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*Supporting Adolescents on the  
Edge of Care.*

*The role of short term stays in  
residential care.*

An Evidence Scope.

Jo Dixon, Jenny Lee, Sarah Ellison and Leslie Hicks.

## The Evidence Scope

was commissioned by The NSPCC and Action for Children. It was carried out by Jo Dixon (Honorary Research Fellow, University of York), Jenny Lee and Sarah Ellison (Independent Research Consultants) and Leslie Hicks (academic consultant, University of Lincoln).

# Supporting Adolescents on the Edge of Care. *The role of short term stays in residential care.*

## An Evidence Scope.

### Acknowledgments.

Many people have given their time, expertise and knowledge in the completion of this evidence scope. We would like to extend our sincere thanks to all of them. We are grateful to managers and staff from local authorities and from other agencies working with vulnerable young people, who responded to our E-survey with views and examples of edge of care provision. Also, many thanks to the practice, policy and academic contributors (nationally and internationally) who gave up time to take part in interviews to share their experiences and wisdom of provision for adolescents in and on the edge of care. We are also grateful to Moorside Respite Residential Unit in County Durham for allowing us to visit (again) and carry out a focus group with staff.

We also owe a huge thanks to those who were able to assist with distributing the E-survey on our behalf – due to the very short time window for our data collection, this proved invaluable – so thanks to all including Kate Shethwood from ADCS, Mandy Wilkins from NSPCC, Emma Smale from Action for Children and Paul Bunker of the Northwest Aftercare Forum. Thanks also to Judy Sebba from the Rees Centre for providing information on the DfE CSCIP projects and securing permissions for us to include example's in the report. The full list of contributors can be found in the Annex 3. Finally, we would like to acknowledge support from the University of York for providing the research team with an office base and facilities within the Harry Fairhurst research hotel, to carry out the evidence scope.

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# 1. Introduction.

## The Evidence Scope

The evidence scope was commissioned by the NSPCC and Action for Children (AFC) to gather material on provision for adolescents on the edge of care and their families. The remit requested a particular focus on innovative approaches, including an exploration of the use of respite stays in residential units.

What became apparent from the start of our exploration was the surge in attention over recent years around edge of care needs and provision within policy and research. This has already been captured in a number of recent literature reviews and reports, two of which provide comprehensive and informative discussions of the literature and research currently available on adolescents on the edge of care (see ADCS, 2013 and Bowyer and Wilkinson, 2013). Given the availability of this detailed literature, the aim of this evidence scope was to build upon the available evidence by drawing together some of the key learning from the existing reviews and adding to this knowledge base by gathering new primary data from policy and practice stakeholders and leading academics on the ways that services can best support this group. This involved carrying out surveys and telephone interviews with children's services providers and experts across the UK and internationally, to gather practice evidence on the range of edge of care provision. This report, therefore, draws together new data based on current practice and learning to enhance evidence from existing sources. In doing so, we hope to further the debate on how edge of care provision for adolescents is currently defined and utilised and to identify scope for its future potential.

The evidence scope took place from February to April 2015.

## Report Structure

**Chapter 1** introduces the evidence scope and the structure of the report.

**Chapter 2** outlines the background of the evidence scope, describing the rationale for commissioning the report and what it set out to achieve. The chapter outlines the high numbers of adolescents entering care, the need to consider the reasons for this, and the context for seeking alternative options to support young people. It provides a brief review of literature on adolescence and the particular needs and challenges facing them as they move through their teens towards early adulthood. A more detailed overview of the literature on understanding adolescents, their needs, why it might be that adolescents form the single most common age-group to come into care is provided in Annex 1.

**Chapter 3** provides a brief overview of the aims of the evidence scope and methodological approach to gathering and analysing evidence for the report. A more detailed description of the three key work strands involved in gathering data and how it has been utilised throughout the report is provided in Annex 2.

**Chapter 4** examines how the ‘edge of care’ is described and defined. It looks at how the term evolved and how it is being interpreted to develop and deliver services to young people at risk of entering care and to identify edge of care service users. The chapter explores how different services and local authorities vary in how they use and target edge of care provision and considers the usefulness of the term, examining the complexities and challenges associated with the definition and operation of edge of care support.

**Chapter 5** Provides a brief overview of existing support for families experiencing difficulties. It reviews the development of interventions and initiatives for adolescents and families on the ‘edge of care’ and the current evidence on effectiveness and considers the scope for developing a different approach that incorporates a menu of responses to need, including respite /shared care (and within this, residential respite, foster care respite and kinship respite).

**Chapter 6** focuses on examples of the range of respite provision for young people. It brings together some of the evidence of from national and international models of respite for different groups of young people to consider what learning can be taken to inform the development of its use to support adolescents on the edge of care.

**Chapter 7** uses case studies and practices examples of residential respite services to highlight promising practice. It draws upon data gathered from interviews, focus groups and reviews of service monitoring reports to provide an overview of the issues associated with operation of the service, the target group and approaches to supporting the adolescent and their family. In doing so it suggests learning points on the potential and challenges of operating such a service.

**Chapter 8** draws together the evidence to highlight key learnings and implications for future policy and practice for supporting adolescents and their families.

### Terminology and Definitions

**Adolescents/ Adolescence:** For the purpose of this report and consistency with existing reviews, we have used the following definition: *‘Those roughly between the ages of 10 and 18. Early adolescence is seen as the period between 10 and 13 years of age; mid adolescence between 13 and 16 years; and late adolescence from 16 into the final teen years’* (Hanson and Holmes, 2014).

**Edge of Care:** The boundaries around care provision involve several points where transition may occur. These include entry from home for the first time, returning home, or moving on to independent living. For the purpose of this report, we consider ‘edge of care’ mainly in terms of going into care. Even so, this may include young people who have no prior experience of being in care as well as those who have been in care in the past and for whom reunification attempts have failed. Definitions are discussed in chapter 4.

**Respite/short term care:** The terms used to describe short stays in care include respite, short term care, short breaks, short stays and shared care. These terms are used interchangeably throughout the report to reflect their usage in the literature and practice evidence. They generally refer to the use of a foster or residential placement or a voluntary carer to provide a time limited short break or a series of short breaks from the young person’s home with the long term aim of supporting the family and preventing family breakdown.

**Therapeutic:** The term therapeutic has been generally used to indicate the presence of a treatment-like intervention or approach designed to have a beneficial effect on adolescent and /or family wellbeing, functioning or personal circumstances. In some instances, we also refer more specifically to a particular therapeutic model, and provide a more precise description of the approach.

## 2. Background: *adolescents on the edge of care.*

This chapter sets out the rationale for the focus of the evidence scope on adolescents. It outlines the evidence on care and post care experiences for older children who currently enter care. It also summarises key evidence on the distinct needs and challenges experienced by the adolescent group and the current service response to meeting these needs. A more detailed overview of the literature on adolescence is provided in Annex 1.

### Background and Rationale

The impetus for the evidence scope arose from three key observations: 1) the distinct needs and vulnerabilities of adolescents and the high number that come into care; 2) the tendency towards poorer outcomes for adolescent entrants to care; and 3) the need to develop more innovative support for adolescents and their families as a means of preventing family breakdown and entry into care. This chapter briefly considers current knowledge around these issues to set the context for the evidence scope.

### Adolescents Entering Care

Adolescents make up the largest age-group within the care population at any single point. This is a combination of the numbers who enter as young children and stay long term, the group Sinclair and colleagues (2007) term ‘adolescent graduates’ and the number who enter as older children ‘adolescent entrants’<sup>1</sup>. National statistics over the past decade on the age profile of the care population confirm that adolescents aged 10 -15 make up the largest age-group of young people within in the care system (37%) (DFE, 2015).

Furthermore, 10-15 years is the most common age-range for *entering care* (28%), which, coupled with the recent rise in the number of young people aged 16 and over entering care (15%) means that almost a half (45%) of entrants last year were adolescents aged 10 – 17 (DFE, 2015). Though neglect is the most common reason for entry to care, evidence shows

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<sup>1</sup>Sinclair et al, 2007 distinguish between two groups of adolescents in care. Adolescent Graduates are those who entered the care system before the age of 11 and are now aged 11 or over. Adolescent Entrants enter the care system aged 11 or above.



that almost half of adolescent entrants come into care as a result of acute family stress, socially unacceptable behaviour or when family circumstances reach crisis point and breakdown (Godor, 2014).

Evidence also suggests that adolescent entrants are likely to have endured longer exposure to family adversity and unmet needs. Research carried out over the past decade shows that many adolescent entrants have been known to social services for several years prior to care (Biehal, 2005; Dixon and Biehal, 2007) and that around half are likely to be re-admissions (Sinclair et al 2007), having therefore experienced one or more unsuccessful attempts to return home to family. This '*oscillation*' between home and care (Farmer et al, 2011), combined with the difficulties that brought them to the service in the first instance means that those who enter care as adolescents are likely to do so with more complex histories and needs. Boddy et al (2009) found that compared to adolescents who entered care for the first time, those re-entering as adolescents tended to spend less time in care, were more likely to be accommodated voluntarily (Section 20) most often in a residential unit, and more likely to be placed owing to family difficulties or problem behaviour than requiring protection due to abuse. Perhaps not unexpectedly therefore, research carried out by Wade, Biehal and colleagues (2011) on outcomes for young people who stay in care and those who return home found, in accordance with earlier studies, that children who experienced moves in and out of care or '*unstable reunions*' were amongst those who had the worst overall outcomes. This and earlier work carried out by Sinclair et al (2007) highlights lack of support for the wider family to help them prepare for and sustain a return home, as a key factor in the failure to resolve difficulties and avoid further maltreatment or family breakdowns that result in readmissions to care.

Statistics show that once in care children and young people tend to stay in care for relatively short periods of time. Data gathered by government in 2013 show that 45% of those ceasing to be looked after had been in care for less than one year and around one third for less than six months (DFE, 2014). Reunification is therefore the most common outcome for all children entering care. However, as noted above, sustaining return home requires effective planning and support. Evidence shows that the likelihood of successful reunification is enhanced where return home is gradual or '*staged*' and supported by specialist work with the young person and family to address the difficulties that brought them to the attention of children's social care in the first place. Importantly, proactive planning and assessment to establish the parents/family's capacity to change and sustain that change prior to the child's return has been found to be a key factor in successful reunification (Thoburn et al, 2012; Hyde-Dryden et al, 2015 ). This is supported by Boddy

and colleagues recent research that reports: *'proactive planning and work with parents, plays a major role in the success or failure of reunification'* (Boddy et al, 2013). A literature review carried out by Ward and colleagues to further understanding of the factors that impact upon parental capacity to change, shows that assessing the needs of vulnerable families and their capacity for change is complex and relies on a number of variables. These include the nature of the adolescent and parent difficulties, the family environment and stressors, the level of post care support, and engagement with support, as well as the ability of professionals to form effective relationships with family members (Ward et al, 2014).

### Outcomes for Adolescent Entrants

The picture for adolescent entrants, who do remain in care, appears somewhat bleak for a considerable number who, after unsuccessful experiences of care, go on to experience difficulties after care. Research shows that they are less likely to settle in their care placements and thus experience greater placement breakdown, instability and an increased likelihood than younger children to be placed in residential care subsequent to foster care breakdowns. Research suggests that, in this sense, residential care can often be seen as a last resort and an option for more challenging young people. (Sinclair et al, 2007; Dixon et al 2006; Biehal, 2008). Existing research on adolescent entrants transitioning to independence from care shows that there is a higher tendency to leave care earlier and to do so with greater difficulties and poorer outcomes than those who enter care as younger children and who find stability. Research on care leavers has shown that those who entered care aged 14 and above fared worse than younger entrants in terms of educational outcomes and preparation for independent living. They were also more likely to leave care earlier at 16 or 17, and were more likely to experience poor outcomes in post care housing stability and participation in post-16 education, employment and training (Dixon et al 2006; Stein, 2012). In addition, research and practice evidence point to links between care and custody for adolescents, A review due to be completed by the Prison Reform Trust in 2016, reports a need to understand why looked-after children aged between 10 and 17 are five times more likely to be convicted, or subject to a final warning or reprimand, than other children (see community care 2015 <http://www.communitycare.co.uk/2015/06/23/lord-laming-review-high-proportion-children-care-end-prison/>)

### Understanding and Responding to Adolescent Needs

In considering some of the reasons why adolescents form the most common age group to enter care, research and practice evidence directs us to the changes and challenges that occur during the adolescent life stage and the current service response to addressing the particular needs. This section provides a brief overview of current knowledge of the adolescence (see Annex 1 for a more detailed discussion). In doing so, it aims to contextualise the particular needs of adolescents, especially those from more troubled or complex backgrounds, and how, as discussed in following chapters, these needs might be most appropriately addressed.

Existing evidence shows that the time around the teenage years, ‘adolescence’, can be a time of considerable change and opportunities. It also shows that it can prove to be a difficult period to navigate and an increasing body of research provides some insight as to why this might be and why for some it can be a distressing and destabilising time for the adolescent and their family.

There is a well-established understanding of the effects of physical development and changes that take place during adolescence, related to puberty and the emotional and behavioural impact of hormonal changes upon young people. Alongside this is a growing body of research on the development of the adolescent brain and how these changes can impact upon emotional and behavioural responses. For example, research suggests that changes to the structure and functioning of the brain during early teens to early adulthood predispose adolescents to risk taking behaviour, a lower capacity to self-regulate and control reactions and the need to seek peer approval and succumb to peer pressure. This goes some way to explaining what can be perceived as the more challenging characteristics of the typical adolescent, which for some families, might prove difficult to cope with (see Annex 1, Collins and Laursen, 2004; Hanson and Holmes, 2014; Blakemore et al, 2006 and 2015; Steinberg, 2010).

These developments and changes during adolescence can be amplified or altered for some young people who have experienced past trauma or maltreatment. Research that seeks to understand the impact of maltreatment on the development of the brain, and also on emotional and behavioural development throughout childhood and into adulthood, has highlighted the potential impact of negative past experiences on continued vulnerability. For example, coping mechanisms can lead to maladaptive responses, which either place young people at further risk of harm by others (see Dutton and Painter, 1993; DePrince, 2005 in Hanson and Holmes, 2014 p19.) or lead to angry or violent outbursts or ‘defensive aggression’ (Farmer et al, 2011) that are perceived as problematic or antisocial behaviours.

Further evidence has drawn links between early childhood deprivation and trauma and adolescent risk behaviour such as truancy, offending, substance misuse and running away. Such: *'adolescent behaviour that heightens risk is often part of an adaptive response to maltreatment and adversity in earlier childhood'* (Hanson and Holmes, 2014).

Coupled with a greater propensity to risk taking and challenging behaviour, are the growing need and opportunities for independence and autonomy, which, researchers have shown, are likely to lead to increased exposure to sources of risk and harm for adolescents than might be the case for younger children (Rees et al, 2011). This can lead to a clustering of risk and vulnerabilities during adolescence including substance misuse, gang involvement, running away, cyber bullying, intimate partner violence and child sexual exploitation (Hanson and Holmes, 2014). A heightened risk of harm from others also includes adolescent maltreatment, most commonly in the form of neglect by parents, which a review of teenagers who had died reported was more prevalent amongst 10-15 year olds than any other age group (Brandon et al, 2014; Radford et al, 2011).

Despite these risks, current evidence suggests a lack of understanding and appropriate response from services in respect of adolescent needs around neglect and risk (see Stein et al, 2009). This might be a consequence of the complexities involved in defining adolescent neglect and in turn, the difficulties in detecting it and developing the necessary interventions required to prevent it (Rees et al, 2011). This is partially explained in terms of adolescents having different parenting needs as they mature, making it less apparent as to whether a parental response is neglectful or an acknowledgment of the adolescent's increasing independence.

A further explanation for what commentators describe as 'service neglect' of adolescents, is the assumption that adolescents are more resilient and thereby require less protection from maltreatment than younger children (Rees et al, 2011). This misconception can impede detection of harm for adolescents and can even serve to justify a lack of intervention (Rees et al, 2011; Interview with Professors Mike Stein and Nina Biehal, 2015). Furthermore, some research in fact suggests that maltreatment in adolescence may have more wide reaching and serious effects than maltreatment experienced in early childhood (Thornberry et al. 2010).

Subsequently, the lack of understanding and focus on adolescent risk and neglect and limited investment in adolescent safeguarding has also tended to reflect the targeting of

scarce resources on areas traditionally considered to have greatest need and a greater chance of impacting on positive outcomes; that being early childhood.

A greater understanding of the adolescent life stage and the vulnerability to risk and harm is therefore, important to enable the development, funding and delivery of age appropriate services. The current research and practice evidence around the impact of adolescent changes and challenges suggests a greater need at policy level to invest in teen focused services and options that provide more tailored support for adolescents and their families. This might include support and interventions in which adolescents themselves have greater participation in services design and delivery to ensure they receive the types and levels of support at the time they are most needed.

Greater investment in and development of support options could both reduce, where appropriate, the need for full-time care, which arguably for some adolescents can be more harmful than helpful, and provide more effective preventative and reunification support to avoid family breakdown.

In all, therefore, there is strong evidence that adolescence can be a time of significant change and exposure to risk and harm. Furthermore, adolescents on the edge of care and entrants to care bring with them a distinct set of needs and many (though by no means all) are vulnerable to a less positive experience of care. Whilst for some, care is the most appropriate option, others may well benefit from alternative approaches to addressing difficulties and meeting their needs as well as those of their families, whether prior to entering care, on reunification or both. The recent Research in Practice evidence scope on service response to adolescent needs, concludes that in knowing more about the risks facing adolescents and what can build resilience and meet their needs and the recognition that, despite some examples of good practice, there is an overall ineffective and archaic service response means '*the case for system-wide change becomes compelling*' (Hanson and Holmes, 2014). In the following chapters we will build on this to consider how the needs of troubled adolescents and their families are met, how best to work with adolescents and their families when the challenges require intervention and what changes to the current system might be required to accommodate more effective support. The report will focus on the use of alternative approaches to care for supporting adolescents and their families, including primarily, the use of residential care to provide edge of care respite alongside a programme of family support as part of a preventative strategy.

### Summary Points:

- Adolescents aged 10 -15 make up the largest age-group of young people within the care system (37%) at any one point (DFE, 2015).
- The most common age range of new entrants to care is 10 – 15 years.
- Evidence suggests that most adolescent entrants have had previous care episodes and have been known to children’s service for several years, suggesting a history of need.
- Research indicates that adolescents in and leaving care tend to have complex histories and corresponding needs.
- Adolescence is a time of immense change in all areas of young people’s lives. Consequently it brings with it a distinct set of needs that require a distinct and service response.
- An understanding of the complexities of adolescent development and the potential impact it can have on emotions, behaviour and interactions can help parents, carers and services better meet the needs and challenges of their adolescents.
- Research shows that despite (and in some case because of) their growing autonomy and developing maturity, adolescents are vulnerable to harm, either from their involvement in risk-taking behaviour or from those they encounter who may pose a risk, including parental maltreatment.
- For a number of reasons, including young people’s growing for independence and perceived resilience, service responses frequently fall away as the transition to adulthood approaches.
- Evidence suggests a strong case for service investment in developing support for this age group.
- Whilst care might be the safest and most appropriate option for some adolescents, others might benefit more from a whole family support package to smooth and sustain living at home.

## 3. Aims and Methodology.

### The Aims of the Evidence Scope

The evidence scope aims to:

1	<ul style="list-style-type: none"> <li>• Understand more about adolescents on the edge of care, their families and their needs.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Define the parameters of edge of care.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Identify existing evidence for effective interventions and family support with a particular focus on the the use of residential care as an edge of care service.</li> </ul>

Our methodology was designed to specifically address the key questions raised in the research tender.

The evidence scope comprised three interconnected work strands:

1. Evidence searches of literature, practice and key contacts in the field.
2. Primary data collection from practice, policy and research experts. This included an electronic survey of strategic leads and managers for children's social care across local authorities, with a modified version for other agencies/organisations, to explore the use of respite provision for adolescents on the edge of care alongside family support. Telephone interviews with 20 key informants from policy, practice and research were carried out in addition to two expert focus groups with practitioners, managers and academics to gather more detailed information.
3. Development of illustrative case studies to highlight examples of practice.

An evidence matrix was developed to include the topics and sub-questions and was used to ensure that relevant information was captured during the work strands. Each work strand contributed a further layer of evidence for each question. As the matrix evolved we were able to cross-reference this evidence (e.g. evidence from the literature review and survey was explored during telephone interviews and expert focus groups). This triangulation of



the data provided a more detailed exploration of issues arising from the each stage of the evidence scope.

As the evidence scope involved contacting local authorities, an application was made to The Association of Directors of Children’s Services (ADCS) and approval was granted on 4<sup>th</sup> March 2015. We also sought a review of our proposed methodology from a virtual meeting of an ethics panel comprising research academics at the University of York. The panel confirmed that they were satisfied with the research team’s approach and adherence to research ethics. In addition, ethical approval was provided by the Ethics Committee at the School of Health and Social Care, University of Lincoln. Contributors to the evidence reviews were asked for permission to reference them directly. A small number preferred anonymity.

<i>Evidence Source</i>	<i>Number completed</i>
<i>e- survey (LA)</i>	<b>19</b>
<i>e- Survey (other organisation)</i>	<b>5</b>
<i>interview with practice expert</i>	<b>11</b>
<i>Interview with policy expert</i>	<b>3</b>
<i>Interview with academic/research expert</i>	<b>6</b>
<i>Focus groups (1 practice + 1 academic)</i>	<b>2</b>

A detailed description of the full methodological approach is provided in Annex 2.

**Summary Points:**

- Primary evidence on practice was gathered via data collection from **36** respondents to an electronic survey (e-survey), telephone interview or focus group discussion.
- Interviews and focus group discussions were also carried out with **13** policy and academic experts.
- Survey and interview data were subjected to thematic analysis to explore common issues and experiences. Telephone interviews and focus group discussions were recorded or noted in detail and subsequently summarised and analysed.
- Two ACCESS databases were constructed for data storage and processing. One was created for contact details and a second recorded all evidence gained from the separate strands.
- Information on 14 examples of current residential short breaks/respite was included in the study.



## 4. The Edge of Care.

As discussed in Chapter 2, the number of adolescents entering care is high, making up the most common age-range within the care population. Yet many stay in care for relatively short periods of time before returning to families. For those adolescent entrants who oscillate between home and care and those who remain in care, the experience and outcomes can be poor, characterised by instability and early and ill-prepared transitions to independent adulthood and longer term difficulties (Sinclair et al, 2007.) In addition, research shows that the adolescent life stage brings with it distinct needs and vulnerabilities due to young people's increased susceptibility to shifting emotional and behavioural states and exposure to risky situations or neglect (see Annex 1). Despite this, research suggests that targeted adolescent support has traditionally been a neglected area of policy and practice focus, resulting in the risk of unmet needs and a lack of policy and service investment and provision.

In all, this suggests a strong social and moral incentive to consider how best to meet the needs and improve the experiences and outcomes for these young people. This is reinforced by a financial imperative across local and national government to cut the costs of expensive care placements, by reducing the numbers who enter care and reconsidering the nature of that care. Taken together, these elements have served to reinvigorate the case for a wider range and greater number of effective preventative approaches that can target young people who are on the brink of care. But how do services accurately identify the edge of care group? How do practitioners know which families and young people will most benefit from remaining together and which would benefit more from a care placement? Furthermore, how do services know where the edge of care begins and ends? This chapter draws together evidence on the characteristics of the edge of care group, what the edge of care means in practice, and considers some of the opportunities and challenges related to defining the edge of care.

### Policy Background for Edge of Care Support

Although the term is relatively recent, the principle of edge of care support has been evident in policy and practice for many years, though it has not always been in favour. Literature suggests that 'edge of care provision' is most commonly associated with support offered under the prevention umbrella. Nina Biehal's work on prevention provides a useful outline of the evolution of preventative provision in UK legislation and practice. The Children and

Young Person's Act (1963) was the first legislation to lay down a statutory duty to provide assistance to families to prevent the need for young people to enter care. This was followed by the Children and Young Person's Act (1969), which introduced 'Intermediate Treatment' and which led to a swell in preventative activity until criticism of its potential for labelling children and families, and its net-widening effects, resulted in a decline in use (Thorpe et al, 1980). Although this was compounded by a series of high profile inquiries into child abuse in the 1970s, which resulted in increased entry to care, there was a resurgence of interest when policy placed an emphasis on prevention through the Children Act 1989, which laid down a duty to offer family support (Department of Health, 1995). Edge of care and preventative support has continued to receive policy attention throughout the decades thereafter, including the *Every Child Matters* agenda, which proposed a three-tiered strategy for services to support young people and families including, in the third tier, services to support families experiencing difficulties (Department for Education and Skills, 2004). Additionally, the *Care Matters* agenda emphasised the need for services to support young people thought to be 'on the edge of care,' in order to prevent the need for them to enter care in the first place or to rapidly return them to their families if they did enter (Cabinet Office, 2006).

