



Higher Aspirations, Brighter Futures:

NRCCI Matching Resources to Needs Report



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Higher Aspirations, Brighter Futures: Matching Resources to Needs Report

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For full list of contributors see Appendix 1



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Higher Aspirations, Brighter Futures

Series Editors: Romy Langeland, Kelly Bayes, Jennifer Davidson

The Scottish Institute for Residential Child Care was commissioned by the Scottish Government to lead a National Residential Child Care Initiative. This NRCCI has undertaken a strategic review of residential child care services and developed a blueprint for their development which will shape the future direction of services and ensure the needs of children and young people are met.

There is a series of publications stemming from this Initiative.

Other titles in this series:

Title: Higher Aspirations, Brighter Futures:
Overview of the National Residential Child Care Initiative

Author: Kelly Bayes

ISBN: 978-1-900743-98-3

Title: Higher Aspirations, Brighter Futures:
NRCCI Commissioning Report

Author: Ian Milligan

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Title: Higher Aspirations, Brighter Futures:
NRCCI Workforce Report

Authors: Jennifer Davidson, Carole Wilkinson, Bernadette Docherty, Maureen Anderson

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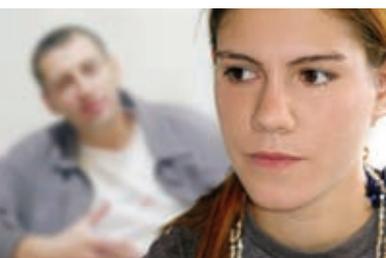
Higher Aspirations, Brighter Futures:

NRCCI Matching Resources to Needs Report

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Executive Summary



1 Introduction

The National Residential Child Care Initiative (NRCCI) was set up in the summer of 2008 when the Scottish Government and COSLA jointly commissioned the Scottish Institute for Residential Child Care (SIRCC) to undertake a review of the context of residential child care services and make recommendations for change. The aim was to make residential care the first and best placement of choice for those children whose needs it serves.

Three working groups were established to undertake work with respect to: needs and resources; workforce skills; and commissioning services. This report represents the key results of the working group on needs and resources. The report draws on:

- The experience and knowledge of working group members,
- Relevant literature and policy documents
- The results of the NRCCI's stakeholder consultations with young people and professionals and comments submitted to the NRCCI web-site
- Questionnaire surveys of local authorities and independent providers conducted in February-March 2009 by the working group.

2 Definitions and scope

Traditionally, residential child care has been taken to refer to non-family establishments offering 24-hour care for children who are looked after away from home in public care. The distinguishing feature of residential care compared with foster care is that children live with a group of other children looked after by paid staff who work on a shift basis and live elsewhere.

Residential establishments and schools for children with disabilities are sometimes included within 'residential child care', though many of their residents are not formally 'looked after' and statistics are usually separate. Arguably some children and young people placed in prison, young offender institutions or in hospitals could or should be in residential child care, so that some consideration needs to be given to these when reviewing the residential child population as a whole.

The working group regarded its remit as focusing on the needs of children, not staff or others. For present purposes it was seen as valuable to distinguish:

1. The *need for* residential child care, i.e., the number and characteristics of children and young people thought to require residential placements.
2. The *needs of* children and young people who use residential care.

The working group regarded the word resources in the present context as mainly denoting the range and types of residential services that are available or desirable, as well as the money required to provide or purchase these. In addition, many young residents receive help and support from a range of health, education, and other professionals and agencies.

3 Recent policy development related to residential child care in Scotland

Governments have repeatedly asserted that residential child care can and should be a positive choice, yet primacy is often given to family placements.

The last wide-ranging review of residential child care in Scotland was provided by the *Skinner Report* of 1992. This affirmed a positive role for residential care and identified five main criteria warranting admission:

Special skills available in the home or school;

A family placement is inappropriate;

A sibling group can be kept together;

The young person prefers a residential placement;

A family placement is unavailable.

The Skinner Report also stated that residential child care should largely serve teenagers.

The *Guidance to the Children (Scotland) Act 1995* similarly described residential care 'as an essential resource', but also stated that a child under twelve should be placed 'only exceptionally' (p. 70). Both the *Skinner Report* and the *Guidance* outlined children's main needs in terms of good food and clothing, personal care, education, health and safety, suitable small buildings, and access to recreation.

The Scottish Government's *Getting it right for every child* (GIRFEC) programme is concerned with a much wider range of children's services than residential care. It aims to promote a more child-centred system and an effective integrated approach across agencies where necessary. It seeks to respond to the needs of individual children and young people to bring about positive outcomes for them. Other Government initiatives have sought to improve support for the education and aftercare of young people in residential and foster care, as well as stability and continuity of placement. The number of nurses who specialise in meeting the health needs of children and young people in public care has increased substantially.

4 Children and young people in residential care

- In recent years, at any one time just over 1,600 children and young people have been looked after by local authorities in residential care.
- 600 children with disabilities are placed in residential schools, though many of these are not formally looked after.
- In 2008 just under 1,000 children with disabilities experienced repeated short breaks in residential services.
- Local authorities vary considerably in the relative proportion of children placed in residential homes (normally in-house) or in combined care and education settings (usually externally provided).
- Most children in residential care are aged 12-15.
- Over the last 15 years, there has been a growth in the numbers of children aged under 12 looked after in residential care, often for very short periods.
- A significant minority of young people in residential care were formerly in foster

care or other residential placements, some with repeated placement breakdowns.

- The number of young people in secure care has fluctuated in recent years, but remains higher than in 2000. Twice as many are in prison, all aged 16-17.
- Small numbers of children are admitted to hospital on mental health grounds each year.

5 Needs and outcomes

Demand for residential care

- The number of children and young people requiring residential child care is stable or slightly increasing in most authorities.
- A significant increase has occurred in the number of children aged under 12 deemed to require residential placement.
- Independent providers offering combined care and education have experienced a recent decline in referrals.
- More referrals than previously are seen to involve young people with multiple complex needs, including some very challenging females in their mid-teens.

Meeting needs

- Residential care usually meets well young people's needs for caring and supportive relationships with staff.

- Young residents are mostly very positive about their relationships with care staff, especially those who show them respect and listen, but often young people question or dislike the rules.
- Certain needs of young people in residential care are not always well met, for example, in relation to physical and mental health, education, participation in planning, receiving positive recognition, and protection from bullying.
- Over the years many studies have shown that most young people admitted to residential care make significant improvements, though the benefits are often not sustained when they return home or leave at 16+. Many young people aged 16 to 18 leave too soon and without being adequately prepared for adult responsibilities.
- Research has shown that good outcomes are produced when residential services provide individualised, responsive care within clear and consistent structures and cultures.

Gaps in knowledge

- A systematic up-to-date review is required of the needs of young people in residential care and in particular of how particular placements in care should address these.
- Systematic external evidence is sparse concerning which specific models of care work best for which kinds of children and young people.
- Little is known about the needs and progress of children with disabilities in residential care.
- Many service providers would like to see wider sharing of understanding about unmet needs and good practice through collating records, consultation forums and research.



6 Current provision of residential child care in Scotland

- The largest numbers of residential establishments are run by local authorities themselves, but residential services which combine care and education are largely run by independent providers (i.e., voluntary and private organisations).
- Residential schools are fewer in number than residential homes, but are generally larger, so cater for a significant proportion of young people looked after away from home and most children with disabilities placed on a long-term basis.
- Among the main recent trends in provision have been:
 - an increased number of providers;
 - reduction in size of individual units;
 - introduction of very small (micro-) units;
 - growth in provision in certain rural areas but not others;
 - diversification of functions, mainly in the independent sector;
 - increase in establishments with explicit treatment, therapeutic or attachment models;
 - growth in respite services (short breaks), mainly for disabled children;
 - expansion of close support and crisis/emergency services.
- At any one time, about half of local authorities have full occupation of their residential placements. Most others have between 10 and 25% of their places 'unoccupied', though in some instances this refers to very small numbers.

7 Planning in the future and planning for the future

The local authority and independent provider surveys and the adult stakeholder consultation demonstrated considerable consensus about a number of proposals to improve services. Suggestions included:

Systemic developments - e.g., promotion of residential care as a positive choice; a central directory of provision;

Improved assessment, admission and planning for individuals

Modification of residential services - e.g. to enable children to live closer to their homes, allow more young people to stay after 16, offer work with families as a whole;

Related to external services - e.g., more flexible and specialist teaching; better access to child and adolescent mental health services.

The improvements wanted by young people consulted for the NRCCI were: different rules and greater freedom; staff to listen or communicate more; and improved accommodation.

Based on the evidence about needs and resources available to it, the working group concluded that innovations and successful outcomes in residential care need to be more widely known. Improvements are required in agency collaboration in assessment and service provision, especially with regard to health and education, as well as young people's meaningful participation. This should be linked to the well-being indicators and the national practice model under *Getting it right for every child*.

KEY MESSAGES AND RECOMMENDATIONS

The report provides detailed recommendations, intended to fulfil the following aims:

- 1. Improving the part played by residential care within a broad continuum of services**, e.g., by specification of the strategic roles of residential care in Children's Services Plans, access to a wide range of residential services matched to needs, care staff making contributions to community-based assessments and outreach support, and more co-operation between residential and fostering services.
- 2. Better information, research and planning**, e.g., co-ordination of information at national and local levels, greater understanding of children with a disability in residential care, and research on outcomes and effectiveness.
- 3. Active participation of young people**, e.g., support for young people to contribute to planning at agency, unit and individual levels, and adults making changes in response to the views of residents.
- 4. Enhanced assessment and care planning**, e.g., assessments that are comprehensive and based on needs of the child/young person and show how a particular residential placements will address/support action to address these needs, consideration of residential care as an appropriate service early in care journeys, fewer emergency admissions, improved choice of placement, usually near to children and young people's communities of origin, and stability and continuity of placements.
- 5. Development of residential services**, e.g., residential placements addressing complex and specialist needs through a combination of in-house and external services, models based on planned recurrent short and/or part-time placements that meet the needs of children under 12, and special arrangements for very challenging young women.
- 6. Improving health**, e.g., a national policy and practice initiative, which addresses the health needs of looked after children and young people, extension of the work of LAAC nurses, and each establishment having a health improvement agenda and access to specialist consultancy and services on mental health issues.
- 7. Improving education**, e.g., every child's plan giving high priority to continuity of schooling and stability of associated relationships, all residential services having detailed plans to support learning and other needs, and the provision of flexible and appropriate multi-agency support.
- 8. Ensuring transitions out of care are positive**, e.g., helping children manage transitions in a planned way, and provision of continued care and educational support after 16.

The NRCCI

The Scottish Government's commitment to improve the life chances of children who are looked after was reinforced in February 2008 when Adam Ingram, Minister for Children and Early Years, made a statement in parliament setting out his ambition **'to work with partners to make residential care the first and best placement of choice for those children whose needs it serves.'**¹ To take forward this commitment, the Scottish Government asked the Scottish Institute for Residential Child Care (SIRCC) to lead the National Residential Child Care Initiative (NRCCI) and develop a blueprint for the development of residential child care in Scotland which would shape the future direction of services to suit children's needs.

This unique opportunity to undertake a strategic review of residential child care in Scotland, contribute to making positive changes to how future services are developed, and ensure we are *Getting it right for every child* who may need residential care, was enthusiastically and warmly welcomed by SIRCC. This report is one of three produced by three working groups led by SIRCC which met from September 2008 until July 2009. It briefly outlines the context in which the NRCCI was established, its aims and objectives, and who was involved. It then provides the remit and evidence for the Matching Resources to Needs working group, briefly outlines the context for this particular group, and describes its findings. The final chapter sets out the key messages and recommendations arising from these findings.

Context for the NRCCI

Since 2000 the number of children and young people who are looked after has increased sharply and although only 11% of them at 31st March 2008 were looked after in a residential setting, this still represents over 1600 children and young people who are

often the most vulnerable and troubled in Scotland. Many have suffered from the impact of poverty and deprivation, the effects of drug and alcohol abuse as well as neglect and abuse. Most of them will have experienced other forms of social work support and intervention, yet 55% of admissions to residential care were unplanned¹. Evidence for this can be found in *Current trends in the use of residential child care in Scotland* (2006)

Concerns about institutional child abuse across the UK have resulted in several inquiries showing that residential child care services need to ensure their focus is on children's rights and needs. An inquiry into abuse at Kerelaw Residential School in Ayrshire was announced in November 2007, the same month as the publication of the *Historical Abuse Systemic Review*² which recommended the development of a culture in residential child care founded on children's rights and respect for children. *Home Truths*,³ published in April 2008, acknowledged that while hundreds of vulnerable children and young people are successfully cared for in residential settings, there are considerable challenges facing the residential child care sector across Scotland in achieving high quality services and positive outcomes for all young people in its care.

Many of these challenges centre around:

- the experience of the increasing number of children and young people with complex and multiple needs being placed in residential care;
- the status, training, education, skills and competence of the residential child care workforce;
- the pattern and the type of provision required for the future to meet the needs of children and young people, and how this can be planned at national and local level.

Aims and objectives of the Initiative

Building on the above challenges the aim of the NRCCI was to:

1. Develop a blueprint for the development of residential child care in Scotland, including:
 - o An audit and strategy for the supply of residential child care services to match the full range of needs of children and young people;
 - o A determination of the right skills mix of professionals working in residential child care to ensure those working with these young people are well-equipped to support these young people to develop their full potential;
 - o An agreement of expectations between local authorities and providers to ensure effective commissioning of services for these young people;
 - o Recommendations on how to address the challenges facing the secure care sector (This aim was dealt with in the *Securing Our Future Initiative* report of February 2009).
2. Recommend to Scottish Government, local government and providers of residential child care the actions required to achieve consistent improvement across the residential child care sector.

Who was involved

The Initiative has been led by a Project Board made up of key representatives from the wide range of agencies and organisations with an interest in residential care in Scotland. It was chaired by Romy Langeland, Independent Chair of SIRCC. Three working groups reporting to the Project Board were established to undertake work with respect to the three elements of the blueprint outlined above and involved further representation from across the sector (see appendix 1). A further group examining secure care reported in February 2009.⁴

To engage as many stakeholders as possible in the Initiative each working group identified themes and issues which were posted on the NRCCI page of the SIRCC website, were debated at four regional stakeholder engagement events held during February and March 2009, and were taken out to working group members' own organisation, association and/or network.

