessary involvement. Yet cases were frequently

re-referred. By the time they were eight, none of the children living at home had continuing support from children's social care although, as we have seen, some were extremely vulnerable.

Conclusion

The children's life chances were shaped by environmental factors such as poverty, poor housing and parents' health needs, all of which became more salient as they grew older, and which intensified the challenges for all the families involved in the study. Within this context, children's trajectories were influenced by the stage parents had reached in the process of change; the availability and quality of informal support and private and public resources; and relationships with professionals and the decisions they made. Some professional decisions, informed by intuitive thinking rather than objective evidence, were over-optimistic and did not take sufficient account of evidence of harm to the child, or parents' capacity to change. Organisational factors such as social work turnover also compromised understanding of complex, long-standing issues. The following chapter discusses how these need to be taken into account if children are to be better safeguarded.

Key points from Chapter Six

- All parents in the study were facing issues such as poverty, poor housing and/or physical and mental health problems which intensified the challenge of parenting.
- Parents in the sustained change group had reached a stage in the change process where they were highly motivated and ready to engage with services. All parents were determined to keep their children, but only those in the sustained change group appeared determined to overcome the problems that placed them at risk of harm.
- There are notable differences in the extent and quality of informal support received by parents in the sustained, the unsustained, and the minimal change groups. Parents in the sustained change group had at least one highly supportive family member who was able to put the child's needs before their own. Support from extended families for parents in the other groups was notably less constructive, and less centred on the needs of the children or their parents.
- All parents were mindful that social workers had the power to remove their children, and were cautious in their relationships with them. In the unsustained and minimal change groups caution was closer to distrust, which sometimes

resulted in a complete standoff. Parents in the unsustained and minimal change groups were reluctant to ask for much needed help for fear of losing their children.

- Virtuous and vicious circles became established in which parents in the sustained change group achieved better relationships with social workers, stronger inter-agency support and better access to resources. The converse was true of parents in the other groups.
- While social work support could be timely and effective, decisions could be marred by inadequate or inaccurate information, and common errors of intuitive thinking. There was little use of objective measures to act as a counterbalance.
- Contact was often well managed by families, but formal arrangements could take too little account of complex issues, particularly where absent parents had previously been barred from entering the home.
- Organisational issues such as rapid turnover of social workers, re-organisation and frequent opening and closing of cases made it difficult for practitioners to develop a clear understanding of long-term, entrenched problems.

Chapter Seven: Conclusion: Implications for policy and practice

Introduction

This is the third report of a prospective longitudinal study of a cohort of children identified as likely to suffer significant harm before their first birthdays. There were 57 children in the original cohort, but many were lost soon after identification; 43 were followed until they were three, 37 until they were five, and 36 until they were eight. This report has focused on the 36 children who could be accessed around the time of their eighth birthdays and explored how their current circumstances and progress have been shaped by what has gone before. Once again the reader should note that the sample is small and skewed towards families with high levels of need. Findings should not be regarded as definitive but as indicators of issues that need to be further explored with a larger cohort of children.

At the time the children were identified their parents displayed complex combinations of risk factors such as domestic abuse, substance misuse, mental health problems and learning disabilities; common experiences also included abuse and neglect in their own childhoods, and a previous history of abusing or neglecting older children who had since been permanently separated through special guardianship or adoption. These factors are known to be associated with a recurrent risk of harm to children (see Jones, Hindley and Ramchandi, 2006; White, Hindley and Jones, 2014), and it was their presence in different combinations that had led to social work enquiry: all the children in the sample had been the subject of a core assessment or Section 47 enquiry before they were one.

By the time the children were eight, over two thirds of the sample had been abused or neglected at some point in their lives, including through substance misuse, alcohol abuse or domestic abuse *in utero*. About a third of them were still experiencing abuse or neglect, although there is no evidence of another third of them ever having been maltreated.

At around their eighth birthdays over half of the sample children were displaying SDQ scores in the ‘high’ or ‘very high’ range. There were almost eight times as many children with scores in the ‘very high’ range as would be expected in a normative population. Child maltreatment constitutes one of the most severe impediments to children’s adaptive and healthy development (Cicchetti, 2013).

> *Deprived of many of the experiences believed to promote adaptive functioning across a life span, maltreated children traverse a probabilistic pathway characterised by an increased likelihood for compromised resolution of stage-salient developmental tasks* (Cicchetti, 2013 p.402).

Emotional and behavioural difficulties were compromising some children's ability to remain in mainstream education or to benefit from school. Primary schools were providing extensive support to many of the children, but there were concerns as to how far this could be continued when they made the transition to secondary school.