Over the past decade, however, the pendulum between prevention and care appears to have been weighted towards entry to care. This in part has been driven by several high profile cases and serious case reviews involving the deaths of children (e.g. Peter Connelly, see DFE, 2010) and others who might have been considered on 'the edge of care'. This is sharply demonstrated by the current record high number of children in care in England, which has seen a 7% increase since 2010 and at 68,840 is the highest in almost twenty years (DFE, 2015). In addition, the number of children in contact with social services has also increased. Current government figures showed a 33% rise in the number of children subject to child protection plans and a 42% increase in Section 47 (child protection enquires) over the past five years (Children and Young People Now, 2015). The high numbers, however, cannot be explained solely by concerns around service failures to detect risk. The recent economic climate has impacted greatly on family life. The high number of families reported to rely on food banks indicates the increased levels of need amongst the more vulnerable sectors of society<sup>2</sup> and cut backs to both statutory and non-statutory services have included a decline in family, child and youth support services, perhaps arguably more so for older children.

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<sup>2</sup> People given three days emergency food supplies has risen from 61,468 in 2010/11 to 1,084,604 in 2014/15 (Trussell Trust, 2015: : <http://www.trusselltrust.org/stats> ).

*‘Services for children and young people have also been reduced, including after-school activities, holiday clubs, play centres and youth clubs – services which can be thought of as at the ‘soft’ end of preventative work.’ (Hastings et al, 2015.)*

In such a climate, the increased numbers coming to the attention of children’s social care may have few options other than to enter care – a situation that brings heavy emotional, personal and economic costs to the young person, family and wider society. This has brought a number of calls within the children’s social care sector for greater investment, options and innovation in the way that services protect and support vulnerable children and their families:

*‘In the immediate future it is critical that government recognises that resource must keep up with demand as well as encouraging further innovation. In longer term, however, there needs to be a more fundamental rethinking of how as a society we keep children safe from abuse and harm’ (National Children’s Bureau, see Children and Young People Now, 2015).*

As Biehal (2008) comments, therefore, *‘research and policy attention to the prevention of entry to care has waxed and waned’*. The recent focus on edge of care, demonstrated not least by the DFE’s Children’s Social Care Innovation Programme (CSCIP) and related funding, clearly reflects a desire to boost the development of services and explore new approaches to supporting adolescents thought to be at risk of care and once again this has become an important feature of the policy and practice landscape. As we will see from the collected evidence in this and subsequent chapters, to be most effective, preventative edge of care services and interventions need to be clearly defined and accurately targeted, at both a local and national level.

### Complexities in Defining the Edge of Care

The term ‘edge of care’ has become general shorthand for defining children and families with a high level of need, such that an immediate or potential risk of family breakdown is present and entry to care is imminent. Research in Practice (RiP) has recently captured this as:

*‘Those children whose safety and well-being are at sufficient risk for the authority to consider removing them from their current situation for their own protection’ (Bowyer and Wilkinson, 2013).*

This is reflected in an Ofsted survey that defined young people on the edge of care as:

*‘Those young people ... for whom entry into care had been considered by the local authority, either on a voluntary basis or through legal proceedings, but who had not entered care’ (Ofsted, 2011).*

Beyond those families in real crisis, where breakdown is imminent and identification more clear cut, there are, however, many more whose difficulties are significant, often chronic, but less obvious or crisis driven. It is for these families, that eligibility for ‘edge of care’ status is much more difficult to determine and around whom it is very difficult to draw clear boundaries for service intervention of any kind in the first place and beyond that, for the appropriate level of service intensity.

This dilemma reflects the complexities of assigning a definition or set of criteria to edge of care services and service users, and was a message loudly echoed throughout existing edge of care evidence and also in the views of policy, practice and academic contributors to this report.

Asmussen et al (2013) for example, conclude more liberally than RiP, that the term ‘edge of care’ can be applied to all children who are receiving a variety of support services aimed at preventing a permanent care placement. However, this potentially encompasses a range of services that some local authorities would not necessarily define specifically as ‘edge of care’.

In some instances, the blurring of the boundary is keenly apparent in comparison with previous ways of working. For example, some adolescents already in care might be considered to be on the edge of care:

*‘Actually, lots of the work that we used to do previously would be around reunification, so actually children on the edge of care might have been children that we worked with in our children’s homes that were actually then returning home and we would do that family link, to keep the services running. That isn’t happening at the moment. I think it will as people look at more creative and innovative ways of working again’. (Jill Sheldrake, Service Director, The Together Trust - Interview, March 2015.)*

The challenges involved in locating the edge of care are further articulated by Mike Stein :

*'It's complex, you can't have an absolute definition....the definition to a large extent would depend on the local authority thresholds for intervention and the criteria used to inform those thresholds. In some local authorities there will be very little difference between young people on the edge of care and those in care.... In our work on neglect, in and out of care groups have very similar backgrounds, looking at family circumstances, instability, chaotic lives.'* (Mike Stein, Focus group discussion March 2015.)

In addition to varying area based thresholds, criteria for receiving edge of care services will also be influenced by local authority and age-related variation in access to support services, such as CAMHS or other interventions:

*'A young person with mental health problems might remain on the edge of care if they have access to CAMHS yet in another area they may not have access to those services and therefore care is used as an intervention. So in one area they will be out of care because they have access and in another they would be in care because of the lack of access'* (Mike Stein, Focus group discussion March 2015).

This supports the findings of Ofsted inspectors, who in the course of conducting their 2011 survey noted that in practice, 'edge of care' was defined differently by different local authorities. Ofsted noted a small number of survey respondents who had not been seriously considered for care proceedings were also provided with edge of care services, in order to prevent their situations deteriorating and reaching the stage where entering care became a serious risk. This variation indicates the inherent difficulty of identifying a clear threshold for edge of care services (Ofsted, 2001).

In addition to broader operational variation across local areas, there is evidence that access to preventative and 'edge of care' provision varies within local areas depending largely on the individual service or support worker that first responded to the difficulty. This issue was apparent in Nina Biehal's research:

*'In my adolescent study, it could be whose door you knocked on first basically, so if a parent was coming to social services because of [the] child's behaviour and says 'I can't have him, I'm leaving him here' then they become by definition 'edge of care', but if they had gone to the police first he might be a young offender and go through a different process, or perhaps they go through a GP or CAMHS route. It felt almost*

*arbitrary where they ended up getting help, if they got any at all, it was where they presented or were picked up' (Nina Biehal, Focus group discussion March 2015).*

Attempts to address the problem of different routes into and around services for child and family difficulties is to some extent reflected in the development of specific teams within local authorities, sometimes called adolescent support teams, and in the various examples of multi-agency approaches that have appeared over the years, though these have often focused on younger children (for example, Sure Start). However, it remains contested as to whether this has eased the process of identifying the edge of care cohort and addressing their needs. There remains evidence of service drift or service *hand offs* where adolescents and their families are passed from one service to the next, experiencing multiple workers, repeated and numerous assessments and making little or no gain, until difficulties escalate to crisis point (Biehal, 2005).

Current endeavours to avoid this scenario are evident within the DFE's CSCIP initiative, which includes a raft of proposed changes to ways of working with adolescents on the edge of care (see Annex. 5). Several programmes have developed a one door access point to a multi-agency hub, which, further to assessment, will allocate a single worker who will stay with the adolescent and family from early intervention support through the various pathways, whether home based support, specialist intervention programmes, entry to care, reunification or transition from care to independent living. This was highlighted during interviews with key stakeholders during the course of this evidence scope.

*'The new mantra is 'one referral, one plan, one worker' taking the child through the pathway of intervention. We are reconfiguring existing staff and commissioning structures to maximise this approach...so the police, mental health, social worker, youth worker, Connexions worker, the strengthening families team, residential worker, foster carer, all will be trained in social pedagogy and restorative practice bringing the people together to form a new team...to give the right intervention at the right time with the least changes of worker, maintaining consistent workers with each family and young person so that relationships can be established, we recognised that relationship is the most significant in making the effective changes in families ' (LA Anon 2, Head of Service interview, March 2015).*



*'Key aspects of our model...for 13 – 18 year olds... are a consistent lead professional using an intensive relational model, 'a team around the worker' approach. We are setting up multi-disciplinary pilot teams that have youth workers, youth justice, Connexions, careers advisors, behavioural psychologists as well as social workers, all in the same team and all working together to deliver the right intervention to that young person'* (Interview with Marcela Phelan, Asst. Director Children and Families, London Borough of Ealing, March 2015).

*'Having the same social worker from a very low level that will be involved with them [adolescents] all the way through, actually somebody consistent whether you're involved in prevention or the CP system, whether you've moved into care, having a consistent person in key because what you are not doing is having the opportunity to slip through lots of hoops'* (Jill Sheldrake, Service Director, The Together Trust - Interview, March 2015.)

In implementing the redesigned service approach for adolescents and their families, some CSCIP work will generate new evidence about which young people and families are best supported by which types and levels of intervention, thereby informing the debate around edge of care. For most programmes, this will be a targeted part of their work, either through the requisite evaluation or by work undertaken during set up to help define the population who may benefit from the services and the cluster of potential risk factors that may prompt early referral and intervention:

*'At the moment we are trying to define [edge of care] ourselves, define who these actually are....for two reasons; firstly we want those families and young people to have better outcomes, also because in the current climate of austerity the current ways we are working are not sustainable nor are they necessarily the most effective'* (Interview with Marcela Phelan, Asst. Director Children and Families, London Borough of Ealing, March 2015).

There is certainly great potential for the relevant CSCIP projects to bring increased clarity to what edge of care provision looks like and how it can be targeted. A working set of definitions of edge of care has been circulated for the Children's Social Care Innovation Programme. Collated by CSCIP Team Leader David Chaters, the paper acknowledges the complexities inherent in the term but attempts to guide the programme developers and evaluators towards a level of consistency:

*'Edge of care, in common use, tends to refer to a narrower group of families where entry to care is being actively considered as a likely option to meet that child's needs. Children and young people on the edge of care are often described as the most challenging, or those with the most complex needs, though this is rarely explicitly defined. Edge of care is used more precisely to describe children and young people who are at imminent risk of becoming looked after or where this is a live option while managing risk in the home placement (e.g. through a child protection plan)' <sup>3</sup>*

The paper acknowledges the pressure for edge of care services to be offered to families much further back from the edge, so to speak:

*'Making these judgements can be challenging, particularly as family circumstances and behaviour can change rapidly. The pressures on the system mean that interventions and projects aimed at those on the edge of care can find themselves pressed to support a wider group where becoming looked after is a more remote possibility'.*

The first round of evaluations is due to report back in March 2016<sup>4</sup>.

In the meantime, evidence from services and practitioners involved in this evidence scope, indicate a degree of consensus albeit somewhat broad, as outlined below.

*'[For edge of care] we have children who are due to come into the looked after population due to issues around their risk of significant harm and then [those] who are likely to come in. Young people involved in criminalised behaviour, now classed as looked after, so working around preventative support for avoiding criminalisation, lots of [school] non-attendance .....also the complexity around disability of the young person and the family's ability to manage, especially with autism as they hit puberty age they become more complex for the family to support' (Jill Sheldrake, Service Director, The Together Trust - Interview, March 2015.)*

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<sup>3</sup> Unpublished paper by David Chaters, CSCIP Team Leader, Department of Education, for the Children's Social Care Innovation Programme 2015 'Innovation Programme Projects working with children and young people on the 'Edge of Care'.

<sup>4</sup> For further information on CSCIP and the individual programmes see:  
<https://www.gov.uk/government/publications/childrens-services-innovation-programme>  
<http://springconsortium.com/about-the-programme/> [accessed 24<sup>th</sup> June 2015]



### How is the Edge of Care Group Defined in Practice?

Our e-survey of local authorities and other organisations working with adolescents and their families found that the age and characteristics of the group were broadly interpreted. We asked respondents to describe the characteristics of those using or being targeted for edge of care services. Although most edge of care provision in our survey appeared to be aimed at children within the seven to 18 age band, some reported working with a wider age range (from new-borns to young adults) in order to address emerging difficulties that could lead to family breakdown.

One example included offering emergency beds to adolescents aged 16 to 23 years of age who are homeless and vulnerable (with a priority for those aged 16 and 17) together with the offer of family mediation and housing support (Org Anon 1, e-survey, March 2015). Another example included short breaks in foster placements for 0-17 year olds with and without a disability. See Annex 4.

*'Short Breaks in Stockport was the first LA to provide a service for children with and without disabilities and to my knowledge remains the only one to do so'. The local authority provides foster carers and child minders for the 0-17 years target group. 'We work with children and families either where there is a need for a 'breathing space' during a difficult time to prevent breakdown and the need to become LAC. Also to provide support to enable parents to engage in services to address issues which could cause family breakdown' (Pat Bugaski, Short Breaks Manager, Stockport MBC, e-survey March 2015).*

The range and level of needs and difficulties of the young people and families accessing edge of care support from our practice evidence was equally broad, reflecting the diversity of the types of provision (or vice versa).

In some cases the net was cast wide with edge of care services incorporating an early intervention remit, offering support at the point that indicators for *future* risk and difficulties became apparent:

*'It would be those young people where we can see the profile building in terms of disengagement with school, problems, behaviour at home...the potential for referral to be made higher up the threshold in social care' (LA Anon 2, Head of Service interview, March 2015).*

The criteria for services, as discussed further in chapter 7, varied from school non-attendance, family poverty, young person's physical or learning disability, young person's antisocial behaviour in or outside of the family home and family conflict (with or between parents and/or siblings).

*'Children referred may have issues with disengagement from school, problems at home and/or behavioural issues that parents are not able to manage. Parental difficulties in the target group include drug, alcohol, domestic abuse and mental health issues. 2 or more risk factors, including: 'at risk of gun or gang crime, exploitation, the edge of care, social exclusion, 15-18 year olds who are homeless, frequently missing from home/school...'(LA Anon 2, Head of Service interview, March 2015).*

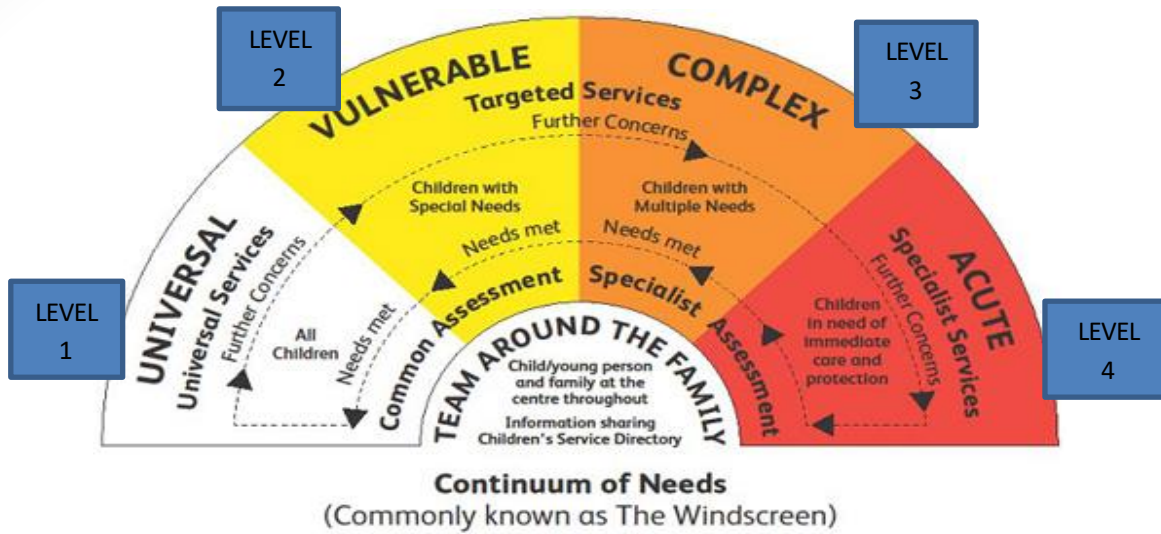
Some local authority contributors commented that services would be aimed at a level three threshold (e.g. based on the common assessment framework, see figure 4.1).

In some cases this had required introducing a further stratum to add some flexibility in allocating support:

*'We have a 3a and a 3b here before we hit 4 so these young people would be our 3a-3b interchange, above targeted but not quite into specialist' (LA Anon 2, Head of Service interview, March 2015).*

*To 'prevent tier four.... we're dealing with the non-existent three and a half tier, where they are either on the edge of going in or they've been in and are coming out and the families aren't ready, able to manager that behaviour' (Lynne Bennett – Team Manager, Children's Services, Wigan - Interview March 2015).*

Figure 4.1 Common Assessment Framework Windscreen Model



Priority, in some areas, was given to poor parenting, young people going missing, youth homelessness and more acute issues with family mental health and/or substance misuse, domestic violence and concerns around serious and imminent risk associated with gang and gun crime and child sexual exploitation. Services also included adolescents involved with offending within their sphere of activity, offering support to young people either on the edge or care or custody.

*'We work with the families of young people aged 11 – 17 where their anti-social behaviour across several settings leads to them being at risk of care or custody'* (LA ANON 5, E-Survey, March 2015).

In many respects, characteristics matched those of their 'in care' peers and, as discussed above, their edge of care status often came down to the availability of wider provision to divert or delay entry to care. Some services therefore highlighted working with adolescents literally on the edge of care, where families had already reached crisis point leading to adolescents requiring an unplanned or emergency care placement. This has resonance with previous research on preventative services, including that on adolescent support teams carried out by Biehal (2005 and 2008) and the use of respite care (Dixon and Biehal, 2007), both of which found that such services were often working with families and adolescents already in considerable distress and difficulty and where family breakdown had occurred. A recurrent scenario in the latter study of the use of respite care was the need for immediate support and in some cases accommodation:

*'I couldn't cope any longer with her aggressive defiance and stealing. I left her at social services and told them to keep her' (mother of 14 year old).*

In the 2007 study the characteristics of the service user showed that young people had:

*'Multiple and severe difficulties....abuse, domestic violence.... which were long standing...abuse was evident for a quarter of the sample and was clearly linked to current behaviour.....over a quarter ...had been known to social services for three or more years' (Dixon and Biehal, 2007).*

The varying levels of family crisis that brought them to the service were outlined by the parents and adolescents:

*'I wanted to get away.....I came to [the service] because of my mam's boyfriend punching me in the face' (15 year old boy).*

*'I wasn't happy that nobody was in the house for me, I had to see to myself at 15... and was having difficulties with dad, I couldn't have a conversation, I ended up shouting which led to arguments' (15 year old girl)'*

*'It was really bad, she was smashing the house up...fighting with her sisters, had a knife to me, her sisters saw everything' (mother of 14 year old).*

*'.....after two and a half weeks [living with his dad] his dad rejects him, all he knows he gets put on a train and from the train he gets picked up by social services, [and he had] been rejected off me. Social Services brought him back here and he proper went for me, there was just so much anger in him, but it was confusion more than anger, had to be' (mother 13 year old).*

Overall, our review of research and practice evidence found a high level of need, which indicated relatively entrenched family difficulties with a history of contact with various support services and previous care episodes, where services had hitherto failed to address the difficulties. This raises the issue of early intervention, or rather a lack of prior effective support that might have prevented the adolescent and their family reaching the edge of care.

### Identifying Needs and Intervening to Prevent Entry to Care

Early intervention refers both to providing help when children are younger and importantly, earlier in the development of the problem, whatever the age of the child. As discussed in Annex 1, adolescents in need may have been struggling with family difficulties, including neglect, for several years, or may be suffering the effects of more recent adverse changes in their family circumstances. It is now widely accepted that earlier intervention in the life of the family in need or the development of the difficulties is both more productive in terms of outcomes as well as more cost effective (Allen, 2011 a. and b.).

Certainly, there is increasing evidence from children and families themselves that earlier intervention would have been more helpful. For example, in consultations held in three major cities with young people who were in care or care leavers, 43% believed that they would not have had to come into care if there had been more support available for their families at an earlier stage (Morgan, 2011). The view was expressed that it is not enough for social workers to say that a family needs help and support, and to refer them for this, unless access to options is feasible. The research noted that if a family needs urgent help to keep a child out of care, it can be a long time after a referral is made before help actually happens, and things can get worse in the meantime: *'help needs to come quickly'* (Morgan, 2011).

Similarly, around two-thirds of parents in focus groups conducted across nine local authorities in 2013 stated that they would have liked help sooner (Easton et al, 2013). Both practitioners and families felt that more help should be offered to families when they have 'low level' needs to prevent their needs escalating. Some parents said they were not sufficiently aware of the organisations that could help them. Others felt that they were not being listened to or that services (particularly education and children's social care) were not acting quickly enough to help them. As one parent explained:

*'I should have been offered it at the time when everything was going on, but I wasn't. I was offered it weeks and weeks after when things settled down ...we should have been helped from day one'* (Easton et al, 2013).

Thematic inspections by Ofsted of early help and neglect found compelling evidence that young people living in complex and damaging circumstances were often waiting too long for help. If high thresholds for further investigation of concerns were not met, then it was often the case that families were offered no help at all (Ofsted, 2015a). In Action for

Children's third annual survey of child neglect in the UK, 26% of social workers thought that the point at which they could intervene was too high (Burgess et al, 2014).

These points should raise a cautionary flag for edge of care services and is one that is reason for concern in other countries where preventative family support models have been utilised far more intensively than in England, and that show that a focus on the family can detract from meeting the child's needs efficiently:

*'In Sweden we use a family service perspective so we have a lot of focus on preventative measures and supporting families.....but I think that sometimes it takes away the focus on the child. It has been a debate in Sweden for some years now that we wait too long before taking a child into care, they are too old when they get to care. My view is that we have been very focused on working to prevent children from going into care at all and sometimes I think we wait too long with the interventions so when children go into care they have had such hard experiences that it's hard for them to adjust ...because they are so damaged'* (Ingrid Höjer, Professor of Social Work, University of Gothenburg, Interview April 2015).

Similarly, pressures on foster care services are increasing in Norway due to the commitment to long-term preventative interventions resulting in:

*'...placing children in foster care that are extremely damaged and you will wear out lots of foster parents because they don't want to use residential care because that's too expensive'* (Elisabeth Backe-Hansen, Research Director, NOVA (Norwegian Social Research), Interview April 2015).

### The Challenges for Edge of Care Provision

Evidence from local authorities and other organisations gathered during this study, though modest in scope, showed that a range of criteria was applied for accessing edge of care provision. This reflects the findings of existing evidence that it is difficult to pigeon-hole the edge of care group. Ofsted's 2011 report found that there was no requirement on local authorities to provide data on a *distinct edge of care cohort*. Though no doubt such data would be useful for service planning and delivery, without a clear and consistent definition this would prove a difficult task.



There is some discussion, however, that applying a more prescriptive definition to the edge of care could be unwelcome or in even detrimental to troubled adolescents and their families:

*'There are lots of different edges that you could see and one of the things that seems to come through consistently is that where you have those service interfaces, thresholds and gaps, that's where problems arise and that organisations that are doing better are trying their best not to really think too much in boxed elements of the system but trying to think in terms of continuums and the journeys of children and young people and get a joined up picture of things going through'* (Susannah Bowyer, Research and Development Manager, Research in Practice, interview March 2015).

The current blurring of the edges around 'edge of care' support might allow services to be more responsive to the needs of their local populations. Applying too rigid a definition, meanwhile, could introduce a further edge to cross in order to access support services, meaning that some might fall short of the threshold. Conversely, by keeping a more liberal definition, services may be open to claims of net widening and labelling at one end and at the other end, worse still, delaying entry to care for those who need it.

Respondents highlighted a number of caveats associated with the concept and with becoming too focused on edge of care or using it for cost saving reasons:

*'The term is problematic, that concept is not used in Europe as they don't see such sharp thresholds – it suggests the idea of falling off a cliff of care and they see it much more as a continuum. The cynical view is wanting to reduce costs by reducing the care population, so edge of care services become a way of reducing placements rather than looking flexibly at each child's individual need'* (Janet Boddy, Professor of Child, Youth and Family Studies (Education), University of Sussex, interview April 2015).

*It's a worrying concept because it's so ill defined.... it's something that has been brought to bear in a reactive manner to reduce the numbers of children in care. It's created a holding area for young people, there are some places where it's used constructively, but it's used little for reparative work, it's mainly about containing and 'just in time'..... Edge of care doesn't have a conceptual framework of care and means there are more steps to get a young person to where they need to be. They may have to go through edge of care first....* (Jonathan Stanley, Executive Officer, The Independent Children's Homes Association - Interview, March 2015)

In the longer term, intensive intervention may be more cost-effective and suitable for some young people:

*'Actually it could be a really stabilising period for a young person to have six to 12 months in a residential placement that actually enables them to be reunified back home, or into a fostering placement, rather than using every other alternative to, and then having a very expensive final three years while that young person is in a home but isn't settling and moving from place to place and actually their outcomes will be far worse at the end of it'* (Jill Sheldrake, Service Director, The Together Trust - Interview, March 2015.)