Through Who Cares? Scotland over 100 children and young people were also involved in debating the themes and issues and provided their expert views in a report

that went to all three working groups in March 2009. Due to resource constraints the engagement of parents was unfortunately very limited.

The experience and knowledge of all those involved on the NRCCI was an invaluable and rich source of information. In addition to evidence from the stakeholder engagement process, working group members actively sought available and relevant research, data, case studies and reports and many consulted their wider organisation/agency/network. Two of the groups undertook surveys of local authorities and independent⁵ providers of residential care.

All of those involved in the NRCCI were in agreement that *Getting it right for every child* who needs residential care is dependent on there being a full range of residential services that can meet individual needs and which have access to both universal and specialist services, are staffed by skilled, competent, appropriately qualified and confident staff teams, and are part of a continuum of services for all children.

Introduction to Matching Resources to Needs

Working group remit

'To audit current provision for children in residential care and to develop a strategy for the development and supply of residential child care services to match the full range of needs of the children and young people.'

1 Evidence

To assist with the audit and gain an understanding of changing and unmet need the working group conducted small scale surveys of all local authorities and 32 independent providers in February-March 2009. The local authority questionnaires had two parts. The first sought information about residential provision run by the authority and about recent changes in demand and services. The second part requested details about children and young people currently looked after away from home and resident in either statutory or independent provision. Returns were received from 23 out of 32 authorities, with 22 completing Part 1 and 18 Part 2. In addition one authority provided information about its residential provision in a separate document.

Part 1 of the local authority survey was adapted for the independent provider survey. This smaller questionnaire was sent to the 32 members of Educating through Care Scotland with 24 responding. Three-quarters of the agencies who took part (18) were residential special schools. Most of these (16) catered for children with social, emotional, educational and behavioural difficulties, but two provided care and education for children with severe autism and associated disabilities. Three further providers offered only crisis care in small units. The final three agencies which

responded each had a different specialism: vocational training for post 16 year olds; work with families; and preparing children for foster placements.

These surveys were supplemented by discussions with experts on disability, at children's services sub-committees of ADSW and ADES⁶ and at a meeting of Educating through Care Scotland.

2 Definitions and scope

Residential child care

Traditionally, residential child care has been taken to refer to non-family establishments offering 24-hour care for children who are looked after away from home in public care. Under current legislation, this refers to children admitted with parental consent to local authority care⁷ or placed compulsorily by a children's hearing or court.

Residential establishments and schools for children with disabilities are sometimes included within 'residential child care', though many of their residents are not formally 'looked after' and statistics are usually separate. The Scottish Government has clarified that children with disabilities who are accommodated in longer term and repeated short term placements ought to have looked after status, in order that they acquire the associated legal, support and protection entitlements.⁸ On the other hand, many parents are reported to see this as inappropriate, some fearing stigma, intrusion or loss of influence.

Arguably some children and young people placed in prison, young offender institutions or in hospitals could or should be in residential child care, so that some consideration needs to be given to these

when reviewing the residential child population as a whole. Sometimes 'mainstream' independent boarding schools are included, as in the *Children's Safeguards Review* footnote and the Care Commission's regulation of school care accommodation services, but they are not covered by this report.

Needs

The working group regarded its remit as focusing on children's needs. The important needs of parents, staff and authorities were seen as beyond the remit of this working group.

For present purposes it was seen as valuable to distinguish:

- The **need for** residential child care, i.e., the number and characteristics of children and young people thought to require residential placements;
- The **needs of** children and young people who use residential care.

The need for residential child care

This refers to the numbers and types of children and young people for whom a residential place is 'needed', whether at a particular point in time or over the course of a period such as a year. There are two linked aspects, namely the circumstances that require children to be looked after away from home for their proper care, safety or education,⁹ and the factors that indicate a preference for a residential rather than family placement (kinship or foster care).

The needs of children and young people who use residential child care

When applied to individual children who live in residential settings, the term 'need' suggests requirements for satisfactory well-being and development¹⁰. Hence residential care has to address the range of such needs for all who experience the service.

The Scottish Government's Policy Framework *Getting it right for every child (GIRFEC)* has promoted a set of desirable outcome dimensions, for children to be Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI)¹¹. By and large, these are consistent with the eight principles set out in the *Skinner Report* on residential child care.

The needs of a young person during the journey through care may differ from or be much wider than the reasons for admission, and it is necessary to consider their universal needs as shared with all children through to their specific and individual needs which will inform placement choice and care planning.



Introduction to Matching Resources to Needs

Resources

The working group regarded the word resources in the present context as mainly denoting the range and types of residential services that are available or desirable, as well as the money required to provide or purchase these and associated services.

Account has to be taken of the nature of residential resource providers and their relationships with each other, in recognition that many young people access more than one facility at different points in time. Some resource issues (e.g., staff and their skills) and certain aspects of relations among providers were dealt with by other NRCCI working groups.

Similarly the interfaces between residential care and a wide range of other resources (services) are important. Many young residents receive help and support from a range of health, education and other professionals. Some require specialist services with respect to issues like addiction.

3 Policy developments related to residential child care

Kendrick has highlighted the ambivalence surrounding residential child care. Governments have repeatedly asserted that it can and should be a positive choice, yet primacy is given to family placements.¹²

The last wide-ranging review of residential child care in Scotland was provided by the *Skinner Report* of 1992, which affirmed a positive role for residential care. The Report began by specifying that residential care served young people requiring additional help and care outwith their family. Considering those who needed residential rather than a foster placement, the report identified the following five main criteria (p. 13):

- Special skills available in the home or school;*
- A family placement is inappropriate;*
- A sibling group can be kept together;*
- The young person prefers a residential placement;*
- A family placement is unavailable.*

The first four of these represent positive reasons for use of residential child care, while the last one indicates that a family placement would have been preferable, but is lacking.

The *Skinner Report* also stated that residential child care should largely serve teenagers and that an occupancy rate of 85% is desirable to ensure an adequate choice of placement at the point of referral. Both these points will be addressed later in this report.



The *Guidance to the Children (Scotland) Act 1995*¹³ similarly described residential care ‘as an essential resource’, but one where a child under twelve should be placed ‘only exceptionally’.¹⁴ Among the advantages of residential care were the wide choice of relationships and experience, the opportunity to provide specialist services and specific programmes, the stable setting, and suitability for keeping siblings together. The *Guidance* stressed the importance of meeting residents’ individual needs, treating them with respect ‘irrespective of the needs of other residents’, and preparing them for adulthood and supporting them until they are fully ‘independent’.

The main subsequent inquiries and reports focusing on residential care have concentrated on young people’s need for safety.¹⁵ These highlighted that one key component of ensuring safe care is to meet residents’ need to be listened and responded to.

Each child’s plan and all interventions are now governed by the principles of *Getting it right for every child* which aims to promote:

- a more child-centred system;
- a heightened focus on the child's needs;
- a greater emphasis on effective outcomes for children;
- more effective collaboration between agencies;
- an integrated approach where necessary across agencies which is effective at improving outcomes;
- the reduction of institutional, cultural and procedural barriers to joint working.

The Scottish Executive report *Looked After Children and Young People: We Can and Must Do Better* (2007) sought to build on the earlier initiative, *Learning with Care* (2001), to promote means for improving the educational outcomes of all looked after children. The report endorsed the term ‘corporate parent’ to designate formal and local partnerships between all local authority departments and services and associated agencies. All of its eight key messages were relevant to residential care and are summarised below, with the third referring specifically to residential provision:

1. strengthening the corporate parent role;
2. raising awareness of the educational needs of looked after children and young people and improving training for all carers and professionals;
3. clarifying the role and responsibilities of relevant managers in schools and residential establishments;
4. flexible and appropriate support during transitions;
5. physical, mental and emotional health and well-being;
6. good quality accommodation to support learning;
7. a range of support for young people in transition to adulthood;
8. stability and continuity of placement.

The Scottish Government’s *Fostering and Kinship Strategy* (2008) included in its introduction a statement that the best place for a child is normally within a family context, but also recognised a continuing need for residential child care. This and other recent policies emphasise that care and support is offered to children and families across a continuum, and that each element should be considered in relation to the whole spectrum.



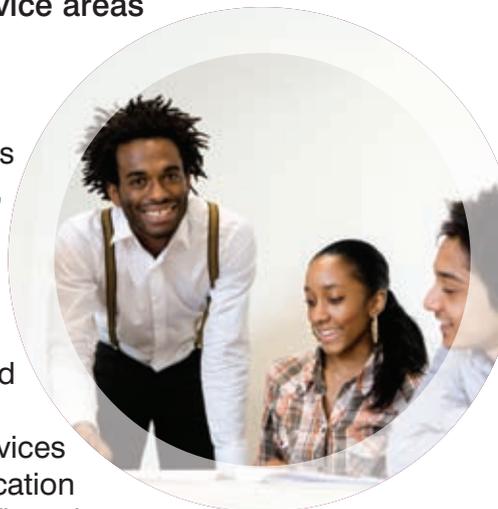
Introduction to Matching Resources to Needs

Despite the repeated positive commitment to residential care shown in review reports and government statements, many people and agencies hold a negative view about residential care and/or see it as a last resort. This has often been part of a wider perception that public care of any kind (including foster care) fails children. The introduction to *We Can and Must Do Better* was very critical of the current position as regards 'outcomes' for children in care, stating that 'the status quo for these young people is unacceptable', and calls for a 'step-change'. However this stance has been challenged by certain academics.¹⁶ While not denying that there is a need for improvement, they argue that available evidence shows public care often makes a positive contribution to children's welfare. Much of the evidence about 'very poor outcomes' in relation to teenage pregnancy and imprisonment rates, for example, derives from a small portion of those who experience a period of foster or residential care. Furthermore, most children enter care with multiple difficulties and disadvantages for which the care system is not responsible, and arguably is often unable to mitigate these.¹⁷ It is also notable that some senior figures¹⁸ have called for an increase in the availability of residential care.

In their Single Outcome Agreements,¹⁹ a number of local authorities have espoused an aim of reducing the numbers of children in residential care and increasing the use of foster and kinship care. The Children's Voluntary Sector Policy Officers' Network (2009)²⁰ criticised this approach and argued that 'for many young people residential care is more suited to their needs²¹ and fostering breakdown is common'.

4 The relationship with other policy and service areas

As will be explored at various points in this report, looked after children do not always receive access to and benefit from universal services such as education and health. There have been a number of pilots in which health, education and social work services have attempted to develop new ways of engaging with looked after children. However there is considerable variation by local authority and health boards.



Central government gave a policy lead in relation to education firstly through the *Learning with Care* initiative and now in actions that have followed from the publication of *We Can and Must Do Better* and HMle/Care Commission guidance on residential schooling. The package of measures introduced include guidance for designated senior managers in education and social work, and guidance for community planning partnerships on how to be a good corporate parent - *These Are Our Bairns* - which promotes the concept of the corporate parent and the role in the promotion of learning that can be played by councillors, senior officers outwith social work and education, and other staff.²² HMle recently published *How Good Is Our Corporate Parenting?* a self-evaluation guide for local authorities.

Although health issues are touched on in *We Can and Must Do Better*, a similar strategy to address the health needs of looked after children and young people and care leavers has not emerged from the government. One excellent general development has been the spread of LAAC nurses. NHS Education Scotland has developed a capability framework for nurses who care for children who live away from home, which outlines the knowledge and skills required by nurses to undertake the role.²³ A few local initiatives in collaboration with child and adolescent mental health services have occurred in places like Glasgow and Moray,²⁴ but these have not been replicated elsewhere.

The whole area of multi-agency working together raises important and challenging issues in terms of the requirement it places on residential and social work staff both to advocate for 'their' child and also to work in a positive inter-professional way with teachers and health professionals, among others.²⁵

5 The expenditure context²⁶

Real expenditure on children's accommodation-based services has grown substantially since 2002/03. The expenditure in 2006/07 was £230 million, an increase from approximately £142 million in 2002/03. Growth accelerated between 2005/06 and 2006/07 with an increase of 20%, but this was followed by the smallest real term increase over the next year. Over this same period, children's accommodation-based services expenditure increased by approximately 100%. In the current economic climate, it is unlikely that similar growth will occur in the near future.

Summary points

- It is useful to distinguish between the need for residential child care (the numbers and characteristics of children who require this form of care) and the needs of children and young people living in residential settings.
- Children in residential care share universal needs of all children, but in addition usually have particular needs arising from their prior experiences, related to choice of placement and living in a group context, and with respect to the transition out of care.
- Repeated Government reports and policy documents have affirmed the value of residential child care for certain kinds of children and young people looked after away from home, though some local authority policies are committed to reducing use of residential care. Steps have been taken to promote improvement in the quality of care and education, and to establish a multi-agency commitment to meeting the needs of those in residential child care.
- Local authority expenditure on residential services has increased substantially in recent years, but overall local government budgets are likely to be constrained in the immediate future.

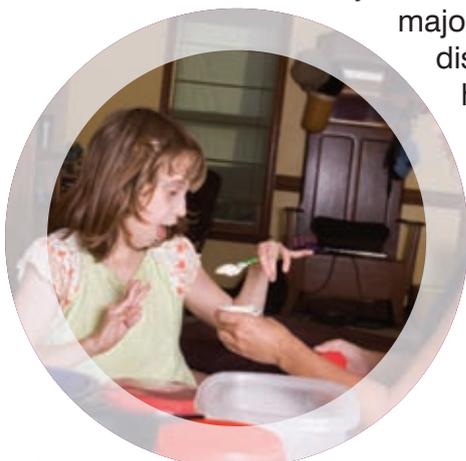
Children and young people in residential care

1 Numbers of residents

In March 2008, just over 1,600 children and young people were looked after by local authorities and living in residential care. This includes an unknown number of children with disabilities, but excludes those in dedicated educational and disability-related provision. The overall *number* has been more or less steady since 2000,²⁷ but represents the lowest ever *proportion* of looked after children, whose total has grown as a result of increased numbers of children on home supervision, the largest category, and in foster placements. In 2000, the percentage of looked after children in residential accommodation was 14% compared to 11% for 2008. The proportion of children looked after away from home (i.e., excluding those on home supervision) who are in residential care is just over a quarter.²⁸

In March 2008, just under 800 children were looked after in residential units and about 650 were in residential schools.²⁹ In addition just under 1900 children were cared for on a series of short break placements for week-ends or holidays in 2008 and half of these were in residential care. Such regular short breaks, formerly known as respite, are primarily experienced by children with disabilities. The

majority of children with disabilities placed away from home for any length of time are in residential schools.³⁰ These cater for about 600 children (Appendix 2).



