SCOTTISH CHILDREN'S REPORTER ADMINISTRATION

Evidence Submission for the UN Day of General Discussion (DGD) on Children's Rights and Alternative Care

SCRA[1] are submitting evidence in relation to objective 5, which states that the purpose of the DGD is to "*expand opportunities to learn from evidence about alternative care options and evidence about what constitutes quality alternative care, with a view to establishing a meaningful process for developing guidance on this*". Our evidence focuses on the use of residential care for children under 12 years of age; herein referred to as younger children.[2]

Background to the use of residential care for younger children

Residential care is considered a placement of last resort that is normally used when a child cannot live within a family setting.[3] Although there is a long-held practice view that younger children should not be cared for within residential settings, in 2008 the Minister for Children and Early Years in Scotland stated that residential care should be "the first and best placement of choice for those children whose needs it serves"; [4] indicating that needs, not age, should be used to make decisions about the appropriateness of residential care placements.

It has been recommended that residential care be used earlier in the care trajectories of children, particularly those with substantial histories of neglect, serious attachment problems, complex physical and mental health needs, and increasingly challenging behaviour that is difficult to manage within family-type placements.[5] Short-term residential care placements to support families struggling with parenting are also seen as appropriate. Despite these recommendations, there is a dearth of evidence about: 1) the extent to which residential care is used for younger children in Scotland; 2) potential benefits and detriments of using residential care for younger children; 3) what constitutes high-quality residential care for younger children.

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[1] The Scottish Children's Reporter Administration (SCRA) operates within Scotland's Children's Hearings System to protect and support the country's most vulnerable and at risk children and young people identified as requiring the full protection of the law due to difficulties, challenges and risks they face. The Children's Hearings System is Scotland's distinct statutory system, in which concerns about a child's circumstances (whether about the care or treatment of the child by adults or the behaviour of the child) are considered by Children's Reporters and then by panel members (specially trained lay tribunal members) in a Children's Hearing, who make a decision about whether there needs to be compulsory professional involvement with the child and family. Full details of SCRA's remit can be viewed at www.scra.gov.uk

[2] SCRA are currently conducting a mixed methods study exploring the use of residential childcare for younger children. The data presented in this submission are interim findings and may be revised as data cleaning and analyses continue. The statistical data was extracted from the casefiles of 101 children who became subject to CSOs with residential care conditions between 01/04/15 and 31/03/17, SCRA casefiles include all statutory documents relating to children in the Children's Hearing System, including: referrals and concerns received about children; social work, education and health reports; police reports; and outcomes of children's hearings and appeals. Casefile data was used to was used to provide an insight into children's trauma histories, service involvement and care trajectories. We also explored the impact of residential care by comparing children's socioemotional wellbeing, mental health, and education at entry into care with the same information collected two years later. Qualitative interviews were used to better understand the lived experiences of younger children in residential care. Semi-structured interviews (n=60) were conducted with social workers, residential care workers, foster carers and Children's Panel Members. Quantitative analyses from this study are due to be published in September 2021 while qualitative analyses are due to be published in February 2022.

[3] The place of residential care in the English child welfare system (publishing.service.gov.uk)

[4] Adam Ingram, Minister for Early Years, 2008: Scottish Parliament, Official Report 7 February 2008, column 5928.

[5] NRCCI Matching Resources to Needs Report (celcis.org)

The use of residential care for younger children

In Scotland, 14000 children are looked after by the state each year [6]. For most, the statutory basis is that a Compulsory Supervision Order (CSO) has been made by a Children's Hearing.

Between 01/04/03 and 31/03/19, 2101 younger children were subject to CSOs with residential care conditions; the majority (63%) were aged 10-11 when these measures were first implemented. Boys were three times more likely than girls to experience these measures. Data from 01/04/18 and 31/03/19 shows that younger children account for 16.6% (n=120) of all children subject to CSOs with residential care conditions and 8% of all children in residential care.[4,6] The total number of younger children in residential care is not available;[7] however, as 35% of children in care do not have CSOs, we estimate that 160 younger children would have experienced residential care over this period. [4,6]

Since 2003 there has been a 43% reduction in the use of CSOs with residential care conditions for younger children.[8] This reduction was greatest for boys (↓45% vs. girls ↓34%). Changes in the types of residential care settings used to care for younger children also occurred, with reductions in the use of both children's homes (↓64%) and residential schools (↓52%). These reductions were accompanied by a 107% increase in the use of 'other residential establishments' such as small group-living environments providing trauma-informed care.