Children's wellbeing was related to parents' ability to overcome the factors that had placed them at risk of significant harm. However as the study progressed and the children grew older their circumstances deteriorated. The proportion of children living with birth parents at low risk of significant harm decreased from 50% at age three, to 36% at age five, to 25% at age eight, as some parents found it difficult to maintain changes that had initially been made. By the time the children were eight, nine (25%) parents (or sets of parents) had succeeded in overcoming risk factors and sustaining changes that had been made since before the children's first birthdays; eight parents of nine children (25%) who had made similar changes had not succeeded in sustaining them and 18 (50%) parents had made only minimal changes.

By the time they were eight, nearly half the sample, whose parents were in the minimal or unsustained change groups, were no longer living with birth parents and had been placed away from home. While some children undoubtedly benefited from care, many children continued to display extensive emotional and behavioural problems. There were particular concerns about children placed with relatives who did not have adequate resources or support to meet their needs.

The findings raise important questions concerning child protection policy and practice. In particular they raise issues concerning the extensive emotional and behavioural needs of this population, and the support given to birth parents, adoptive parents, special guardians and foster carers to help them address their needs. The final section of this chapter explores these issues and asks what policies and practices might be developed to ensure that children are better safeguarded from harm, to provide better support for very vulnerable parents and families, and to help children and young people overcome the consequences of abuse and neglect whether they remain with birth parents or are permanently placed away from home.

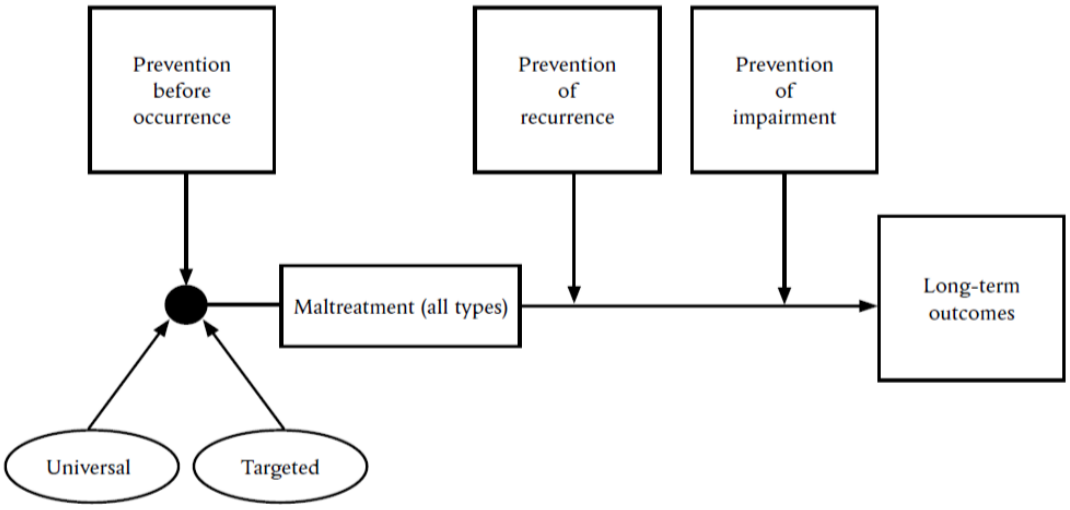
Implications of findings: meeting children's needs

The findings concerning the high incidence of children with severe emotional and behavioural difficulties should be of particular concern. They show that these children were not adequately safeguarded from harm, and indicate that insufficient measures were in place either to prevent abuse or neglect from occurring or to protect those children who were maltreated from suffering long-term impairment to their health and wellbeing. By the time they were eight at least one in three of these children were displaying emotional or behavioural difficulties of sufficient severity to suggest that they had already developed or were likely to develop mental health problems that would

require clinical intervention. Their chances of achieving educationally were also compromised. Other research shows that educational achievement at seven is closely associated with later attainment; in particular children who have not achieved basic literacy at this age will find it increasingly difficult to access other parts of the wider curriculum (see Warren and Paxton, 2013). For some of the children, their emotional and behavioural difficulties were compromising the academic progress they were able to make at school.

Figure 7 below is often used as a conceptual framework to help distinguish between preventive interventions, designed to reduce the likelihood of maltreatment occurring, and often provided through universal and targeted services, and therapeutic interventions, designed to prevent the recurrence of abuse and neglect and long-term impairment to children's health and wellbeing, and usually provided through more intensive, specialist services tailored to the specific needs of children, parents and families. The findings from this study have implications for the development of policy and practice in both preventive and therapeutic services.

Figure 7: Framework for Intervention and Prevention of Child Maltreatment[18]



[18] Reproduced from Davies, C and Ward, H. (2012) *Safeguarding Children Across Services*, London: Jessica Kingsley Publishers.