2 Local authority variations

Certain local authorities have consistently had relatively high rates of usage of residential child care, allowing for their total populations, e.g., South Lanarkshire, Argyll and Bute, Orkney, East Dunbartonshire. The absolute numbers per authority naturally tend to reflect the population size,³¹ though with some anomalies. The following all had over 50 young people in residential care on 31 March 2008, excluding secure and crisis placements:

Local authority	Residential ³²	Secure
Glasgow	214	23
Edinburgh	114	14
South Lanarkshire	105	0
Renfrewshire	93	2
Aberdeen City	83	7
Fife	74	5
Highland	65	3
North Ayrshire	56	3
North Lanarkshire	54	1

Of the local authorities who responded to the survey, the lowest number of children in residential care in an individual authority was five.

Some authorities care for most of their looked after children in residential care in-house, whereas others mainly rely on external resources. This means that certain authorities make much greater use of residential schools than others, allowing for population differences.

The characteristics of those in residential child care

The majority of young people looked after in residential care are placed there compulsorily. On 31st March 2008, just over 1,000 were in placement as a result of a children's hearing supervision requirement: 43% of these were in residential schools; 42% in local authority residential units and 15% in other residential placements.³³

Most young people in residential care have spent time away from their family home prior to admission. Scottish research has shown that for between one fifth and one quarter of residents, their placement immediately before admission was foster care.³⁴ The Stakeholder consultation and independent provider survey indicated that some are admitted following multiple previous placement breakdowns.

Compared with foster care, children placed in residential care tend to be older and to stay longer. Also the proportion of boys is higher in residential care.³⁵ In the local authority survey nearly two thirds were males (597 versus 340). This pattern was fairly consistent across authorities. In several cases, twice as many boys as girls were recorded, and in only two authorities was the gender ratio close to parity (15 males and 14 females in one; 43 males and 37 females in the other).

The majority of young people in residential care are aged 12-15, though about one quarter are aged 16+.³⁶ The local authority survey showed 15 years to be the peak age. Most young people living in residential care do not stay long after their 16th birthday, even though the Scottish Government Guidance on Care Leaving recommends that 18 is usually a more appropriate age for embarking on 'independence'.³⁷

National figures show that children under 12 represent a small but significant and growing proportion of all in residential care, i.e., around one in ten. On 31 March 2008, about 150 children aged 5-11 were in residential placements, including one in secure care. Ten times as many under 12s were in foster placements. Three children aged less than five were in local authority children's units.³⁸ Similarly the survey found about 10% of those in residential placements were aged 10 years or younger, including three infants below the age of one year. In one larger authority about a quarter of the children were aged ten or younger. This indicates a significantly higher usage of residential care for pre-teen children than the few exceptional cases envisaged in the *Skinner Report*.

According to a study by Milligan et al.,³⁹ these younger children often have complex behaviour difficulties and are sometimes placed following one or more fostering breakdowns. The research also indicated that a high proportion of the under-12s had very short-term placements of between one day and one week, which may indicate crisis measures.

In Scotland, the numbers of children and young people in residential care who are from minority ethnic backgrounds is small (under 2%) and little is known about their circumstances or needs.⁴⁰ A few larger local authorities have admitted small numbers of unaccompanied asylum seeking young people in recent years.

Numbers and characteristics of children in secure care

About half the young people in secure care are admitted through children's hearings, the rest by court sentence or remand.⁴¹

The number of children per year made subject to a secure authorisation⁴² rose significantly in 2006-7 and stayed almost as high the following year:⁴³

2004/5	317
2005/6	327
2006/7	381
2007/8	370

The number of secure places available increased after 2006, but usage remained relatively constant.⁴⁴

Smaller numbers are in secure care at any one time. Between 2000 and 2006, the number in secure care on 31st March fell from 90 to 78, but had increased markedly to 113 by 2007, only to fall the following year. In 2008, 93 young people were in secure care.⁴⁵

For about 90% of young people admitted to secure care, the primary reason is their own safety, while smaller numbers are admitted for the protection of others.⁴⁶ The majority of young people in secure care are male. Females make up only about 10% of those sent by courts, but nearly half of those admitted via hearings. Most young people are admitted to secure care from residential school or parental/family home, though nearly half of those sentenced by the courts were already in secure care.⁴⁷ The most common destinations on leaving secure care are also residential school and parental/family home.

3 Children resident elsewhere

It is helpful to consider the numbers of children and young people who are resident in custodial settings and mental health facilities, since some believe that certain of these individuals could and should be placed in residential homes or schools with access to appropriate support services.⁴⁸

Children in custody

On 26 March 2008 no children aged under 16 were held in custody in Scotland, but 227 young people aged 16 or 17 were,⁴⁹ i.e., more than twice as many as were in secure care.⁵⁰ Nearly half of the young people in prison were on remand.

Numbers resident in hospitals

On the 31st March 2007, 26 children aged up to 14 were in hospital for mental health reasons. About one third of these (nine) had been resident in hospital for more than a year, suggesting they had a severe condition.⁵¹ During the year ending on 31st March 2007, 46 children of that age were discharged. Most had been in hospital for up to six months, but six had been resident longer than that, including one for over a year.

The number of children and young people aged up to 18 who were resident in hospitals and psychiatric units receiving mental health treatment as at March 31st each year increased by approximately 13% from 2003 to 2007. By 2007 the total number of residents was 179 individuals. Additional psychiatric places have been made available for young people or are planned.⁵²

The statistics given above indicate the total number of inpatients receiving treatment at a single point in time. Government data on children leaving hospital give an indication of the turnover. The total number of inpatient discharges for children and young people from 2003 to 2007 declined from 474 to 358 discharges. The periods of care before discharge ranged from a single day to several years. This decline was most obvious for the 15-18 year old cohort, falling by approximately 35% compared with a 16% decline for the 0-14 year old cohort. The implications of this change require further investigation, to clarify how we can best meet the needs of this population.

An unknown number of children with a disability and/or life-limiting conditions are in a hospital or hospice.



Summary points

- In recent years, at any one time just over 1,600 children and young people have been looked after by local authorities in residential care.
- 600 children with disabilities are placed in residential schools, though many of these are not formally looked after.
- In 2008 just under 1,000 children with disabilities experienced repeated short breaks in residential services.
- Local authorities vary considerably in the relative proportion of children placed in residential homes (normally in-house) or in combined care and education settings (usually externally provided).
- Most children in residential care are aged 12-15.
- Over the last 15 years, there has been a growth in the numbers of children aged under 12 looked after in residential care, often for very short periods.
- A significant minority of young people in residential care were formerly in foster care or other residential placements, some with repeated placement breakdowns.
- The number of young people in secure care has fluctuated in recent years, but remains higher than in 2000. Twice as many are in prison, all aged 16-17.
- Significant numbers of children are admitted to hospital on mental health grounds each year.

Meeting the needs of children in residential child care

This section of the report reviews evidence about the needs of children and young people for residential care, their needs while they are there and preparation for their future after they leave.

1 The need for residential child care

Children may be placed in residential care by a decision of a Children's Hearing or by social work services in agreement with parents in terms of the Children (Scotland) Act 1995.⁵³ It may not immediately be clear whether the placement is long or short term and the choice to be made when a child is removed from home is between some kind of family setting (kinship or foster care, adoption) and residential care. If the needs of children are to be met effectively, ensuring the best possible outcomes for them as they grow up, it is important to make the right choice of placement. The underlying task in the placement of a looked after child or young person is to recognise and enhance their individual resources and potential through resilience or strengths-based approaches.⁵⁴

Research evidence

Research over several decades has established that children who are looked after away from home predominantly come from households in poverty where there has been serious discord and/or neglectful or abusive care-giving.⁵⁵ An English study of children's homes asked residents of children homes, parents and social workers why the original admission to care had occurred.⁵⁶ The main reasons given were; family relationship problems; the young person's behaviour, including risk-taking; abuse or neglect of the young person. More young people than formerly are

admitted as a result of parental substance misuse, so that not only do their parents need help to address their behaviour, but also the children will require assistance with adjusting to the consequences.⁵⁷

A key question is, therefore: *which kinds of children in what kinds of circumstances will have their needs better met in a residential placement rather than an alternative family placement?* There is no research which is able to indicate conclusively which children will benefit from residential placement rather than substitute family care, although some academic writers have sought to draw conclusions from broader studies of residential child care,^{58 59} as to when residential care is most likely to be helpful. Research has also shown that the young person's own preference for foster or residential care is a strong indicator of the likelihood of engaging positively with either.

Writing about looked after children, Clough et al. stated that in practice 'the main reason for choosing residential care is to control or improve difficult behaviour....'⁶⁰ This means that the primary goal may be framed in terms of the young person's need to change attitudes and conduct, which may result in neglect of meeting associated or underlying needs (e.g., for security), though effective assessment should pick up both types of need.



Stakeholder and survey evidence about the need for residential child care

Some local authorities which responded to the survey identified a growing demand for residential places, while others noted stability or a reduction. Several recognised a growth in admission of younger children (under 12); for a few the main increase had been in the mid teens, particularly of girls.

While local authorities reported a trend of stable or increasing demand for residential services, the survey of independent providers revealed that the majority had seen a significant decline in referrals during the last 12-18 months for both residential and day places. This suggests that local authorities are largely dealing with the growth in assessed need within their own facilities. Most independent providers in the survey reported an increase in the age of those referred, and two had witnessed fewer referrals for primary-aged children, which would seem to indicate a preference by local authorities to accommodate younger children in their own small units rather than the combined education and care facilities offered by a number of independent providers.

Apart from age, considerable agreement existed among both local authorities and independent providers about the needs of children increasingly being referred for residential placements, very often in crisis:

- Increased complexity of needs/challenging behaviour, including young people with drug/alcohol problems and sexualised behaviour
- Higher percentage of children with parental drug/alcohol problems
- Young people whose educational needs were not being met
- Mental health issues increasing^{61 62}
- Very challenging adolescent girls requiring placement, for example with self-harming or violent behaviour.

A few authorities mentioned increased referrals of very specific groups such as unaccompanied asylum seeking young people.⁶³ Some independent providers expressed the view that a few children referred for day placements would be better off in residential care, as their care and safety needs at home were not being well met by community based staff.⁶⁴ There was a widely expressed recognition by those who did not specialise in autism that there are increased referrals of children diagnosed with serious autistic spectrum disorder.

Several local authorities noted that more young people are staying longer. One consequence is that the age span is spreading.

Choosing and matching placements

Having a range of placement options is important in terms of young people's expressed needs (to have a say in where they live) and professionally assessed needs (matching a young person to the kind of provision best able to promote his/her welfare). Matters to be considered may include: to be placed with a sibling; to be near to their home area or, less often, to be placed at a distance; to be able to continue at the same school as before. Some individuals may be seen to require single-sex provision.

Research has shown that the need for choice is often poorly met. Admissions to both residential and foster care have long tended to depend mainly on which placement(s) are available rather than need, with often only one or two possibilities being seriously considered.⁶⁵ A SWIA review similarly concluded that 'access to resources was determined more by availability than by the level of risk presented by the young person'.⁶⁶ Many placements are made in an emergency,⁶⁷ so that matching is difficult and the probability of a later change of placement high. In some instances, sibling groups have

had to be separated because of a lack of placements where they could stay together.⁶⁸ Adult stakeholders pointed out that the number of local placements is inadequate and that some children are placed too far away from significant adults in their lives.

An English survey of young people living in children's homes asked them to comment on the location and environment of their home. The responses indicated that they preferred homely settings in a quiet area with plenty to do and nearby shops. The most common complaint was about being located in a 'bad estate'. Living in a remote rural area was liked by some, but resented by others.⁶⁹

The timing of placement is important. Both the local authority and independent provider surveys identified a perceived growth in 'crisis' or 'unplanned' admissions, which are likely to militate against a smooth transition to an appropriate placement. A number of independent providers stated that young people were admitted following fostering breakdowns. Their view was that some of these foster care placements had not been in the children's interests, and earlier residential placement would have been preferable. Several independent provider respondents attributed unhelpfully late referrals to local authority financial constraints and fieldworker shortages or turnover.

Very little research has been carried out on children with a disability in residential child care. Short residential breaks can provide welcome family support. Stalker concluded that admission to residential school is usually a response to two factors 'inability to meet a child's educational needs locally and pressure on families'.⁷⁰ Disability experts noted the importance of this early availability of 'short breaks' in giving families support so that more extended help was less likely to be needed at a later stage for this group of children.

2 How well are we meeting the needs of young people in residential child care settings?

Children and young people in residential care have the same needs as all other children for warm and responsive care, stimulation, continuity and respect. Access to recreational activities can help children develop transferable skills that will help their social integration, education and career prospects and to manage life as an adult.

Complaints and enquiries over the years have revealed instances of serious ill treatment in residential care,⁷¹ but evidence suggests this is exceptional. Recent studies have found that most residential establishments meet young people's care needs well. Clough et al. concluded from a literature review that, in the main, staff are caring and supportive to young people.⁷² Also young people often emphasise in surveys that relationships with staff are the most crucial and positive aspects of living in residential care. The NRCCI stakeholder consultation with young people confirmed that most of those in residential care feel safe, cared for and listened to.⁷³

Having somebody that would listen to me and that would try to help me.

(Female care leaver, 16)

It's safe here.

(Male unaccompanied young person, 15)

Children's need for nurture often requires physical comfort, but some concern has been expressed that residential staff might feel inhibited in making physical contact with children and young people for fear of allegations.⁷⁵ However a Care Commission report found that the vast majority of staff said they would provide physical comfort to a distressed young person and were clear about boundaries.⁷⁶

A recent Who Cares? Scotland survey of children and young people⁷⁷ found that many felt they had success in their lives. Many attributed this at least in part to support, encouragement and motivation provided by residential staff (as well as others, including family members and friends). Their successes were often shared and celebrated with staff, but nearly half thought that at times their achievements were not recognised. This might be because of their own diffidence, but other reasons given included staff busyness and competition for attention from other young people. In view of the earlier negative experiences of young people before being looked after, it is particularly important that residential workers meet their needs for approval and positive feedback.