The tendency to regard edge of care services as a panacea may result in the positive value of intensive services being overlooked for young people with particular difficulties, for whom entry to care would offer constructive opportunities:

*'Early intervention is not the answer to intensive placements, we will still need those and [will need] a targeted spend'* (Jonathan Stanley, Executive Officer, The Independent Children's Homes Association - Interview, March 2015)

At times it is deemed necessary to move away from seeing care as a 'last resort', towards a more beneficial view:

*'...making the case for care in a way, because what tends to happen in these conversations is this sort of veering between one extreme and another, of 'let's not get any of them into care', when actually for some young people that is the right choice..... [there is a] powerful case actually for care being a jolly good option for children and young people, especially where emotional abuse and neglect is an ongoing issue'* (Susannah Bowyer, Research and Development Manager, Research in Practice - Interview March 2015).

This reinforces the point made in Annex 1 from the research by Stein et al (2009), where family relationships may be too poor to permit preventative interventions occurring for adolescents. Indeed as Jones points out, entry to care, where appropriate should not be seen as a service failure (2009):



'We have to acknowledge that ... some families are simply untreatable. These cases do not represent failure, but in fact successful professional practice, to the extent that a sustained focus on child welfare has been achieved (Jones, 2009).

Additionally, the case for a whole systems approach to utilising care in conjunction with a range of locally delivered provision that includes edge of care services is arguably more useful than developing new dimensions of services in isolation:

*'more promising approaches [are] where there is something about a whole systems shift to think about principles and values behind quite a range of work that's going on'* (Susannah Bowyer, Research and Development Manager, Research in Practice - Interview March 2015).

Such a shift represents a flexible approach to children's services, which accommodates fluctuations in needs. The allocation of a single worker to build a lasting relationship with the adolescent and family, no matter their legal status or pathways through services, as discussed above, would play a part. Additionally, comprehensive and accurate assessments would play a fundamental part in addressing needs over the longer term:

*'Better social work assessment would identify needs and meet these the first time around'* (Jonathan Stanley, Executive Officer, The Independent Children's Homes Association - Interview, March 2015).

Assessment of need is of course essential to identifying the most appropriate support or intervention and thereby the edge of care group. Assessments exploring child and parental difficulties, family functioning, the risk of future harm and also the parent's capacity to change are considered key elements in informing professional decision making (see Shlonsky and Wagner, 2005 in Ward et al, 2014 p50).

### Summary Points:

- Edge of care is currently most commonly associated with prevention, rather than reunification.
- In practice, the definition of edge of care, and thereby eligibility criteria, varies across, and potentially within, local authorities and other services working with troubled young people and their families.
- It can be driven by thresholds for entry to care and to other services; the level of and availability of resources, both financial and in terms of access to mainstream and

specialist support; the presence of intervention programmes, some that include their own fixed eligibility criteria; and by the needs of the local population.

- Existing evidence suggests that whilst there is some attempt to address lower levels of need or intervening as indicators of future difficulties becoming apparent, most edge of care provision is targeted at adolescents and families that have high levels of difficulties and risk and are thereby much closer to the edge.
- The range of difficulties experienced by the edge of care group include young people with:
  - *emotional and behavioural difficulties*
  - *issues around risk of significant harm*
  - *physical or learning needs*
  - *criminalised behaviour.*
- There is some consensus that edge of care is an unhelpful term and concept that can be cynically used to focus on cost savings rather than meeting needs.
- That said, commentators have also highlight edge of care as representing a more fluid and responsive approach to meeting adolescent and family needs that forms a continuum or broader menu of options.

## 5. Supporting Families & Adolescents.

This chapter briefly explores some of the key developments over recent years aimed at supporting families and young people in difficulty. It outlines some of the main national policies and programmes, their aims, approaches and, where possible, key insights into their effectiveness. It considers some of the implications for the continued development of support for adolescents on the edge of care and their families.

### Key Policy Developments

Over the past ten years, state support for families in difficulties has been characterised by a shift in focus from the universalist approach epitomised by the Sure Start programme towards a more interventionist, targeted approach aimed at a more selective cohort of families with particularly complex needs (Featherstone, 2013). Labour's Respect Agenda provoked renewed efforts, and funding, to selected local authorities, to improve the integration of adult and children's services in order to provide a more holistic response to such families.

Family Intervention Projects (FIPs) were introduced in 2006, initially to work specifically with families identified as anti-social. These were predominantly families with older children therefore, who were manifesting much of the anti-social behaviour. The aim of the intervention was to prevent these families from becoming homeless and their children being taken into care. Together with 20 Intensive Intervention Projects (IIPs), an extension of the model implemented as part of the Youth Task Force Action Plan in 2008, FIPs were subsequently rolled out to target families living in poverty and affected by inter-generational unemployment, as well as families with children at risk of offending – the latter of which became by far the dominant type (Lloyd et al, 2011). The intervention was characterised in particular by a 'carrot and stick' approach, whereby sanctions could be applied if encouragement and support alone was resisted – an approach that has been maintained as interventions with this cohort of families have developed (see below).

A review of the FIPs in 2010 (DFE, 2010a) reported that this *challenge and support* approach, appeared to be effective (in combination with broader enabling factors, such as strong leadership across the relevant agencies), and contributed to positive results, including

improved edge of care outcomes (e.g. 37% reduction in child protection concerns amongst families involved in the programme).

However, evaluations of these interventions have generally been limited, not least because the monitoring systems only collected quantitative data such as the number of contact hours, with the result that very little is known about the actual content of any of the interventions (Lloyd et al, 2011). Also, in 2010, the Coalition Government removed the ring-fence for its Early Intervention Grant funding to local authorities, which was the prime source of funding for Family Intervention Projects. In line with this, the specific grant conditions that included a requirement for local authorities to complete data returns on their family intervention services were also removed.

The number of FIPs and IIPs began to dwindle following the removal of the ring-fenced grant, which the charity Catch 22 identified with regret in a 2011 report (Catch 22, 2011). The report described whole family support, such as FIPs and IIPs, as ‘smarter’ support and, in the light of what it perceived as the government’s ‘short-sighted’ focus on early intervention with young children (see Allen, 2011a and 2011b), it urged authorities not to overlook support for families with older children.

*‘Nobody would disagree with the concept of early intervention but early isn’t just about age; families can face challenges at any time.’ (Moseley, in Puffett, 2011)*

FIPs were designed around the assignment of a dedicated key worker and it is perhaps unsurprising therefore, that the key features Lloyd et al (2011) identified as critical to the success of these interventions include:

- Having a dedicated key worker who works intensively with each family
- Recruitment and retention of high quality staff
- Small caseloads
- Staying involved with a family for as long as necessary.

FIPs, along with fifteen Pathfinder pilot projects, were part of an evolving *Think Family* agenda launched by the Labour administration in 2007 which, in its later stages, included funding to support and encourage local authorities to re-design their services towards a more holistic model, in terms of both a whole family focus and a joining up of the different services that a family might need. In 2012, following the removal of this ring-fenced funding, the coalition government launched their own Troubled Families Programme, which targeted the recently estimated 120,000 most problematic families in England and, in

keeping with the ‘carrot and stick’ description of FIPS, was described as delivering a ‘tough love’ approach (Aiken, 2011).

In a review of the evidence base for this type of family intervention, to underpin the design of the Troubled Families Programme, the Department for Communities and Local Government (DCLG) concluded that five key components characterized the most effective interventions:

- A dedicated worker, dedicated to a family
- Practical ‘hands on’ support
- A persistent, assertive and challenging approach
- Considering the family as a whole – gathering the intelligence
- Common purpose and agreed action

(DCLG, 2012)

Other targeted initiatives that have been developed or implemented in recent years include Family Group Conferencing (FGC) and the Family Drug and Alcohol Court (FDAC). The idea of the FGC, which originated in New Zealand, was introduced in the UK in the Children, Young Persons & their Families (CYP&F) Act 1989, which aimed to encourage a more participatory approach between professionals and families in the decision making process relating to potential care proceedings. The initiative depends on the involvement of an independent co-ordinator, whose task is to ensure that the views of all parties are heard and considered equally, including those of the children, and that the interventions ultimately agreed upon represent a genuine consensus. Increasingly, FGCs have come to be seen as part of a restorative approach to social work, alongside restorative justice approaches but, as Frost et al (2014) point out, FGC has made slow progress because it relies on referral by social workers, many of whom have continued to opt for the more conventional, professionally led process of the Child Protection Conference.

Evaluation of the effectiveness of FGC is weak as relatively few studies internationally focus on outcomes and those that attempt to do so suffer from significant methodological problems (Frost et al, 2014). However, Frost et al.’s comprehensive review concludes that the process evidence is overwhelmingly positive, and that families and children feel listened to and valued.

The Family Drug and Alcohol Court launched in 2008. Financially assisted by a group of government departments, this initiative was inspired by the commitment of a District Judge, Nicholas Crichton, who had seen the model working successfully in the US where it originated, and was concerned to improve the failings of existing care proceedings in the

UK, such as late intervention, excessive duration of proceedings and poor parent and child outcomes. It differs from ordinary care proceedings in three key ways; judicial continuity, fortnightly court review without lawyers, and a specialist multi-disciplinary team attached to the court that provides both therapeutic and practical support to the families.

The evaluation conducted by Harwin et al (2014), albeit a modest sample, demonstrated improved substance abuse cessation and reunification rates compared to outcomes from ordinary care proceedings in families with fewer problems aside from their substance abuse. However, in families struggling with a particularly complex set of problems as well as their substance abuse, the FDAC rates of cessation and reunification showed no statistically significant difference (see Harwin et al, 2014). Nevertheless, the FDAC has won a number of awards and considerable praise for its work, and the Department for Education has recently announced a limited rollout of the model to other parts of the country, as part of its Children's Social Care Innovation Programme (see below).

The most recent policy initiatives in family support have stemmed partly from the Munro Review (2011), commissioned in the wake of the death of baby Peter Connelly, and partly from a review of the children's care system by the Association of Directors of Children's Services (ADCS, 2013). Taken together, these reviews conclude that the care system in particular and family social work in general require a radical shift away from compliance and risk avoidance towards more innovative, child-centred approaches. Thus, the two principle aims of the recently launched Social Care Innovation Programme are i) to promote a re-thinking of social work in relation to children and families, and ii) to promote new initiatives for adolescents on the edge of care (see further below).

### Key Therapeutic Developments

The precise nature of a family intervention, as indicated above, has not always been carefully documented. However, alongside funding for particular policy developments around family support over the past decade, governments have also funded the development of particular treatments. These may be delivered as the principle content of a particular policy package, or they may simply be on offer as part of the general family support service a local authority provides.

As the pressure to improve standards of evidence has grown, a number of family interventions originating in the US have been adopted in the UK, which are highly structured and therefore easier to subject to more rigorous evaluation, including Randomised

Controlled Trials (RCTs). Whilst much of the evidence base continues to come from the US, strong, home-grown evaluation is also now accumulating.

In summarising here the principal therapeutic developments for adolescents of the edge of care, two recent evidence reviews are particularly relevant – one concerns models of adolescent care (Bowyer and Wilkinson, 2013), the other reviews intensive interventions suitable for children on the edge of care (Asmussen et al, 2013). The two interventions identified in both reviews as having the strongest evidential base in the UK are Multi Systemic Therapy (MST) and Functional Family Therapy (FFT).

#### Multi Systemic Therapy (MST)

MST was first introduced in 2008 by the Department of Health (DoH), in partnership with the Youth Justice Board (Fox and Ashmore, 2014) on the basis of a small-scale trial carried out in North London between 2003 and 2008 (see Butler et al, 2011). It is designed for families with children aged 12 – 17 who are *'at risk of coming into care due to serious anti-social behaviour and/or offending'*.

The MST model draws primarily on ecological theory and family systems theory and sees the young person's caregiver(s) as the primary agent(s) of change. The MST therapist is on-call 24 hours a day, seven days a week, and provides intensive support in homes, neighbourhoods, schools and communities, over a period of three to six months. Fidelity to the programme is important and the originators have developed very strict treatment protocols (DfEa, undated).

A number of methodologically rigorous RCTs have been carried out in the US by the developers, which have found that MST is significantly more successful than normal services in improving family relationships and reducing both the short and long-term rates of re-offending amongst serious young offenders. Studies have also shown that MST is cost effective in the long-term (see Bowyer, 2009).

An independent RCT has recently been carried out in England with an ethnically diverse sample of 108 families who were randomised to either MST or the usual Youth Offending Team services (see Wiggins et al, 2012). Results showed that, compared with the control group, at 18 month follow up, MST significantly reduced non-violent offending, youth-reported delinquency and parental reports of aggressive and delinquent behaviours. Qualitative interviews carried out with parents and young people assigned to MST approximately three months after the intervention finished were also positive.



Fox and Ashmore (2014) have reviewed the evidence for MST and summarised both the strengths and the weaknesses of MST as a potential intervention for children on the edge of care. It is of note, from the point of view of this scoping study at least, that the authors identified an important limitation, namely that it is not compatible with the offer of respite care.

*'The emphasis [of MST] is on building up informal social and family supports, and decreasing the involvement of statutory agencies and formal inputs such as respite care.'* (Fox and Ashmore, 2014 p8)

A more recent variant of MST has been developed for families where there is evidence of child abuse and/or neglect (MST-CAN), which has also shown positive results from an RCT in the US, demonstrating significant reductions in abusive and neglectful parenting behaviours, as well as out-of-home placements. In addition, parents participating in MST-CAN were significantly more likely to report improved mental well-being and increases in their informal family support networks in comparison to families participating in the control group. Significant improvements for children included reductions in post-traumatic stress disorder (PTSD) and other anxiety related symptoms (see Asmussen et al, 2013).

#### Functional Family Therapy (FFT)

FFT was also originally developed in the US in the 1970s and was piloted initially in the UK (Brighton) in 2007 (Prevention Action, 2009). It is considered appropriate for families with children aged 10 – 18 who are 'engaging in persistent antisocial behaviour, substance misuse and/or youth offending'.

The FFT model draws on a wider range of theoretical sources for its therapeutic content, including family systems theory, social learning theory, ecological theory and cognitive behavioural principles. It is not as intensive as MST, being structured around discrete weekly sessions rather than 24-hour on-call support, and a key feature of the intervention is the therapist's ability to match evidence-based strategies to the specific needs of each family (DfEb, undated.) As with MST, however, the young person must be living at home for the duration of the intervention, which raises similar difficulties for its compatibility with an offer of respite care.

Most of the evidence base for FFT relates to families with a child in the criminal justice system, as this is the population it was originally designed for. The states of Washington and Florida have been applying the intervention to young people on the edge of care for some years but, as yet, the evidence is confined to monitoring data and a small scale, non-



random comparison study (Asmussen et al, 2013). Both have demonstrated positive results, with the comparison study recording fewer out-of-home placements among the group receiving the FFT intervention than the comparison group. Asmussen et al describe the evidence base for young people on the edge of care, therefore, as ‘promising’, compared to ‘strong’ for families with a child in the criminal justice system.

The first UK RCT is currently being conducted by Kings College (Institute of Psychiatry, Psychology and Neuroscience) in partnership with Brighton and Hove Youth Offending Services (see the SAFE research project, Kings College London, undated).

MST and FFT are the two intensive interventions backed by government funding. Other key therapeutic developments include the following:

#### Strengthening Families Programme 10-14 (SFP 10-14)

Again emanating originally from the US, this programme has been practised in the UK for the past 15 years, particularly in mental health settings but also in social work settings. Unlike MST or FFT, it is based on group work and is intended for families and their teenage children considered to be at a less serious stage of difficulty. It was originally developed to increase resilience and reduce risk factors for alcohol and substance misuse, depression, violence and aggression, delinquency and school failure in high risk children and their substance misusing parents (Coombes et al, 2006). In the UK it has been made available to parents in any kind of potential difficulty with children aged 10 – 14, to help improve family functioning.

SFP 10-14 also draws on a variety of theoretical sources including the biopsychosocial vulnerability model, which encourages the development of family skills and resources to ‘buffer’ other stresses, the resiliency model, which helps young people manage their emotions and behaviour, and the family process model, which considers how economic stress can negatively affect parenting behaviours (DfEc, undated; MoJ, undated). It is not an intensive intervention like MST or FFT, but it is more compatible with an offer of respite care and indeed is used, for example, by residential staff in the Blackburn with Darwen respite service (see Chapter 7, Case Study 5).

Much of the evaluation evidence has been conducted by the developers themselves (which is also true of MST and FFT, although to a lesser extent now that more recent independent studies have been conducted) and, as Velleman (2009) points out, there is considerable

evidence that more positive research findings are produced from evaluations conducted by the initial developers of an intervention. Nevertheless, key outcomes include:

- Reduced substance misuse on the part of both parents and children
- Fewer conduct problems at school
- Improved child management and education skills in the parents
- Improved self-management skills in parents and children
- Improved family relations.

(Velleman, 2009)

The first (independent) UK RCT is currently being conducted by researchers from the universities of Cardiff, Swansea and Oxford Brookes (University of Cardiff, undated)

### Social Pedagogy

Social pedagogy is a set of principles rather than a programme as such and, whilst very well established in Europe, has only recently been piloted in the UK. As an approach most commonly used in residential settings it is thus relevant to the provision of residential respite care.

The essence of social pedagogy, as described by Hämäläinen (2003) is:

‘... to promote people’s social functioning, inclusion, participation, social identity and social competence as members of society. Its particular terms of reference apply to the problems people have in integration and life management in different phases of the lifespan.’ (p76, cited in Berridge et al, 2011)

As the term suggests, practitioners are theoretically trained to at least degree level, but they are also taught practical, organisational and communication skills. Petrie et al (2006) summarise the key principles of pedagogic practice as follows:

- It builds on an understanding of children’s rights, focussing on the child as a whole person, and supporting the child’s overall development
- Relationships are at the core of the approach. Practitioners see themselves as in relationships with the child or young person and their training prepares them to share in many aspects of children’s daily lives
- There is an emphasis on team work and on valuing the contributions of others, such as families, community and other professionals
- Pedagogues are encouraged to constantly reflect on their work and to bring both theoretical understandings and self-knowledge to the process.

Though the international evidence for social pedagogy is strong (Boddy et al, 2009), evaluation evidence of the initial piloting of social pedagogy in the UK has documented, amongst many other implementation difficulties, the skills gap in particular between the pedagogues brought in to disseminate practice and the existing residential staff (Berridge et al, 2011), highlighting the disparity in professional qualifications between UK residential workers and those in other countries. In summary, Berridge et al question whether social pedagogy is a valuable way forward in residential care settings, which currently occupy a more marginalised position of last resort in the UK compared to those in Europe. However, Bowyer and Wilkinson (2013) found that interest in social pedagogy had been stimulated by the pilot and its evaluation, and that it is being adopted or further developed in a number of areas (see Bowyer and Wilkinson, 2013).

### Where next for family and adolescent support?

The development of family and adolescent support programmes over the past two decades or so has, therefore, seen a myriad of approaches and interventions being developed and introduced to address the multiple needs of troubled and vulnerable parents and their children. Most of these programmes have a common goal, the aim to help families stay together by addressing their difficulties as a family unit, whether these involve emotional, behavioural, social or practical difficulties – a holistic family approach. In the recent economic climate, the potential for family distress and breakdown has heightened and, as discussed earlier, the number of families coming into contact with social care has risen sharply (see Children and Young People Now, 2015). As the need for preventative support increases, so too will the search for access to a range of options to meet increasing and diverse needs. As Ward et al note:

*‘..where parents are facing complex, multi-layered problems, an integrated package of support may be required, tailored to meet the needs of each member of the family’*  
(Ward et al, 2014).

A key theme in the latest government initiative for adolescents on the edge of care is to help services become more integrated and flexible in order to provide a more diverse menu of interventions that could be better adapted to suit young peoples’ needs as well as those of their families. Several such approaches have been introduced under the CSCIP funding stream (see Annex 5.). An example is Action for Children’s innovative Step Change Programme, which represents the first UK programme to bring together three separate evidenced based interventions; Multi Systemic Therapy (MST), Functional Family Therapy (FFT) and Treatment Foster Care (TFCO) within one overall programme. Step Change

operates across three London Boroughs to provide adolescents and families with access to the most appropriate intervention from the three on offer, whether that is intensive support within the family home or time limited entry to specialist foster care. Importantly, the programme provides a dedicated worker (step change advisor) to support the adolescent and family through the programme.

The development of a more diverse and needs led menu of options under the current initiative '*would include a more fluid use of care to provide respite while the intensive work with families and young people is undertaken*' (DfE, 2014 a) p11).

As the above overview of policy and therapeutic developments indicates, there are challenges to this objective when the consequences of decisions about funding streams and the pre-requisites of particular interventions are both taken into consideration. Interventions are vulnerable to the ebb and flow of funding and the requirements of some interventions, particularly those described as 'intensive', might rule out their use with other potential offers on the menu such as respite.

One question to be drawn from this, therefore, is whether an intensive intervention could be designed that would be compatible with respite care. If not, then either respite care should be considered as unsuitable for those on the edge of care, or the term 'edge of care' perhaps becomes unhelpful to describe the group of young people and their families that respite is able to help.

Two further questions are also raised. One concerns the standard of evidence required before interventions are rolled out and, related to this, are the potential –and the unknown – effects of any interplay between interventions when they are used in conjunction with one another or indeed the cumulative effect (on recipients and also on evaluation outcomes) if used sequentially. It is beyond the brief of this scoping exercise to examine the complex relationship between evidence and practice, but it is nonetheless the case that the more prescribed and tightly controlled the intervention, the more possible it becomes to evaluate it by means of an RCT, which is the standard of evidence that is increasingly looked for. It may be, therefore, that the desire for more flexibility and interaction of treatments raises very real challenges for a determination of what works, for whom and in what circumstances.

The next chapter looks specifically at out of home support using short term or respite approaches that combine with family interventions to provide a holistic package of edge of care support.

### Summary Points

- In recent years, government policy has supported interventions using a ‘tough love’ approach to target families deemed to have particularly complex and anti-social difficulties.
- Evidence of the effectiveness of these programmes is often patchy and of varying quality. The clearest message to emerge from evaluations is the importance of a dedicated, well qualified, key worker who works closely, and in partnership with, the family for as long as is necessary, providing continuity and therapeutic, as well as practical, support.
- Alongside these policy driven initiatives, there has also been a growing use of imported, manualised therapeutic interventions that can be, and have been, more rigorously evaluated. There is scope for greater use of independent evaluations.
- So far, only one of the therapeutic interventions mentioned here, MST, has been subject to a UK based RCT. Findings demonstrate significant reductions in aggressive adolescent behaviour and improved family functioning. UK based RCTs have been commissioned for FFT and SFP 10-14, but are yet to report.
- Social Pedagogy is a child-centred approach, which also emphasises the importance of social functioning and participation. It is commonly used in residential settings in Europe, but has only recently been piloted in the UK. An evaluation, which documented significant implementation difficulties, has highlighted the status of residential care in the UK as the place of ‘last resort’ rather than part of a continuum of care, as it is more commonly treated on the continent.
- The latest government initiative for adolescents and their families aims to develop greater flexibility of service provision so that interventions can be customised from a menu of options to suit particular needs.
- There is a need, however, to understand more about the interplay between the more intensive, manualised, therapeutic interventions. Arguably, by their nature, they might prove to be less compatible with this ‘pick and mix’ approach, and it is perhaps the less intensive interventions, therefore, such as SFP 10-14 that might prove more conducive to being used in conjunction with the offer of respite care.
- A landscape of more customised, multi-packaged interventions raises very real challenges for teasing out and understanding their effects.

- Furthermore, as Ward et al caution: *'many intensive programmes are still relatively new. They may well prove to be effective but many have not yet been adequately validated in the UK and are not available in all areas of the country'* (Ward et al, 2014).

## 6. Keeping families together? The use of short-term care.

The previous chapters have outlined the challenges facing both the care system and family support services in meeting the diverse and complex needs of adolescents and families in distress and difficulty (see also Annex 1). They have also considered some of the ways in which services and interventions can impact on positive outcomes. This chapter considers the evidence and prospects for an approach that brings these often separate pathways together to establish a common ground; the use of short stays in care within a programme of wraparound family intervention.

### Respite and Integrated Family Support

Evidence of poor outcomes for adolescent entrants to care and the failure of care to effect a positive change within the family environment for some who return home through reunification or when ageing out of care, signposts a need for combining direct work with young people with targeted work with their families before, during and after care. This will require greater integration of care placement and family support services.

There is a range of available evidence on the development, use and effectiveness of family and adolescent support services, as discussed in the preceding chapters. In comparison, however, evidence on the use of short term care placements is somewhat limited. That which exists tends to focus on children and young people with disabilities; young people who are homeless; and less formal options such as drawing upon the support of extended family and friends to provide a break away from home.

The origins of short term care, though most often associated with the Children Act 1989, actually date back to the post war children's departments of the late 1940's, where short term foster or residential placements were arranged on a voluntary basis for families under stress due to disabilities, as part of social work intervention or for '*bringing temporary relief from the drudgery of living in permanent poverty*' (see Aldgate and Bradley, 1999). Although the 1989 Act, and its regulations and guidance, acknowledged the potential of respite or short term out of home placements to widen the range of support for all children in need '*a wide variety of services including short-term out-of-home placements, may need to be*



*employed in order to sustain families through particularly difficult periods'* (DoH, 1990), evidence of putting this into practice appears limited.