Policy implications: preventing the occurrence of abuse and neglect

Firstly, it is important to understand the challenges facing families such as those in this sample. At some stage in the children's lives almost all their parents had been dealing daily with issues such as poverty, poor housing, isolation, and living in a hostile and sometimes dangerous environment. Those parents who were employed were in low paid and often precarious occupations. By the time the children were eight, many parents were already beginning to experience a range of physical, as well as mental health conditions, associated with long-term exposure to multiple deprivation. Issues such as these are not the direct causes of abuse and neglect, and indeed the majority of disadvantaged families provide nurturing homes for their children. However material deprivation and living in an impoverished environment increase the challenge of parenting and add to the stresses that make those primary risk factors which *are* closely associated with maltreatment, such as substance misuse, domestic abuse and mental health problems, more likely. Policies designed to reduce child poverty and inequality, to strengthen communities, and to maintain and improve access to services are particularly important because they can improve the context of parenting for families such as these.

A number of studies have shown that, following the 2008 financial crisis, austerity measures have had a disproportionate impact on the most disadvantaged families, such as those in this study and their communities (see, for instance, Haddad, 2012; Hastings et al., 2015). Those parents in this study who were successful in maintaining change benefited from easily accessed universal and targeted services such as those provided through children's centres. However, many of these are no longer available. Very vulnerable children such as those in this study need to be protected from the adverse impact of cuts to services and welfare reforms, and broader policies designed to address child poverty need to be integrated with more targeted safeguarding policies.

A high proportion of parents had experienced abusive or neglectful parenting in their own childhoods, and this was a major factor in their relationships with their children. There is some evidence to suggest that policies that frame child abuse and neglect as public health issues that need to be tackled at all service levels have had some traction in reducing the physical abuse of children (see Davies and Ward, 2012, Chapter Three). Introducing population based policies which disseminate some of the recent research on sensitive and emotionally intelligent parenting that is responsive to children's needs might be of universal benefit. There is also some evidence that population-based initiatives may be more accessible to very vulnerable families, partly because they are viewed as less stigmatising. A universal approach that aims to shift the norms of parenting behaviour across the whole population may also influence parents who show extreme, abusive behaviour patterns to change in the same positive direction (see Davies and Ward, 2012, p. 57-8 for further details). It should, however, be noted, that while parenting programmes, such as Triple P-Positive Parenting and the Incredible Years Parent Programme have been shown to be effective when implemented on a population-wide basis (Health Scotland, 2007; Prinz et al., 2009; Sanders et al., 2008; Webster Stratton et

al., 2011), very vulnerable families do not always make use of them. Only those parents in the sustained change group in this study found parenting programmes helpful - and even they were initially sceptical of their value.

Targeted safeguarding policies need to focus on close inter-agency cooperation, particularly between adult and children's services. The parents had multiple needs; those who were more successful in overcoming their problems had benefited from a range of services, coordinated by a strong core group. Their progress acted as an incentive for practitioners to work more closely together and establish a genuine team around the child. However it was noteworthy that, when children were first identified as suffering or likely to suffer significant harm, there were no referrals from psychiatrists and only one from a substance misuse worker concerning the 53 children for whom we had such information in the full cohort (see Ward, Brown and Westlake, 2012a). Fluctuating mental health issues were a major reason why some parents were unable to sustain changes. Closer liaison between adult and children's services might have resulted in children being better safeguarded while remaining with their birth parents. Closer inter-agency working between children's social care and early years providers might also strengthen preventive initiatives.

Policy and practice implications: preventing abuse and neglect by supporting children living with birth parents

About half the children were classified as being at high or severe risk of significant harm at some stage in their lives, and the possibility of their being permanently separated from birth parents was a real issue, for these were children living on the edge of care. As our previous report has shown, decisions to place children away from home are not taken lightly and permanent separation through long-term care or adoption is quite rightly seen as a last resort, to be considered only when all other options within the immediate and wider family have been explored. However if very vulnerable parents such as those in this study are to safeguard their children from harm and promote their wellbeing, they need sufficient support to do so. Parents who continued to look after their children tended to receive relatively short-term specialist support from social workers, with cases being closed as quickly as possible. Many were reopened. Support from other agencies also tended to be short-term and sporadic. Asking parents to progress within a few months from a position where they might have their children permanently removed to one where they were expected to look after them with minimal, or only sporadic, support could be unrealistic. It is noteworthy that most of those parents who succeeded in overcoming their problems and providing nurturing homes received coordinated, planned packages of care and/or long-term support from a professional who acted as their champion.

Extended family members upon whom professionals relied to help safeguard these children from harm also usually required support. Relatives who took in a very vulnerable mother and baby were sometimes offered financial support by the local authority to

compensate them for lost working hours or to provide additional resources. However such support was strictly limited (as was the offer of respite care to help parents who needed some relief). This was not only because resources were tight, but also because of concerns about growing dependency. Yet many of the children – and their parents - had extensive needs, and in our view a certain degree of dependency was inevitable if they were to be adequately safeguarded. Policies designed to keep families together need to be supported with resources that can be available for as long as they are needed by the child.