Both the NRCCI stakeholder consultation with young people and an English survey⁷⁸ indicated that as many as half of those consulted were critical of the rules and boundaries they experienced for restricting their freedom and social associations in minor as well as major ways. Young people who are looked after want to feel 'normal' and not to feel they have all kinds of restrictions about their health and safety which are far from usual for teenagers elsewhere.

Being in residential, they don't let you out, with pals, being normal and that. I think that's bad. They don't know where you are, only down town. It's like it's better when you're locked up, they know where you are. Jails are for older people, I don't think that's right either.

(Male, secure accommodation, 13)

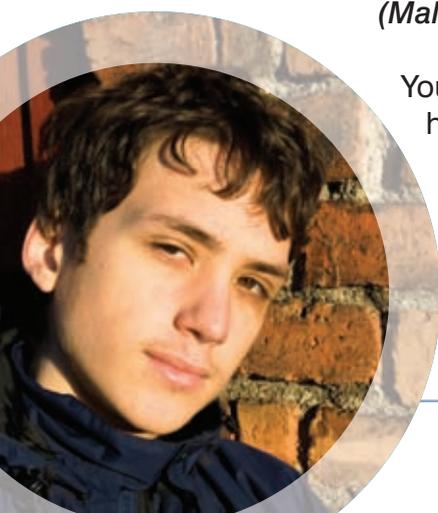
Young people in residential care have specific needs arising from their care and circumstances prior to placement. Many need additional support for learning, as a result of poverty, poor quality basic

care and/or changes of school experienced when younger. This can be compounded by lack of curricular and teaching continuity when placed away from home, as the quality of education provided is variable.⁷⁹ The last 10 years have seen concerted efforts to improve the educational support given to looked after children and young people.⁸⁰ Pilot projects have been followed by improvements in attendance and attainment beyond the national average.⁸¹

Children admitted to care often have below-average physical health and sometimes a poor record of immunisations. Frequent changes in contact with primary care services have sometimes led to inadequacies in health records.⁸² One English study found that about half of children looked after away from home had a physical or health condition requiring outpatient treatment and a significant proportion of these had multiple physical conditions and/or impairments, though few were registered disabled.⁸³

A Scottish survey of young people aged 10+ found that three quarters of over 200 people in residential units were current smokers.⁸⁴ The smoking rate was much lower in foster care and had declined more sharply over the previous 18 months. There is also evidence of unmet dental health needs.⁸⁵ The appointment of LAAC nurses has led to substantial improvements in attention to both physical and mental health care, according to the Care Commission⁸⁶ which concluded from its 2007-8 inspections that residential staff are 'good at health promotion and are supported by LAAC nurses in this'.⁸⁷ Access to health services was regarded as generally good, though some young people, particularly in secure care, had difficulties in seeing primary health care professionals.

Many studies of residential child care in both England and Scotland have revealed high rates of behavioural difficulty and mental



health problems rooted in years of trauma and adversity, which are often assessed inadequately and are very difficult to address.⁸⁸ These include risk-taking and addictive behaviour, as well as sexual health issues. Self-harm is a common problem in residential units.⁸⁹ Many young people in secure care have experienced serious trauma, and only some receive appropriate therapeutic help.⁹⁰ Similarly, an English study reported that a high proportion of residents in children's homes were depressed, yet few received help for this.⁹¹

Where there is good collaboration with local child and adolescent mental health services (CAMHS) both young people and their care staff benefit from specialist support and guidance.⁹² However, collaboration with CAMHS is patchy and gaining access to psychiatric or psychological help can be very difficult. The Care Commission found that many residential staff were ill-equipped to work with children of drug misusing parents. Links with specialist addiction services are often poor.⁹³

Young women in residential care have different needs from young men,⁹⁴ and these are often not acknowledged or else dealt with unhelpfully as a result of stereotypical reactions, especially with regard to sexual behaviour. Early pregnancies give rise to major support needs for young mothers and their infants. There is a widespread view that such young women are not being appropriately helped in their journey through care and that we need to find more effective ways of assisting them.

Young people in residential care have particular needs related to their separation from their family and to their living environment. Whitaker et al. noted a

number of common issues reflecting both pre-care and separation experiences.⁹⁵ They needed to learn to control impulses and chaotic behaviour; be less fearful of school; have more confidence about themselves and the future; have a trusted supporter; cease or reduce offending; deal with sexualised behaviour; improve family relations or reduce worries about family.

Behaviour and offending

Young people in group care settings may learn new behaviour as a result of the pressure of peer-group influences. Such 'contagion' effects may apply to offending, absconding, or self-harm, for example,⁹⁶ and managing this pressure is one of the important tasks within residential care. A considerable proportion of young people in residential care have previously been involved in offending. While many are helped to desist, others persist or even begin to offend as a result of being in a group setting. A Who Cares? Scotland survey⁹⁷ revealed that some young people felt that offending was prompted by a range of factors: imitation and group processes; anger at their situation; indifference to consequences; boredom; bullying; staff not respecting them or 'winding you up'. In addition, young people may be reported to the police and even charged and convicted as a result of incidents that would not be criminalised in other contexts.⁹⁸

Some young people in the Who Cares? Scotland survey felt they were not supported to reduce offending and a few felt that sanctions (loss of leave and privileges) made them more likely to re-offend rather than less. On the other hand, some believed their residential experience had helped reduce offending, especially in providing alternative activities and interests. Some valued cognitive-behavioural programmes, while others were cynical about their value and impact.⁹⁹



It has kept me out of jail because the situation I was in was getting out of control. It was messing me up emotionally and socially. It showed me a better life and introduced me to new people. It opened me up to have a more caring side, group living and younger kids helped me to look after myself and others.

(Male care leaver, 20)

The greatest challenges in residential care are represented by young people with complex, multiple needs accompanied by aggressive behaviour directed at themselves or others.¹⁰⁰ As would be expected, young people in secure care have particularly high levels of mental health, behavioural and educational difficulties.¹⁰¹

Peer relations

Co-residents can act as a resource to young people, providing them with company, advice and support. The peer group operates to monitor and secure the safety and well-being of fellow residents' safety and acts as means of maintaining group culture.¹⁰² However bullying by peers has been found to occur commonly within residential care.¹⁰³ The stakeholder consultation with young people found not

only reports of bullying, but also quite common reports of disliking life shared with strangers and of personal items stolen.¹⁰⁴ An English study found that most young people in a sample from 14 children's homes had experienced physical assaults as victim or perpetrator and that verbal aggression was widespread. Sexual violence was less common, but most girls had encountered this.¹⁰⁵

Get pissed off easily as you've got to deal with lots of different personalities. Sometimes there's gonna be conflict with staff and young people. Having to get used to living by their ways rather than the way you've been raised, even if it is for the better.

(Male care leaver, 20)

Stakeholder views about key unmet needs

The adult stakeholders concluded that when the needs of young people in residential care were not being met, this was most often as a result of a lack of access to appropriate services, especially:

- Psychiatric and psychological services;
- Education suited to the young person's needs and motivation;
- Specialist services e.g. for self-harm, trauma, substance misuse, sexual harming, autism, ADHD;¹⁰⁶
- Through care and after care;
- Family work and counselling.¹⁰⁷

Long delays were reported for health and disability assessments. In addition it was thought that residential workers required better training and support to deal with the special needs described above. In this context it would be helpful to ensure there is regular monitoring of the Scottish Government's target of 'providing basic mental health training to all those working with children in care', as set out in the Scottish Executive report *Delivering for Mental Health* (2006).

Meeting the needs of children in residential child care

The local authority survey was not able to tackle the full complexity of assessing how well needs were being met, but one question asked about individual children in residential care and the extent to which the current placement met the child's needs. Four possible replies were supplied on the questionnaire (See Table 1). In two-thirds of cases, it was thought that the child's needs were wholly met. In 13% of cases needs were partly met and very rarely were needs not being met at all.

Table 1: Did the placement meet the child's needs?
(N = 832 children from 16 authorities)¹⁰⁸

Wholly	589	71%
Mainly	154	19%
Partly	78	9%
Not met	11	1%

In addition one authority provided answers in the form of Yes (84) and No (10).

Individual authorities varied considerably in the extent to which they admitted to deficiencies in meeting need. At one extreme, an authority claimed that all 80 of its children had their needs wholly met, whereas at the opposite pole another described only one of its 33 children as having their needs wholly met (compared with 18 mainly and 14 partly).

How well do young people feel their needs are met in residential care?

Young people in residential care should be safe, maintain positive family contacts, be listened to, and not feel stigmatised.¹⁰⁹ The stakeholder consultation with young people showed that most young people in residential care do feel listened to, though a Care Commission Report found that a minority felt their needs for privacy, trust, respect or support were not well met.

Similarly, a minority said their needs for family contact, placement and educational continuity and even personal safety were sometimes not met.¹¹⁰

(A disadvantage is...) Being away from home, distance to see family.

(Female, children's unit, 16)

The Children (Scotland) Act 1995 states that young people's views should be taken into account in decision-making affecting themselves, yet according to the young people stakeholder consultation many young people appeared to know and understand little or nothing about their plans and reviews.¹¹¹ This is a key element in the *Getting it right for every child* principles, values and core components:

I've heard about my care plan: my social worker told me about it and it's in my minutes of my reviews and hearings. I can't remember what it is though.

(Female, children's unit, 14)

The adult stakeholders also reported that reviews are often not 'user-friendly' and that quite often agreed action is not carried out, perhaps because recommended services are not available. Young people have to manage placement moves without clear targets or appropriate timing. Access to advocacy is uneven, yet this is essential to ensure that all young people can participate effectively in decisions affecting them.¹¹² The working group supports the views of the report 'Moving Forward in Fostering and Kinship Care' (2009) regarding the appointment of independent review chairs for LAC reviews.

3 Meeting needs of young people beyond care

Like other forms of care, including parental and foster care, residential child care is judged not only by the extent to which it addresses current needs, but also by the degree to which it can prepare young people for future challenges. It should be borne in mind, though, that subsequent poor outcomes may result from factors other than the residential experience itself. Very negative earlier experiences may be difficult to overcome at the teenage stage and residential or indeed foster care is not able to offset this in many cases,¹¹³ especially if the follow up arrangements are not positive and well structured. Moreover the length of stay may be insufficient to have a lasting impact. Certainly many providers believe that children are sometimes removed too early from placement and that local authorities are often unwilling to pay for through care and after care.¹¹⁴

Many people have argued that it is unreasonable to expect vulnerable young people in residential care to make the transition to living independently as soon as they usually do. Approximately eight times as many young people leave care at 16 as leave at 18, even though most people in the general population leave home later than 18 and often return as young adults for short or longer periods.¹¹⁵ The *Sweet 16?* report¹¹⁶ highlighted serious deficiencies in preparing young people in residential care for life afterwards and in supporting them in the transition to adulthood, despite widespread development of throughcare and aftercare services over the last decade or so.¹¹⁷ Problems include getting into rent arrears, becoming involved with drugs and/or alcohol, difficulties with neighbours, threat of eviction which sometimes leads to

homelessness, and difficulties sustaining education. A low proportion of young people leaving residential care at 16+ proceed to further or higher education.¹¹⁸ Thus clear evidence shows that there needs to be much more effective investment in young people once they have left residential care if they are to make the successful transition to independent adult life.

The Care Commission has reported that a minority of staff have little or no knowledge about after care policies and guidance.¹¹⁹ In general residential services implement Pathway planning and involve young people in this, although according to the independent provider survey, many young people leave residential care without a formal exit plan. Services usually claim to encourage young people to keep in touch after they have left, but data about what happens in practice is lacking.

It has been a long-standing concern about services for children with a disability and their families that support often reduces when they make the transition to adulthood, sometimes abruptly. An expert informed the group that they commonly lose access to the services they have been used to 'and have to fit into adult services when many of them are not ready for such a dramatic change'.



4 Which children should be placed in residential care?

The Working Group think that there should now be a wide discussion on which children can most helpfully be placed in residential care and in what circumstances. Many children are helped in group care settings; others will flourish better in a family environment. The assessment that is made when a child is first looked after needs to look objectively at his or her needs and how these can be met. The evidence reviewed, though not definitive, suggests that the following issues should be considered:

- A residential placement is normally preferable to foster care when young people have had repeated unsatisfactory experiences within one or more family settings and/or are unwilling to commit to a family placement. As well as requiring good quality care and education, most have additional needs related to their family relationships, behaviour and/or emotional well-being.
- Residential care is usually needed when young people have major attachment problems and/or display challenging behaviour that is not being contained or helped within other settings, or when they present a serious risk in the community. This is usually related to previous experiences of abuse, attachment difficulties and/or family conflict.
- The statement in the *Skinner Report* that children under 12 should be admitted only in exceptional circumstances is no longer appropriate, as we believe that certain younger children can and do have their needs well met in residential care. It is still expected that the great majority of children aged under 12 looked after away from home will be placed in foster and kinship care, but a small but significant number could do better in small residential units. This applies particularly to children with very complex needs who have severe attachment difficulties and especially those who have experienced fostering breakdowns.
- For some children and young people, an earlier decision that they should enter residential care would lead to better outcomes. This would mean that needs and difficulties could be attended to before problems worsen and perhaps reduce the likelihood of further placement moves or breakdowns. To identify those who would benefit from early admission requires effective assessment within the GIRFEC model (or reassessment following placement breakdown), and needs to be informed by research evidence about vulnerability to repeated failure in community support and foster care.

Whenever a foster home breakdown occurs, consideration should be given to the likelihood that a residential placement may then be in the child's interests, possibly to help the child develop better readiness to return to a family at a later date.

- Residential care has a valuable part to play in keeping brothers and sisters together, especially when a group is likely to be too large or challenging for fostering. Every effort should be made to enable sibling groups to be looked after together, unless there are strong reasons why this does not best meet the needs of the children. The permission of heads of service should be necessary before siblings are separated.

- There is a continuing need for access to single sex provision, especially for adolescent girls with highly complex and challenging needs.
- It is believed that some young people currently in prison could be cared for successfully in residential placements, if adequate specialist support were available. There is a need to develop a suitable form of residential care for young people aged 16-17 who would otherwise be placed in custody.