Characteristics of under 12s subject to CSOs with residential care conditions

Our casefile analysis indicates that the median age of younger children who became subject to CSOs with residential care conditions between 01/04/15 and 31/03/17 was 10.67 years (range 6.29-11.93 years).

Trauma histories

Younger children subject to CSOs with residential care conditions had significant histories of adversity and maltreatment:

- 95% had 4+ adverse childhood events (ACEs) [9]
- 60% had 6+ ACEs
- 52% had been sexually abused
- 61% had been physically abused
- 73% had been physically neglected
- 40% had been emotionally abused
- 67% had been emotionally neglected
- 73% had grown up with domestic violence.

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[6] https://www.gov.scot/publications/childrens-social-work-statistics-2017-2018/pages/3/

[7] This data would be available from the Scottish Government upon request but it has not been sought at this time due to pressures upon statistical bodies created by the ongoing coronavirus emergency.

[8] This reduction is similar to the overall reduction (45%) in the use of these measures for all children aged 0-16 over this time period.

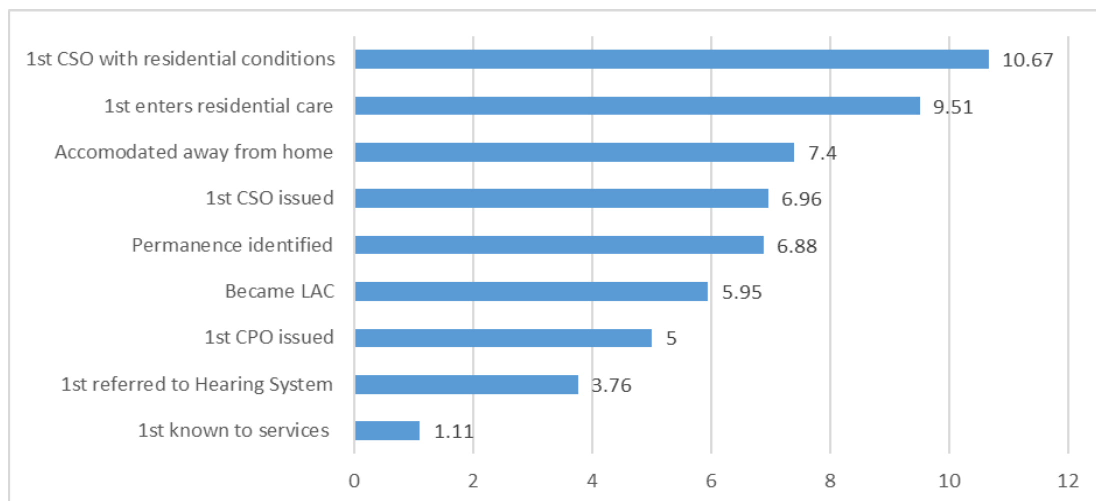
[9] Felitti et al (1998), Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med 14 (4): 245-58. doi: 10.1016/s0749-3797(98)00017-8

Service involvement

Younger children subject to CSOs with residential care conditions had a long history of being known to services:

- 48% were known to social work prior to birth or by age 1
- 85% were known to social work by age 5
- 22% were known to SCRA by age 1
- 67% were known to SCRA by age 5
- 27% had one or more child protection orders before they became looked after [10]
- 9% became looked after by age 1
- 35% were looked after by age 5
- 8% had been accommodated [10] by age 1
- 26% had been accommodated by age 5

The figure below shows the median time in years from birth to key transitions within the care system for children subject to CSOs with residential care conditions prior to their 12th birthday.



Our quantitative and qualitative data indicate that the time between a child being first known to services and being accommodated is associated with high levels of support being provided to families to try and prevent children being removed. These supports included: treating parental mental ill-health and/or addictions; addressing domestic violence; financial and housing supports; parenting interventions; earlier access to nursery education; additional education supports for school-aged children; and addressing offending by both parents and children. [11] The majority (95%) of families in our casefile analysis had received support for more than one child.