Such planned short term placement options (known variously as time out, shared care, short term care, short breaks and respite care)<sup>5</sup> have, therefore, until relatively recently, been less apparent within the policy and research literature on preventative support for non-disabled young people at risk of family breakdown. Nevertheless, as this chapter shows, evidence of their use with other groups of young people, nationally and internationally, suggest that they could provide an innovative and creative approach to providing planned relief from the difficulties that lead to family breakdown, whilst facilitating work with adolescents and their parents in the home environment. In doing so, as our practice examples demonstrate, such integrated respite and family support models might offer potential for diffusing crises, dissipating difficulties and enabling young people to remain, where safe to do so, with their families (Dixon and Biehal, 2007; Webb, 1990).

This chapter considers the range of current options, for which evidence is available, for offering short term / respite care. Examples include family and friends care, voluntary carers, mainstream and specialist foster carers and residential options.

## ***1. Informal and Family Based Respite***

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### **Informal and Formal Kinship Support**

An area we know little about, despite its prevalence, is the impact that informal care by family members can have on preventing family breakdown and young people entering care. In most families, whether there are significant difficulties or not, having the opportunity to spend time apart when children go off to a grandparent, aunt or uncle for a weekend or during school holidays, can provide a welcome breathing space within family life for parents and children. For some, this might prove essential during times of difficulty, illness or acute family stress. Research on young people who are in care or homeless, shows that many vulnerable adolescents have spent periods of time staying with other family members. In some cases this might mean sofa surfing, until circumstance break down and services become involved.

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<sup>5</sup> We have tended to use the term respite to refer to the range of short term options but use other terms accordingly to reflect the range of programmes and models.

In addition, research shows that informal family support is also used for longer term care with around 165,000 children being brought up by relatives on an informal basis (Selwyn et al, 2013).

A further 9,000 or so children and young people, meanwhile, are living with extended family members on a formal basis under kinship foster care arrangements. Research evidence on the use of kinship care tends to be mixed. Studies have shown that outcomes for children looked after in kinship arrangements tend to be better on a number of levels (behaviour problems, wellbeing, placement stability etc. ) than young people looked after by foster carers or in residential care (Ward et al., 2014). Evidence also shows that kinship carers are often poorly supported by services and receive less resources and access to specialist support to help them to care for young relatives when parents are unable to do so. Research by Selwyn and colleagues (2013) showed that kinship carers can suffer significant hardship as a consequence, and yet despite this, many local authorities do not have a consistent approach to family and friends care. For example, MacMillan et al (2009) found that kinship carers had less access to caseworker and post placement support than unrelated foster carers, and received less financial support and lower or discretionary payments (Selwyn et al, 2013).

Our evidence scope found some examples of approaches to increase support for informal and formal kin carers, as a means of preventing breakdown of arrangements and entry to care. One model being used in Ireland is provided by a charitable organisation that works with young people, families and communities:

*'In relation to a general population of older young people on the edge of care, Extern (all-Ireland wide) provide a range of early intervention and support programmes for young people to help reduce the risk of kinship placement breakdown and include short residentials for young people at risk of abuse or harm<sup>6</sup> (Berni Kelly, Senior Lecturer, Queen's University Belfast, interview March 2015).*

Another example of support for kinship carers was found in one local authority that already offered a range of preventative support, including short breaks. The local authority has secured DfE CSCIP funding to enhance their service and extend the amount of support available to preventing adolescents coming into and remaining in care. This included acknowledging and building upon the role of extended family. The manager explained:

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<sup>6</sup> See <http://www.extern.org/>

*‘Most young people who end up coming into the care system in adolescence have usually bounced around the family a bit beforehand. So what we are going to bring into the model is a fostering social worker who will work to support family members, where a child is not with their primary family. We’re going to put in a fostering social worker to work with that family as though they were foster carers on the basis of if the support was provided to the adults caring for the adolescent is that a significant factor in making a difference? So we’ll do that, have social workers in there who will do the doing not the referring, moving away from a referral culture, the adult mental health worker will go and do the work with mum, if needed’*  
(LA ANON 2, Interview, March 2015).

In addition to informal support from family members, there was evidence of projects offering respite with voluntary carers or hosts. One example of non-statutory arrangements for providing respite to families struggling and at risk of escalating difficulties, was a model of unrelated family based respite that sits outside of formal foster care. Safe Families for Children (SFFC) began in Chicago 10 years ago and was recently introduced in the north east of England with start-up funding from the Vardy Foundation. SFFC has since received further support through CSCIP, to develop the model further and expand provision across the UK.

### ***Practice Example – Safe Families for Children<sup>7</sup>***

*Safe Families for Children (SFfC) is a volunteer organisation that gives support to families in crisis, including short breaks with host families and befriending. The model originates in Chicago, where it began in 2003 and is now operating in 65 cities across the USA. SFfC is a faith based organisation built on the ethos of compassion and hospitality. The organisation began in the North East in 2012 and is currently expanding across England (as part of the Innovation Programme), together with developing services in Wales and Scotland.*

*Volunteer hosts and befrienders are recruited from the church community, but all applicants who share the ethos of the organisation are welcomed. There is a rigorous*

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<sup>7</sup> See <https://www.safefamiliesforchildren.com/> for more information.

*recruitment and training process, after which applications are presented to a panel within the organisation, to assess their suitability to work as a volunteer and/or to provide host services. Once a volunteer is approved the organisation will try to find out what situation they are comfortable with and will match volunteers with the families.*

*The aim of the organisation is to work with families in crisis/families that are isolated, in order to reduce the number of children entering care. The organisation works with families who have at least one child under 10. Referrals are made from identified local authority social care departments.*

*The services offered are predominantly befriending for the parents and children and/or hosting and short-breaks. On referral the organisation will look to see what other formal and informal support and services are available to the family, e.g. the extended family or friends. If the family has no alternative support SFfC can offer practical and emotional support, daytime activities for the children and/or the hosting service as appropriate. The short-breaks service may be offered as a one-off night up to a maximum of 28 days. Children may not be known to statutory services or may be CIN or subject to child protection plans. Goals are set in partnership with the family and the volunteer(s).*

*An example of a hosting situation: 'A recent hosting we did, involved children aged 10, 12 and 14. A single mum who had to go into hospital for an operation. So they were hosted by a family for 2 nights in order to give the mum a chance to recover and then the volunteers actually helped the mum in terms of preparing meals and went in to ease things after the operation.'*

*'If you didn't exist what would have been the option for this family? That is something we always look at...We look at what other support the family has. We look at what would be the alternative if we couldn't help. Where there is other support, in terms of maybe extended family, anyone else that can help, we would always encourage the family to look to that first. So we actually know there is a real need. We look at families that are isolated. Some families have no family support at all and no extended friendship network or anything like, so that is an ideal family for us to support.'*

*'Anything that will reduce the isolation, reduce the pressure on the family, we will look at.'*

*[Family Support Manager]*

*Currently the organisation is working with Dartington Social Research Unit to monitor and review the organisation, including referral processes and cost savings for the local authorities using the services of SFfC.*

*The main benefits of the services were identified as:*

- *An alternative to care for isolated families*
- *Services are provided by volunteer families rather than statutory authorities so families may be more willing to take up hosting and befriending*
- *It provides vital respite and support to a parent who is only just coping.*

*Challenges were identified as:*

- *Occasions where families disengage from the organisation*
- *Managing volunteer expectations around what it is possible to offer.*

*'Hard to measure the results but would hope we are saving the families from crisis. Sometimes we are offering a service there is no other substitute for.'* [Family Support Manager]

**Source:** Telephone interview with Family Support Manager plus review of website and secondary sources.

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Other forms of respite and short breaks provision identified during the evidence scope included models that were targeted at specific groups of young people.

## ***2. Respite for Young People Who Are Homeless***

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Young people who are homeless and young people on the edge of care are in many instances one and the same, however, they may have different entitlements to access targeted schemes. A number of examples of therapeutic respite to emerge from the literature search included those provided in the USA by services for young homeless people, where there is a well-established form of provision, across many states, typically known as placement shelters. The following two examples, include models that involve access to family support and mediation.

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### **Youth and Family Alternatives Inc. (Florida)**

Shelter Services are provided as part of the Florida Network of Youth & Family Services, Inc. and include: 24-hour availability, youth supervision, food and clothing, life skills education, crisis counselling, individual and family counselling, recreation and leisure activities, and case management services.

The eligibility criteria for the service is

*'Youth age 10 through 17 who ....need short-term respite or crisis placement due to family conflict (amongst other reasons)'*

The primary goal of the program is to empower families and youth to address these behaviours and provide a safe transition back into the home or alternative placement.

**Source:** <http://www.yfainc.org/services/runaway-homeless-youth-crisis-shelters>

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A similar approach required family members to participate in at least one family mediation session per week to establish plans for resolving difficulties.

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### **Haven Youth and Family Services (Illinois)**

Haven collaborates with two local group homes to offer adolescents emergency housing. The temporary shelters accept boys aged 12-17 and girls aged 12-18. In situations where emergency housing for a young person is deemed appropriate, permission of a guardian is necessary to proceed. A housing agreement requires families to attend a minimum of one family session per week with a Haven counsellor. The majority of youth are housed in a shelter to provide temporary respite. This establishes a 'cooling off' period, which allows family members to regroup and engage in productive family communication, under the direction of Haven counsellors.

‘As a police department, we rely on Haven to provide emergency housing for our youth. This service is important to our community since it helps to deescalate the crisis that takes place between parents and teens. Most importantly, Haven’s short term placement of teens prevents them from needing to be placed in the larger DCFS [care] system. Our police department has benefited from their program for years and we look forward to working with them for many more in the future.’

**Source:** <http://havenforyouth.org/pages/emergencyHousing.html>

We found a small number of UK examples where therapeutically supported respite had been offered to adolescents (necessarily aged 16+) who presented as homeless (e.g. Quarriers in Scotland, and previously St Basils, Birmingham – see below). This route, which originally worked on the basis that homeless young people could be accommodated temporarily on a voluntary basis, is likely to have changed in light of the Southwark Judgement<sup>8</sup>, which clarified the law on homeless young people aged 16 and 17, who should now be formally accommodated as looked after children.

Two UK examples of support for young people aged 16 to 18 at risk of or experiencing homelessness, came to light during our e-survey.

***Practice example: Barnardos Youth Homeless Service, Swansea.*** A restorative practice model to prevent family breakdown; including a supported lodgings service for 16-18 year olds, family mediation, home support and a social worker specialising in practice with 16 to 18 year olds. The Youth Homeless Service social worker will sign post young people to in-house and external services such as: supported accommodation, home support work with families to meet their needs, drug agencies, Careers Wales, Barnardos mediation service, DWP, Trehafod Child & Family Clinic, Info-Nation advice Centre for 11-25 year olds and GPs.

**Source:** e-survey.

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<sup>8</sup> See [https://england.shelter.org.uk/\\_data/assets/pdf\\_file/0005/231269/G v Southwark briefing revised Nov 11.pdf](https://england.shelter.org.uk/_data/assets/pdf_file/0005/231269/G_v_Southwark_briefing_revised_Nov_11.pdf)



**Practice example: Org Anon 1 – a national Not for Profit Organisation providing emergency and support services for 16 to 23 year olds in two towns in the North West of England.**

*'In the [Town A Scheme] we have an emergency bed which is used by our mediation service. In [Town B] we have an emergency bed used by the local authority and EDT. (Emergency Duty Team) These are both based within our 24hr staffed supported accommodation projects.' 'Usually the services are for 16 and 17 year olds, but sometimes a little older. The young people are almost always section 17 – homeless and vulnerable. The emergency bed in [Town B] accommodates section 17's and 20's primarily, but will also take young people on a full care order.'*

*Org Anon 1 also has a Nightstop service in [Town A] and a number of longer stay housing options with floating support. The duration of the breaks is from one night (in the Emergency beds and Nightstop) to longer more settled accommodation, if the young person cannot return home (generally up to a year).*

*Org Anon 1 provides a mediation service funded through the local authority and DAT [Drugs and Alcohol Team] for young people struggling at home. 'We can give a couple of weeks respite in the Emergency Bed at our 24hr staffed Project in [Town A] whilst mediation work is being done. Usually young people will then return home. However, if relations have broken down, we can assess them and bring them into the [Scheme] where there are various levels of supported accommodation and supported lodgings available.'*

*'We do not have the funding for therapeutic approaches. Our work is mainly about housing related support, however, alongside this is a lot of emotional support for the young person and help to move them on to the most suitable accommodation; whether this is back home or to their own independent accommodation.' It was reported that young people often do return home from the emergency beds.*

**Source:** e-survey.

Despite the limited evidence of developments of therapeutic respite for homeless young people in the UK, we found a clear recognition of the need for such provision. For example, to offer 'time out' or breathing spaces alongside support to the wider family:

*'We heard from those working with young people in supported accommodation about the importance of respite... according to the young people themselves, a break from the situation for both them and their parents could have stopped the escalation of emotions getting completely out of hand and prevented [them] from getting into the vicious cycle of homelessness'* (Scottish Parliament, Equal Opportunities Commission 2012).

*'Greater Investment should be made in timeout projects to allow some space for young people and their parents to rebuild relationships before it gets to crisis point'* (Homeless Link Policy Team, 2014).

Research carried out by Debs Quilgars and colleagues on homeless youth in the UK also identified a need for the further development of this approach, particularly where provided in conjunction with family intervention work:

*'One of the clearest messages arising from the research was a call for the development of 'respite' arrangements, whereby young people could move to safe, high quality accommodation for a short period of time to give them and their families a 'breather', and provide a supportive environment for all parties to rebuild their emotional resilience and renegotiate relationships. Such respite arrangements could be highly cost-effective if, for example, a two week stay could remove the need for a young person to leave home in an unplanned way and become homeless'* (Quilgars et al, 2011).

Quilgars et al. reported that the idea of therapeutic respite was raised unprompted in two of their case studies, as well as by a number of the national key players. They also found a rare example of such a service having been developed in Birmingham. This service was followed up during this evidence scope, however, we learned, from our own interview with the prevention services manager that the service no longer operates. See St Basil's below.

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### **St Basil's Time Out Project**

Prior to the implementation of the Southwark Judgement 2010 (see below), homeless services for 16 and 17 year olds had a two week window before a formal homeless application had to be made. St Basil's had been running a mediation service for some time and they combined this with the offer of up to two weeks in a supported housing scheme, during which time they carried out intensive mediation work with the family and the young person. There was no legal or statutory underpinning to the provision of accommodation to the young person. Arrangements were informal and based on the consent of the young person and their parents. The scheme was funded by a homelessness grant, and monitoring procedures recorded that 78% of young people utilising the provision returned to the parental home.

The Southwark Judgement imposed a legal obligation on councils to provide accommodation and to prioritise services under Section 20 of the Children's Act before considering a homeless application under Part 7 of the Housing Act 1996. The statutory basis for accommodating a young person thus had to be formalised immediately. This introduced additional costs and administrative duties, which proved prohibitive for St Basils, affecting the ability to continue the service. In 2011, following restructuring across the authority as a whole, the service was replaced by a more restricted Crash Pad scheme, which was itself then replaced, from September 2013, by a Supported Lodgings arrangement.

The Prevention Services Manager at St Basil's expressed regret that the more formalised regulatory framework, albeit one that offers greater protection and access to statutory support to homeless young people, had meant that the Time Out model was no longer viable within the local authority.

**Source:** Telephone discussion with prevention services manager and review of websites.

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### 3. Short Breaks for Children and Young People with Disabilities

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In the UK, the use of respite or 'short breaks' has a firmer footing within services for children and young people with disabilities. This model of short breaks has been widely developed across UK local authorities and Northern Ireland Trusts and there is consensus

that it is an effective, well established provision (Dowling et al., 2012). Short breaks away from home is essentially provided to give the parents (or carers) a break, and does not normally provide them with any therapeutic family support work – the presumption being that the family is functioning well except for the stress of coping with the practicalities of the child’s disability. Services available to the young people while they are being looked after are typically organised around activities that may contain a therapeutic element, but this is generally targeted at the improvement or management of the disability for the duration of the out-of-home stay.

The short break can be provided in foster care and residential unit settings. Children and young people with disabilities accessing such services in England are classed as V3 or V4 in the government statistics to underline the fact that they do not become looked after children and, as a result, the provision conforms to certain requirements (e.g. a pre-planned 12 month programme of breaks, which do not exceed a maximum number of days per visit or a maximum number of days in total during the year). We found a number of examples of the use of this type of short term care for children and young people with physical disabilities and, some that also included young people with learning difficulties (See Annex 4.).

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#### **Slough Home from Home Scheme**

A programme operating in Slough Borough Council provides a short break scheme with respite foster carers for children and adolescents aged 0-17 years who have *‘disabilities and/or learning difficulties and who are, in the main, not Looked After Children’*. The Home from Home scheme offers family based care for children currently living at home with parents or family members and can offer respite in a host family setting from a few hours per week to weekly overnight stays. **Source:** Correspondence with Selena Makepeace, Family Placement Service, Slough Borough Council.

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The extent to which these short break models provide much needed services for disabled young people and their families is demonstrated by the following example which reported a lack of capacity to meet demand.

### St Helen's Council

*St Helen's Council offers a short breaks service, the House Fostering Service, which provides short breaks provision. It includes 13 foster carer families and a residential respite facility for up to four young people with disabilities. The council report that both services are well utilised and that the residential unit reached 95% occupancy in 2013 – 14. The council note insufficient capacity to cope with peak time demands (weekends etc.) and that an increasing number of young people with learning disabilities are accessing the service, suggesting the need for a broader range of provision to meet short break needs of this group, as well as those with physical disabilities.*

**Source:** St Helen's Council, document review March 2015)

A similar model of short breaks for young people with disabilities is Shared Care. The main difference appears to be the voluntary nature of the carer relationship with the child and family. This model is becoming increasingly evident within UK services for children with disabilities and their families. Volunteer carers receive training and support to provide short breaks within their homes as well as an allowance to enable access to a range of activities. Evidence suggests that local authorities providing short break support have identified considerable need.

Although short breaks provision for young people with disabilities is mostly focused on offering a break and could be considered to reduce the likelihood of family breakdown, some provision for young people with disabilities has a more explicit remit to prevent entry to full time care. One respondent to the e-survey described their approach to supporting disabled young people with complex needs by using short breaks within a residential unit, alongside family based support.

### Thameside Metropolitan Borough Council

The residential unit provides short break care for young people aged 11-18 years, who have complex needs arising from disability. Young people using the services generally access respite for one night per week on average and do so as part of an agreed package of support, under either Section 17 or 20 of the Children Act. The service is integrated with health (speech and occupational therapists, complex needs, learning disabilities nursing) and education. In addition to the provision of short breaks, home based interventions, including a behaviour therapist, take place with the young person's family.

The Service Head outlined some of the benefits of the respite and family support provision: *'Enhanced respite provides a breathing space for parents to recommit to the young person. Support is provided on return home to enable the young person to continue to live within the family for as long as possible. For those young people going through transition it supports families and them into independent living. Provides a stable environment for assessment purposes related to long term planning for the young person.'*

The challenges of the service were the 'risk of increasing dependence on services' and the young person being unable to return home and therefore needing a full time care placement.

**Source:** E-survey provided by the Head of Integrated Services for Children with additional Needs. See Annex 4 for detailed practice example.

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Research carried out by Berni Kelly on young people with disabilities, highlights some of the factors that contribute to the effectiveness of short breaks provision for young people with disabilities and identifies possible learning points for the expansion of the model to young people without disabilities;

*'Short breaks should benefit the young person as well as offering a break for their parent/carer. The timing and nature of the short break is important for the family. Consistency of family carers or the residential staff has also been highlighted. In addition, support with the management of challenging behaviour or complex needs is valued. I expect all of these themes from research on short breaks for disabled children would be relevant to the development of a short break model of care for adolescents*

*on the edge of care'* (Berni Kelly, Senior Lecturer, Queen's University Belfast, interview March 2015).

Kelly and colleagues (Dowling et al., 2012) further note the need for more capacity within this type of provision to meet demand for disabled young people. They point to existing research that outlines the key benefits of short breaks for young people with disabilities and their family, which include: parents having a greater sense of control and feeling refreshed after having time to recoup their energy; reduced carer distress and depression; improved family functioning; an increased sense of 'normal' family life; and an opportunity to focus on other family members (Nankervis et al., 2011; Damani, et al., 2004).

Importantly, research in this area concludes that;

*'One of the key contributions of short breaks is that they may enable parents to continue caring for their son or daughter at home rather than seeking an out-of-home placement. Further investment in short break provision to extend the service available for families in need and, in particular, those on the [section] 47 'edge of care' may prove both cost effective in the longer term as well as supporting the life chances of disabled children and young people at this critical stage in their development (see McConkey et al, 2004 in Dowling et al, 2012)*

Whilst the overall aim of short breaks for young people with disabilities (i.e. to prevent family breakdown by providing a breathing space) is ultimately shared with such provision for non-disabled young people there are clear differences in broader objectives. For example, short break care for young people with disabilities is less likely to focus on young people and parental behaviour management unless it forms part of the disability, and is unlikely to work with families around parenting capabilities and family functioning. Short breaks for young people with disabilities might also form a long term feature of the child's life, offering support throughout childhood rather than a time limited intervention to carry out distinct work with the family, as is the case with edge of care short breaks. The literature also suggests that effective short breaks enables and empowers parents to *'take the lead in defining both the duration and mode of delivery in respite services they need'* (Aldgate and Bradley, 1999). Whilst short breaks care has the potential to empower and work in partnership with young people and families, that used for the edge of care group is less likely to offer the level of flexibility in delivering the short breaks provision. It might also be the case that edge of care short breaks is more goals orientated as the level of risk to the



child and thereby risk of removal from the family home is likely to be greater than that for young people accessing short breaks related to their disabilities alone.

Nonetheless, the research evidence on the effectiveness of short breaks provision for young people with disabilities carries some important messages for developing the model for other groups of young people (see Aldgate and Bradley, 1999; Dowling et al, 2012). Important features include:

- consistency of carer for building a strong, trusted and supportive relationship and offering stability
- short breaks of one or two nights work better than all-week breaks
- age-appropriate activities and matching helps increase engagement with short breaks services
- embedding short breaks within packages of support that include other services to maximise effectiveness
- ensuring short breaks provision is planned and reviewed to avoid slippage; recognition of individual needs in planning the package of support
- providing a local service to ensure the child can continue to attend school and other regular appointments and activities during the short break stay.

A key benefit that also transfers across the different recipient groups, and was echoed throughout the literature, was that time apart offers benefits for the child receiving the short breaks service who might gain from experiencing a positive care environment, as well as for the parent/carer and wider family as parents can focus on their own needs and those of other children or family members whilst their child is benefiting from care in a safe and supported environment. That said, the literature also cautions that steps need to be taken to minimise the negative impact of short breaks. Aldgate and Bradley draw attention to studies that have highlighted '*poor respite care arrangements and practice*', and stress the need for:

- assessment and supervision of respite (short break) homes, whether foster or residential settings
- recognising the importance of managing the potential consequences of separation (however short term) on young people
- being aware of the potential for drawing families into a culture of dependence.

The need for good preparation, matching, planning and review was highlighted as a means of mitigating against this (see Aldgate and Bradley, 1999, p2-3).

#### **4. Respite for Young People In and On the Edge of Care**

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The use of respite models, either in foster or residential care, for non-disabled young people at risk of family breakdown is more firmly established in other countries than in the UK. Research carried out by Janet Boddy and colleagues on preventative support for young people and families across four European countries, for example, found that both respite models and therapeutic interventions played a less prominent role in the English care system when compared to Denmark, France and Germany (Boddy et al, 2009).

Further examples of preventative respite models internationally include 'Shared care' schemes in the USA and the contact family service in Sweden, which provide alternative approaches to care by offering family support alongside respite provision (Andersson, 2003). Such examples have mainly been used to support families with younger children.

In Israel, a model of specialist short term foster placement was used to provide a time limited opportunity to carry out a full assessment of children in crisis to assess whether they can remain at home or may need to be received into care. This short term option provided placements at the point that difficulties had escalated to the point where it was felt necessary to remove the child to provide an opportunity for full assessment and treatment and though time-limited involved entering the foster placement full time during the assessment period.

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**The service is for children from birth to the age of 8 who are removed from home by emergency court decrees when they are in immediate risk of harm or coming into care.**

'The purposes of those families are first to protect the child and provide his/her needs; to diagnose the physical, developmental and emotional status; to diagnose the parent-child dyad. The result of those diagnose is a written report that will enable the committee which decides where to place the child to take an informed decision. A return back home is one possible result of this process with a therapeutic support to the child and the family during the child's stay at home. It could also be decided to place the child in public care if that's the picture that emerges from the process of diagnose. The question is.... whether at all and under which conditions the child could go back home. The child's stay in the respite care family is about three months....to usually about six months.

Another situation that could happen is that a child is in a regular foster care family placement and there is a crisis and he will be placed for a short time period in such a respite care family in order to dig out what is the best solution for him/her.

The diagnosis is made by paediatrics, developmental doctors (if needed), psychologists (specializing in young ages) and sometimes psychiatrists. Sometimes the intervention and diagnosis demands the intervention of a psychotherapist, it depends on the diagnosis needed.