Current provision of residential child care in Scotland

1 Introduction

Information was gathered from a range of sources including the SIRCC and Care Commission databases in order to identify all the residential services for children in Scotland in March 2009 (Appendix 2). This exercise highlighted difficulties in collating and classifying reliable data on all residential services and places. The reasons for this were:

- Classification is complicated and there is no agreed set of definitions and typology of units.
- Some very small units open and close within a short period of time.
- The Care Commission's data categorises services into three groupings (Care Homes for Children, School Care Accommodation, Secure Care Accommodation) and does not allow for distinctions within these categories. Registered services may consist of a number of small physically separate units, but the Care Commission only provides information on the full service and not the individual units within it.
- Information for SIRCC's database of all residential units¹²⁰ is provided by units themselves and sometimes errors and inconsistencies occur in use of some terms like 'respite'. SIRCC carries out annual updating but does not have the resources to make sure this is done comprehensively.

2 Providers of residential services for children and young people

Children's residential services have always included a variety of provision, run by statutory and independent sector bodies. However the number of providers has grown, mainly as a result of new private organisations entering the field.¹²¹ In 2004 there were 72¹²² providers in Scotland but 90 in March 2009. These comprised three roughly equal groups:

1. The statutory sector – 31 local authorities¹²³ (all Scottish councils, except one, have their own residential service).
2. Voluntary and private organisations who are members of Educating through Care Scotland (30).
3. Other independent organisations (29).

All 23 authorities that took part in the survey made use of placements in the independent sector and although a few noted a recent increase in use of external resources (which for two island authorities meant placing children on the mainland) the general level of demand for independent provision has reduced.



3 Types of provision: numbers and trends

Overall numbers of services and places

Traditionally residential schools and residential units have been the two main types of provision. In the former, education is provided on the premises, while in the latter children normally attend local authority day schools. This distinction has become blurred in recent years, with the development of providers offering education in learning centres for residents from more than one unit.

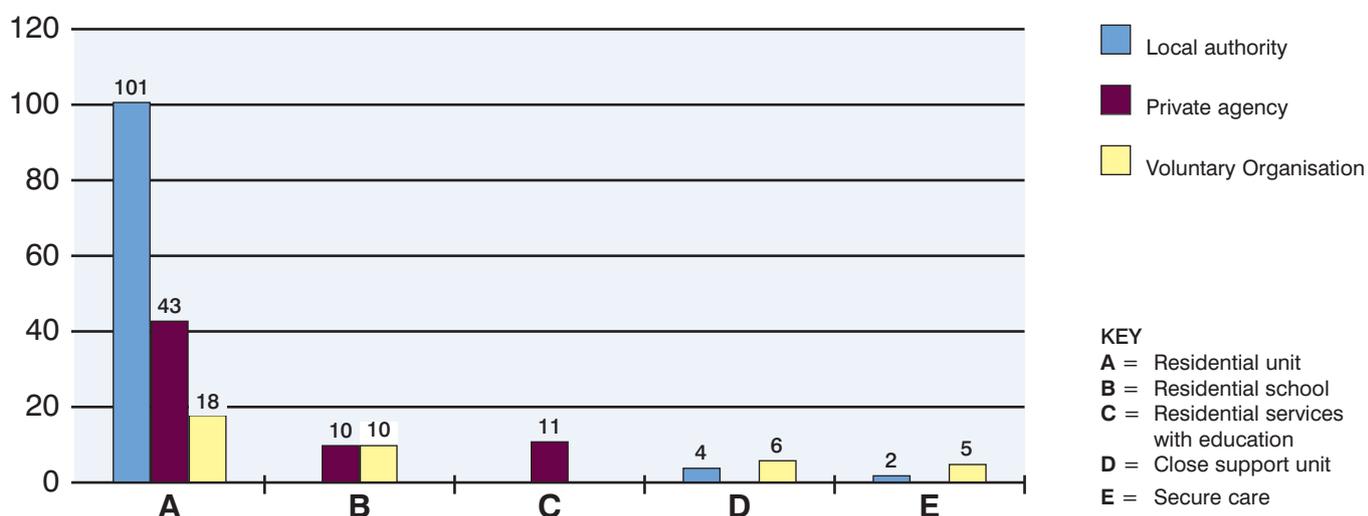
For the purposes of this report, information from SIRCC and Care Commission relating to March 2009 was collated into five categories (Appendix 2). We consider first provision for looked after children; arrangements specifically for children with disabilities are attended to at the end of this chapter.

As Chart 1 shows, the most common type of establishment were *residential units without education*,¹²⁴ totalling 162. There were far fewer *residential schools* (20) or other smaller units where the providers offer education (11). Finally there were small numbers of close support units (10) and secure care services (7).¹²⁵

Each type of service had a distinct pattern of providers:

- ✧ Nearly two thirds of residential units (101) were operated by local authorities, although a significant number (43) were provided by the private sector.
- ✧ The residential schools were evenly divided between the voluntary and private sectors.
- ✧ All combined care with education services, apart from secure and close support, were private.
- ✧ *Close support* units totalled 10, six voluntary and four local authority.
- ✧ Seven establishments were partly or wholly classified as *secure care*, five of which were voluntary and two were run by local authorities.

Chart 1: Numbers of different types of provision by type or provider



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Most authorities operate fewer than 10 children's units each, the number being roughly in proportion to the size of authority. Several have only one. The Local Authority Survey revealed that a few local authorities have opened new children's units, mainly to replace larger ones with smaller ones or to locate children closer to home. Several others planned to open new or replacement units. Others have modernised or extended the buildings or changed functions. Thus most were committed to renewing or extending their in-house provision, though one had set up a specialist team to 'divert from residential care where appropriate' and others reported developing alternatives.

Of the 18 authorities who completed the full survey questionnaire, about half (11) only used external providers for residential schools, disability services and secure care.

Secure care

The official number of places in secure care, which is sometimes provided within the same establishment as open care and education, was 124 on 1st April 2009. Another working group which focused specifically on secure care reported in February 2009.¹²⁶

Size and location of establishment

Many residential schools typically have 20-40 residents, usually divided into internal units of fewer than 10.¹²⁷ On account of their generally larger size, residential schools and units with education provide a higher *proportion* of places than care only establishments (over one third).¹²⁸ However, at least five schools cater for fewer than 20 pupils each. The new forms of residential care with education provide care in separate small-scale units linked to a shared learning centre.

Over the last 15-20 years all residential units have become progressively smaller with most now catering for fewer than 10 individuals. According to the SIRCC database, 90% of residential units provide for between two and nine children. One local authority has a unit with 18 places, but most have units with 4-6 places, and a few with 8-10.

A significant number of new residential unit services have been established by the private sector in recent years, many being very small in scale (1-3 beds) to provide crisis help and/or intensive therapeutic input.¹²⁹ The local authority survey showed a small number of children placed in singleton units, all in the independent sector (Appendix 3).

Most of the new very small, and in some instances specialist, units, run by the private sector, are located in rural areas, usually in the south of Scotland.¹²⁹ This means that a lot of new provision is at a distance from most placing local authorities, and hence from the home areas of most residents. Access to appropriate services may also be difficult. Meanwhile the cities and north of Scotland have seen hardly any new independent sector provision.

ADSW has expressed concern about young people being placed outwith the placing authority in small units without dedicated educational provision, as local schools often cannot provide the additional support required, especially in rural areas.

The development of very small units, some intended for young children, means the sharp distinction that used to exist between residential and foster care has become blurred, especially with the development of 'professional' and salaried fostering schemes.¹³¹

Gender and age

Children’s units normally admit both males and females. All those recorded in the local authority survey were mixed, except for one five-bedded long-term girls’ unit. Several residential schools, however, are for boys only, with one school and a small unit within another school admitting girls only.

The majority of local authority residential homes have an age range of 10 or 12 to 17 or 18, i.e., they were designed for teenagers. Some include younger children in their age ranges, including a few meant to cater for the whole spread from 0 to 18.

At least one independent provider and one local authority have recently opened units dedicated to younger children. In one case the unit aims to provide a therapeutic and stabilising placement for children of this age who have experienced repeated fostering breakdown.¹³²

4 Functions of residential services

Nearly all local authorities described their own residential units as generic. This denotes that they do not specialise and might suggest a lack of specificity, but equally ‘generic’ can be interpreted to suggest a flexible service that adapts to meet the needs of a wide range of children. Two authorities explicitly referred to the recent introduction of bespoke packages.

Besides those that cater for children with a disability, others concentrate on particular groups such as primary age children with experience of multiple placement breakdown, and functions, e.g., close support, training for independence/through care, treatment. Several descriptors like ‘close support’ and/or ‘treatment’ are, however, used with varying meanings.

Prior to 1996 there were a number of ‘care-leaving units’ operated under a variety of names which aimed to prepare ‘older’ young people for leaving care. According to the SIRCC database no local authorities are currently operating such facilities. Limited provision has been operated by the voluntary sector, while some new facilities have developed in response to the *Sweet 16?* report.¹³³ In the local authority survey, however, a number of young people were reported to be placed in the authorities’ own youth homeless provision, somewhat more than those placed in external homeless services (Appendix 3).

5 Occupancy levels

Figures from the local authority survey about estimated average occupancy levels over the past year should be treated with caution, as they were explicitly estimates and because the total number of places was often quite small. Just under half reported a 100% occupancy level. The others were spread between 72.9% and 97.4%.

Occasionally, occupancy above 100% has occurred with children sleeping on sofas or in dining rooms on camp beds.¹³⁴ This has invariably been because the local authority has had to accommodate a child or young person and there has been no available place. In these circumstances, in order to fulfil the authority’s duty to care, a residential service has gone above their registered number. When this happens, discussion with the Care Commission results in a plan to return occupancy to the registered level or below as quickly as possible.

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6 Linked services in the care continuum

Local authorities have traditionally provided a spectrum of services, including family support, fostering, residential care and throughcare and aftercare services. In the survey several authorities reported increased use of specialist and community based services to enhance their residential provision (e.g., in relation to psychological needs, education, autism).

Over the last decade, several independent providers have expanded their provision to include throughcare services, specialist services and/or foster care. This is in

keeping with an emphasis on co-operation across the care spectrum. Besides the deployment of professionals dedicated to psychological or trauma-related work, many mainstream residential staff are now trained to undertake attachment-promoting practice.¹³⁵

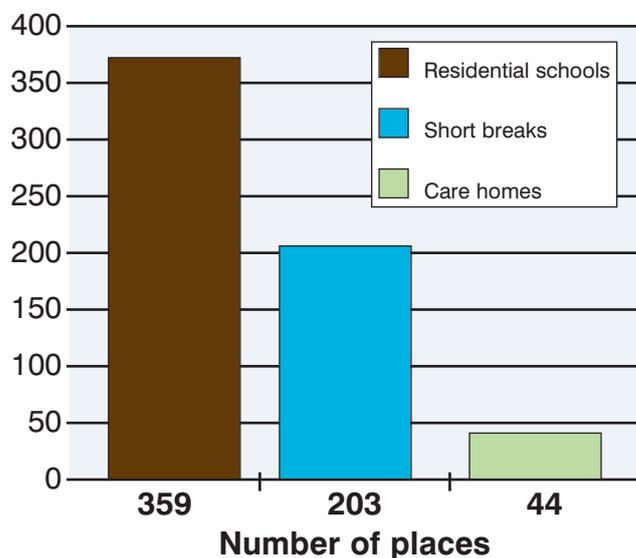
Increasingly the activities of many residential staff are undertaken off-site through outreach work. Family work is also growing, and some agencies provide training for this in residential care. In at least one authority, residential staff with social work qualifications have taken on full case responsibility.

7 Residential services for children with disabilities

The preceding information will have included some children with a disability, but information is lacking about the numbers of such children. Here we focus on facilities dedicated specifically to the needs of disabled children and young people.

In March 2009 the residential disability sector comprised 21 longer term establishments (13 with education on the premises), and 36 short break or respite services. The majority of the provision was in the voluntary sector, but there were 10 short break services run by local authorities and one by a private provider, two local authority schools, two local authority care homes and one private care home (Appendix 2). The number of places available is shown in Chart 2, as follows:

Chart 2: Number of places in different kinds of provision for children with disabilities



Central government has continued to part-fund six long established special residential schools – the Grant-Aided Special Schools (GASS).¹³⁶ Residential schools for children with disabilities have gradually reduced their numbers and tended to focus on the needs of the most multiply-disabled, e.g., the Royal Blind School and Donaldson’s now take children with sensory impairments and significant disabilities.

Residential respite or short-break provision has grown markedly, especially in the voluntary sector. New or expanded services have developed to serve the increased numbers of children with severe disabilities and those with life-limiting conditions, including the establishment of two

children’s hospices. Services for children with autism have grown, with some provided by new voluntary organisations devoted entirely to autism.

The experts on disability confirmed that medical advances have resulted in more children surviving with complex and severe impairments. Also certain disorders (e.g., autism spectrum) are being diagnosed more widely, leading to a greater awareness and wish for appropriate services, some in residential form. Local authorities tend to concentrate on providing for children with less complex needs, with the result that there has been a higher demand placed on specialist services, which have had to cater for a wider range.

Summary points

- The largest numbers of residential establishments are run by local authorities themselves, but residential services which combine care and education are largely run by voluntary or private organisations.
- Residential schools are fewer in number than residential homes, but are generally larger, so cater for a significant proportion of young people looked after away from home and most children with disabilities placed on a long-term basis.
- Among the main recent trends in provision have been:
 - an increase in the number of providers;
 - reduction in size of individual units;
 - introduction of very small (micro-) units;
 - growth in provision in certain rural areas but not others;
 - diversification of functions, mainly in the independent sector;
 - increase in establishments with explicit treatment, therapeutic or attachment models;
 - growth in respite services (short breaks), mainly for children with disabilities;
 - expansion of close support and crisis/emergency services.
- At any one time, about half of local authorities have full occupation of their residential placements. Most others have between 10 and 25% of their places ‘unoccupied’, though this refers to very small numbers in some instances.

Planning in the future and planning for the future

In this section we review how residential services might develop in order to address more effectively the needs of children and young people. Here we draw primarily on data from our surveys, the stakeholder consultations and the views of the working group itself. There are implications for planning services at a strategic level and for the care planning for individual children.

