CHAPTER 6

Looking after children

In the previous chapter, we talked about protecting children and we discussed the types and theories of child abuse. In this chapter, we will consider the various alternatives open to a child who is being 'looked after' by a local authority.

Objectives

When you have read this chapter, you should know what the term 'looked after' means. You should understand recent trends in the numbers of children being looked after, principles underlying good practice in working with looked-after children, and the advantages and disadvantages of using the government-produced Looking After Children (LAC) materials when working with children living away from their families. You should have a better understanding of kinship care, foster care and residential care as ways of providing for children needing to be looked after. The chapter will also cover secure accommodation and adoption practice, including a consideration of 'open adoptions'.

Children who are 'looked after'

Before we discuss the various alternatives open to children who are being 'looked after', it will be as well to note briefly a few facts about them – including what exactly is meant by the term 'looked after'.

What does the term 'looked-after' denote?

In England and Wales, social services for children and young people are provided under the Children Act 1989. Under the Act, the term 'looked after' denotes all children subject to a care order or who are provided with accommodation on a voluntary basis for more than 24 hours. This includes those children who are the subject of an emergency protection order, police protection powers, or an interim or full care order. It includes children and young people committed or remanded to local authority accommodation, or made the subject of a residence requirement of a supervision order in criminal proceedings, and those transferred to local authority accommodation under the provisions of the Police and Criminal Evidence Act 1984. Finally, it includes those accommodated in community homes following sentence under Section 33 of the Children and Young Persons Act 1963 (NCH Action for Children, 1996).

In Scotland, social-work services are provided under the children (Scotland) Act 1995. The 'looked after' and 'accommodation' provision are similar to those of the Children Act 1989.

How many 'looked-after' children are there?

The number of children looked after in England decreased steadily from over 90,000 in the late 1970s, to 60,000 in 1985 and 48,000 by 1995 (Department of Health, 1995). As a consequence of the implementation of the Children Act 1989, the number of children under care orders fell from 36,600 in 1992 to 26,800 – or 55 per cent of children looked after – in 1995. Before the Act came into force, some 59,834 children and young people were under care orders. In addition there has been a rise in the proportion of children looked after by voluntary agreement from 17,300 in 1991 to 20,600 in 1995 (NCH Action for Children, 1996).

What are the general characteristics of 'looked-after' children?

Deprivation is a common condition among young people who are being looked after. A study of 2,500 children found that before entering the care system, only a quarter were living with both parents. Around three-quarters of their families received income support. Only one in five lived in owner-occupied housing, and over half were living in poor neighbourhoods (NCH Action for Children, 1996).

The study found that additional factors which increased children's chances of admission were: overcrowding, linked with large families; having a young, often a teenage, mother; and having parents who came from different racial backgrounds from each other.

The study's authors argue that it is probably not just the poverty of single parents but also their lack of available social supports that increases the likelihood that their children will be placed away from home. Also highlighted is the interaction of environmental problems or disability and family stress, with breakdown. Indeed, a 'broken family' was found to be the factor most highly correlated with entry to care (Bebbington and Miles, 1987).

More recently, Jackson (1998, p. 47) has argued that:

> even when all the factors contributing to a likelihood of material disadvantage are combined, the chances are only one in ten that a child will enter the care system. ... For this to happen ... there have to be other factors, most commonly the mental illness of a parent, domestic violence, or the physical and/or sexual abuse of the child. The family has probably become isolated or alienated from friends and relatives or someone would

have stepped in to care for the children. Of course, there are exceptions. Parents still fall ill and die; they may lack an extended family network, their coping capacities may have been overwhelmed by a series of catastrophes. But, in general, children within the care system are most unlikely to come from 'ordinary' working class families, that is, those which simply lack material resources.

Age is also a factor. Approximately two-thirds (63 per cent) of children accommodated are aged over 10 years. Between 1992 and 1995 the proportion of children aged 10 to 15 looked after in England rose from 39 per cent of the total to 43 per cent (NCH Action for Children, 1996).

Where are 'looked-after' children placed?

Almost two-thirds of children (65 per cent) looked after in England on 31 March 1995 had been placed with foster carers, while 17 per cent (8,200) were in residential homes. Most of these youngsters (5,700) were placed in local authority community homes. In addition, an estimated 2,100 were placed for adoption and 4,300 were placed with their parents (NCH Action for Children, 1996). The proportion of looked-after children fostered rose from 50 per cent in 1985 to 58 per cent by 1991, although the *number* of children fostered fell by 2,000 during the same period. The number of these children in community homes fell from 23 per cent in 1985 to 14 per cent by March 1995 (NCH Action for Children, 1996).

Principles of child placement

Principles and philosophies in child placement, as in anything else, evolve over time. For example, Table 6.1 depicts trends in child welfare during the latter part of the twentieth century. As the table shows, the progression has moved quite swiftly from the idea that children ought to be brought up as normally as possible within a family rather than an institution, to the idea that it ought to be a permanent family, to the idea that preferably it should be their own family. With the diversification of the nuclear family (two biological parents bringing up their mutual children) into an increasing number of alternative family forms (for example, blended or reconstituted or step-families, and single-parent families), the focus has shifted to maintaining the child's ties with the family over time whether that family consists of parents and siblings or the extended family network.