[10] In Scotland a child can become looked after at home by their parents with social work support under what is known as a home supervision order. They may also be accommodated away from the home in kinship, foster, residential or secure care placements.

[11] The data these findings are based upon were collected when the age of criminal responsibility in Scotland was 10. It has now been raised to 12 and discussions are being undertaken as to whether it should be raised further.

Placement histories before entering residential care

In our casefile sample, younger children had a median of 3 placements (range 0-12) prior to entering residential care; 36% had experienced 4+ placements. Breakdowns of foster care placements were common and characterised by caregivers struggling to cope with escalating levels of emotional dysregulation among children. Commonly reported behaviours included: persistent absconding; poor sleep and emotional regulation; age-inappropriate toileting behaviours (e.g. soiling and smearing); aggression towards caregivers, other children and pets; assault of caregivers with knives; fire raising; age-inappropriate and problematic sexual behaviour; and significant levels of mental distress, including self-harm and suicide attempts. The level of training foster carers had received did not appear to be associated with placement breakdown, with extremely qualified foster carers struggling to deal with the behaviours being presented.

Beyond the provision of respite services, little support was given to foster carers. This contrasted sharply with the intensity of support provided to birth families prior to children being accommodated. Foster carers cited better access to timely mental health intervention for children as a means of preventing the cycle of placement breakdowns that preceded residential care admission. For many younger children, entry into residential care occurred through emergency admission after a crisis point had been reached. In many cases, foster carers had already indicated that the placement should end as they were unable to keep the child, themselves or other children in the household safe. Where emergency admissions occurred there were often no alternatives to residential care available. In rare cases emergency admission resulted in children sleeping on couches while longer-term placements were identified.

Although emergency admission was common, one in five younger children experienced residential care as a first placement. In these cases it appeared that there had been significant levels of care planning undertaken to identify the resources that could meet a specific need within the child; for instance, by providing psychotherapeutic interventions, specialised education services and access to high-quality care for complex disabilities. There was also evidence that residential care was used to provide a period of enhanced intervention for these children, while interventions were also provided to parents and/or foster carers in order to promote the child returning to family-based care.

Benefits and detriments of using residential care for younger children

Residential care provided a safe and structured environment where younger children received consistent care from highly trained staff. Other key benefits included: being able to build a team around the child to identify and address their needs; access to specialised psychotherapeutic interventions, either in conjunction with in-house psychological services or through looked after children's mental health teams; and being able to develop and implement care plans that were trauma-informed and used attachment-based parenting techniques. Increased access to looked after children's nurses and educational support, either through outreach workers or having specialist educational premises on site, were also identified as benefits of residential care.

Our casefile data indicates that residential care placements can improve younger children's socioemotional wellbeing, mental health, and educational experiences. Two years after they became subject to CSOs with residential care conditions, younger children showed reductions in: sleeping difficulties (42% vs. 14%); concentration difficulties (28% vs. 13%); anxiety (71% vs. 53%); low mood (36% vs. 16%); anger management issues (82% vs. 67%); inappropriate sexual behaviours

(47% vs. 20%); age-inappropriate toileting behaviours (32% vs. 11%); episodes of self-harm (36% vs. 14%); school absences (33% vs 7%); and school exclusions (40% vs. 10%). They were also more likely to be described as coping with education (26% vs. 72%) and having a trusted adult that they could talk to about their worries (42% vs. 70%).

Detriments of using residential care for younger children included: 1) the risk of long-term institutionalisation; 2) exposure to risk behaviours and being traumatised by the behaviours of other children; 3) the potential harm caused by children ageing out of placements; 4) the use of restraint.

Rehabilitation of children to birth families or long-term family-based placements was the main solution proposed to the risk of long-term institutionalisation. Many of those interviewed stated that residential care could be used to achieve this by providing birth/kin/foster families with periods of respite while targeted interventions were identified and delivered to both children and their caregivers. If rehabilitation was not successful, it was felt that the assessments of need conducted during this period could be used to improve the process of matching children to appropriate caregivers. Where rehabilitation was successful, the provision of outreach services was seen as key to supporting children and families. Exemplars of good practice included Kibble's shared living foster care service in which foster carers were provided with intensive key-working services by residential carers.[12]

Short-term usage of residential care was identified as a way of reducing the exposure of younger children to risk behaviours and further trauma within placements. Better matching of placements, including how the trauma histories, ages and personalities of children, would interact within the care setting were also viewed as important; although it was noted that this was not always possible due to the frequent use of emergency admissions into residential care.