In addition, the foster social worker is responsible on the diagnosis of the relationships between the child and the parents and the parents' ability to benefit from the dyadic treatment provided, all along the period the child stays in the respite care family.

The foster parents that belong to the respite care family are not also doing regular foster care. Children are coming in and out and it wouldn't be appropriate to mix long term foster care children with those [respite] children. The regular foster care family should provide the children with permanency and belonging, and therefore those are separated kinds of families.

To conclude the above, this special form of foster care is designed to enable the understanding of the situation (functioning) of the child and the ability of the parents to benefit from treatment that can lead to a change in their functioning and, if they do improve, the child goes back to them.

We do not have exact percentages to report but, estimates that about 30% of the children go back home after staying in such a treatment.'

**Source:** Correspondence with Dr Shalhevet Attar Swartz and Shalva Leibovitz (See Annex 3).

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### Respite Foster Care

Until recently there was relatively little UK research and policy evidence on the use of respite provision for non-disabled adolescents. One of the earliest UK studies focused on younger children being placed in respite foster care (Aldgate and Bradley 1999).

The review of evidence for the current study found a number of examples where respite foster care was used to provide short breaks for young people on the edge of care as well as those already in care. For example, respite foster care was used when existing foster or residential carers were unable to care for the child temporarily (during illness or holidays for example) or when a breathing space was needed to prevent care placement breakdown. This model has also been extended to young people as a step down approach from care to home (e.g. as part of reunification support), where the young person's care plan includes gradually reducing the number of days per week spent in care towards full time return home.

#### Lancashire Intervention for Families Team (LIFT) - Foster Carers Mentoring Families:

- Aims to facilitate a mentoring scheme whereby foster carers work with birth families when children come into care for a short period and where rehabilitation home is the plan.
- All foster carers are already approved. Foster carers who volunteer receive training – Level 2 Solihull training (see link <http://www.lancashirechildrenstrust.org.uk/resources/?siteid=6274&pageid=45365>)

Models also encompassed whole family respite support.

The Save the Family charity<sup>9</sup> was set up to provide whole family respite accommodation and family support. It reports success, in case studies and feedback, in diverting children away from care over many years but its residential offer is currently being squeezed out by the diversion of funds to the Troubled Families Programme (CSJ, 2014).

Respite support schemes are also available specifically for adopters, to provide supported short breaks to young people who are adopted to address their particular needs and to directly or indirectly relieve family stress and reduce the chance of adoption breakdown. For example the DfE funded therapeutic short breaks for adopted adolescents delivered by the charity After Adoption (See [afteradoption.org.uk](http://afteradoption.org.uk)) and also The Open Nest, which also

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<sup>9</sup> See <http://www.savethefamily.org.uk/aboutus/>

offers short breaks for adopted children and their families, (see <http://theopennest.co.uk/support-services>)

The existing evidence base suggests that the most common example of edge of care respite support in the UK is Support Care. Support Care, which utilises foster care, has been operating, since the early 1990s, and estimates suggest that, with the backing of The Fostering Network, around fifty models were in operation by 2011. The model is characterised by offering preventative short breaks from home, tailor made to suit the needs of the child and family. Existing research on this model, by Brown and colleagues (2005), has helped to promote its benefits and uses (as outlined below).

Support care has also been examined in terms of its costs benefits. One study carried out by the team at Loughborough University estimated that the annual cost of support care for a single child was just over £10,000, compared with an annual LAC cost of over £45,000, making it less than a quarter the cost of becoming looked after (Holmes et al 2010).

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### **Support Foster Care**

In April 2004, the Fostering Network was awarded a government grant to promote the development of support care in England. Research based on this initiative found positive results and produced recommendations on why and how support foster care should be developed. *'Support care sits at the interface of fostering services and family support services, offering a preventative intervention that avoids families becoming separated'*.

The provision offers planned, time-limited, short breaks away from home in conjunction with family support focused on promoting change and resolution of stresses.

*'Resources offered are flexible and tailor-made to suit family circumstances, providing day, evening, and overnight or weekend breaks that meet the needs of individual families. The flexibility of schemes allows the service to be responsive to families' needs and provide practical intervention when it is needed most'*.

The authors note that *‘Fostering departments constantly struggle to recruit sufficient full-time foster carers and they rarely have the capacity, within existing mainstream carers, to offer planned short breaks to children and families in need. Support care offers the option to foster part-time and is attracting both a new population of carers and carers who no longer wish to foster full-time’.*

**Source:** The Fostering Network <https://www.fostering.net>

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The authors concluded that 85% of completed support care placements surveyed were judged to have met the aims of the placement in full or in part. Key factors associated with success included:

- having, at strategic and operational level, a clear commissioning strategy; well-defined strategic aims, financial commitment and pro-active senior management support.
- effective communication between fostering, social work, family support teams and support carers.

The author’s also highlighted the importance of wraparound family support, recognising *‘that support care is not a stand-alone short-break service, but an integral part of planned family support work.’* They stress the need to work in partnership with families to empower them to retain parental control and choice and importantly to provide opportunities for regular consultation with young people and their families to enable the service to meet the needs of the young person and their family. (Greenfield and Stathum, 2004; Brown, Fry and Howard, 2005).

An increasing number of schemes around the country offer a series of respite foster placements over a period of several months for young people considered at risk of family breakdown. One of the earliest examples of a short breaks service can be found in Stockport.

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***Practice example. Stockport Metropolitan Borough Council Short Breaks***

*Stockport's Short Breaks Project is a well-established, integrated service offering edge of care short breaks with foster carers, as well as respite services for children with disabilities. 'We work with children and families either where there is a need for a 'breathing space' during a difficult time to prevent breakdown and the need to LAC. Also to provide support to enable parents to engage in services to address issues which could cause family breakdown and the child becoming LAC if not addressed.'*

The manager described the origins of the service;

*The original short breaks service was an in-house service set up in 2001 and, as such, possibly one of the earliest in England. The original referral criteria was children without disabilities, aged 0 –17 years with an allocated social worker. In August 2005 the Short Breaks service remit was expanded to include work with children with disabilities by bringing in-house the respite service previously provided by a voluntary organisation.*

*The Short Breaks Project predominantly works with children under Section.17 but will also support Section.20 placements when living with family members on a care order. The procedure for setting up short breaks placements is as follows:*

- *Referral from social worker (following a comprehensive assessment to check suitability for Section. 17 placement)*
- *Visit to the family in need, including: "Ensure they are ok with us sharing information with carer and understand that we work as a team"*
- *Risk assessment*
- *Matching up carer with the child, ensuring the carers are equipped to meet the needs of the child: "Consideration is given to family's needs and carers' skills sets, personalities and areas of interest and availability"*
- *Introductory visits to carer's home for child and parents*
- *Placement agreement meeting*
- *Individual safer caring plan to ensure that the child's specific needs are being met*
- *Assessment of training and support needs of the carers: "The training and support needs of the carer are given consideration and plans made on how these are met. For example, if a child with complex medical needs is placed and has mobility issues we would need to look at whether we need to arrange bespoke training around moving and handing and administering some medications. The carer supporting a teenager may need more support and advice on how to engage the young person and work to improve their awareness of risk and how to promote their confidence, self-esteem and ability to make decisions to keep them safe and develop positive plans for the future."*



*The Short Breaks Project Manager comments on the characteristics of referrals: ‘Older children and teenagers are often referred due to their parent’s inability to meet their needs and/or manage their behaviour. There may be a history of [Domestic Violence], Child Protection issues, substance misuse, mental or physical health issues, poverty, relationship breakdown and changes in the family, loss and separation, CSE, poor parenting etc.’*

*The Short Breaks placement aims and objectives involve a range of tasks to work towards supporting the child and the parents. The frequency of the breaks is usually ‘occasional’ overnights, i.e. two per month but, where there is a need, breaks can be as often as weekly. “We aim to move children through so that we have a transient population. Whilst we try to increase support when families need it we also try to decrease the level of support when things are improving. We work to end placements when families’ situations have improved in order to free up the placement for children in greater need. We therefore work to review placements on a regular basis and remain clear of our aims and objectives with each case.”*

*The role of the carer includes developing relationships with the child and family, building support, monitoring progress on the child’s development and abilities to socialise and feeding back: ‘The carer is a useful source of information, not only on how the child is doing, but they can also feedback on how the parent presented and engaged with them, which is often useful in the monitoring of cases where there are a very high level of concerns.’ It is noted that carers may be perceived as less threatening to parents than social services staff: “The carer’s role will be to develop a working relationship with the parents and work sensitively to provide them with help and support to develop their skills and awareness. Sometimes parents will not listen to professionals involved but will be more open and take advice from the carer.” Given the importance of the relationship between the family and the carer(s), the Short Break Coordinators “need to be mindful of this and ensure that carers retain ‘professional distance’, adhere to boundaries and have clarity of role.”*

*The amount of time carers commit to the Short Breaks Project varies: “Some carers do other full time or part time work outside of the home and only provide limited support to short breaks – i.e. 2 or 3 weekends a month and may only be linked with one child or sibling group. Others carers work full time for the project and will be linked with several children who may be worked with on a one to one basis or in groups depending on the outcome of the risk assessment and the carers experience, wishes and abilities.”*

*Note - children under 8 tend to have day provision with a registered child-minder or foster carer.*

*The Short Breaks project has included services for children with disabilities since 2005. Funding has been acquired from Aiming High to develop The Home from Home service, specialist foster services for children with complex needs; carers are employed on an intensive basis and their homes may need to be fully adapted.*

*Numbers and outcomes: As of 13/08/14 '84 children currently in Short Breaks placements (of these there are approximately a third of children in each of the three age groups – under-5 years, aged between 5 and 11, and over 11 years of age).' Of the 70 placements that ended in the financial year 2013/14, twelve of the children who had received placement had a LAC status. This included five children who had begun the placement as a looked after child, i.e. only seven went on to be looked after having received Short Breaks services.*

**Source:** E-survey response, Short Breaks Manager (March 2015) including supporting information.



Evidence from a recent costs benefits analysis of the Stockport model, separately undertaken by IMPOWER, showed that the model was delivering positive results in the years prior to our case study data above. The costs evaluation studied edge of care cases (i.e. excluding the disabilities services). It found that between April 2011 and March 2014, 189 interventions had been completed, of which only 20% (35) had since entered care full time by 2014. The research also reported that the scheme had worked with 15 adolescents who were already LAC and of these, 27% had been supported to return home by the time of reporting in 2014.

The cost benefit methodology applied involved the following approaches and limitations, as reported by IMPOWER:

stage	approach	caveat
Calculate costs of providing support care	<ul style="list-style-type: none"> <li>Identify aggregate yearly costs for the service, including management and corporate overheads, referral, review and closure processes and services that would</li> </ul>	Overheads have not been forensically calculated – manager estimates used

	<p>not be commissioned if the child or young person was accommodated</p> <ul style="list-style-type: none"> <li>• Divide by number of service users per year to establish unit cost</li> </ul>	<ul style="list-style-type: none"> <li>• Identification of wrap around services / costs reliant on managers viewpoints – no data available</li> <li>• Where an average, top-down unit cost has been used this doesn't show the wide variation of costs between cases</li> </ul>
Determine likelihood of support care users otherwise entering / remaining in care	<ul style="list-style-type: none"> <li>• Identify evidence of status and future journey of child before support care intervention</li> <li>• Develop conservative assumptions with service managers as to proportion otherwise destined for (continued) care placement</li> </ul>	<ul style="list-style-type: none"> <li>• Dependent on service manager views and estimates as this is counterfactual</li> </ul>
Establish effectiveness of support care intervention	<ul style="list-style-type: none"> <li>• Review outcomes data for completed support care cases</li> </ul>	
Calculate cost benefit	<ul style="list-style-type: none"> <li>• Calculate impact based on outcomes vs. likelihood of requirement of alternative</li> <li>• Calculate benefit based on cost of alternative</li> <li>• Subtract / divide by cost for net benefit / ROI</li> </ul>	

The costs of the Stockport model were estimated as follows:

Total cost to the authority of delivering support care (per year)	Average unit cost of delivering support care intervention	Headline prevention rate - % of non-LAC cases who would have entered care, and didn't	Total gross saving per LAC placement avoided (cumulative)
£277,400	£3,963	47%	£205,799

(Source: Thompson and Hammond, March 2015. North West Expanding Foster Care Consortium, Support Care Cost Benefit Analysis, IMPOWER.)<sup>10</sup>

The authors estimated that this equates to return on investment of 348% from support care for Stockport Council.

Another successful example of using short breaks in foster care that was found in the south of England. The service included in house and independent respite foster placements for adolescents, funded from the fostering budget. Again, a key area of work involved focused

<sup>10</sup> Permission to include information from Will Hammond, April 2015. For further details contact: whammond@impower.co.uk IMPOWER Consulting Ltd [enquiries@impower.co.uk](mailto:enquiries@impower.co.uk) [www.impower.co.uk](http://www.impower.co.uk). The authors note some of the limitations of their research: 'It is important to highlight that, due to the availability of data within the project timeframes and because savings calculations are based on counterfactual outcomes without randomised control trials, a number of averages, assumptions and estimates have been applied to which the outcomes are sensitive'.

work with the family, including a range of specialist interventions provided by a specialist team. This model placed emphasis on an early intervention approach to ensure that adolescents and families received the most appropriate type of response to meet their needs. The team aimed to reduce the number of adolescents entering care but also increase appropriate entries to care. A review of the service reported positive outcomes for the majority with most being appropriately diverted from care.

**Practice example. LA Anon 4 – Intensive support for adolescents on the edge of care, including short-breaks in foster care - Council in the south-west of England**

*The dedicated team [HYP] has been providing an intensive response to support young people on the edge of care to stay at home, or with wider family and friends and in their community, since September 2014. [HYP] focuses on early intervention with 'new' families and/or pieces of work with existing cases held by other teams.*

*'Aims of the service*

*1. The primary aim of [HYP] is to work with young people and their families on a consensual, Child in Need basis, to reduce the number of unplanned and emergency admissions of adolescents into care. A further aim of [HYP] is to increase the number of appropriate and planned admissions of adolescents into care. Admissions of this nature will be planned with a good understanding of needs and a high level of understanding of the young person's views which have been fully incorporated in the planning. All other options will have been assessed and tested (if appropriate) including FGC and kinship care.*

*2. [HYP] works with young people of secondary school age 12-15 for a period of 3-6 months with the aim of achieving positive and sustainable family and community based outcomes. The focus is primarily on young people aged 13-15 displaying difficulties that occur in adolescence. Practitioners involve multi-agency partners, including Health, Education and the voluntary sector to reduce the pressure on young people and their families. The work is highly influenced by the Functional Family Therapy (FFT) sessional model and processes. It also uses the same model in terms of maximum benefit being achieved within 6 months. FFT provides a clear evidence base for engagement, work and endings including step down within the 6 month period.*

3. A range of interventions and approaches are to be used, including Signs of Safety, Motivational Interviewing, Restorative Justice, Family Mediation, and Functional Family Therapy (FFT). FFT will constitute a third of the work of [HYP]. FFT is a home based intervention which supports families to have a greater understanding of their situation and helps them to look at ways in which tensions can be reduced. FFT focuses on engaging with adolescents and their families to reduce negative interactions. By using the strong emotional forces often present in these families as motivating factors, FFT seeks to reduce or eliminate the problematic behaviours and accompanying family tension by creating individualised behaviour change interventions [FFT not appropriate for all families].’ (Report to Senior Management Team, January 2015)

Referrals to HYP come from three routes: multi-agency referral unit, social work assessment and resource and care panels. Priority is given to working with young people who are at risk of being admitted to care and are exhibiting the following risks:

1. Are in an unplanned or emergency admissions to care, particularly those occurring out of hours and those who may have had such admission to care in the recent past
2. May be in unstable arrangements e.g. ‘sofa surfing’ (homeless 16yr and 17yr olds are worked with using current joint agency housing/social care protocol via CIN and 16+ teams)
3. Where there is evidence of the following risks:
  - Going missing from home (especially frequently and for prolonged periods and whereabouts not known)
  - Chronic and serious non-school attendance
  - Serious anti-social behaviours, offending, self-harming, alcohol and substance misuse, risk of child sexual exploitation.

Foster care short breaks are provided for 11 – 16 years olds in-house and independently as part of the HYP service, as appropriate. The care plan and package of respite is tailored to individual needs. The funding for the short-breaks comes from the fostering /agency budget.

The service requested an evaluation, including feedback from service users, staff and partner agencies. The Report for Senior Management Team (January 2015) concluded the following about the initial referrals: ‘...The vast majority of which have achieved positive outcomes and the young people’s circumstances have been stabilised and the young people have been successfully and appropriately diverted from care.’ The report

*discusses referral on and the challenges of the exit strategy: '[HYP]'s involvement will taper off gradually recognising that the ending of relationships can itself present challenges to young people and families. [HYP] is also mindful of the need to end interventions in a way that maximises the potential for service users to come back to [HYP] if they have not been able to sustain the changes.'*

**Source:** E-survey response by senior manager (March 2015) accompanied by in-house report, dated January 2015.

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The use of longer term foster care to provide preventative respite support can offer a crucial alternative to care for those young people and their families who might benefit from a breathing space, time to diffuse an immediate crisis and embark on a programme of work to resolve difficulties. As such it might constitute a valuable resource and option for those families for whom it is safe to remain together and also for local authorities, that can benefit by reducing the numbers coming into care and ensuring that those who do come into care are correctly assessed and placed. Whilst it represents considerable potential there are also challenges.

Whilst respite foster placements can provide a useful and suitable option for some adolescents on the edge of care, problems associated with the recruitment of foster carers could limit the potential expansion of this type of respite provision. Estimates from The Fostering Network suggest a shortfall in the region of 9,000 foster cares in the UK. In addition, managing the logistics of arranging short term stays for several young people using one foster placement could present obstacles for the local authority and the foster carers. This suggests that alongside the benefits of respite foster care, there is both scope and a need to expand the range of respite options to include residential options.

Furthermore, foster care is not always preferred by many older adolescents who need to come into care. A recent study of multidimensional treatment foster care (MTFC) for adolescents found that when asked about previous placements, though 50% of adolescents said they preferred foster care, 30% expressed a preference for residential care. The latter highlighted the group setting as being less intimidating '*I cope better in residential, I get stressed out living with a stranger*' and the desire to avoid replicating a family or a parent figure '*I already have a family*' (Biehal et al 2012).



Research also suggests that residential care may provide a more effective base for delivering short term therapeutic programmes of support to adolescents at risk of coming into care. Studies indicate that good residential care has the potential to better address the more challenging and complex needs of adolescents and is better able to tolerate difficult behaviour, than foster care (Biehal, 2008, Cliffe and Berridge, 1991). This may reflect the types of approaches used within residential care. The recent evaluation of MTFC for adolescents in England, for example, reported that *'on the surface, there was a lot of similarity between the support available in MTFC and in residential care, particularly in education and behaviour management [programmes]. The greatest contrast was with ordinary foster care where the structured programmes of support were not available'*. (Biehal et al 2012).

This reflects cross national research carried out by Boddy and colleagues. They found that in France, Denmark and Germany residential care was often the first choice, and emphasised its potential as *'an intervention for young people with complex and challenging needs that needed greater professional expertise than could be offered by foster care'*. The authors report that this approach very much emphasises some of the key differences between English and other European care systems, perhaps most strikingly in the uses and ethos of residential care. In particular the authors note that the use and effectiveness of residential care *'in part reflects the presence of a professionalised social pedagogic residential care workforce'* and rather than being viewed as a last resort, it is seen as *'a specialist intervention for young people whose needs cannot be met in family placements'* (Boddy et al, 2009 and 2013). Their research also suggests that residential units were more conducive to the working with family members, and noted that the involvement of birth families *'was seen as less challenging when children lived in residential settings than if they were placed in foster care'*.

Taken together this suggests considerable potential for harnessing the benefits of residential care for delivering innovative approaches to working with adolescents on the edge of care. Indeed residential options might prove particularly appropriate, *'since adolescents at risk of family breakdown typically have serious emotional and behavioural difficulties'* (Biehal, 2008, 2005; Sinclair, Garnett and Berridge, 1995; Triseliotis, Borland, Hill et al., 1995).

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## 5. Residential Respite Care



In contrast to Europe, where there is evidence of extensive use of respite or short term placement options in foster and residential care for children at risk of entering the care system (DCSF, 2009), the extent to which residential respite care is available for adolescents on the edge of care in the UK is difficult to ascertain. There is no single source of data in the UK that provides information on the prevalence of planned residential respite or short term preventative provision, either within the independent or local authority sector. During the course of this evidence scope, however, we located a number of examples of edge of care residential respite models operating or being developed across the UK. Nevertheless, there has been limited policy and research attention to this area, so the current evidence base is thin. We might surmise, perhaps, that in contrast to other European countries this is a relatively untapped area in the UK, as suggested by Janet Boddy in discussing her European research:

*'I was really struck by the lack of residential options compared to the other countries in the study – in all the other countries, the study found a version of emergency residential accommodation for children of any age with professionalized therapeutic support...In Europe (e.g. Germany) the emergency accommodation is a specialist service – well advertised, and the staff are specialists in crisis work, which is all they do. The provision is widespread so that, e.g. if you've got a family where the parents might go on weekend benders, the child might be OK in the home during the week, but then needs somewhere to go that's local at the weekends, and these services are set up for this kind of need'* (Janet Boddy, University of Sussex – Interview, April 2015).

Examples of short term residential care in other countries include:

- The use of weekday only residential provision for children that include an opportunity for parents to visit during the week to participate in therapeutic family work with their child and return home for the child at weekends (Germany)
- The use of boarding school provision for children on the edge of care<sup>11</sup> and
- Emergency accommodation with counselling services for young people running away (Germany, France and Denmark) perhaps akin to the services available to homeless young people described earlier.

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<sup>11</sup> Note - a similar approach is being piloted by Calderdale council as part of their CSCIP funding. Early findings will be available from March 2016.

The research evidence suggests that such provision can provide a beneficial and useful option within an overall framework of support and menu of options (Boddy et al, 2009). An important factor within these types of models is the scope for sustaining and building upon family relationships by involving parents in direct work, whilst focusing on the needs of the young person. Involving respite carers in carrying out direct work with families, as Boddy and colleagues have observed, requires specialist skills. In their European work, they found that residential staff in particular, had higher levels of qualifications compared to residential workers in England, often educated to degree or masters level in fields such as social pedagogy, family therapy or psychology (Boddy et al, 2013).

One of the few English studies to date to look at the use of residential respite care found promising results.

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### **Integrated Residential Respite Care**

A model of an edge of care service offering residential respite for the adolescent as part of a package of support to the whole family was identified and evaluated by Dixon and Biehal (2007).

The research examined one local authority's preventative approach, which brought together three services; social work, the community support team and an in-house residential unit to provide an integrated package of support for adolescents who were on the cusp of going into care. The service, based in County Durham, provided a series of stays of between one to three nights per weeks over a planned period of time in a four bed unit, alongside focused work with the adolescent while staying at the unit and also within the family home. A parallel package of support was undertaken with the parent(s). A range of approaches were undertaken, including positive parenting around boundary setting and communication skills, behaviour and risk management and positive activities for adolescents. The model, which continues to operate, is described in more detail in the following chapter.

The study focused on a sample of 25 adolescents aged 12-16 years, who received this preventive service in response to a perceived risk of imminent placement in substitute care. Data was gathered from adolescents, parents and the assigned worker from

each of the three key agencies at baseline when adolescents began the programme of respite care and at follow-up nine months later.

The key findings from the research include:

- The prevalence of high level difficulties and needs of the adolescents and their families using the service. Most adolescents and parents had multiple and severe behavioural and emotional difficulties, often long-term. Domestic violence, parent and adolescent substance misuse, truancy and running away featured in many cases.
- The importance of flexibility across the three professional teams in undertaking the programme of work with the adolescent and their families.
- Whilst the immediate crisis that brought the adolescent and family to the service was diffused, the more entrenched difficulties remained over time. For example, some difficulties associated with adolescent or parent behaviour or mental health, might have reduced but were still apparent at follow-up. The difficulties did become less severe and qualitative data showed that many adolescents and parents felt that the respite and support service had contributed to this improvement. Nevertheless, most remained above the clinical threshold for emotional and behavioural difficulties on the Strengths and Difficulties Questionnaire (SDQ).
- What often made the difference, however, was the ability to manage that difficult behaviour, demonstrating that improved parenting, communication skills and behaviour management skills for both the parent and the adolescent had improved coping strategies and relationships, thus avoiding family breakdown.
- At follow-up, the majority of adolescents had been diverted from care and remained at home with their parent(s).
- Importantly, as many as two thirds had spent time away from home in addition to the respite service over the follow-up, e.g. staying with other family members or entering care 'full time' for a short period of time.
- One fifth of the sample (five young people) had subsequently and appropriately entered care longer term; this appeared a positive outcome, as all had experienced rejection and emotionally abusive parenting over a long period of time.
- Factors that indicated likelihood of success included where families had successfully engaged in the programme of support and where parenting style had been characterised as weak and inconsistent.