Policy and practice implications: preventing recurrent abuse through separation

Just under half the children could not be adequately safeguarded by their birth parents and were placed away from home. Consonant with the principle embodied in the Children Act 1989 and the United Nations Convention on the Rights of the Child, that children are best looked after within the family, wherever possible children were placed with relatives or family friends as kinship carers. However, these kinship carers were largely living in similarly impoverished environments as the birth parents. They had taken in the children as an emergency, to prevent them being cared for by strangers, but were ill prepared, and often ill equipped to provide a permanent home for a child who was likely to have additional support needs. Nor were they prepared for the changes in family dynamics that ensued or for the inevitable questions as children grew older and needed to understand their identity and antecedents. The kinship care arrangements in this study have revealed a greater number of weaknesses than other British research on this issue (see Hunt et al., 2008; Farmer et al., 2008). Nevertheless, this study found that kinship carers and special guardians receive inadequate material support to undertake the task of providing a permanent home for a child, and insufficient professional support to help them meet children's complex needs. Again, policies that aim to keep children within their birth families need to acknowledge that families can be fragile, and provide adequate resources in money, time and skills to ensure that children's needs can be met.

We cannot compare outcomes of children placed for adoption with those of the rest of the sample because the majority of adoptive families could not be accessed after the child had been placed. However we do know that a number of children were safeguarded by being placed away from their birth parents. In our view, at least three children from the sample might well have died had they remained with birth parents who were unable to ensure their safety. Some children flourished in care, special guardianship or adoptive placements, particularly where there was 'communicative openness' and contact arrangements with birth families were working well. However the quality of care was not always of a high standard; there are examples of both local authority foster carers and kinship carers who neglected or emotionally abused the children, and one kinship carer struck up a relationship with a sex offender and placed both her own child and the study child at risk of abuse. As many other studies have found, careful selection and

assessment of carers whether they are strangers or relatives, is fundamental to ensuring that children's needs are met (see, Sinclair, 2005 for an overview).

Practice and policy implications: preventing long-term impairment to children's health and wellbeing through intensive, tailored services

The most significant findings from this study concern the prevalence of serious emotional and behavioural problems by the time the children were eight. These are indicative of impairment to children's health and wellbeing, both in the present and in the future, and are associated with a wide range of negative outcomes in adulthood (Goodman and Goodman, 2011; Norman et al., 2012). Many of these problems had been evident for at least five years, although their impact increased as the children grew older. They were related to children's experiences of abuse and neglect, including *in utero*. They were more prevalent amongst those children who had remained living with, or been late separated from, birth parents who had been unable to make or sustain changes to harmful lifestyles and relationships.

The findings also indicate that many of these difficulties persist whether children remain with birth parents or are permanently placed away from home; such problems are not the product of care, but they may be compounded by insensitive parenting and a lack of transparency concerning children's identities and antecedents when they are living away from home, and these issues need to be addressed as part of the training for all substitute carers.

However the persistence and prevalence of children's emotional and behavioural problems indicate that birth parents, adoptive parents, special guardians and schools, as well as the children themselves, all needed high levels of timely, skilled support to help address them. It should be of concern that those parents and carers who did ask for support were sometimes advised that no specialist help with emotional or behavioural problems could be offered until the children were older, by which time their difficulties would have become more entrenched. It should also be of concern that many of these problems went unnoticed or ignored until the children started school, when their delayed speech and language development and/or their disruptive behaviour alerted teachers to the need for specialist support to prevent long-term impairment.

Policy implications

Emotional and behavioural problems have impacts that are at least as damaging and long-term as many physical health problems; however while it is normative practice to monitor children's subsequent progress following the identification of a physical health condition, mental health conditions do not receive the same careful attention. The findings from this study would indicate that concerns about children's emotional and behavioural problems should be treated with the same gravity as concerns about physical problems. Moreover at a policy level, systems need to be in place to flag up

children who are known to be at risk of significant harm, for instance because they have had a child protection plan following identification of abuse or neglect in infancy, or because significant problems have emerged at an early age. Their emotional and behavioural development as well as their physical development should be monitored regularly until it is clear that there is no continuing impairment. Services should be developed that can support much younger children and their carers than those that are currently available, and they should be accessible according to need rather than status.

Neither parents, nor kinship carers, foster carers, or adoptive parents are adequately equipped to meet some of these children's extensive support needs. High quality, specialist support is required, by practitioners working jointly with children, parents and carers where appropriate. It needs to be offered as an integrated package, coordinated between children's social care and schools; for it needs to be both available wherever children are placed and whatever their status. It also needs to be continuous, moving with the child from one school or placement to another. At present, children in local authority foster care can access additional services by dint of their status as a looked after child: for instance, when one child was placed with a foster carer, she received extra tuition to help her catch up at school and dance classes to build her confidence, paid for by the elevated pupil premium for looked-after children. Had she been adopted or in special guardianship she would have received the same pupil premium and possibly the same level of support. However if she returned to her birth mother, she would not have been entitled to the same level of support, and the services might not have continued, although she might well have had the same level of need. If the purpose of such services is to meet children's needs they should be equally accessible wherever the child is placed. Once again, policies which aim to ensure that, wherever possible, very vulnerable children can remain with or return to their birth parents, need to be underpinned with resources that help parents to meet their needs.