1 The evidence about 'effective' residential interventions

Over the years many studies have shown that most young people make significant progress in residential care, though the benefits are often not sustained when they return home or leave at 16+.¹³⁷ Concern has been expressed in Scotland that most young people return to 'unresolved family and community issues' which make successful readjustment difficult.¹³⁸

Research has identified a number of characteristics that are vital for residential care to achieve good outcomes, but has been less specific about the models of service that work well and with which kinds of young person. The vital importance of individualised, responsive care was established early on.¹³⁸ Sinclair and Gibbs concluded from their detailed study of residential homes in England (they did not include residential schools) that these worked best when they were small, had clear leadership and staff pulling in the same direction.¹⁴⁰ Similarly the study by Whitaker et al. suggested that clear and consistent structures and cultures were vital ingredients for success.¹⁴¹ Small size permits individualised attention and a non-'institutional' ambience. However larger establishments offer the benefits of a sizeable peer group,¹⁴² and one study found



that teenagers who went to residential schools were particularly likely to make good progress.¹⁴³

Repeated studies have shown that young people value relationships with staff who treat them with respect, listen carefully and communicate informally.¹⁴⁴ Reliability and confidentiality are other important qualities that young people value.¹⁴⁵ The Young People Stakeholder consultation reaffirmed the importance to young people of caring, open and responsive relationships.

My keyworker helped with problems I had. She listened. My key worker did everything for me. If I needed professional help, she would help me. I might not have thought that I needed help, but she told me and I got it. She was always honest / straight with me.

(Female care leaver, 19)

2 What do we need for the future?

The local authority and independent provider surveys indicated that residential services are primarily supporting – and therefore must be designed to care for – children and young people with complex needs and often challenging behaviour. These are mainly teenagers, but include significant numbers of children under 12.

The local authority and independent provider surveys and the adult stakeholder consultation taken together demonstrated consensus on a number of proposals to improve services. The suggestions most commonly made were:

Systemic developments:

- Promotion of residential care as a positive choice;
- Wider sharing of understanding about unmet needs and good practice, through collating records, consultation forums and research;
- Better review and planning of resource development by local authorities, service providers, the NHS and the Scottish Government, which is informed by the needs of children and young people;
- National co-ordination of the work of education, care and health professionals in relation to residential care;
- Joint early training among social workers and teachers;
- A central directory of provision.

Changes in assessment, admission and planning for individuals

- Placement of young people to be based on in depth assessments within the context of a long term plan with explicit outcomes, i.e., in accordance with the child's plan under GIRFEC;
- Every young person in residential care to have an allocated field social worker;
- All young people having sufficient contact with their social workers, so that a trusting relationship can be built and the worker has in-depth understanding of the young person's views and needs.

Modification of residential services;

- Distribution of services to enable children to live closer to their homes;
- Better emotional and social support;
- More specialist help, both through appropriately qualified staff and access to external services, e.g., counselling or therapeutic work, modification of challenging behaviour, dealing with substance misuse;
- More longer-term provision in view of the lengthening stays beyond 16 and difficulties faced by those who leave early (possibly backed by legislation to strengthen the duties of local authorities);
- More provision which can meet the very particular needs of the younger age range of children, e.g., small units with a high ratio of well qualified staff;
- Continued support and work from residential bases after young people have left and access to out-of-hours support;
- More opportunities for residential staff to support young people and their families in the community, in collaboration with other services;
- Development of work with families as a whole, perhaps in regional family centres;
- More respite provision.



Planning in the future and planning for the future

Related to external services:

- Improved educational provision to ensure all residents receive appropriate full-time education;
- More flexible and specialist teaching, including outreach from mainstream schools and residential special schools;
- Better access to child and adolescent mental health services.

It was noteworthy that when local authority representatives were asked to state what alternative resource was required to meet better the needs of individual children currently in residential care, the most common response was for foster care (33 children in five authorities). This reflects the common preference for family placements noted earlier in the report.

The improvements young people wanted were somewhat different and largely related to current settings. The most common wish was for different rules, for greater freedom about when and where to go out, to choose their placement and to smoke. Evidently some of these wishes are in tension with adult perceptions about the need for structure or with national health policies. Next most frequently expressed aspirations concerned staff – for them to listen or communicate more, to show more interest, be more experienced or better paid. Also important was improved quality of accommodation, such as better and more private bedrooms, better access to IT or good quality facilities.



3 Improving planning and information

The working group considered that for effective planning of residential care provision, within the context of other services for children and families, it is vital that good understanding exists at local and national levels of the profile of needs of the population. This requires regular, detailed review within the context of integrated children's services plans. These plans should clarify what strategic role residential care will fulfil within the context of all local, regional and national services and develop services accordingly.

In turn, good planning is reliant on accurate, relevant and up-to-date information. Much useful data is available, as summarised earlier in this report, but significant discrepancies and gaps need to be addressed so that we can have a better understanding of the journeys that children are making in care, how their needs are met, and how to improve outcomes. In particular, details are lacking about issues such as the legal status and needs of children with disabilities in residential care, the nature and aims of crisis and emergency admissions, and the numbers and circumstances of children moving between foster and residential placements.

Young people's rooms are disgusting and other young people steal, don't flush toilets, don't wash their hands: their hygiene is disgusting.

(Female, children's unit, 14)

Decision-makers and purchasers need good current information about the resources available to them, and local authority staff responsible for placements should have ready access to a current and comprehensive database so that they can properly evaluate services and make confident and appropriate choices to match the needs of individual children.

The group welcomes the work that is being done to strengthen the role of local authorities as corporate parents, but recognises that there are still challenges and scope for improvement. The Scottish Government guidance *These Are Our Bairns* (2008) emphasises the important role that local authorities have as corporate parents, and the vital contribution of community planning partners as members of the wider corporate family.

4 The economics of provision

The stakeholder review highlighted finance as a primary barrier to matching needs and resources. The consultation recognised the high cost of residential services and the financial constraints that local authorities operate under, leading to tensions and mistrust between authorities and providers. A significant number of independent providers indicated that in their experience local authorities often made decisions on the basis of cost rather than needs, preferring options other than residential care largely or solely because they were cheaper. Linked to this there was also a perception within the independent sector that the Concordat has resulted in local authorities having more control over the deployment of resources than previously and that this partly accounted for fewer referrals to their services. ADES noted the high opportunity costs of making a single external residential placement and suggested that this could not be justified unless and until outcomes were 'demonstrably better than elsewhere'.

The working group discussed the fact that charges for individual residential placements are high compared with alternatives, although cost comparisons often do not take into account hidden costs and a successful placement in residential care will make savings in both human and economic terms in the long run. Cost-benefit analyses have been carried out (mainly outside Scotland) and yield useful findings.¹⁴⁶ Such studies, however, tend to be short term and it is very difficult to attribute to individual interventions the responsibility for particular outcomes. One comparison of young people's wellbeing over 12 months found that young people who stayed longer in residential care improved more in their overall quality of life than those with briefer stays.¹⁴⁷ A different



evaluation concluded that short-term savings from limiting use of residential care may adversely affect the futures of vulnerable children and hence place a greater burden on services later in life.¹⁴⁸

5 Assessment of children for residential care placements

Decisions about when and where to place children and young people in residential care should be 'needs-led', that is, based on a comprehensive, multi-agency assessment of their needs as perceived by professionals and young people themselves, and what caregivers and settings can best meet those needs.

In accordance with legal requirements, young people should be fully involved in planning and have their views taken very seriously. Their hopes and dreams should inform placement plans and goals.

A co-ordinated approach to choosing residential placements should consider needs, actions and outcomes with respect to the eight wellbeing indicators outlined in *Getting it right for every child (GIRFEC)*.¹⁴⁹ The national practice model GIRFEC embraces integrated assessment where it is required by the needs of the child and young person, and promotes an approach which takes the assessment, analyses the information against the strengths and pressures facing the individual, and leads to an integrated planning approach where necessary. This approach, including the development of a shared understanding and common language, will ensure consistency of assessment across professional and authority boundaries, and should facilitate earlier intervention based on an earlier identification of how to improve outcomes, taking into account a child's strengths and weaknesses.

The group is supportive of policies that focus on early intervention. Early placement may act as a form of early intervention in relation to long term outcomes, as it is likely to prevent the escalation of problems. Careful assessment should identify children who would gain from earlier placement in residential care which would avoid the effects of recurrent failure at home or in foster care.

The child's or young person's plan should be used to identify what requires to be done, who should do it and what the expected outcomes are.¹⁵⁰ There may also be benefit in looking at how placements are currently identified.

In addition to the conclusions of the integrated assessment process, placement decisions should use available information about the establishment and its particular educational and care packages as well as the outcomes of the integrated assessment process. The work of the commissioning group for the NRCCI has laid out further significant views on the work required in relation to monitoring and evaluation, and of the requirement for needs assessment and identification.

6 Emergent models of residential care

Clough et al.¹⁵¹ suggested a residential child care strategy for Wales in which three categories of provision would relate to increasing levels of challenge and complexity of needs among residents. This working group felt that a diversity of provision is required to meet the varied needs identified in previous chapters, but thought that Clough et al.'s category of mainstream homes providing only good basic care was flawed, because nearly all children in residential care need more than this. Virtually all residential placements have to address complex and specialist needs by a combination of in-house and external services, often in conjunction with family or peer-related work in the community.

Models of residential care may be considered as having several different dimensions, including:

1. structural models (e.g., children's homes or houses; small units within residential schools; care and education provided by the same agency on different sites);
2. 'treatment' approach (e.g., adventure, intensive, social pedagogy);
3. additional on-site services (e.g., trauma therapy; programmes for sexually aggressive young people; work with families);
4. combined services (e.g., residential plus fostering or throughcare);
5. flexible shared care (where young people spend part of their time in residential care and part with their family).

A number of new models of residential care have started to appear in Scotland with innovations in new kinds of provision, and of structural changes or altered ethos within existing services.

Whatever model they adopt, providers should articulate the theoretical, skill and

training base for their work, along with evidence about the effects. In order to address the significant needs of looked after children resulting from their early experiences, local authorities and residential providers must have access to a range of professionals, including teachers and health professionals, and sources of support and advocacy.

7 The continuum of care within services for children

Residential care is part of wider care services for children in need and many young people will experience care in more than one service, both in the community and if they are accommodated. It is therefore particularly important that fostering and residential care services work together so that placement choices fit the child's needs and that moves between one and the other are made as satisfactory as possible. A considerable body of knowledge exists about the interface between residential care and fostering, the factors which lead to one being chosen over the other for particular children and how outcomes compare for each.¹⁵³ This understanding should help identify which children placed in foster care might be better suited to residential care and vice versa; and how the two services can work together to support children best. There are many overlaps between them; there are large foster homes and some single child residential arrangements, and consideration needs to be given to what kind of experience is being offered to children in each.

8 Future participation models for young people

The working group considered that it is vital that all forms of residential care have inclusive processes for ensuring the full participation of young people in relation to both individual and collective matters. A range of roles and mechanisms exist, including key workers, unit meetings, access to Children's Rights Officers and Who Cares? Scotland workers, complaint procedures¹⁵⁴ and the internet, but there remains scope to improve arrangements for young people to express their views, gain appropriate support and advocacy, and be effectively listened to. All young people are entitled to independent advice, advocacy and support. The young persons' stakeholder report highlighted the emphasis that young people place on being able to express their views, be listened to, and influence rules.

Health and safety: we're not allowed to go to the beach 'cause a boy drowned. Our TV and PC were destroyed and then all the money's spent replacing stuff. We're not allowed our deodorants in our rooms in case young people use it as a flame thrower and a young person has an allergy to it.

(Male, children's unit, 15)

More recognition could be given to the resources that young people have to offer each other.¹⁵⁵ This is illustrated by peer education and establishments that promote peer support. Former looked after children can also make significant contributions, for example, as befrienders, mentors and lay inspectors.¹⁵⁶

The future development of residential care provision should involve routine consultation with young people,¹⁵⁷ so the



resources can be regularly adapted to take account of their views, including reflections on what has helped them over time. Such consultations should feed into children's services plans. Providers are already encouraged to seek the views of young people and stakeholders and to undertake more self-evaluation as part of the inspection processes, and this change of culture needs to continue and develop. Agencies such as Who Cares? Scotland and Scottish Commissioner for Children and Young People should also continue to facilitate the representation of young people's viewpoints. All possible methods should be employed to ensure appropriate participation, including specialist and more general fora (e.g. youth councils and parliaments). Young people should be given options about how best to convey their views, whether face-to-face or using technical aids, such as web-based comments and discussions. Imaginative means may be developed for young people to exercise more influence over spending in their own interests.

9 Young people over 16

The group noted that the age of leaving care and the importance of effective transitions are crucial issues for young people. As the *Sweet 16?* report argued, it is vital for young people to be able to stay in residential placements until the age of 18 or beyond when they wish to do so and this is in their best interests.¹⁵⁸

At present, young people are entitled to aftercare only if they were looked after by the local authority on or after reaching the minimum school leaving age. This is not widely understood. Some young people are discharged from supervision requirements shortly before reaching this threshold, thus making them ineligible, even though they may have spent a substantial or significant part of their life in care. The Care Commission also found that half of the young people leaving residential care were not properly supported.¹⁵⁹ Similarly, SWIA¹⁶⁰ concluded that throughcare and aftercare arrangements are critical for young people who display sexually harmful behaviour. Their report stated the need for better integration between residential and community services, as well as a more comprehensive preparation for leaving care.

SCCYP's *Sweet 16?* report suggests there should be more investment in semi-independent living units that act as a staging post towards independence and may provide somewhere to come back to when things go wrong. The report also shows that too many young

people are still being placed in bed and breakfast establishments despite official guidance to the contrary.¹⁶¹



Hence it is essential that coordinated long term support is available for young people who have been in residential care, including attention to attachment and continuity in relationships while building independence. Such services for care leavers might include:

- a one-stop shop for monitoring their development through and after care, and support the corporate parenting role of the local authority;
- brokering places at college or university for young care leavers;
- employment schemes;
- local authorities routinely assessing the impact of their policy decisions on care leavers.

10 Future research and information sharing

In order to improve placement decisions and matching, as well as service development, it is important that knowledge of systematic research evidence is available and key findings effectively disseminated to decision-makers. This has to be applied alongside the assessment of the individual young person and available provision. Some new research will be necessary to fill gaps in understanding and to evaluate emergent forms of provision. In particular, the group identified several high priorities for Scotland: a study of close and high support models of care; longitudinal studies on the efficacy of different residential care models, both open and secure; and controlled comparisons with non-residential care alternatives.