An important issue that emerged from the Durham study was the immense value of taking a step back from the edge of care, not only to have an opportunity to work towards resolving the crisis, but also for services to get to know the adolescent (and family) in a more gradual and holistic way so that assessments and approaches can be more accurately achieved rather than being based on crisis presentation.

*'Douglas presented with multiple difficulties, including truancy and offending at referral to the service'. His social worker believed that attending 'Hilltop' had made a huge difference: 'He was very well behaved there. He was very positive and the staff there gave him some excellent positive feedback that he wasn't getting at home. They even reinforced...that deep seated belief in himself, that he was a really nice young person, intelligent, hardworking and it was a very positive experience. Praised him to the hilt and he took it on.'*

Having a cooling off period and time to readjust or at least cut through the anger and frustration that accompanies crisis, can prove invaluable to young people and their outcomes, whether they remain at home or move into long term care.

**Source:** Dixon and Biehal, 2007.

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### The integrated respite model

Over the ten years since this research was carried out, there appears to have been limited policy or research attention to this approach. That said, interest is increasing, perhaps incentivised by the DfE CSCIP initiative and related funding and the need to consider more effective, creative and cost effective approaches, including respite:

*..'A broader, more effective response to families reaching crisis point would include a more fluid use of care to provide respite while the intensive work with families and young people is undertaken... There should be flexibility for young people to access residential support in a crisis or as a form of respite'* DfE Children's Social Care Innovation Programme Rethinking support for adolescents in or on the edge of care (DfE, 2014a).

In addition the DfE recently highlighted the current situation where entry to care in some cases amounts to unintended respite provision, where many entrants to residential care, (and indeed foster care) return home to families within a matter of weeks anyway. The key difference being that they do so without the level of child and family intervention that planned preventative respite could offer.

*‘The DfE’s Innovation Fund (CSCIP) prospectus acknowledges that, currently, residential care frequently operates as a large, expensive, and often unplanned respite service, as one in four adolescent entrants are looked after for less than eight weeks and, in the worst instances, young people may return to homes and families that look little different from those they left a few weeks before’ (DfE 2014a).*

Our review of the policy literature found increasing reference to the value of respite in principle for adolescents and families in crisis as shown in the excerpts below.

A report by Homeless Link advocated a single integrated service gateway, jointly delivered and/or commissioned by Children’s Services and Housing which would offer, inter alia, therapeutically supported short-term accommodation if needed (Young and Homeless, Homeless Link’s 2014).

Respite for adolescents, as part of a wider package of support for families, also received attention in a report by Equal Opportunities Commission (Scotland) 2012:

*‘Mediation, respite and education are all vital elements of prevention and we recognise the extensive mediation work already being undertaken. We note that, whilst the value of respite was recognised by some, we heard much less about it. We believe that respite should be integrated into the mediation approach, as an option where mediation alone is unsuccessful’.*

Opportunities for respite to be made available more widely were also advocated by young people. Responses from 110 young people, either in care or care leavers, in consultations around the UK were reported by OFSTED:

*‘We heard that respite care, giving everyone a break from a difficult family situation, could keep a family together. The child or young person could go to a foster home or a children’s home for a short period’, and ‘respite would give all the people in the*

*family a break – so they won't explode'* (OFSTED Children on the Edge of Care (young peoples' views) 2011 (p9)).

The greater use of respite provision within a family support model also finds favour with The Association of Directors of Children's Services (ADCS). In a position statement on adolescent care, the ADCS recommended that *a model of shared or 'part time' care which 'deconstructs the binary care system'* should be considered:

*'Shared care may help to address some of the negative impacts associated with reunification, particularly repeated reunification attempts. This shared care model should be designed to help adults improve their parenting whilst providing an appropriate placement for the young person concerned. Shared care modelled on Special Educational Needs and Disability provisions, where care is provided within and out-with the family, and in a respite context, can allow a young person to maintain a level of connectedness to home and family particularly if the responsibility for care is shared with a supported kinship carer'. (ADCS, 2013)*

Challenges to practice included managing supply and demand, managing capacity and vacancies and avoiding empty beds, matching the group and, planning and reviewing provision. European research also highlights the need for a well-qualified and trained residential workforce to ensure high quality respite support. Importantly, there is a need to define what respite is and should look like, who it might best work with and in what statutory capacity, and at what stage does respite become something more akin to full time care or something else. For example, as Holman et al (1988) in Aldgate and Bradley, 1990) argue that after a month or so, short –term respite becomes 'shared care'.

In the following chapter, we present examples of current models of residential respite care in more detail.

### Summary Points

- Respite (also known as short term care, shared care, short breaks and time-out) can take many forms, including informal arrangements with family and friends or voluntary carers, as well as planned short stays in foster and residential placements for children already in care, those moving out of care, adopted children, young people with disabilities as well as children and young people considered to be on the edge of care.

- Evidence suggests that respite care, including that provided within residential care, is more firmly embedded within international (particularly European) children's social care systems.
- Much of the existing literature on the use of short term care for young people and families in the UK relates to young people with disabilities and to the use of short term foster care.
- In terms of the use of short term *residential* respite for edge of care provision, there appears to be little published or systematic evidence on the prevalence of such models in the UK and less still on its effectiveness. However, our own evidence scope has found a number of respite models operating across the UK, some of which have come about fairly recently and others that have been operating for several years to some extent under the research radar.
- Evidence from the review of existing models suggests that respite offers a variety of timely opportunities to support troubled adolescents and their families including: 'time out' to diffuse the immediate crises or relieve high levels of distress and tension. extend the scope to fully assess and understand the difficulties and thereby the needs of young people and the means of addressing them without immediate entry to long term care, which can exacerbate distress and difficulties; reducing the numbers subsequently going into longer term care and increasing the number of those for whom longer term care is the most appropriate option.
- There is emerging evidence from a few small scale evaluations and local authority internal monitoring reviews that short term respite options can represent cost savings to local authorities by reducing the numbers coming into full time, longer term care.
- To be most beneficial, however, the current examples suggest that respite should not operate in isolation, but as part of a planned programme of family and adolescent support to ensure that the safety of the child and support needs of the whole family are addressed.
- Evidence from the use of residential care per se suggests that it might provide a good base for undertaking short-term, intensive work both with young people and their families, including the use of evidenced based therapeutic approaches and outreach work. It is therefore possible that, for those more troubled adolescents, placements in residential respite care may be particularly helpful.
- Given the rising numbers of adolescents in and on the edge of care and the evidence of poor outcomes for adolescent entrants to care, there is a need to develop and test such methods of working with adolescents at risk of long-term placement.



- The use of respite can facilitate a move away from a binary system of being in care or out of care in which care is often seen as a last resort, towards a continuum or menu of options to meet immediate need with a view to addressing long term outcomes.
- Given the indications that good residential units are often better at addressing difficult behaviour than foster care, *residential* placements may provide an appropriate option for some 'difficult' adolescents, particularly where therapeutic or systemic approaches are used to work with young people and their families.
- The need for good quality preventative support to meet the particular needs of troubled adolescents and their families, however, highlights the importance of well trained and qualified carers. Research carried out on European preventative services found that professionals tended to be qualified to degree level in areas such as family therapy, psychology and social pedagogy (see Boddy et al 2013). Providing respite alongside family and child support will require a diverse skill set and UK respite carers (whether residential or foster cares) will need high quality training and support to deliver effective preventative approaches.

## 7. Residential respite care in practice.

In this chapter we focus on current models of residential respite within a programme of family and adolescent support for young people on the edge of care in the UK. We will refer to such models of integrated residential respite care and family support packages as *integrated residential respite*.

This chapter showcases five examples of current models from our primary data collection. It is worth noting that a broader range of approaches emerged from our review of the literature and from the responses to our e-survey and telephone interviews and these are described in Annex 4. These include a number of models already operating or proposing to operate integrated residential respite provision. Interestingly, given the lack of information readily available, some of these programmes are well established, having been operating for some years, below the radar of general research and policy knowledge. The chapter draws upon these examples (14 currently operating and 1 proposed) to explore the development, key components, delivery and perceived benefits and challenges of integrated residential respite models, including the rationale, aims and target group for the services. It concludes by highlighting some key factors for consideration in the further development of this type of provision.

### 1. Durham County Council

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#### **Case Study One. Durham County Council 'Moorside' Residential Respite and family support service.**

##### **Overview:**

Durham County Council provides a respite service for adolescents as part of a comprehensive preventative strategy. The council has provided respite for adolescents on the edge of care using residential units for the past decade. Moorside, operates as a dedicated respite unit. It provides respite for adolescents at risk of entering care and will also provide respite for young people looked after who might be returning home or require a break to prevent a care placement breakdown. The respite service involves an integrated package of support for the young person and their family, including access to respite, support from the community support team (CST) and the social work

team. The council also offers respite via the fostering team, mainly for young people with disabilities and for young people looked after in foster care where holiday respite is needed.

#### Rationale and history:

Moorside, was opened as a respite facility in 2004 following the closure of a local authority residential unit. The council identified a local need for creative options and made use of the closure of the unit to draw upon the expertise of the experienced staff team to reconfigure the remit of the unit towards offering respite. The service represents an early intervention approach, in picking up families with difficulties and acting quickly with a range of options *'the sooner you get out to the family, the sooner they get the help and support and you're more likely to resolve something'*.

There is a strong ethos of flexibility and responsiveness to best meet the needs of adolescents and their families.

#### Description of the service:

The residential respite provision is embedded within an integrated adolescent and family support service. Approaches to working with the adolescent and the family group include family group conferencing, mediation and restorative practice. The service comprises a multidisciplinary staff base with workers within the CST and Moorside bringing a range of expertise including youth work, mental health and substance misuse work and experience of working with young offenders.

The CST includes a manager, two team leaders and 18 community support workers; one of whom deals solely with family group conferencing, one leads on delivering and co-facilitating mediation and one worker leads on child sexual exploitation work. The wider remit of the CST covers pre-birth to 21 years of age.

Respite is provided at Moorside, a six bed local authority run unit, with a staff team of 12.5, including the house keepers. The respite unit has increased in size by one extra bed during its operation, to meet demand. One of the beds is generally kept as an emergency bed, if capacity allows it. The manager noted that the unit runs *'quite flexibly to meet needs...so we don't have a set percentage of emergency beds'*. Respite is offered for one to three nights per week with the same nights each week being agreed in advance to ease planning and consistency for the service and the family. The duration of the respite component will usually last for 12 to 16 weeks *'so the work remains focused'* though there is scope to extend the respite offer.

Staff from the residential unit will undertake outreach work by maintaining contact with the adolescent and family on days away from the unit.

Support from the CST continues beyond the respite provision to facilitate full reintegration of the adolescent and family and to continue support around working through difficulties and to assess

whether the family has the capacity to change. *'I would say its normally six months but it can go on significantly longer than Moorside, sometimes we've been involved for a year where there has been neglect'*.

The social worker retains responsibility for the care plan and case but has less input *'it was hoped that the social worker would be able to do more direct work but they haven't been able to'*. The CST worker takes responsibility for drawing up the work plan and three objectives are identified to address need. The work plan and objectives are agreed with the family and adolescent and shared with the residential worker. Though the nature of the work is clearly set out, there is a high degree of flexibility and responsiveness in who will carry out the work: *'everyone will be clear about the work they are going to do, it might be that the child doesn't engage with my [CST] worker and we might pass it over to the [residential] key worker to do, but we would build on it anyway'*.

The service has access to a range of family interventions and parenting programmes including mediation, restorative practice, family group conferencing and group work under the strengthening families programme. Direct work with adolescents includes anger management, communication skills, building safe relationships, including work around CSE and grooming and online safety. In addition, access to education support and positive activities is available to ensure a holistic approach to supporting the young person. *'Moorside will focus on the young person's talents and strengths and their interests and hobbies'*. The manager noted that this required careful planning to ensure that activities were accessible on return home to the family (and to other siblings). Review meetings for the respite service are held every fortnight.

#### Referral routes:

From the outset, the three teams operate jointly. A worker from the CST, the residential unit and the social worker will visit the family to discuss the respite option. Referrals to Moorside tend to follow two routes, either as a planned response (see below) or on an emergency basis, when the family is at crisis point and the young person is at risk.

*'if was this child is in danger of being accommodated today that we would step in and offer a crisis response to the family home, which we would then do together, one of the unit staff the CST staff and the social worker go out and in that case you talk to the parent about the local authority's policy not to accommodate and how can we support you, and they will be explaining community support, Moorside, family group conferencing, mediation and all the things that we can offer but giving a clear message to the family that we are not just going to take Jonnie into care to day'* (CST service manager)

The more common route is via a planned response to family difficulties as part of a broader package of support. The service operates a single assessment process and team around the family (TAF) approach. A referral to the respite service would usually occur after the first TAF meeting and 10 day assessment when some initial intervention had taken place via the CST. The placement panel

meets every two weeks so there will be some time after referral to undertake initial assessments, to unpick what has happened and what services have been accessed, and if at that stage the child can't stay at home, at which point they either go into care or if there is scope to work towards keeping the child at home, with intensive family support, respite will be suggested.

*'it might be further down the line when maybe community support have been involved for quite some time and you realise just how difficult things are for the family and suggest Moorside' (service manager)*

#### Characteristics of the target group:

The age range for the respite service is '12 up to the age of 18. There are occasions when we could take younger people but that happens very rare. It's really about safely matching groups on board, we have pondered over whether we need a similar facility for younger children but we haven't got the capacity to do that at this point really' (manager 1, Durham)

The services tend to work with adolescents with 'high end' difficulties and needs. The reasons for referral to the service include:

*'It would be around boundaries/ground rules broken down, parents inability to manage the young person's behaviour, it might be that they're on the cusp of being excluded from school, education, often CSE, they might be on the edge of criminality child sexual exploitation... Often it's an offence against the family, stealing from a family member or something like that that causes that outburst of conflict really.'*

The most common reasons for coming to Moorside are 'currently we'd say it was family relationships .... causing conflict sometimes, explosions of aggression either way with girls it tends to be them being aggressive to parents, with boys it often the other way round'

The legal status of young people using the service is most often Section 20 (S20), though on occasion young people are a Section 17 (S17 children in need) or on a full care order. The team explained that S20 provides some additional leverage. It is used to ensure a robust framework as young people will be subject to the usual looked after reviews as well as access to other resources for looked after children such as local looked after children education services, if it was felt that a particular young person would benefit:

*'...with LAC reviews you've got a broader view of the needs, their health and education. We've got certain services that can't get involved unless a child is a S.20.'*

The service manager noted that the LA's monitoring systems allow them to calculate the looked after children figures excluding those young people involved in the respite service. This meant that

the figures on placement movement and numbers going in and out of care were not affected by respite stays<sup>12</sup>.

### Effectiveness

The effectiveness of the integrated respite and family support service is evidenced by the demand for the service and extent to which it is achieving its aims. The service was estimated to have worked with around 1800 young people since it began in 2004. The council's own monitoring report for 2012-2013 showed that 82 young people had used the service that year and, of these, 37 had returned home and did not become looked after (some of the 82 were already looked after young people).

The council's data shows that the number of children in foster and residential care is decreasing... *'this is cost effective, Durham has always had a strong invest to save strategy, always put in money in the front with the will to saving at the back end, and it does work.'* The cost benefits also reflected positively on the service. Funding comes from the general children's services budget. A 2013 monitoring report showed that the annual running costs of Moorside stood at £542,000.00 *'a breakdown of how much money I believe we had potentially saved from having Moorside is £5million'*.

### The benefits:

In terms of the added value of the respite, in addition to the family support service, the manager summarised the key benefits:

*'I think it gives the family space and it helps young people to broaden their horizons...if they're in conflict at home or issues around neglect, they come here and they go to school and it's a different life. If they are accessing Moorside, it helps them to see a different life...introduces them to something in their local community or someone who can be a role model'*.

The manager also noted one of the key benefits of offering respite within a residential unit:

*'Some young people just aren't interested in another family...it's not that foster carers can't manage the behaviour, it's sometimes the young person won't invest in family life'*. In addition to this, managers agreed that it might be unrealistic for the level and range of work to be undertaken by a foster carer, however skilled they might be. For example, the residential workers will carry out work with the family in the family home and will work closely with the school, as well as having access to a range of resources.

A further benefit of respite was for those young people who did go into longer term care, did so in a planned way, which increased placement stability: *'everyone who had moved onto residential care from Moorside, stability has been 100%. We haven't moved anyone or had a placement breakdown'*.

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<sup>12</sup> Department of Education guidance on submitting SSDA903 returns state that young people using respite should be recorded as V3 or V4 (see DfE, 2014c).

## The challenges

The main challenges of running the respite provision involved coping with the level of demand *'the phone never stops ringing. It's really busy, so keeping on top of activity is challenging'* There is also an increased level of statutory and administrative procedures to process when working with a large group of young people using the residential unit, and the flow in and out each week including risk assessments, which are completed before the first respite stay and are updated weekly as staff get to know young people and issues become more apparent. There might also be a need to increase staff levels if some young people have a higher level of risk and require more one to one support.

Operating the service across a large county could also incur some challenges, particularly around transport charges to get the young person to and from the residential unit and the young person's school or family home.

## Why it works?

### **Senior management and structures**

Durham has managed to maintain their front line services within the current economic climate. The team also noted the impact of having strong and supportive leadership: *'we've been encouraged over a number of years to think creatively about how we offer services and our senior managers have welcomed ideas and support them... We've got a head of services that believes very strongly in Moorside and the benefits, it's a working way of preventing a child becoming looked after'*

### **Engagement with family and young people**

The team emphasised the importance of building relationships with the family and getting them on board with the provision. A strong message to the parents is that they too need to work alongside the services to resolve the difficulties: *'respite is not a sticking plaster – it has to be part of a longer term package of family and adolescent support 'it's about giving parents a clear message that we acknowledge that you're having difficulties with your child...and we can offer you some respite, but whilst you're accessing that respite we want to have someone work with you too..., so respite...it won't resolve unless you work with the CST and you must work alongside the key worker allocated to your child from Moorside'.*

To facilitate engagement, considerable effort is put into direct contact with the family from the outset, including visiting the family and arranging a visit to Moorside prior to the first respite stay to reassure the family group. *'I think young people and families have a stigma around being in a children's home and taking that initial step is hard for families'*

It was also felt that having access to a more diverse staff team who were not social workers might also facilitate engagement in the early stages, even making the process less adversarial or intimidating:



*'..We will be creative about how we introduce them to Moorside.' It might be that the social worker isn't the best person to take the young person for a visit...the fear of the young person if they go with the social worker, so a CST worker might take them'.*

## 2. North East Lincolnshire

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### **Case Study Two. North East Lincolnshire Vulnerable Young People's Project**

The North East Lincolnshire Vulnerable Young People's Project has been established since July 2009. The VYPP is an in-house 3-bed residential respite/short-breaks unit funded by the local authority. The residential unit is registered for young people aged 8 to 17 years old of both genders. Two beds are for planned respite and the third bed is for young people in more acute crisis, i.e. due to a care placement breaking down or referred by the police due to family breakdown. The service aims to provide a breathing space for young people and their families on the edge of care and to those young people who may oscillate between their birth family and care. The unit booklet for the young people says the following:

*'[VYPP] is a three bedded short term respite service offering sleepovers for young people that need some time and space to themselves. The unit is run by North East Lincolnshire Council to provide respite care for young people aged from 8 to 18 of either gender, who for whatever reason have chaotic and hectic lifestyles.'* (Welcome to the Vulnerable Young People's Project, 2012)

Planned referrals are predominantly from social workers and may be to prevent re-entry to care, in addition to first entry to care. All of the young people are S17 CIN and/or on child protection plans and there has to be a minimum of three agencies involved in the young person's life. Referrers must prove that they have explored all avenues prior to respite being requested. The planned respite includes careful matching based on extensive referral paperwork. Parallel family support is provided by the Family Resource Service, working within the Children's Assessment and Safe-guarding Service (CASS).

Respite starts at 3pm every day and ends at 8.30/9am the next morning during school term-time. During school holidays it operates 24 hours a day. The provision offers activities, trips and helps young people to develop independent living skills and positive relationships with adults. Most respite stays are for 1 night a week and respite could go on for some months or years, depending on the needs of the young person. In summary, the package of support, respite frequency and duration, and exit strategy are needs led. The number of nights of respite/year is also dictated by

legislation, i.e. avoiding young people being eligible for looked after status (reported by the Unit Manager as being a maximum 75 nights per year).

*'...Part of the referral process...there is a clear bit at the bottom that clearly says 'Why does the young person need respite?' We really make the social worker elaborate as to what their needs are, whether it is self-esteem or nurturing or whatever it is...From an Ofsted point of view they want a baseline of where the young person is at when the young person comes to us and then they want to see the progress we have made. So we clearly record all progress as well.'* (Unit Manager)

*'We don't drag young people kicking and screaming here. It's got to be something they want to do and want to engage in...sometimes we invite them once week just for an hour for a tea visit and then the next week for another tea visit and then the following week they may go on an activity with us and maybe the other young person here. Then eventually it gets to the point where they are asking us if they can stay'* (Unit Manager)

The unit was previously rated as outstanding by Ofsted. The internal progress and outcomes report for the ten month period April 2014 to February 2015 states that family breakdown was judged to have been prevented for 62% of those young people receiving planned respite (13 out of 21 individuals). Five individuals (24%) did enter care, two remained in their long-term foster placement and one went into independent living.

*'...there are a few that do come into care, but some children need to come into care. There is no point in us trying to prop something up and sort something that is not right.'* (Unit Manager)

The NE Lincs VYPP also runs term-time alternative educational services for young people who have been excluded from school. These are pastoral services and taken up on one or two days a week by the young people.

Source:

Planned and recorded phone interview with Sandra Snell, Unit Manager (March 2015) plus reviews of service documents and outcome data.

### 3. Shropshire County Council

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#### Case Study Three. Shropshire County Council Havenbrook Short Breaks

Havenbrook opened as a 'short breaks' provision in June 2014, initially as a planned short breaks facility for children who had been identified as vulnerable children in need and at risk of family breakdown. In September 2014 the provision of emergency short breaks was incorporated into the scheme for children experiencing an immediate crisis.

A key principal of the service is early intervention. According to the 'Shropshire Council, Havenbrook Short Breaks Planned & Emergency Pilot Evaluation Report, June - December 2014' (January 2015) the provision is part of the wider Looked After Child strategy which has the following principals:

- To prevent children and Young People needing to come into the Local Authority care system where it is possible and to support them to remain in their family care where it is safe to do so.
- To deliver services with flexibility and using innovative approaches to provide a range of services to children and families to provide the right service at the right time.
- To ensure that where children need to come into LA care assessments and care planning are progressed without undue delay, achieving permanent and stable outcomes as soon as possible.

Havenbrook is an in-house four-bed unit that originally operated as an assessment unit for children entering long-term care. Alongside the short-breaks facility, family support is offered, including parenting programmes focusing on teenagers and Family Group Conferencing. Currently Shropshire is investing in outreach services as part of the residential redesign.

The target group for respite provision are those children and families that do not have an informal network of support to help through the family crisis (e.g. extended family or friends). Children can be referred aged 8 to 16 years. Characteristics are broad, but predominantly children with behavioural challenges and relationship difficulties with parents and/or siblings. Further difficulties include substance misuse, learning difficulties and violent behaviour. The majority of referrals are through social services and the families are likely to have had previous contact. Referrals may also be made by lead professionals in education or health. Social work and early help assessment tools are used to develop intervention plans. Usually children enter the service as Children in Need under Section 17, but some will revert to a targeted early help plan once the short breaks intervention is in place. Those families in crisis that do have an informal support network are likely to be offered family support services and Family Group Conferencing.

*'At first there's an element that's down to that professional assessment and professional judgement, but we believe without the resources and without the intervention that the child's family would break down and would need to go into LAC. We would still work with children's families who are experience problems under section 17 or in early help that are not the edge of care because their own family and friends can be their network of support, with working family group conference. It's those that we are working with who don't have that network of support,*

*or they aren't in a position to offer help and support with the needs of the child'. (Head of Children's Social Care Services and Safeguarding)*

Short breaks are for a duration of 4 days. Initially a social worker can book in 3 periods of respite at Havenbrook before the care plan is reviewed to see if the child's needs have been met. The frequency of stays varies from just one visit to a succession over the year. The maximum available is three per month. Where children are using Havenbrook on a planned basis the staff are able to pay attention to matching.

*'So those that have short breaks on a regular basis (maximum monthly 3) the unit are able to match those children. If they come and they really get along with someone and they're planned to come for another break we will match them to come together. Or if two haven't met yet and we know them we might think those may get along well together, we not had anybody who doesn't get along'. (Head of Children's Social Care Services and Safeguarding)*

Staffing levels are equivalent to those residential units for children looked after: 7.5 res social workers, 3 shift leaders, a deputy and a registered manager. Havenbrook offers children a break from the difficulties they may be experiencing. Activities offered build on their current interests and leisure pursuits, but also look to spark interest in new occupations, e.g. swimming, walks in the countryside and car mechanics. Parents are then encouraged to set up equivalent activities within their own community. If the child is attending school they will be taken by staff.