Practice implications

Although the findings indicate that services to prevent long-term impairment should be as accessible to children living with birth parents as to those permanently placed in substitute families, parents in the unsustained and minimal change groups, whose children showed the greatest levels of need, mistrusted and avoided social work interventions. Such findings corroborate the work of Forrester and colleagues (2008, 2012), and suggest that social workers may need to be more aware of service users' perceptions of their role and the power struggles that can ensue when parents are unready or unwilling to engage with services. Understanding theories concerning the process of behavioural change (Prochaska et al., 1992, 2002) may be helpful in enabling practitioners to understand how far parents have become motivated to change. The introduction of motivational interviewing techniques may also facilitate this process (see Forrester and colleagues, 2012). There is much to be learnt here from the small group of parents who succeeded in making and sustaining changes to previously adverse

lifestyles and relationships, the ways in which they overcame initial reluctance to engage with professionals, and the inter-relationships that led to positive and mutually satisfying service involvement.

The findings also indicate that practitioners should be more alert to both the implications and the aetiology of children's emotional and behavioural problems. Better dissemination of research evidence concerning the impact of abuse and neglect on early childhood development might help social work practitioners gain greater understanding of the rationale for early intervention. Simple, standardised measures, such as the Strengths and Difficulties Questionnaire are currently only used routinely for looked-after children; their wider use for other children at risk of significant harm might alert practitioners earlier to indications of serious behavioural difficulties and encourage swift referral to specialist services. Such measures can also act as a counterbalance to some of the common errors of reasoning (Munro, 1999) engendered by intuitive thinking.

Careful observation of children's behaviour might also alert practitioners to some of the underlying issues behind such disturbance. Children's behaviour deteriorated when they became confused about their identity and their place in a substitute family, or when they suspected there was a hidden reason why they had no contact with an absent parent. A high proportion of this sample had been through traumatic experiences in their early years. There was a need for life story work not only with children but also with many parents and carers who were struggling to explain complex family relationships or to decide how much about an absent parent's previous history of abuse it would be appropriate to reveal. In this context it is worth noting that contact was not always beneficial to children; when fathers had been excluded from the family home through arrangements made by children's services or court orders, an application to re-establish contact caused enormous stress and consternation. In such circumstances decisions needed to focus firmly on the best interests of the child; one could perhaps argue that, where an injunction has been served, re-establishing contact should not be considered until a child has reached a particular age. The findings also reinforce those of other studies which show the importance of close liaison between social workers and schools (see for instance, Daniel, Taylor and Scott, 2011). Teachers (and school nurses) are best placed to identify children who are experiencing abuse and neglect. This study shows that their concerns were not always adequately acknowledged by children's social care. As the children grew older there was less social services involvement and schools sometimes felt abandoned to devise strategies to meet children's extensive needs, without having the authority to take proactive action to safeguard them from harm. Close inter-agency working between schools and social workers will be of particular importance as these children make the transition from primary to secondary schools.

Conclusion

The implications of key findings from this study concern the extent to which parents and carers can be supported to meet the needs of very vulnerable children. Reframing child abuse and neglect as a public health issue makes it easier to explore how policy and practice can be strengthened both to prevent maltreatment from occurring in the first place and to protect children who have been abused from experiencing long-term impairment. Focusing on how children's needs can best be met wherever they are living and whatever their status should facilitate the delivery of more effective and better coordinated services.

Key points from Chapter Seven

- Findings come from a relatively small sample of children that is biased towards those at greatest risk of significant harm. They therefore cannot be regarded as definitive.
- Nevertheless, they have implications for the development of policy and practice that might both reduce abuse and neglect from occurring or recurring and protect children from long-term impairment.
- They indicate that attention should be paid to the challenges parents face when bringing up children in impoverished circumstances. The impact of welfare reforms and reductions in services on the wellbeing of vulnerable families should be monitored. Policies designed to address child poverty need to be integrated with more targeted safeguarding policies.
- Population-level initiatives to disseminate recent research messages on positive parenting that are sensitive to children's needs might shift the norms of parenting behaviour and influence those who show extreme, abusive behaviour patterns to change in the same positive direction.
- Closer inter-agency working between children's social care and adult mental health services might better support those children whose parents' mental health problems fluctuate over time.
- A fundamental principle of law, policy and practice is to enable children to be brought up by their birth families wherever possible. However, families in which children are suffering or likely to suffer significant harm are fragile. Both policy and practice needs to acknowledge that they will require adequate material resources and probably long-term professional support to meet their children's needs.