A detailed examination of costs and funding sources would be very helpful, given the high price of residential services and widespread belief that local authorities sometimes cannot afford to pay for the residential care which a young person is deemed to need, or continue it as long as

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needed. The connections between costs and outcomes merit further exploration, taking account of the Audit Scotland Public Performance Study of 2009. The Audit Scotland study 'Quality and costs of residential provision for looked after children', due to report in 2010, will be a further important contribution to this.

It is also valuable to learn from studies on residential care elsewhere in the world. SIRCC has a role in disseminating findings of research and practice experience from other jurisdictions as well as Scotland and there are a number of ways in which

international links could be developed. For example, it may be useful to develop a regular forum for discussion of best practice with researchers and practitioners from outside Scotland, web-based communication between Scottish agencies and international partners, further international conferences and comparative research (as carried out by the Institute of Education in London with respect to social pedagogy). Such activities would also provide opportunities to publicise developments and successes in the Scottish residential care sector.

Looking to the Future

Based on identified unmet needs and models of good practice, the group would like to see:

- A range of residential services jointly planned on the basis of careful assessment of needs locally and nationally, with resources assigned to match those needs;
- Individual placements made to address the needs identified in holistic assessments and clear, participative care plans;
- A greater range of residential provision with new types developed to meet the needs of groups likely to increase, including under 12s;
- Integrated models of care having a better interface with other forms of intervention/provision (community services, foster care, etc.);
- Greater emphasis on education and health needs;
- New technological tools: for instance, the use of ICT by young people to promote home learning and knowledge of the care system; staff deploying computerised assessments about attachment and behaviour to guide intervention;
- Improved access for young people to independent advice, support and advocacy;
- Greater involvement of young people in developing models of care;
- The views of children, young people and carers always taken seriously into account when residential services and policies are planned and reviewed at unit, local authority and national levels;
- Further development of specialist programmes (sexually harmful behaviour, trauma, anger management, self-harm);
- A systematic review of residential services for children with disabilities;
- Ongoing expert review of the residential sector in Scotland;
- Regular reviews of best practice and research in an international context.

Conclusions

1 Summary of key points about needs and resources

Information from a wide range of sources has identified a continuing need for residential services. The profile of children and young people who require residential care is not dissimilar to those who can be fostered (e.g., history of care and protection referrals; parents with substance misuse or mental health problems). What distinguishes them is that many looked after young people do not wish to live with a family other than their own, and those with very serious attachment issues often manage better in a residential setting.

The demand from social work services for residential child care places shows high proportions of young people with complex needs and a widening age range. Virtually all children and young people in residential care need additional help beyond basic care and safety. Future services must adapt to the needs of the increasing numbers aged below 12. Many of the children and young people in residential care are placed there after a number of placement breakdowns which have added to their distress and vulnerability. In certain instances repeated foster care breakdowns could be avoided by earlier admission to residential care.

Research has shown that residential care usually meets well the needs of vulnerable children for sensitive care, safety and stability, though the evidence is less clear about what forms of residential care produce the best outcomes. Repeated surveys have revealed positive feedback from most residents. Many make good progress across a range of dimensions, though a number continue to have major

problems. Longer-term outcomes are often poor for two main reasons. Firstly, young people who enter residential care usually already have multiple disadvantages, which are very difficult to offset. Secondly, benefits from residential care are hard to sustain without adequate long-term support after leaving.

The working group concluded that there is a significant proportion of residents who have one or more of their needs not adequately met. These include needs related to:

- Education;
- Physical health and diet;
- Emotional well-being, mental health and addictions;
- Family relationships;
- Challenging behaviour and bullying;
- Preparation for independence;
- Sustained support when leaving care, whether post-16 or earlier.

Addressing such needs better might well be expensive, but the future human and financial costs of not sustaining positive outcomes into adulthood are also very high. This requires improved access to health, education and specialist services, but also an enhanced role for well trained residential staff.



The forms of residential provision have changed markedly in the last 15-20 years in response to perceived needs. These include much smaller size of units, more qualified staff, access to more diverse and flexible educational and health support, introduction of close support and ‘crisis’ services. Further changes are likely to be needed and to occur in future, but children’s services planning in general often lacks good information and evidence about best practice. The frequency of emergency placements and limited matching of a young person’s assessed needs to the most suitable placement reflect wider problems about resource availability and co-ordination. Young people want and are entitled to more input into individual decision-making processes and the rules of residential units and schools. Much better understanding is necessary of the experiences and needs of children with disabilities.

Drawing on the evidence reviewed in the report,¹⁶³ the working group identified a set of principles for a residential child care strategy, which is set out below and followed by specific recommendations. Many of our recommendations are not new. Some have been repeated in reports on residential care over many years and are already embodied in current legislation and guidance, as well as good practice. Therefore a high priority is to ensure that existing principles and policies are implemented more effectively.

2 Principles underpinning a strategy for residential child care provision

- Residential care should be seen as providing a positive contribution within a spectrum of care and services for children and their families.
- Effective residential services require collaboration with relevant universal and specialist services for children.
- Diversity of provision is necessary to offer choice to the young persons and give a range of options to decide which best meets the needs of individuals, rather than the child having to fit into available resources.
- The range and types of residential provision should be planned at local and national levels on the basis of detailed and up-to-date information about trends in the demand for residential care and the needs of residents.
- Placement in residential care must be based on individualised, holistic assessment and clear plans, which ought to be reviewed frequently thereafter.
- Placements should be timely. Residential care ought not to be used only as a last resort, but at various points during a young person's time in care and for positive purposes.
- Emergency admissions and changes of placement should be kept to a minimum.
- The views of young people about their current and future needs and about what resources they require should be routinely obtained and fed into care planning and everyday practice.
- Residential placements should as far as possible promote continuity of children’s existing positive relationships, interests and experiences.
- Residential care must assist young people in building up interests, skills and social connections that will help meet their future needs.
- Transitions into, during and out of care ought to be well planned, prepared for and supported.
- All residential services must have explicit policies and practices promoting the health and education of young people.

Key Messages and Recommendations

1 Residential care within a broad continuum of services

Addressing the needs and improving the outcomes for children and young people in residential care requires collaboration between agencies in the provision of relevant universal and specialist services. Virtually all children and young people in residential care need additional help beyond basic care and safety. There is scope for better co-operation between residential and fostering services, for example in relation to possible shared care, preparation for transfer, adjustment to placement changes, training and improved post-16 support.

1. Through the Children's Services Plan, each local authority and its planning partners should be able to evidence a robust continuum of care which supports the diverse needs of children and young people and provides a range of flexible community-based services, fostering and residential provision, including short breaks, and throughcare and aftercare services.
2. The Children's Services Plan should identify the particular strategic role which residential care will fulfil within the overall range of services. This must include attention to children with a disability and others with additional support needs.
3. Local authorities require access to a range of residential services, so that choices are available when children need placement and each child can be matched with a model of care that meets their individual needs and has access to any additional services required.

2 Information, research and planning

A significant amount of management information and other data is collected, and consideration should be given as to how this can be most usefully deployed to improve understanding of the current and future needs of children and young people, as well as the role of residential care within the range of available options, in order to deliver improved outcomes for children.

There is very little Scottish research on the effectiveness of different interventions used in residential care which could help to inform the development of the sector.

1. The Scottish Government, COSLA and other appropriate agencies should jointly consider the production of an effective planning template which will support each local authority and its partners in identifying the information required, in order to undertake planning and commissioning for future need.
2. Building on work currently being undertaken by the Scottish Government, Care Commission and SIRCC, efforts should be made to ensure the compatibility of the various data sources and to identify information gaps. Additional information is required, for instance on children with a disability in residential care.
3. The Scottish Government, local authorities, residential care providers and other agencies should consider ways of using existing sources of data more effectively and innovatively, identify gaps in information and priorities for new research, and seek opportunities to commission research, in order to examine factors affecting the experiences and long-term outcomes for children and young people in residential child care, and the effectiveness of different approaches and interventions.
4. The Scottish Government's Looked After Children website (www.LTScotland.org.uk/lookedafterchildren) should be utilised to hold more information about best practice, information and statistics relating to residential care, and to facilitate the sharing of practice amongst professionals and carers and other interested parties.

3 Active participation of young people

Children and young people in residential child care have a clear right to participate in the decisions made both about their individual care and the wider provision of services. This is closely linked to their rights for care and protection and we would strongly endorse the comments made in the Kerelaw Report.¹⁶⁴ The Scottish Government has commissioned a review of advocacy services for looked after children and the outcomes of this will be important in informing future practice.

1. Local Authorities and their planning partners should promote and evidence a rights based approach in Children's Services Planning.
2. Local authorities, residential care providers and other agencies must ensure that clear mechanisms exist to promote the views of children and young people in service planning and decision-making. Important components include independent support, advice, and advocacy, as well as effective complaints processes.
3. All residential establishments must ensure that children and young people have their views taken seriously in the formulation of the child's plans and reviews, and that they understand as fully as possible the implications of plans affecting them. The expectations and rules that apply should also take into account young people's views.

4 Assessment and care planning

Integrated and holistic assessment is the key to identifying the needs of individual children and young people. Equally, ongoing care planning, assessment and review are crucial in meeting the changing needs of children and young people in residential care. Pressure within the system too often means that placement is resource-led rather than needs-led.

1. All assessments should follow the principles of GIRFEC. They should be multi-professional, child-centred, proportionate and timely. One assessment should cover all of the child's needs, whether education, health and well-being, safety, social or developmental. Assessments must include information related to the particular requirements of residential placements and identify long-term goals.
2. Residential child care should be considered as an appropriate service for children and young people early in their care journey and should more often be contemplated as a realistic option for younger children who have serious attachment problems and complex needs.
3. Whenever possible admissions should be planned and prepared for well in advance. All those involved in care planning should articulate and commit to clear

shared expectations about the planned outcomes for individual children and young people. The child's plan(s) should articulate how residential care interventions and those provided in collaboration with others can achieve agreed outcomes.

4. Children and young people's views and aspirations must be taken seriously at every stage, and support and advocacy provided; young people should all be given a copy of their plan prior to admission, as well as copies of subsequent review documents.
5. It would be beneficial if admission and review meetings had independent chairpersons.
6. Stability and continuity of placement are a high priority. Placement changes and breakdowns should be regarded very seriously, monitored closely and reviewed for the lessons to be learned.
7. A national review is required of the experiences and needs of children with a disability in all forms of residential care. This should include examination of their legal status and focus on the commonalities and differences compared with the wider looked-after population in terms of needs and resources.

5 The nature and roles of residential services

Residential staff work on a daily basis with the young people in their care, and they know a great deal about their needs and preferences, and how they respond to stress. This knowledge and understanding is too often not used effectively to inform integrated assessments and decision making, both in relation to assessment and to future care planning. Residential staff are integral to changes of placement, planning the transitions and supporting the change. A model of care which is likely to be of great relevance in future, and therefore should be given due consideration, is analogous to shared care models used for children with disabilities.¹⁶⁵ Young people would have recurrent short stays and/or spend parts of the week at the same residential facility at times which fitted with their needs as part of a long-term plan.

1. The location, design and work of residential services should aim to support continuity of children's key relationships with family, friends, professionals, school and community, except when this is contrary to the child's interests.
2. The Initiative has highlighted that there are particular groups of children and young people, who have specific or complex needs, and residential care services with appropriately trained staff and ethos must be available to meet these needs. They include:
 - children under 12;
 - challenging young women;
 - children with disabilities.
3. The contribution of residential staff in family and community assessment, joint work and post-placement support should be extended. This could include opportunities for families to obtain help on a residential basis.

6 Education

Recent attention to educational attainment for looked after children through the We Can and Must do Better report and the range of work being undertaken following this report have undoubtedly led to improvements, but the challenge now is to ensure the policy and practice initiatives emanating directly and indirectly from the report are embedded into everyday practice. Too many young people are still not getting the learning opportunities and support they require. Many young people have to change school several times, receive only part-time education or do not receive appropriate additional support for learning.

1. All providers of residential child care must be able to demonstrate that their staff actively support and engage in the education of the children living in each of their establishments.
2. As part of their cycle of inspections the current Inspection agencies and the future scrutiny body (Social Care and Social Work Improvement Scotland – SCSWIS) should be asked to report on the educational outcomes achieved by local authorities and other providers of residential child care in each establishment, and on the action plans aimed at improving educational outcomes and experiences, use of training materials, and self-evaluation.

7 Health

Children and young people in residential care have significant physical, mental and emotional health needs. The work of LAAC nurses must be built on to improve health assessment and care in residential establishments. The recent guidance to Health Boards in relation to Action 15 of We Can and Must do Better is welcomed and it is important that this is fully implemented as a matter of urgency.

1. There should be a national policy and practice initiative, which addresses the health needs of looked after children and young people, similar to that which has focused on the educational needs of looked after children. A key role for each health board director with responsibility for looked after children and young people and care leavers must be to drive continuous improvement in the health assessment and care of these children.
2. Each establishment should have a health improvement plan, detailing goals and actions to promote healthy diets, life-styles and oral care in accordance with key national health improvement messages, and support attendance at health appointments.
3. Building on best practice, it is important that multi-agency services are provided to support the mental health and well-being of children and young people in residential child care. CAMHS teams have a crucial role in offering direct help. All residential services should have access to specialist consultancy to find the best approaches to help individual young people. Residential staff should be equipped and supported to identify and assist with common, non-psychotic mental health problems such as depression and anxiety, as well as addictions.

8 The transition out of care

Research tells us that the important progress that young people make during their period in residential care is not always sustained after they leave. There has been recent attention to the needs of care leavers at 16+ in the *Sweet 16?* Report, but the statistics show that young people of all ages experience many placement changes in care and these transitions ought to be equally well planned and supported by the staff who work with them.

1. As emphasised in the comprehensive guidance on corporate parenting, *These Are Our Bairns*, it is critical that the transition out of care and out of secure care for all young people, regardless of age, is well planned and supported and that pathway plans are in place for all young people.
2. The legislation and policies that require or enable continued care and educational support after 16 should be implemented more effectively. The recommendations of *Sweet 16?* about the age at which children and young people leave residential care and the support they need should be embraced.