*'...it's just giving young people time, attention, sometime it's just a break from a very busy or stressful family life, time for them to clear their heads and have some time out. Equally the parents the [at the] other end who [are] spending time with other siblings, whilst knowing their other child is having a great time. The biggest thing that works for us, is that has been said by the children and the parents, that they haven't been put in care, and that feeling that the parents have put their kids in care, they can't cope any longer so they're going to put them in care. However desperate the parents feeling at that time, children feel rejected and the parents feel guilty and what we know as Children's Services is that we have to then work with a whole lot more problems and emotions, and challenges that have come about because the child has been put into care. They don't have to rebuild relationships as they haven't broken down'. (Head of Children's Social Care Services and Safeguarding)*

Havenbrook staff offer consistent approaches to behaviour and aim to support children to break the cycles of negative behaviours. *...Havenbrook is a great chance to rewrite them...* (Head of Children's Social Care Services and Safeguarding). The new outreach staff will be working with parents on behaviour management as part of their remit, using approaches adapted for teenagers that have proved successful in the past. Funding for the short-breaks provision is from the placement budget (residential), i.e. local authority core funding. Havenbrook is also used to aid reunification where the care plan has identified that short-breaks will aid rehabilitation for the child and family.

Benefits identified – the short breaks and outreach provision adds to the range of options beyond full-time care. It is estimated that the prevention through Havenbrook saves at least four months costs of residential care. Entering care can add a secondary layer of issues for the child and family to address, in addition to the primary concerns. The respite and family support model means that the primary difficulties can be addressed.

*‘sometime when your child has come into care and gone into another environment, either a residential or foster care, all of the emotional things that come with that, none of those things are to do with the actual reason that the family broke down with in the first place, they’re all new problems and challenges and problems because that child has come into care, and to be able to take those away is amazing’.* (Head of Children’s Social Care Services and Safeguarding).

Challenges identified – Weighing up best value against the wider picture. Not feeling that a bed has to be filled by an inappropriate referral just to fill it. Balancing the resources with the individual needs of the children using the service and maintaining the flexibility required, e.g. not every child needs a monthly short break. Paying very close attention to risk assessments and plans of those coming in on a crisis basis.

Outcomes and evaluation - ‘Shropshire Council, Havenbrook Short Breaks Planned & Emergency Pilot Evaluation Report, June - December 2014’ (January 2015) reported that of the 29 children taking up planned respite in the 6-month pilot period: 27 remained with family, 2 went into care. Of the 27: 10 continued to have short breaks on a regular basis, remaining 17 only required respite on short-term basis, e.g. on 1 occasion only. Of the 13 young people who received a crisis short break, six went on to be received into local authority care, six went home to parental care (including 4 who continued to receive short-breaks) and one moved into a 16+ supported living arrangement. Parents contributing to the evaluation talk of the family situation being calmer due to having a breathing space and children’s responses indicate positive outcomes, including the majority feeling that Havenbrook helped them with difficulties at home.

The report concludes: *That the provision of short breaks for children on the edge of care and at risk of family breakdown achieve positive outcomes for the child and family which have been sustained for up to six months...The threshold for ‘edge of care’ is applied and therefore the evaluation evidences a reduction in demand (33 children) for LA care although this needs to be seen in the context of rising demand for social care and LAC care in Shropshire, regionally and nationally.*

Source: Planned and recorded phone interview with Tina Russell, Head of Children’s Social Care Services (March 2015) and review of Safeguarding, Shropshire County Council plus in-house evaluation report.

## 4. Wigan Council

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### Case Study Four. 'The View' Short Breaks Service, Wigan Council

The View 'Edge of Care' service has been in operation since November 2013. It offers a 'dual purpose service to support young people and their families where there are risk areas which could lead to family breakdown inevitably leading to the young person becoming looked after by the Local Authority'. The service uses 'a restorative, asset building approach with families'.

#### Rationale and history:

- Growing number of adolescents with challenging behaviours entering care. *'Over the last seven to eight years, we've got...more young people coming in to care around 14, 15 and even 16 years of age, the late entrants really, all with quite challenging behaviours and many of them were around families managing those behaviours...once they come into care so late you're not going to affect massive changes and young people just drift in care.'*
- Exploration of MST approaches, in addition to the use of residential short breaks. *'I was asked, can you do something – clearly there's a need in Wigan, where young people are coming into care late, but then going home quickly as well – is there something we can be doing better, to support families, to prevent these children from becoming looked after children? So that was the model we tried to look at, and we came up with a template and that was how we set up The View.'* Moving away from the one size fits all model of through-care services.
- Closed down an in-house residential unit and operated the short breaks and family support service with the existing staff.

Registered for five beds: four beds for planned short breaks and one for emergencies.

#### Emergency provision:

- For young people on police protection orders or children subject to the Police and Criminal Evidence Act who have been abandoned or emergencies where there's no primary carer available.
- For a period of up to 72 hours, by which time the service will have either managed to get the young person home with the family or an extended family member or a further decision will be made by a placement social worker that a longer period of accommodation in fostering or residential is required.
- If the stay is for over 24 hours the legal status is automatically Section 20.

#### Planned short breaks:

- Most young people take up planned short breaks on a Section 17 basis. Those entering emergency respite for over 24 hours automatically become Section 20.



- Preventative, planned social work intervention which usually lasts around six months. The plan may or may not involve short breaks, depending on the needs of the family and whether the breaks would help to relieve some of the pressure.
- *'We don't do more than two or three nights a week, on a planned basis, the idea being that if they have a short break, it starts off quite high and then by the time we're ready to close the case they're not having breaks at all, we step it down, and they [the family] become able to manage that young person themselves, within their own family.'*

#### Characteristics of the young people and families:

- Teenagers
- Some at risk of CSE.
- Risky behaviours, e.g. substance misuse
- Challenging behaviour.

**Referrals from:** *'It usually comes via the SW, who will have reached the point where they're really struggling with a family and they would do a template referral and most of them do get accepted. It's very few and far between that we say no, we're not going to go with this. We'll then have a placement meeting where we'll discuss what is it that the family need...build a plan and then we'll have an introduction, the family will come and visit, we'll show them the resource and what to expect, and then we'll have regular weekly meetings, where each keyworker is aware of everyone else, so that if they're on shift they know what's happening with each family; a bit like the MST model.'* Contracts and expectations agreed between the family, young person and service.

**Family Support:** *'each worker has a caseload of around four or five young people. They do planned interventions, it can be anything from activity based in the community; getting them to engage in things. It can be giving parents strategies in how to respond to young people in a certain way. It could be self-esteem work, it could be working on safe internet use, whatever really is identified in the referral as a need for that family. We also use Family Group meetings. We have a team of staff that work very closely with The View, they will go in and help build on the strengths within that family. They look at asset-building, what are you good at, what do you do well, where's your family support, and then help them build up their own network.'*

**Multi-agency working:** YOT (including restorative solutions), substance misuse team, Brook (sexual health) and healthy living trainer. Looking to obtain funding for an EET worker, as many of the young people have issues with poor school attendance and employment. Virtual School is only for LAC.

**Stepping down/exit strategy:** *'When everyone agrees that there's less concern about whatever brought the young person into the service, there would be a meeting and there would be support literally on outreach only, and then we would close the case. What we're hoping to do, we've only just been fully functioning for just over a year, we're going to track those young people at six months*



and 12 months, after the case has been closed, to see whether improvements have been sustained and how the families are coping.’ Only a couple of re-referrals to-date.

Current funding: Existing children’s homes budget.

#### Benefits:

- Reduction of the number of young people coming into care.
- Reduction in cost of long-term care and leaving care services.
- Better outcomes for young people through maintained relationships with their families.

**Challenges:** The negative aspects of the mix of young people staying in the short break service, particularly around escalating high risk behaviours. This was addressed via group work with young people and support provided to parents to help in addressing high risk behaviours and CSE in particular.

Lessons for other local authorities thinking about setting up a short breaks residential unit:

*‘Certainly about the mix of young people - to get that right. To be clear in referrals about the characteristics - it certainly can have a massive impact on the productive work. I think having confident staff, because initially we didn’t have any training for the staff, they were just the residential workers, and it was about sourcing the right sort of training that gave them confidence, like the restorative solutions that was really helpful for staff [from YOT].’*

#### Innovation funding and new developments:

- Edge of care residential short breaks for young people with mental health and behavioural difficulties (e.g. self-harming) – for adolescents on either edge of a secure setting.
- Specialist wrap-around service with CAMHS – including outreach and support.
- Safely furnished and refurbished in-house residential unit – in addition to “The View”.
- 4 beds - 3 planned short break beds and 1 emergency.

Represents a longer term, planned reduction in residential care with an overall shift away from residential provision towards family support.

*‘It’s a balance of having quality residential placements which will always be needed... we’re investing in a clear system provision for the long-term children’s homes, but also moving the focus to edge of care, so we do preventative... It just felt the natural way to go really. It just seems the next stage really. It was done out of goodwill and it seemed right, and we just got on with it.’*

Source:

Planned and recorded phone interview with Lynne Bennett, Team Manager, Wigan Council, plus In-house Scrutiny Report, March 2015.

## 5. Blackburn with Darwen Council

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### **Case Study Five. Blackburn with Darwen Adolescent Support Unit**

Prior to 2006, services for adolescents in Blackburn with Darwen included a number of children's homes and a therapeutic support team doing outreach. The children's homes provided full time care for adolescents who had to be looked after, and the therapeutic team worked Monday to Friday during office hours. There was a recognition that neither was set up in a way that was as user friendly as it could be. Full time care was not suited to some young people's needs, and the outreach team was not flexible enough.

Together with the influence of an Invest to Save initiative, managers came up with the idea of therapeutic residential respite care both to improve provision and reduce residential costs. The success of providing respite care to families with disabled children was also part of their thinking.

The residential unit consists of 4 beds 3 of which, in principle, are allocated to planned and ongoing respite needs, and the remaining bed is kept back for emergencies. Overnight respite care is available up to four nights per week from Friday to Monday inclusive. The unit is open until 10pm Tuesday to Thursday. The young people/staff ratio is always at least 2:1, and the manager can call on additional support if any of the young people are particularly difficult to handle, though this is rare.

Staff in the unit are experienced residential workers who have either developed good, if informal, skills in mediation, or who are trained to deliver the Strengthening Families Programme. Part of their remit is to provide outreach, and to work with the families in their homes to try and prevent family breakdown. If necessary, specialist staff can be brought in for particular therapeutic needs.

A Panel is held every Wednesday to consider referrals, which all come through social workers. The target age range for the service is 11 – 16. They will consider and have worked with quite a few families with 10 year olds, but they won't offer the young person respite accommodation until they are 11. They will also continue working with young people past the age of 16 if they need it.

Two of the biggest challenges are the practical logistics, and the need to 'match' the young people in the unit.

*'If there isn't an emergency, we can allocate the 4th bed to whoever we think needs it – or, sometimes we have 3 – 4 emergencies and have to prioritise. Friday afternoon can be a little bit manic sometimes ... depends on the individual plan – some young people don't have any overnights, some maybe have 2 nights a week over a period of time. Some we need to work with intensively at the beginning – they might come for three nights, some come for one. We have worked with 45 – 50 families at a time, but some of them only need outreach maybe once or twice a week. Some of the families we've been involved with for quite a time and they just need a bit of a maintenance programme, maybe see them once every couple of weeks once we've got them stable ... Maintenance is really important because otherwise things could go pear-shaped again... It's all individually planned, no set rules at all ... If we get a 14 or 15 year old with particularly risky behaviour, we have to be very careful about who we would put that person with – so we have to think about matching, or maybe getting an extra member of staff in – we do work extremely flexibly.'* (Residential Services Manager)

Statutorily, the young people can be either S17 or S20 Children Act referrals. The manager reported that, at one time, the young people would have had to have been formally accommodated the minute they came in, but now there is the time to do some work with the family first – 'we can give them that time out'.

At a national conference workshop in October 2014, it was reported that, as a result of the unit's work, the numbers of teenagers coming into care fell from 47 to only 18 in 2013/14.

The new service (which began in 2014) has attracted press interest, including the Guardian (<http://www.theguardian.com/social-care-network/2014/oct/29/blackburn-innovative-support-unit-residential-care>) and recently hosted an open day that attracted visitors from a number of local authorities and service providers.

Source: Planned and recorded phone interview with Sandra Martin, Unit Manager plus Survey Monkey response, service documents and press articles.

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### What Can We Learn From The Models Of Integrated Residential Respite Provision?

Qualitative analysis of the 15 practice examples gathered from our e-survey and telephone interviews (see case studies above and practice examples in Annex 4) was conducted to explore some key themes around components of service development and delivery and the characteristics of service users.

- 1) Service rational and aims

In exploring how and why the integrated residential respite provision had come about there were a number of key drivers, including improving services and outcomes for adolescents, making more efficient use of existing resources (such as care homes) and financial incentives around reducing the numbers coming into care.

There was a strong recognition across the models of the distinct challenges and difficulties experienced by older children and young people who come to the attention of children's social care and the desire to better meet their particular needs. This included a common aim to make greater use of preventative strategies to work with troubled and vulnerable adolescents and their families: *'we try really hard to keep the family together'* (Swansea Family Support Service, Deputy Manager). This aim appears to be driven by a number of different factors (either individually or combined). For example, a number of the models specifically state the aim to reduce the high number of adolescents going into care, either as a means of improving individual outcomes for young people and families (e.g. a chance to address the primary difficulties for the young person rather than the secondary difficulties that can arise from coming into long-term care, as noted in case study 3 above) and/or to reduce the financial costs to the local authority of entry to care:

*'The rationale was based on the national figures that for ...young people who went into the care system over the age of 14, 1 in 4 go home in 8 weeks to families that haven't changed, and many of those come back into the system as well. We know that the outcomes of the young people who enter the system late are not good. When we looked at our own figures we were 1 in 2 not 1 in 4. It was costing us a lot of money to basically offer short term respite, in the sense of removal from home'* (LA ANON 2, Head of Service).

Some of the models were driven by a desire to explore more flexible, creative or tailored options to meet the individual needs of troubled and vulnerable adolescents and families. Equally, integrated residential respite was also seen as a means of addressing difficulties earlier and more effectively, thus diverting the crisis that could often result in entry to longer term care: *'the sooner you get out to the family, the sooner they get the help and support and you're more likely to resolve something'* (Durham Focus Group). For example, the provision of planned and supported short term entry to care was seen as an opportunity to provide a breathing space for young people and their families, during which further work to identify and assess needs could be undertaken and further plans put into action accordingly, including, a more planned and supported admission to full time care where needed:

*'Even if children eventually are looked after I think you can say actually we have done everything we can to really look at if this will work to keep the child at home and hand on heart could we say that now for all children and families...Sometimes all parents need is the ability to have a break, have some time out, have some additional support...and some intensive work to have been done with the child as well as the family' (LA ANON 3 – Group manager).*

Further motivation for developing an integrated residential respite model included recognition of the benefits and successes of short breaks schemes for children with disabilities operating across the country, as was the case for a proposed model (see LA Anon 3) and case study 5 above.

In around half of the examples explored, the need to reconfigure staffing and resources after restructuring or closure of long-term residential units was highlighted as the impetus for developing residential respite provision. The development of the model was viewed as a good use of vacant residential units and importantly an opportunity to retain residential staff teams and make maximum use of their skills and experience of working with older children and young people:

*'...originally we closed one children's home and we developed strengthening families...intervention with young people and their families within the community to prevent the need to go into the care system and this has been very effective' (LA ANON 2, Head of Service).*

## 2) Characteristics and referral criteria

There was some variation in criteria for accessing the integrated residential respite models, though all focused on the adolescent age group. The age criteria ranged from eight to 17 years at the point of referral, with most receiving young people aged 10 to 17. In some local authorities it was stated that the associated family support services worked with children younger than eight, which in some case could include the younger siblings of the young person initially referred to the provision.

Contributors to the study offered broad terms to describe the characteristics of the families and young people falling into the edge of care target group, such as:

- At risk of family breakdown
- On the *'cusp of care'* including those needing emergency accommodation
- Considered at risk of becoming looked after

- Family in conflict/in crisis
- Having ‘*high end*’ difficulties
- The young person has a hectic and chaotic lifestyle
- Family known to the service/has had previous admissions to care and experiencing continued crisis
- Known as ‘*troubled families*’.

More specifically, young people and families with a high level of need and a range of risk factors were described. For the young person this may include characteristics such as:

- Emotional and behavioural difficulties
- Challenging behaviour, sometimes of a violent nature
- Involvement in criminality
- School disruption, absence and exclusion
- Running away / absence from home
- Substance misuse
- Risk of child sexual exploitation.

In addition, the young person may be subject to neglect or domestic violence in the home and/or the parent/s may be unable to parent due to substance misuse, mental health difficulties or the demands associated with the young person’s behaviour.

There were a number of examples of additional criteria being attached to planned referrals, in order that the family qualify for residential respite and the wider edge of care services. Qualifying circumstances included one or more of the following:

- The young person has two or more risk factors
- Family support services such as FGC have been tried
- Extended family/kinships options or other forms of informal support have been tried or are not available
- There are a minimum of three agencies involved in the young person’s life
- All other avenues have been exhausted.

As discussed in Chapter 4, defining the needs and characteristics of service users tended to reflect the local population needs and the range and availability of support options available within the local areas and therefore varied across local authorities.

### 3) Referral routes and assessment

Referrals for planned integrated residential respite were predominantly internal, i.e. from Children’s Services team members, but could also be made by other professionals via multi-agency hubs, e.g. education, health, police, youth justice professionals. Some practice

examples emphasised the need for extensive paperwork at referral, to enable assessment by the family support teams and/or referral panels to assess whether the adolescent/family reached the threshold for services and the appropriateness of residential respite, and in order to develop appropriate packages of support. The contributor from North East Lincolnshire for example, highlighted the need for obtaining detailed information about young people being referred for respite in order to understand their needs at baseline and thus to be able to identify progress and outcomes. Gathering detailed information also aided matching (see below). Some practice examples stressed the importance of teams working together at referral so that a needs led packages of support could be devised and relationships built with families from the outset, as was the demonstrated by Durham's approach. A key theme was the development of contracts and care plans in consultation with the family and young people, with clearly defined programmes of work, goals and respite periods.

Some local authorities, as discussed earlier, had (or were in the process of developing) a single referral pathway or 'one door' approach for assessing, allocating and in some cases supporting adolescents throughout the various pathways, whether into care or into preventative interventions. This approach, designed to provide a streamlined multiagency needs led approach that enables allocation of a consistent support worker, is a key feature of several interventions being tested by the DfE CSCIP projects (see Annex 5).

Many of the residential units included one bed that had been assigned for emergency/crisis intervention in addition to beds for planned referrals. In the case of Swansea, the residential respite provision was devoted to crisis entry (see Annex 4). Crisis beds were for young people who had been thrown out or abandoned or had run away or left home and were at immediate risk of entry to care due to family breakdown. In these situation referrals were made by the Police, Emergency Duty Team or social work teams.

#### 4) Duration of respite provision

The duration and frequency of respite provision was dependent on the number of factors including capacity. The residential units tended to be small group homes with the number of beds available for respite varying from three to six across the different models with most including at least one bed for crisis/emergency referrals. Staffing and resources also impacted upon different levels of provision, for example. Blackburn with Darwen offered overnight respite from Friday to Monday inclusive, whilst Durham provided respite seven days per week.



The duration and frequency (availability allowing) was, according to most respondents, tailored to the individual needs of the young people and family:

*'The provision varies and is tailored around the young person/family's needs, in some instances it can be for a period of a number of short breaks whilst working alongside the family within the home'* (Kingston-upon-Hull, Assistant City Manager).

*'The majority of young people who use this service do so as part of an agreed package of support. Packages vary in frequency but the average number of nights is 4 per month'* (Thameside Metropolitan Borough Council, Head of Integrated Services).

Models tended to gradually decrease the respite intensity as the intervention progressed and some were able to offer respite to re-referrals or increase the duration of respite provision beyond the usual timeframe, where needed. There was considerable variation across the different practice models, ranging from a one-off stay of one to three nights; a series of overnight stays ranging from one night per week over the course of one month to one night per week over a year (e.g. North East Lincolnshire); up to three nights per week over a four month package (e.g. Durham) or over a package of up to six months (e.g. Wigan); to providing a continuous respite stay for up to 12 weeks, depending on the model and programme of work (e.g. Swansea). As discussed above, the frequency and duration of stays is closely tied into legal status and guidance as to the definition of 'respite' or short breaks placements (see DCSF, 2010).

The respite provision involved initial assessments and planning and review meetings. Most models referred to carrying out reviews of respite stays at set intervals and building in exit strategies within the care plan, and building in plans for referrals to further support options, whether mainstream services or entry to full time care. For example, in one local authority a tailored 12 week package of supported respite was provided, which included a planning meeting once referred to identify needs and plan the nature and level of services; assisting young people and parents with behaviour difficulties; putting strategies in place to work towards resolving difficulties; clear communication of a set of agreed goals, 12 week maximum duration and exit strategy and sign-posting to other services. The work is reviewed after six weeks and again at 12 weeks at which point it will be assessed as to whether adolescents and families require continued support within the service and/or would benefit from referral onto other specialist services (LA ANON 1).

##### 5) Legal Status

The legal status of children and young people entering respite varied both within the residential unit/family support provision and across the local authorities. There are some

examples of young people receiving residential respite under Section 17 (Children in Need) e.g. see North East Lincolnshire above. Alternatively, other edge of care services were making use of Section 20, including 'Moorside' (Durham County Council) where it was felt that this provided access to a greater range of services and to the cycle of reviews. Whilst the nature of the package of respite offered by Swansea, i.e. up to 12 weeks, classified young people under Section 20.

Some practice examples described the legal status of young people as 'having a child protection plan' on entry to residential respite or Section 17 (CIN), which then converted to a 'targeted early help plan' once in the unit (see Shropshire above). A number of the units received referrals from young people who were already accommodated or living with their parent or family on a care order and the placement had broken down or was at risk of breaking down.

As the practice examples show, the duration of respite provision and the legal status of young people accessing the provision varied across the practice models. This reflects the degree of diversity in how local authorities were interpreting the guidance on using short breaks and respite (DfE, 2014c) and in how they were defining their own types of provision. This perhaps highlights an issue that requires further exploration and clarification. The duration for short breaks set down by the Children Act was revised after the introduction of new legislation in 2012. The statutory guidance now states that each short break (or respite stay) must include at least one night away from home and should not exceed 17 continuous days or more than 75 days of accommodation away from home under a single agreement in any twelve-month period. The guidance also states that short stays/respite should be classed as section 20 and coded as V3 or V4 for the purpose of monitoring to avoid the associated administrative burden of registering each respite stay as an entry to care. The legal status of young people accessing the service (e.g. a section 17 or section 20) carries wider implications for regulations around planning and reviewing provision and accessing broader statutory services (DfE, 2014c).

#### 6) Matching and managing the respite group

A key feature of residential respite provision is by its nature, the frequently changing resident group. Not only will different young people stay for different durations each week but each young person's stay might change week by week as the intensity of their support decreases according to need. Matching might also need to take into account staff rotas to ensure consistency of key worker and support. For a number of the models, this necessitated careful and thoughtful planning not only to introduce a degree of consistency and stability but also to ensure that the group worked well together. Matching of young

people taking up the planned residential respite was highlighted as a key factor in the success and smooth running of the provision by a number of contributors to the survey. The factors that were taken into consideration included: age, the level of need and behaviour of the young people, consistency of staff and peers and, for large county councils where there was a need to arrange transport to collect young people, geography. In the main, minimising the age variation was felt to be important for safety and compatibility, however, it was noted by two contributors, including LA ANON 1, that the personality of the young people was often the deciding factor, for example, in cases where an older young person had displayed nurturing qualities and might prove to be a positive role model, it could be useful and appropriate to match them with younger children (see Annex 4).

A key challenge arising from residential short breaks was concern about the potential negative impact on young people if the mix proved not to be compatible, particularly around escalating high risk behaviours. In addition, where young people are referred to residential respite on an emergency basis, matching will not be possible and the potential for disruption may be greater.

Though matching, where it was possible to do so, might go some way to ensuring that respite stays were well planned and managed, consistency and stability and in some cases negative group dynamics are nevertheless important considerations for respite provision, whether within residential or smaller foster care settings. For example, one contributor offering short breaks in foster care for adolescents on the edge of care noted:

*‘Challenges could be faced in bringing young people together who are in similar situations which could create a negative influence’ (Head of Service, London Borough of Lambeth).*

#### 7) Approaches to adolescent and family support

Unsurprisingly, given that many of the models had developed in isolation and in order to accommodate local need and settings, service provision across the models varied to some degree in terms of service user characteristics, referral routes, as noted above, and also the types of provision and approaches offered to adolescents and families as part of the integrated package of respite support. Nevertheless there were also a number of common features across the practice examples.

In broad terms, most of the models described the need for holistic and flexible approaches that could be tailored to address the individual needs of adolescents and their families.