- Members of the extended family who support very vulnerable birth parents and/or who become kinship carers and special guardians also require more extensive material resources and professional support than they currently receive.
- Social workers may need more support in understanding the power dynamics of their role and in engaging and supporting service users through the process of change.
- Severe emotional and behavioural difficulties such as those shown by a high proportion of children in the sample are indicative of incipient and possibly long-term mental health problems as well as a range of adverse outcomes in adolescence and adulthood. They should be treated with the same gravity as incipient long-term physical health conditions.
- Systems need to be in place to flag up children who are known to be at risk of significant harm and their emotional and behavioural development as well as their physical development should be monitored regularly until it is clear that there is no continuing impairment.
- Wider use of simple, standardised measures, such as the Strengths and Difficulties Questionnaire might alert practitioners to indications of serious behavioural difficulties and encourage swift referral to specialist services
- Services for such children should be developed and made available at a much earlier age than is currently the case. They should be available according to need rather than status, and they should be continuous, following the child whether they are living with birth parents, foster parents or adoptive parents and supporting all carers to meet children's needs for as long as required.
- Schools should have better access to children's mental health services, and teachers and SENCOs should have access to further professional development concerning supporting children with emotional and behavioural difficulties which relate to past adverse experiences.

Appendix One: Challenges associated with maintaining the sample and the practicalities of data collection

This is an exceptionally hard to reach population: the study is dependent to a large extent on the active participation of birth parents and other primary carers. Informed consent from birth parents was necessary before any child could be recruited to the sample and each year following this. The birth parents were recruited to the study at around the time of the pregnancy and birth of the index child. During this time the birth parents were not only dealing with the usual emotional stress of pregnancy and child birth, but were also experiencing substantial difficulties including: intimate partner violence, problem alcohol and drug use, mental illness, experiences of abuse in childhood, experiences of the permanent removal of older children, housing problems including homelessness, financial problems including bankruptcy, and learning disabilities. The difficulties the parents were facing as well as the high level of intrusion into their lives from child protection services undoubtedly limited the likelihood that they would participate in the study and further limited their commitment to it over a prolonged period.

Children fit the sampling criteria if they had come to the attention of children's social care for concerns in relation to abuse and neglect before their first birthday in one of the ten participating local authorities during 2006. Birth parents of the children who fit these criteria were invited to participate. Statistical tests however have since confirmed that the sample is skewed towards children who were at higher risk of harm.[19] These children are therefore some of the most vulnerable in our society, they include; infants who were not fed for so long that they ceased crying; a three year old who could explain how to prepare heroin; a toddler who was allowed to taste speed; and a child who self-harmed. Our sample comprises the children, our data shows, who keep the professionals who work with them awake at night out of fear that they might be the next Peter Connelly or Victoria Climbié. Consequently, however, extensive efforts are required to conduct research with this cohort.

The following sections explore the parents' and carers' incentives to participate; the importance of the relationship between the researcher and participant; the practicalities of data collection; and the approach necessary for data collection.

Incentive to participate

Over the years, we have been keen to understand from the perspectives of parents and carers what their incentives were for taking part over such a prolonged period. Following

[19] Our qualitative data indicates that the parents who responded to the study felt disempowered by the level of intrusion into their lives from children's social care, participating in this study was a way for them to get their stories heard. Some had very negative stories and some were very positive.

each interview, parents and carers were given a £20 gift voucher for a supermarket of their choice, however their reasons for taking part spanned more widely than this. When asked, the most common reasons given by the parents and carers were; to help others; to have their voice heard/ to be listened to; to feel empowered; or to effect changes in services.

It was therefore important we considered how these incentives might be achieved in our approach and design of methodologies. For instance, asking the parents and carers to complete a set of standardised scales and/or structured questionnaires and nothing else would not have allowed them the opportunity to sufficiently express their views and tell their stories. It was important that we took the time to listen to each participant and to be interested in what they had to say, even if what they were telling us was not entirely the answers to the questions we wanted to ask.

We tried to ensure that taking part was not a negative experience. We wanted the parents and carers to feel that it had been worthwhile, and that the information they provided to us was valued. Above all we wanted to participants to feel empowered through the process, and, of course, wanted them to invite us back the following year.

Relationships

The relationship that the researcher was able to form with each participant was extremely important to the data collection process. The following were important factors:

- Continuity: the research team remained the same throughout the study. The researchers knew each family personally.
- Trust: it was important that the participants felt that they could trust the researcher, that they would not be judged or criticised, and that their views were being listened to and respected.
- Independence: the research team were not part of the decision-making processes, such as care proceedings or statutory child protection services. Therefore the parents and carers could express themselves freely and away from the scrutiny of statutory services.