Age-based registration criteria for residential care meant that younger children frequently aged out of their care placements. Ageing out was viewed as particularly harmful for children who had been in placement for a long time as leaving residential care meant leaving their home. Some residential organisations had altered their registration criteria to prevent younger children ageing out of placements; however this was not seen as a long-term viable solution as all it did was create additional challenges for services by reducing the number of specialist placements for younger children.

Our casefile analysis indicates that one in two younger children in residential care had been physically restrained. This was concerning as we were told that the holding techniques used had not been designed to be used on younger children. Restraint was viewed as an intervention of last resort, with many residential carers emphasising that restraint should only be used when the safety of children and staff could not be maintained. Working with psychological services to reflect upon restraint episodes and to identify the circumstances that led to the restraint occurring was seen as important for developing de-escalation techniques and identifying safe alternatives to restraint; for instance, by encouraging the use of sensory spaces, punching bags and outdoor activities for children experiencing emotional dysregulation.

[12] https://www.kibble.org/services/intensive-fostering/

What constitutes high-quality residential care for younger children?

High-quality residential care consisted of 2-4 children of similar ages living together. Having high staff-to-children ratios were considered important to: 1) prevent burn-out of residential carers due to the emotional and behavioural difficulties that younger children can display; 2) provide children with a wide choice of adults that they can form attachments with. Care that was trauma-informed, reflexive and identified the psychological needs of children was also viewed as important. Building a team around the child, working closely with psychological services and implementing psychotherapeutic parenting interventions within day-to-day practice were identified as examples of high-quality care. As was care that promoted educational engagement for children. Where children were capable of succeeding within mainstream schools, high-quality residential care established strong links with education services. Where children were not capable of being educated in mainstream schools, high-quality residential care used outdoor spaces, forest school approaches and blended learning practices (i.e. combining home schooling with reduced levels of classroom attendance) to develop a curriculum around the needs and interests of children.

Considerations for children's rights

The Promise, Scotland's commitment of change to children in care, states that *"in response to the suffering of many children, before they came into care, whilst in care and after, Scotland has developed a system of rules and procedures to try to ensure that those tragedies do not happen again. Those rules have not always prevented further harm and have had a significant impact in preventing caring and loving relationships from developing*".[13] Given the potential benefits of residential care for younger children, we believe that a discussion is needed about: 1) whether systemic biases against residential care unintentionally cause harm to already traumatised children; 2) whether residential care could be better utilised to support access to assessment and intervention for children, regardless of whether they are looked after at home, in foster care or in residential care. At the heart of this discussion must be how the rights of children, as outlined within the UNCRC, can be upheld.

Articles 24, 28, 31 and 39 of the UNCRC state that children should have: the best possible health; access to good-quality healthcare and education; the ability to relax, play and take part in cultural activities; and support to recover their health, dignity, self-respect and social-life after experiencing neglect or abuse. Our data shows that residential care for younger children these rights by providing a safe environment where access to health care, education and cultural activities are enhanced beyond what is available within family placements.

Articles 9 and 18 outline that children have the right to be cared for by their parents and that the state should support those parents to care for their children adequately in order to prevent unnecessary separations. Our data indicates that prior to younger children entering residential care there was often intensive support provided to families, and that children were only accommodated when their Article 19 rights (i.e. the right to be protected from violence, abuse and neglect) were violated. However, the same level of support was not provided to foster carers, even where there was evidence that placements were at risk due to increasing levels of emotional dysregulation and risk being displayed by the child. If living in a family-based placement is considered to be in the best interests of the child, then greater support for alternative families is required to maintain children's Article 9 and Article 18 rights. Using residential care to provide respite, better access to mental health services and

[13] p16, https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

training in psychotherapeutic parenting interventions for foster carers could support this.