Endnotes and References

- ¹ The Minister's statement to Parliament, 7 February 2008, quote at column 5928: <http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-08/sor0207-02.htm>
- ² Shaw (2007); Frizzell (2009).
- ³ Scottish Institute for Residential Child Care (2008).
- ⁴ Securing Our Future Initiative (SOFI), (2009). www.sircc.org.uk/publications/documents/sofi
- ⁵ Independent providers included voluntary and private providers.
- ⁶ Association of Directors of Social Work and Association of Directors of Education Services.
- ⁷ Section 25 Children (Scotland) Act 1995.
- ⁸ Stalker (2008).
- ⁹ Hothersall (2006).
- ¹⁰ See e.g., Pringle (1980); Maslow (1964); Aldgate et al. (2006).
- ¹¹ Social Work Inspection Agency (2006).
- ¹² Kendrick (2008a).
- ¹³ The Scottish Office (1997), pp.70, 73.
- ¹⁴ As noted later in the report the number of these 'exceptions' has actually increased in recent years and a demand for short-to medium term residential care for younger children has emerged.
- ¹⁵ Kent (1997); Shaw (2007).
- ¹⁶ See e.g. Forrester (2008).
- ¹⁷ Ward (1995).
- ¹⁸ Such as Sir Ronald Waterhouse (author of Lost in Care, the North Wales Inquiry report) and more recently Martin Narey, The Chief Executive of Barnardos.
- ¹⁹ These are agreements reached by individual local authorities with the Scottish Government about their service and spending plans and priorities.
- ²⁰ Children's Voluntary Sector Policy Officers' Network (2009), p. 9.
- ²¹ i.e., compared with foster care.
- ²² For further information see the national Looked After Children website www.ltscotland.org.uk/lookedafterchildren.
- ²³ NHS Greater Glasgow and Clyde (2008).
- ²⁴ van Beinum (2008).
- ²⁵ Milligan and Stevens (2006).
- ²⁶ The statistics quoted in this report are the latest available to the group at the time of writing. On some matters, these will be more recent than others.
- ²⁷ Elsley (2008); Scottish Government (2008). <http://www.scotland.gov.uk/Publications/2008/08/29115839/0>.
- ²⁸ Children Looked After Statistics 2007-8 <http://www.scotland.gov.uk/publications/2008/11/25103230/1>
- ²⁹ In addition, just over 100 were in secure care and 52 in 'other residential accommodation': Elsley, (2008); Scottish Government (2008). <http://www.scotland.gov.uk/Publications/2008/08/29115839/0>.
- ³⁰ Stalker (2008)
- ³¹ Scottish Government (2008). See <http://www.scotland.gov.uk/Publications/2008/08/29115839/0>
- ³² All forms except for crisis and secure. Few authorities recorded use of crisis provision.
- ³³ Scottish Children's Reporter Administration (2008)
- ³⁴ Kendrick (1995); McPheat et al. (2007).
- ³⁵ Department of Health (1998); Social Work Inspection Agency (2008).
- ³⁶ Scottish Government. (2008).
- ³⁷ Elsley (2008); Scottish Commissioner for Children and Young People (2008).
- ³⁸ Scottish Government (2008).
- ³⁹ Milligan et al. (2006).
- ⁴⁰ Kendrick (2008b).
- ⁴¹ Scottish Government (2008); Scottish Children's Reporter Administration (2008).
- ⁴² Authorisations do not always result in a young person being placed in secure accommodation, although the majority do.
- ⁴³ Scottish Children's Reporter Administration (2008).
- ⁴⁴ Securing Our Future Initiative (SOFI) (2009).
- ⁴⁵ Scottish Government (2008); Elsley (2008); Securing Our Future Initiative (SOFI) (2009).
- ⁴⁶ Walker et al. (2006); Barclay and Hunter (2008).
- ⁴⁷ Securing Our Future Initiative (SOFI) (2009).
- ⁴⁸ See e.g. Securing Our Future Initiative (SOFI) (2009).
- ⁴⁹ Securing Our Future Initiative (SOFI) (2009).
- ⁵⁰ Data from Scottish Government via SOFI working group
- ⁵¹ Information provided by Scottish Government Information Services Division
- ⁵² Scottish Government (2007).
- ⁵³ Hothersall (2006).
- ⁵⁴ Daniel (2003).
- ⁵⁵ Bebbington and Miles (1989); Hill (2002); Hothersall (2006).
- ⁵⁶ Sinclair and Gibbs (1998).
- ⁵⁷ Milligan et al. (2006).
- ⁵⁸ Whitaker et al. (1998).
- ⁵⁹ Clough et al. (2006), p. 71; Bullock, (2009) p. 212 .
- ⁶⁰ Clough et al. (2006).

- ⁶¹ As one voluntary agency stated in its contribution to the inquiry into child and adolescent mental health services 'There seems to be little general understanding or common agreement of what the term 'mental health' actually means. For some it encompasses emotional health and well-being, whilst for others it is confined to actual diagnosed conditions'.
- ⁶² Public Health Institute of Scotland (2003).
- ⁶³ These have a wide range of social, educational, legal and emotional needs, as well as many strengths. Kohli (2007); Hopkins and Hill (2006).
- ⁶⁴ Independent Provider Survey.
- ⁶⁵ Triseliotis et al. (1995); Kendrick (1997); Sinclair and Gibbs (1998).
- ⁶⁶ Social Work Inspection Agency (2008), p. 6. Findings of SWIA Reports collated for the NRCCI.
- ⁶⁷ Adult stakeholder consultation.
- ⁶⁸ Milligan et al. (2006); Elsley (2008).
- ⁶⁹ Ofsted (2009).
- ⁷⁰ Stalker (2008), p 111.
- ⁷¹ See e.g. Berridge (1996); Shaw (2007); Frizzell (2009). Sadly, abuse has also occurred in the main 'alternatives' – foster care and return home.
- ⁷² Clough et al. (2006).
- ⁷³ Who Cares? Scotland (2009).
- ⁷⁴ All the quotations from young people are from the stakeholder consultation undertaken for the NRCCI by Who Cares? Scotland.
- ⁷⁵ Milligan (2009).
- ⁷⁶ Care Commission (2009b).
- ⁷⁷ Siebelt et al.(2008).
- ⁷⁸ Ofsted (2009).
- ⁷⁹ ADES submission
- ⁸⁰ Scottish Executive 2007; Francis (2008).
- ⁸¹ Connelly et al. (2008).
- ⁸² Hill (2009).
- ⁸³ Skuse et al. (1999).
- ⁸⁴ NHS Greater Glasgow and Clyde. (2008).
- ⁸⁵ NHS Greater Glasgow and Clyde (2007).
- ⁸⁶ Care Commission (2009b).
- ⁸⁷ Care Commission (2009b), p. 6.
- ⁸⁸ e.g. Meltzer et al. (2002); Meltzer and Lader (2004); Scott and Hill (2008); van Beinum (2008).
- ⁸⁹ Sinclair and Gibbs (1998); Walker et al. (2002).
- ⁹⁰ Dillane and Hill (2005).
- ⁹¹ Sinclair and Gibbs (1998).
- ⁹² Kendrick et al. (2004).
- ⁹³ Care Commission (2009b).
- ⁹⁴ O'Neill (2008).
- ⁹⁵ Whitaker et al. (1998).
- ⁹⁶ Whitaker et al. (1998); Taiminen et al. (1998).
- ⁹⁷ Cruickshank et al. (2008).
- ⁹⁸ Hill et al. (2005).
- ⁹⁹ Barry et al. (2008): http://www.whocaresscotland.org/report_this_isnt_the_road.htm
- ¹⁰⁰ Clough et al (2006).
- ¹⁰¹ Barclay and Hunter (2008).
- ¹⁰² Emond (2002).
- ¹⁰³ Kendrick (1997); Barter. (2008); Kirton (2009).
- ¹⁰⁴ Who Cares? Scotland (2009).
- ¹⁰⁵ Barter (2008).
- ¹⁰⁶ Attention Deficit and Hyperactivity Disorder.
- ¹⁰⁷ Elsley (2008).
- ¹⁰⁸ This includes one authority which slightly adapted the suggested range of answers to very well, reasonably well, not particularly well and very poorly.
- ¹⁰⁹ Skinner (1992).
- ¹¹⁰ Care Commission (2004).
- ¹¹¹ Possibly in some cases young people had been involved in plans or reviews, but the adults had not explicitly labelled the meetings as such.
- ¹¹² Elsley (2008).
- ¹¹³ Forrester (2008).
- ¹¹⁴ Independent Provider Survey.
- ¹¹⁵ Stein (2009).
- ¹¹⁶ Scottish Commissioner for Children and Young People (2008).
- ¹¹⁷ Dixon and Stein, (2005).
- ¹¹⁸ Francis. (2008).
- ¹¹⁹ Care Commission Bulletin (2009a)
- ¹²⁰ The Residential Unit Database – RUD.
- ¹²¹ Elsley (2008).
- ¹²² Disregarding private boarding schools, NHS provision and youth custody.
- ¹²³ This compares with 12 up to 1994.
- ¹²⁴ Some were called children's homes or houses.
- ¹²⁵ The SIRCC database recognises two other categories of provision: firstly youth homeless services usually run by local authority housing departments and not covered in these figures; secondly singleton services where one young person is cared for by a group of staff on a rota basis. This is a highly specialised form of residential unit.
- ¹²⁶ Securing Our Future Initiative (SOFI) (2009).
- ¹²⁷ Elsley (2008); Independent Provider survey.
- ¹²⁸ See Appendix 2.
- ¹²⁹ Elsley (2008); Milligan (2009).
- ¹³⁰ Milligan (2009).
- ¹³¹ Farmer et al. (2004); Walker et al. (2002).
- ¹³² Elsley (2008).

- ¹³³ Scottish Commissioner for Children and Young People (2008).
- ¹³⁴ Care Commission data.
- ¹³⁵ See e.g. Moore et al. (1998).
- ¹³⁶ These comprise the Royal Blind School (RBS), Donaldson's School for the Deaf, Corseford and Stanmore (Capability Scotland), East Park and Harmeny.
- ¹³⁷ Bullock et al. (1993a); Triseliotis et al. (1995); Hicks et al. (2007); Bullock (2009).
- ¹³⁸ ADES submission.
- ¹³⁹ e.g. Payne (1981); Bullock et al. (1993b)
- ¹⁴⁰ Sinclair and Gibbs (1998).
- ¹⁴¹ Whitaker et al. (1998)
- ¹⁴² Clough et al. (2006).
- ¹⁴³ Triseliotis et al. (1995).
- ¹⁴⁴ Triseliotis et al. (1995); Sinclair and Gibbs (1998); Siebelt et al. (2008).
- ¹⁴⁵ Clough et al. (2006).
- ¹⁴⁶ See e.g. Beecham and Sinclair (2008); Ward et al. (2008).
- ¹⁴⁷ Hicks et al. (2007).
- ¹⁴⁸ Lawlor. (2008).
- ¹⁴⁹ See Chapter 1
- ¹⁵⁰ Scottish Government (2006).
- ¹⁵¹ 2006.
- ¹⁵² ADES submission.
- ¹⁵³ e.g., Hill (2002); Schofield and Simmonds (2009).
- ¹⁵⁴ Including the opportunity to complain directly to the Care Commission.
- ¹⁵⁵ Hudson (2000).
- ¹⁵⁶ Findings of SWIA Reports collated for the NRCCI.
- ¹⁵⁷ and other stakeholders including parents.
- ¹⁵⁸ Scottish Commissioner for Children and Young People (2008).
- ¹⁵⁹ Care Commission (2009a).
- ¹⁶⁰ Social Work Inspection Agency (2008) Findings of SWIA Reports collated for the NRCCI.
- ¹⁶¹ Scottish Commissioner for Children and Young People (2008).
- ¹⁶² The English/Welsh framework 'Every Child Matters' contains within the standard national contract a range of outcomes and indicators which might inform this.
- ¹⁶³ Guided also by the Children (Scotland) Act 1995 and Government policies like GIRFEC.
- ¹⁶⁴ Frizzell (2009).
- ¹⁶⁵ Berridge and Brodie (1998).
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Higher Aspirations, Brighter Futures:

NRCCI Matching Resources to Needs Report

Appendix 1

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For a full list of the Project Board and membership of the other working groups, see the NRCCI Overview report.

¹ Association of Directors of Education

² Association of Directors of Social Work

³ Educating through Care Scotland

⁴ Secure Care Forum

Appendix 2

Number of residential units/schools and places in Scotland, early 2009

Based on national data collated from the SIRCC and Care Commission Databases
by Ian Milligan and Bryan Livingstone

A. 'Looked After Children' Provision (non-disability)

	Voluntary sector schools /units	Voluntary No. of places	Local Authority schools /units	LA No. of places	Private sector schools /units	Private No. of places	Total No. of schools /units	Total No. of places
Residential (WITH education)	10 schools		0		21 (10 schools, 11 units)		31	
		281		0		286		567
Residential (WITHOUT education)	18		101		43		162	
		68		632		132		823
Secure (WITH Education)	5		2		0		7	
		90		16		0		106
'Close support' units: ('alternative' and 'adjacent' to secure)	6		4		0		10	
		49		20		0		69
Total no. of units	39		107		64		210	
Total no. of places		488		668		409		1565

B. Disability sector

Disability services (WITH education)	11 schools		2 schools		0		13	
		344		15		0		359
Disability Services (WITHOUT education), i.e. longer-term care	5		2		1		8	
		26		8		10		44
Disability Services (respite)	25		10		1		36	
		141		52		10		203
Total no. of units	41		14		2		57	
Total no. of places		511		75		20		606

Appendix 3

Number of children in residential resources – local authority survey figures

(N = 22 authorities , 1182 children)

January 30th 2009

Type of resource	LA in-house provision	External provision	Total
Children's homes	364 86%	57 14%	421
Residential schools	0	268 100%	268
Homes for children with disabilities or complex needs ¹⁶⁷	83 43%	110 57%	193
Res. schools for children with disabilities	4 4%	101 96%	105
Young homeless services	48 61%	31 39%	79
Secure care	2 5%	37 95%	39
Children's homes with education from care provider	4 15%	22 85%	26
Close support units	2 10%	19 90%	21
Singleton services	0	20 100%	20
Other	0	10 100%	10
Not specified	196	51	247



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