Practicalities

To conduct a study of this nature face to face interviews were necessary. The most appropriate place for the interviews to take place were the homes of the children. However in many of the their homes, the noise of cartoon or music channels on the television was the back drop to daily life. It may seem that asking a participant to turn the television off, or down, might be straightforward, but making such a request could inhibit their ability to feel comfortable during the interview. This needs to be balanced with the

necessity for the researcher to concentrate on asking the most appropriate questions and, ideally, get a reasonable quality data.

Many of the children's homes were very overcrowded, and most were living with siblings including babies and toddlers. It was an ongoing challenge to find a calm, private space in which to conduct an interview. For instance, the majority of interviews with parents took place with a younger child present as well as in some of the least peaceful areas of the home, such as in the kitchen whilst the parents are cooking, cleaning, washing etc. On one occasion the researcher was sat on the kitchen floor on a pile of laundry because it was the only *private space* available.

It was important that the researchers balance the need for robust data with the practicalities of collecting it. This was a continuous compromise.

Approach

Throughout this study flexibility and persistence was key to maintaining the sample. Although face to face interviews were necessary for a study of this nature, they brought with them a number of practical difficulties. Firstly, many of the participants led transient and chaotic lifestyles and tended not to keep to appointments. If they had a mobile phone, it was almost always without credit, or lost. Social network sites only proved successful in contacting a very small number of parents. Parents usually did not answer the phone to a number they did not recognise and were unable to listen to voicemail or respond to a text because they did not have credit to do so. On average, in this study, it took three visits to a birth parent's home before a successful interview could be achieved. The most effective way of achieving a successful interview with the birth parents was to make ourselves available in an area for a few days at a time and to call round to their home several times until they were available.

Each of the parents and carers also required a very individual approach. We have established a close research relationship over the years, and developed an understanding of the best ways of working with each of them. For instance, one mother preferred only to be contacted by letters written on lilac paper. It could be several weeks and months before we would get a response from our letters, and several missed appointments before we achieved a successful interview with her. Another mother preferred not to be interviewed at her home, choosing instead to be interviewed in a supermarket car park during her break from work. She did not know when her break would be and could not access her phone during her shift, therefore we would to wait around for most of the day until she contacted us to say that she was on her break and available for the interview.

Each parent and carer required a different approach. It was therefore important that the researchers did not adopt a static approach whereby the same script or set of instructions was adhered to for each interview.

Appendix Two: Interviewing the study children and the methodology employed

Interviews with the study children

The cohort children were seven to eight years old when the interviews took place, and many had emotional and behavioural difficulties and/or developmental delay. The children were interviewed in their own homes, however many of the households were chaotic, often with several young children, adults and family pets present. Opportunities to interview children in a quiet, private space was rare. The willingness and capacity of the parents to participate in the research, as well as that of the children themselves, varied from day-to-day and some interviews required several visits before a successful interview was possible at all.

The consent process, with the children's parents or carers, initially, involved the development of a detailed protocol about areas that could and could not be discussed, which was an important factor in establishing trust with the parents or carers. The consent process with the children themselves also required careful consideration. Building and maintaining rapport with both parent and child was crucial in all instances. With the children in this cohort it was particularly important for the research team to be very flexible in our approach, and be able to respond to the needs, circumstances and abilities of each individual child.

Research has shown that children find it difficult to respond to direct questions about their emotional wellbeing (Ligarski, 2009). This may be because they do not necessarily have the cognitive abilities to do so. When conducting research with children, any technique should be used sensitively and with appropriate care, taking account of each child's particular circumstances, interests and abilities (Carter and Ford, 2012; Teachman and Gibson, 2012). For example, some of the cohort children had no memory of having a social worker, or of their birth families, and were unlikely to be aware of their family's past need for the provision of services. It was therefore vital that the research team did not reveal or suggest the involvement of children's social care, particularly where children were permanently separated from birth families, or where parents had succeeded in overcoming difficulties. The approach used also needed to reflect the children's varied competencies and capacities and it was important that the researcher was able relate to the child's world, and gain their trust.

A further consideration in determining the tools selected for data collection was the role of the researcher's personal choice and preferences (Sewell, 2011). For example, some researchers will be more drawn to visual approaches than others. Sewell (2011) suggests that image-based research may best be undertaken by researchers who have strong empathetic and interpersonal understanding and have themselves been exposed

to the arts. The preferences, skills and experience of the research team was an important consideration in the selection of the approach utilised in this study.

Access to the children

Over the year leading up to this phase of the longitudinal study, the research team held informal face to face discussions with parents and carers about their willingness, or otherwise, to give consent for their child to participate in the study through an interview with the researcher. Just over half of the parents and carers indicated that they would in principle allow their child to take part. However, some parents implied that they could find this a threatening prospect and some stipulated that they would not give permission for a researcher to speak with their child directly about the involvement of children's social care. In addition most parents stated that they would require detailed information about the methods used and areas to be covered prior to consenting.