There was an emphasis on rapid and timely responses to difficulties providing the *'right intervention at the right time'* for the family. Common features included work on relationship building that included supporting young people and parents or carers to rebuild and strengthen their relationships with each other. Importantly, there was also an emphasis on the need to foster positive, consistent and trusted relationships between adolescents, families and the professionals supporting them:

*'We'd recognised that you know that a relationship is the most significant in terms of making effective changes in families and for young people'*( LA Anon 2, Head of Service).

In several examples, this involved utilising the skills and experiences of the residential workers themselves, or in some cases upskilling staff, to provide outreach support to families to carry out support to prevent family breakdown and deliver some of the approaches outlined below. This also encompassed work to fully reintegrate young people and families after the respite provision had ended. Work with young people within the residential unit (and in some cases residential worker outreach support) tended to be delivered in parallel to support from a separate team of family and adolescent support workers carried out with the family home.

Most of the models shared common goals, these being to resolve difficulties by improving family relationships, addressing problem behaviours, maintaining education participation, and promoting empowerment and positive youth and family activities and increasing skills. Work to signpost future sources of help, activities and information was also undertaken to ensure families sustained positive progress beyond the programme of respite and family support. The strategies and approaches to achieve these goals, however, tended to vary according to the menu of programmes and approaches available to the local models. A full exploration of the types of programmes delivered by the models was not possible within the remit of this evidence scope, often because our interviews were carried out with residential managers rather than the family support team managers who were responsible for delivering the programmes of wider family support. Behaviour and anger management programmes and communication skills were frequently mentioned as was youth empowerment and participation opportunities such as leisure activities, car mechanics, outdoor pursuits and locating and establishing networks and opportunities in the young people's home locality:

*'It's about how can we link a child into what is going on in their local community. How can we get involved, whether that's sports, leisure, arts clubs...how can we get them linked back in to their local community and build those sort of support networks around them'* (LA Anon 3, Group Manager).

Examples of more structured support and evidence based practice models, where available to local teams, included parenting programmes such as Triple P, Family Group Conferencing (FGC), restorative practice, mediation, asset building and strengthening families' approaches. Some models provided or brought in specialist or therapeutic services and workers to address particular needs:

*'...challenging behaviour is a key trigger for parents to question their ability to continue to care for the young person. Behaviour Therapists will provide practical support in the home and across the range of settings the young person accesses'* (Thameside Metropolitan Borough Council, Head of Integrated Services).

One example involved therapeutic services based on motivational interviewing, solution focus thinking and signs of safety techniques to help families through crisis situation (see Swansea Family Support Service Annex 4).

#### 8) Monitoring and evaluation

Data on service impact and assessments of outcomes for adolescents and families were limited across our practice examples. That which was provided verbally or via hard copy related mainly to internal monitoring reports or reviews of the numbers referred to adolescent support teams and respite services. Only a few models referred to external evaluations (e.g. see Durham and Stockport). Very little monitoring information was made available for this evidence scope but data gathered during the course of the interviews and via the e-surveys indicated a high degree of satisfaction amongst service managers and staff with the delivery and impact of services to date. This was mostly expressed in terms of the numbers considered to have been diverted from entering full time care, at least in the in the period soon after integrated residential respite had ended. Internal data and evaluation reports commented positively on the reduction of adolescents going into care and some were able to provide data on the associated cost savings to the local authority. There appeared to be a lack of detailed and longitudinal exploration of the different models and their impacts at organisational level and importantly from the perspectives of service users, highlighting the need for robust evaluation. Those services receiving funding through the CSCIP programme, however, welcomed the opportunity for external evaluation, as required

by the programme. As noted earlier, the first round of evaluation results will be available in spring 2016.

### Potential for change.

Our data suggests potential benefits associated with the development of respite support that involves direct work with young people and is accompanied by work with their families, with the goal of preventing family breakdown and entry to care.

For young people, respite services can provide a stabilising environment, where opportunities for comprehensive and gradual assessment of their immediate and surfacing needs can facilitate better planning and long term support. Respite also offers an opportunity for interventions to take place with young people directly in a supportive and in some cases, less intimidating environment, where resilience, self-esteem and family relationships can be strengthened through positive engagement, targeted support packages alongside maintaining the relationship between adolescents and their families.

An integrated respite approach also offers benefits and gives opportunities to families themselves. Respite care offers opportunities for a breathing space to reduce relationship pressures and to decrease a sense of isolation in coping with difficulties. In addition, a common message arising from the data was the benefits of providing a less adversarial approach that can promote a more positive working relationship between families and professionals. For example, the provision of non-statutory outreach provision might be more appealing and therein foster a more productive relationship between parents and professionals where support with improving parenting skills and behaviour management techniques are embedded within a whole family intervention package of. Respite can also avoid the negative impact or 'shock' of a sudden entry to care, providing a smoother transition into a placement, whether temporary or for those who need to remain in care.

Respite also brings benefits to services and local authorities. Service managers emphasised the need for respite services to be embedded within a package of family support to be most effective. This required a strong multi-agency strategy and one that can operate fluidly yet robustly, with clear and agreed objectives. There was also evidence that this type of service offers an opportunity to work with the complex needs of young people and families in a cost-effective manner that could prevent the need for long term care placements. This could bring about reductions across several areas. For example, in the numbers of looked after children; in the costs associated with residential care; and in the costs associated with having to address unmet needs for young people transitioning out of care as young adults.



It is important, however, that cost savings and reducing the numbers in long term care do not blur the wider benefits of the approach. There is a need to more fully understand if and how this option improves outcomes and how it might fit within the overall offer to adolescents and families in difficulties and distress.

Our review of the practice evidence demonstrates innovative approaches utilising residential respite to support adolescents on the edge of care as part of an integrated package of family support. The practice models discussed illustrate the potential for broadening the menu of preventative options and offering scope to meet a wider range of family and adolescent needs. For this to happen effectively there is a need to review how care is used in the UK. As commentators have noted it is time to reconsider how care is both viewed and delivered and to move away from a delineated model of ‘in care or out of care support’ where care, and residential care more so, is seen as a last resort. The examples of respite provision discussed in this report (whether in residential or foster settings) demonstrate a more creative and flexible approach and show that the sector is already taking steps towards the ‘continuum’ approach. It seems timely, therefore, to consider a comprehensive policy review of how such options might operate most effectively alongside rigorous evaluations to understand how and with whom the various options work best. The current innovation programme (see CSCIP summaries in Annex 5) will demonstrate the ways in which local authorities and service providers are making changes to the way care and edge of care support is delivered. The resulting practice and research evidence carry the potential to greatly inform developments in future policy and practice.

### Summary Points

- The scoping study has provided evidence on a range of established residential respite models. These varied in terms of the packages of support they offered adolescents and families.
- Evidence from the practice examples suggests that respite can make an important contribution to offering appropriate and timely support. It can provide an all-round ‘breathing space’ – for young people, for their families and for services to be able to gain a deeper understanding of need over time rather than at the point of crises.
- For those who are assessed as needing longer term care the gradual steps into care might facilitate a more successful adjustment to moving from home to care, improving stability and longer term outcomes by avoiding or minimising the sudden jolt of going directly into full time care during crisis.



- Using residential respite, rather than respite foster care, might prove particularly useful in addressing some of the logistical issues of respite stays (e.g. residential units offer scope for several young people making use of short respite stays each week and can prove less disruptive as they come and go than might be the case within a family environment) and can meet the needs of older adolescents with more challenging behaviours.
- Experts caution against parachuting in another approach to the current system. They call for greater fluidity in responses to adolescents in need of support, which should break away from the view of care as a last resort and from a binary system of in care or not. This would require moving towards a continuum in which full time, part time, long term and short term care forms an option within a menu of complementary elements, intervention and approaches (that can be mixed and matched) to best support the young person and family.
- A number of factors were identified by contributors as being key to effective respite provision. These include rigorous referral and assessment mechanisms, appropriate matching of young people, the need for tailored, needs led packages of support.
- The variation in approach suggests a need for greater clarity and review of the legal status of young people accessing respite and the current regulations governing respite stays.
- Further research is necessary to understand if and how the use of respite combined with family support can improve outcomes for adolescents on the edge of care. This includes scope to understand what changes might be required at policy and operational level to facilitate the effective use of this option and what the longer term impacts upon adolescents and their families are, e.g. does it divert adolescents from care or delay entry to care.
- Care will be necessary for some young people at some point in their lives, but a proactive approach to dealing with needs can ensure that if and when it becomes necessary it can be used effectively and efficiently to achieve the best outcome.

## 8. Supporting adolescents on the edge of care: opportunities and challenges.

### Messages from the review

The three aims of the evidence reviews included:

1

- Understanding more about adolescents on the edge of care, their families and their needs.

2

- Defining the parameters of edge of care.

3

- Identifying existing evidence for effective interventions and family support with a particular focus on the potential of residential care as an edge of care service.

1

Adolescence is a vulnerable age and far more so for those who are in or on the edges of care due to risk, trauma, neglect and family distress. The number of children and young people in care is currently higher than any time in the past twenty years. Adolescents make up a significant proportion of those currently in and at risk of entering care. Early adolescence (10 -15 years) is the most common time to enter care. The evidence demonstrates that older care entrants tend to have more entrenched and complex difficulties, which can be related to their long term exposure to maltreatment, difficult home circumstances and their own increasing vulnerability to risk and behavioural difficulties associated with the adolescent life stage.

Alongside this, there is a continuing pressure on local authorities to provide sufficient care options coupled with a shortfall in the number of foster carers and in other options due to

the costs and closures of residential units. This has to be juggled with the pressure to reign in the costs of expensive care placements by reducing the number entering care.

Despite a raft of legislative changes and practice developments focused on improving experiences and outcomes for care experienced young people, recent research continues to echo over two decades of findings that many young people leaving care do so with a range of continuing difficulties and inadequately addressed needs, placing them at long term disadvantage and in need of support services. The rates of homelessness, mental health problems, offending and non-participation in education, employment and training are higher in comparison to same age young adults who have not been in care.

Furthermore, 'adolescent entrants' to care are less likely to settle in care and therefore more likely to move on from a care placement to independent living early, aged 16 to 17. They tend to do so with a higher number and level of difficulties, which in part might be connected to a lack of opportunity for the assessment of needs and receiving appropriate support whilst in care, due to placement movement and earlier transitions to independent living.

Care statistics also show that entry to care for adolescents can often be short term and crisis driven, and many will return home within a few months, often to families where there has been no change in circumstance or support to resolve the difficulties. Evidence of long term contact with children's services prior to entry to care and, also of previous care episodes for adolescent entrants, suggests a history of failed attempts to return young people home safely.

While recognising that in some instances, care is the most appropriate option for some young people for whom remaining at home is not safe or possible, there are groups for whom the need for entry to care is less clear cut and for whom care should not be the only option. There is scope, therefore, to give more focused attention to the needs of these adolescents on the edges of care. A greater consideration of their particular life-stage, their vulnerabilities, the complex and various ways that past experiences will manifest during adolescence and the particular ways in which older children and young people might cope with and react to trauma and change. Of course adolescents are not all the same – though there is a growing body of research that has identified patterns that suggest that certain emotional, behavioural and social traits and risks can be attached to adolescence. Whilst certain evidence, such as that around brain development, are relatively new and attract a level of caution, drawing upon the full evidence base could nevertheless be more effectively

utilised to plan and deliver a wider range of age and need appropriate options for adolescents who can't rely on family networks alone to help them navigate through, what experts have called 'that *difficult age*'.

A consideration for services, therefore, is whether policy and service developments are operating creatively and effectively enough to best engage with and support adolescents.



Edge of care is commonly understood to refer to prevention strategies aimed at avoiding family breakdown and the need for entry to care for children and young people. The evidence on defining the edge of care suggests that it is complex, difficult to locate and varies according to different local authorities and services. Furthermore, there are concerns that the concept unhelpfully implies (and even creates) further thresholds for families to cross in order to access support. There is also the concern that it emphasises the view that care is a last resort, reached by '*falling off the edge*'.

A further concern is that edge of care provision is driven by cost savings in its focus on reducing the numbers going into care instead of focusing on the needs of the young person and family.

There are (and have been) a considerable range and number of national and local programmes aimed at supporting troubled families and young people, who might be considered to be at or moving towards the edge of care. This has been accompanied by substantial investment - at least at programme start up.

Reviews of the practice evidence and the respective evaluations of the family support interventions, report some positive findings on effectiveness (e.g. the number of service users experiencing improvements, numbers being diverted from care or custody etc.). They also highlight factors that contribute to effectiveness at both:

- an operational level (multi-agency working with clear roles and responsibilities, effective leadership and commonly, the allocation of a dedicated worker to support the families through the various service pathways)
- an individual level (types, intensity and duration of the difficulties, willingness and/or ability to engage with the programme etc.).

There is an increasing use of evidence based practices and new attempts to reshape services. Most, however, operate fixed eligibility criteria, which might limit their ability to

reach certain groups e.g. based on age, type and level of difficulty, type of circumstances etc. So, whilst there appears to be evidence of positive outcomes, the geographic or eligibility driven patchiness in availability means that it is not always an option for adolescents and families in difficulty. A further obstacle that might affect availability, as seen from previous programmes, is the funding stream for programmes, which can dry up or be diverted as national or local government priorities change or evidence based practices come in or go out of favour.

The current CSCIP funding stream has served to reinvigorate the attention on developing creative approaches to supporting adolescents and their families, and includes a focus on edge of care provision. The evaluation programme, which will report back in March 2016, should provide an opportunity to gather more detailed evidence on how edge of care provision is defined, targeted and operated, and in what ways it can make a difference to the outcomes for young people, their families and services.



Data from the practice examples and case studies gathered during this brief evidence scope demonstrate some benefits associated with the development of respite services, which aim both to support young people and to work with their families, with the goal of preventing family breakdown and entry to care. As discussed in the previous chapter, these levels of perceived gain – young people, family and local authority services – are the central drivers for the reconfiguration of support for young people. For young people, respite services offer access to a positive and potentially stabilising environment, where robust assessment of their needs enables effective long-term planning for their support. Respite also affords the opportunity for interventions to take place with young people directly and to focus on strengthening self-esteem and resilience through positive engagement while maintaining the relationship with their families. Additionally, respite was thought to help in supporting young people to ‘break the cycles of negative behaviours’.

For families and parents, respite care offers opportunities to reduce relationship pressures where these are escalating and to decrease a sense of isolation when handling difficulties. Additionally, non-statutory outreach support presents a potentially more appealing relationship with professionals, where parenting styles and behaviour management techniques can be developed and the prospect of keeping family members together seems to be achievable with tailored support. Respite can also reduce the potentially damaging impact, or even shock, of going into care, providing a smoother transition into a placement,

even for those who need to remain in care: *'sometime when your child has come into care and gone into another environment, all of the emotional things that come with that.. they're all new problems and challenges ... because that child has come into care, and to be able to take those away is amazing'*.

With the benefits to services in mind, it was apparent to participants that respite services present an integrated opportunity to work with the complex needs of young people and families in a cost-effective manner which could prevent the need for long term care placements. Potentially, this results in three major reductions: in the numbers of looked after children; in the costs associated with residential care; and in the costs associated with leaving care. Furthermore, keenly felt service advantages were seen to lie in families retaining responsibility for their children.

While the above advantages of respite provision seem hard to dispute, there are challenges presented in bringing about this shift in service direction. At a very pragmatic level, respite services need to retain under-occupancy and this may be difficult to sustain in the face of the need to fill beds to maximise cost efficiencies. In a similar vein, the issue of needing to retain flexibility in service delivery is set against the need to plan a service. Firm agreements for multi-agency support need to be negotiated. Importantly, the move towards preventative work with young people and families was seen to require overall commitment at all levels of an organisation and concomitant, coherent leadership to bring this about. Our respondents emphasised that a singular approach to this development was unlikely to be successful: *'just launching into something in isolation like that isn't going to get you to where you want to be'*. The value of informed leadership was thought to be fundamental, where a whole systems approach was used in bringing about this change. This involves a nuanced understanding of the purpose and function of all forms of care, as distinct from simply alternating away from support for residential care towards a preference for preventative work. Much depends on the influence of elected members and senior managers, and time and attention needed for establishing their understanding, clarity and support.

A fundamental concern lies in the issue of positive engagement of young people and their families: *'it's got to be something they want to do and want to engage in'*. For those services with experience in work of this nature, there was an awareness that engagement could be difficult to secure: *'where the families, although they've signed up to the work, they haven't engaged, they've avoided and we've had to close some of the cases because clearly it's not right for that family'*. A vital aspect in this respect was seen to be the strength

of the agreement made with families: *'it's about giving parents a clear message that we acknowledge that you're having difficulties with your child...and we can offer you some respite, but whilst you're accessing that respite we want to have someone work with you too'*.

A counterbalance to potential lack of engagement was seen as the potential for increased dependency on services and also an accompanying opening of floodgates or net widening effect: [there is] *'certainly a cycle where you might get increased pressure on services where you're identifying more families who need help, if you're doing early intervention effectively'*. There was acknowledgement that this brought with it a need for assessments to accurately identify the levels of need whilst ensuring the availability of appropriate support to meet those who required it. Alongside this came the awareness that returning home after a short break may be difficult to achieve at times, as a positive direction in relationship developments was not straightforwardly accomplished.

The demands placed on respite staff could be difficult to manage, particularly where residential staff were being moved towards providing outreach services or particular therapeutic interventions. Improved staff training and skills and a willingness to work alongside other service professionals to achieve the best outcomes for the adolescent were thought to be essential. Much of the potential for good practice was seen to depend on the accuracy of ongoing assessments within the respite service, particularly in terms of crisis-driven admissions. Just as living in residential care brings with it the potential for negative associations, respite breaks were thought to offer a chance for negative influences to take hold, and again, these present challenges to staff, young people and families. The need for regular risk assessments, as issues come to light and for careful matching of the young people to manage risk and group dynamics were discussed as ways around some of these challenges.

Reflected in our data was the abiding and intractable difficulty with the move towards family-based preventative services. This was the lack of potential for respite services to address the needs of those young people in situations where poor family relationships lie at the root of the difficulties that young people experience: *it's not simply a matter of everyone's better off at home, because quite clearly they're not'*. For some adolescents on the edge of care, difficulties of this nature are likely to form entrenched aspects of their everyday lives and preventative approaches might prove ineffective or indeed detrimental if they delay entry to care.



This brings us back to the issues of whole system change, where prevention and entry to care form a more integrated part of a child and family support system, along the lines of European models, rather than care being seen as a last resort and therefore something to be avoided. Where there is a need for long term care, the process could be better managed and less delineated. Equally, the need for high quality and effective care placements remains, and developing other options should not divert from investment in good quality foster and residential care for those who need it.

As discussed, whilst respite care appears to present many opportunities and benefits within the wider edge of care menu, it is important that cost savings and reducing the numbers going into care do not obscure the need to more fully understand if and how this type of support might contribute to better outcomes for adolescents and their families. Our practice examples suggest that the frequency and quality of measurement and performance data is currently variable and often limited to internal monitoring reports. There is a need for further research to unpick how this option might improve the chances of successful family reintegration or offer a smoother and more stable transition into (or out of) care. The recent DfE CSCIP funding stream explicitly acknowledges the potential benefits of therapeutic residential respite for edge of care adolescents and their families and it will offer scope to test out this approach more widely. That said, a long term external evaluation to explore how such provision is operationalised and if and how it can achieve its goals to safely prevent entry to care and produce positive long term outcomes for adolescents and their families, is essential for establishing a robust evidence base.

### Key Messages

The evidence scope raises a number of considerations for the use of residential respite or 'short breaks' to support adolescents on the edge of care:

### Policy Makers

- Our review of existing evidence found support for a restructuring of the care system to facilitate a wider and more responsive and age appropriate menu of options for troubled adolescents and families, including the use of residential respite. Some commentators have suggested a move away from a binary system where adolescents are either in care or out of care to one where care is no longer a last resort but an option within a continuum of child and family support.
- Within such a system, the dual purpose of respite would include providing an opportunity to undertake therapeutic work with adolescents and families in order to prevent entry to care and equally, for those for whom care is considered

the most appropriate option, afford the opportunity for a more detailed needs assessment and a planned and smoother transition into care.

- Policy makers should continue to consider the scope for using residential respite as part of innovations in adolescent provision to expand and improve the current range of accommodation options for young people aged 16 and over. For example, the development of further options for residential ‘Staying Put’ accommodation for care leavers aged 16+, such as *staying close* models being piloted in Calderdale’s Right Home Project, under the CSCIP funding (see Annex 5).
- The wider development and use of respite residential care could benefit from a review of existing national policy and procedures on respite provision to explore how it might best address the needs of adolescents on the edge of care. This might include further clarity on how residential respite is defined in terms of duration and frequency, the legal status of service users and their entitlements to reviews, assessments and other support.
- The further development and use residential care options, crucially depends on the skills and status of the residential workforce. As European models have demonstrated, this is particularly the case when working with young people and their families and where residential workers are often trained in specific therapeutic approaches.
- Given the considerable variation in how the edge of care group is defined and therefore how edge of care services are developed and delivered, there is a need for greater understanding of how these young people and families are currently identified, assessed and supported across local authorities.

### Commissioners and Strategic Leads

- As discussed above, there is variation in how local authorities (and services within them) are defining the edge of care group and how close to the edge adolescents need to be in order to access services (e.g. do services represent early intervention or crises intervention?). Greater clarity on the criteria and eligibility for accessing services will ensure efficient and effective service development, targeting and planning.
- There has been a growth in support services and interventions for families and young people experiencing difficulties and distress. This includes the introduction of a range of national programmes as well as a variety of evidence based practices. Some of these have restricted inclusion criteria and not all have been fully tested within a UK context and with particular groups of adolescents. It is

important to understand if and how different provisions sit together and the potential impact they might have on each other as well as outcomes for service users..

- Existing research suggests that good residential care can provide a more suitable option than foster care settings for certain young people who are older or with more complex or challenging behaviour. It also indicates the potential for residential units to provide a more appropriate level and type of support and approach to working with such young people and their families, for example using therapeutic approaches within the residential setting and offering outreach support within the family home.
- Residential respite provision relies on the availability of residential units and often within a reasonable distance of the young people's home base. Many local authorities no longer have residential provision; therefore residential respite might not be possible or economically viable in some local authority areas. Our practice examples were making use of in-house residential units and staff to provide a cost effective service. In some cases this had involved making use of units that had been or were about to be decommissioned and redeploying residential staff to provide family and adolescent support. We were unable to find evidence of residential respite provision for adolescents on the edge of care within the independent care home sector, though Sefton Council was in the process of putting out a tender for residential respite under the CSCIP programme. Whilst there might be potential for this type of provision within the independent sector, managing capacity and referrals is likely to raise different challenges for commissioners.
- Managing the flow of respite referrals to fill vacancies and achieve capacity can prove challenging, particularly in residential units, and will have cost implications. Careful planning and management of referral criteria, referral routes and demand is required. Several of our practice models had developed systems to manage this whilst also maintaining an emergency bed. Raising awareness of the service and maintaining a degree of flexibility in service use (e.g. offering preventative respite as well as reunification /step down respite) were amongst the strategies employed to manage occupancy rates.

### Residential care

- The practice examples suggest that small four or five bedded units dedicated to respite stays worked well. Most were able to retain one bed for emergency

admissions, though there was recognition that this could be difficult to sustain financially.

- Careful planning and matching of the respite stays offered stability familiarity and scope for young people to engage in positive group work during the respite stays.
- Residential workers were often involved in outreach work with adolescents and their families as well as direct work with adolescents during the respite stay. Placing residential staff at the frontline of preventative work raises the importance of specialist training and a robust and varied skill set to maximise the potential for positive outcomes. Our practice examples showed that residential staff were using restorative practice, being involved in family group conferencing and undertaking other therapeutic approaches when working with young people and families to improve communication, rebuild fractured relationships and address anger and behaviour management.
- The provision of respite within a package of family support required negotiation of joint working procedures as well as relationships, roles and responsibilities with other key professionals. Contributors to this evidence scope noted the need for flexibility in approach to avoid duplication of work, minimise the number of workers involved and to facilitate a consistent supportive relationship.
- A common factor within the practice examples was the aim to provide bespoke, needs-led packages of support for adolescents and families. Services identified the need to establish shared goals with the adolescent and family, a framework for assessment and review, exit strategies and opportunities for re-referrals. This could involve identifying wider sources of ongoing support to address education, substance misuse or health needs and increase participation in positive activities.

The evidence from the literature on preventative strategies and our practice examples show creativity and flexibility in how edge of care provision can be used. A particular focus of the evidence scope was to explore how residential respite support might contribute to this area. Respite itself can offer a breathing space, a chance for the immediate crisis to dissipate, difficulties to be addressed and prevent family breakdown and entry to care. It can just as readily provide an opportunity for planned and detailed assessment and the gradual transition into a longer term care placement for those who cannot remain at home or a step down out of care for those returning to family. There is emerging evidence from some service providers that residential respite has proved effective in reducing entry to care, increasing the number of appropriate entries and delivering costs efficiencies. Its potential, however, relies on it being embedded within a package of family support and within a menu of options. A key challenge lies in establishing a system that can support a variety of

approaches and innovative provision that can address the complex needs of adolescents on the edge of care and their families.

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