As this report has shown, the parents and carers of the children were vulnerable and many were living with difficulties including, domestic violence, substance misuse and mental illness such as depression, anxiety, Obsessive Compulsive Disorder (OCD) and agoraphobia. In addition to these difficulties many families were also experiencing high levels of stress in their day-to-day family lives. Parents often found it particularly hard to speak about their experiences when difficulties were most *raw*, usually when children's social care became re-involved with their family. At times participants felt that they were more able or willing to take part in the research than at others, and it was likely that this was also reflected in their willingness, or otherwise, to allow permission to speak with their child. For instance, one permanent carer expressed concern that her child seeing *another* professional could confuse and unsettle him. Therefore gaining access to speak with the children required great sensitivity and careful timing.

Once parents' permission was granted, consent from the children themselves was required. Some children chose not to take part in the research for a range of reasons, including for instance, feeling wary about talking to *another* professional or being too busy or distracted by other activities. Ensuring that children were able to give informed consent was a challenge, particularly given the different experiences and levels of understanding of the cohort children. It was important that they understood; the role of the researcher, as distinct from a therapist or a social worker; that the researcher was unable to affect direct change in their lives; and that the relationship with the researcher was not ongoing.

Once permission from parents and children was given, the practicalities of conducting the interviews with the children was also complex, this has been described in Appendix One.

Methodology for the interviews with children

Thirty-one face-to-face interviews were conducted with parents, adoptive parents or kinship carers. Of these, 29 agreed to discuss with their child the possibility of an interview, or gave permission for a foster carer to discuss a potential interview with their child. Two parents refused permission; one because she was concerned about her child's behaviour and the other because she did not want the child's carer to know that she was taking part in the study.

A further five parents or carers took part in the study by telephone. All these parents and carers had previously taken part in face-to-face interviews in the study, but were unable to do so in this phase due to circumstances such as severe health difficulties, or acute difficulties managing their child's behaviour. These parents and carers were not approached about the possibility of their children being interviewed to ensure that the research team did not add to the stresses they were already experiencing.

Twenty-six children of the 29 parents were invited to take part. The three children who were not asked were all in mainstream foster care, and their carers could not be located within the time frame of the study. All the children who were invited to take part in the research agreed to participate. Their parents or carers had given them an information leaflet from the research team, discussed it, and sought the child's permission to participate before the researcher met the child.

The twenty-six children in the interview sample included eight girls and 18 boys. This ratio of girls to boys reflects that of the study's overall sample of children. The children's average (mean) age at interview was eight years and one month. With the exception of one child who was five years and nine months, all the children were over seven years old when interviewed. The oldest child was aged nine years and six months.

A framework for inquiry and discussion was developed for the interviews which took account of the children's developmental levels as well as their chronological age. It was adapted by the interviewer to ensure that each interview was sensitive to the needs and wishes of each child.

Only three of the interviews with children took place without an adult presence. A further six children were interviewed alone but with adults entering the room from time to time to check to see how the children were feeling. The occasional brief contributions the adults made while they were in the rooms did not seem to have an impact on the children.

Seventeen of the 26 children, however, had at least one parent or carer present throughout the interviews. Five of these 17 adults simply listened. The other 12, however, actively participated with prompts, clarifications and/or elaborations of the children's contributions. Occasionally the adults also challenged the children's views and perceptions of relationships, added contextual information and questioned the ways in,

and extent to, which various professionals were helpful. Some also encouraged the children themselves to elaborate their answers.

The interviewer had a strong sense that some children chose to share, or not to share, important information that might have upset the adult who was with them. She was surprised that some children did not mention highly significant information that had previously been discussed with her during interviews with parents and carers. The reporting of the findings therefore occasionally includes contextual information about the interviews which may help to explain the children's responses.

The first part of the interview involved the children using stickers depicting abstract human and animal forms to create 'eco maps' of their family and friends on large sheets of coloured paper. The maps were then used to explore the supportive nature of their relationships with adults and other children in their home lives. More particularly, the children were then asked who in the picture they would turn to if they were worried about something. The children were then given a set of 'helping people' cards, showing pictures of professionals who work with children e.g. a teacher, social worker, doctor and police officer.

To explore the children's perceptions of their own emotional wellbeing, a brief measure of global wellbeing was used - *Cantril's Ladder. Cantril's Ladder* is a visual analogue measure of the child's global assessment of his or her life satisfaction. It consists of an image of a 'self-anchoring' ladder of 10 rungs with its base at '0' (relating to the 'worst possible life') and the top rung at '10' (relating to the 'best possible life'). Children are asked where on the ladder they would position themselves at the moment.

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