However, the Children Act 1989 supports the principle that, if at all possible, children should still be cared for by their own biological families. The primary goal of child welfare is therefore to prevent removal of the

Table 6.1 *Trends in child welfare in the twentieth century*

Time	Reform	Focus	Philosophy
Before 1970	Family foster care	Foster family	Children belong in a family rather than an institution.
1970s	Permanency planning	Adoptive family	Children belong in a permanent family: no child is unadoptable.
1980s	Family preservation	Biological parents	Children belong with their biological parents: reasonable efforts must be made to maintain the family.
1990s	Family continuity	Extended family	Children belong in a family network that continues relations over time.

child from the home, if this is consistent with the child's best interests, by offering appropriate services to the family. This is *family preservation*. If the child must be removed, the goal is then to reunite the child with the family as rapidly as possible, again consistent with the child's best interests. This is *family reunification*.

Family reunification, usually the preferred goal for permanency planning, is defined by Pine, Krieger and Maluccio (1993, p. 6) as:

> the planned process of reconnecting children in out-of-home care with their families by means of a variety of services and supports to the children, their families and their foster parents or other service providers. It aims to help each child and family to achieve and maintain, at any given time, their optimal level of reconnection – from full re-entry of the child into the family system to other forms of contact such as visiting – that affirms the child's membership in the family.

In earlier years, family reunification was viewed *only* as the physical return of the child to parental care, with full parental rights returned, after a limited period of supervision. It is now seen as a continuum of relationship and reconnection, an acknowledgement of the importance of family continuity. A child may remain, for compelling reasons, in planned long-term care but may still be reconnected to his or her parents.

Given these basic principles, we can also identify a number of other guidelines for child-placement practice which are drawn from research. In 1991, the Department of Health published *Patterns and Outcomes in Child Placement* (Department of Health, 1991d). This was intended as a sequel to the 'Pink Book', *Social Work Decisions in Child Care* (Department of

Health and Social Security, 1985a). As with the earlier volume, the purpose of *Patterns and Outcomes*, as it came to be known, was to make recent research findings accessible to social workers and demonstrate their relevance to day-to-day practice. The review that follows is based on major research studies funded by the Department of Health, together with other national and local studies concerning child-care placements. Although this research was carried out some ten years ago, it is of continuing relevance. The findings of the studies and their implications for policy and practice are presented in terms of four themes: promotion of the child's welfare; partnership with parents and carers; policies, planning and decision-making; and evidence-based practice. These findings constitute principles on which effective child-welfare practice should be based.

Promotion of the child's welfare

For the sake of brevity and clarity the principles drawn from the research findings are presented below in point form.

- Preventative services, geared to family preservation, must involve a combination of practical services and help with family relationships, and should focus on the functioning of family and social networks.
- Notwithstanding the need for prevention, short, medium and even lengthy periods in care or accommodation can be beneficial and appropriate, and least detrimental for particular children. Thus, there is no room for inflexible policies regarding admission and the timing of 'permanency' plans.
- Greater attention must be given to the health and educational needs of looked-after children. Many children placed away from home require remedial help and treatment to overcome the adverse effects of deprivation and abuse.
- Changes in placements, resulting in a breakdown and discontinuity of relationships, are a persisting problem. Children of families under stress may need frequent or regular periods in accommodation. They must be able to return to the same respite-care placement and the supply of such placements must be increased to meet such demand. Innovative provision such as a small network of carers known to vulnerable families, and perhaps linked with residential provision, may be required. Special consideration should be given to the needs of socially disadvantaged families who find it difficult to use respite services.
- Ideas about permanence should be expanded to embrace continued family contact through open adoption or permanent fostering. Premature or routine termination of contact when a permanent placement is made is usually inappropriate.

- Attempts to rehabilitate children with their families should begin immediately after admission in view of the finding that the period after which children are likely to have a long stay in care can be measured in weeks rather than months.
- The key to discharge is visiting; contact is highly beneficial for children's welfare and does not increase the risk of placement breakdown. Informal barriers to contact, such as the attitudes of foster carers and residential staff, should be addressed through training.
- Relatives can offer stable placements, particularly in relation to long-term placements; they are also a major source of family contact, and visits by grandparents, aunts and uncles can often be encouraged.
- Too little attention has been given to the role of siblings and other children despite the fact that this factor is known to affect the outcome of placement. For example, the presence of 'own' children close in age to a foster child is associated with negative outcome. In contrast, placement with siblings is usually beneficial and highly valued by the children concerned. Equally, it is clear that other youngsters can be a source of stress rather than support. Thus, caregivers must be aware of the need to protect children and not leave them to 'fight their own battles'.
- Ethnic monitoring should be routinely carried out with regard to services for black and ethnic minorities; the findings should be translated into policy, service design and practice; the outcome of this process should be monitored. In addition, special attention should be given to children of mixed parentage or heritage who are placed away from home in disproportionate numbers. More attention must be given to what the phrase 'cultural issues' means in relation to direct work with children and families and the provision of services.

Partnership with parents and carers

The importance of partnership with parents and carers is another primary thrust of the Children Act 1989. Unfortunately, the studies discussed in *Patterns and Outcomes* revealed that major changes in the attitude of social workers towards parents would be necessary to make partnership with parents an integral feature of social-work practice. Real partnership requires self-awareness on the part of practitioners and the ability to empathise with parents' feelings and concerns, skills in the use of written

agreements, and the attendance of parents at reviews, case conferences and planning meetings.

With regard to looked-after children, it was evident that a fundamental reappraisal of roles and expectations would be required before social workers and agencies could serve as parents' agents when providing accommodation. However, it was noted that partnership models had already been used successfully in respite-care schemes and in adoption. Finally, as mentioned above, it was clear from the research that more attention should be given to the needs and feelings of carers' own children; a factor which is known to play a part in the success or otherwise of foster-care placements, but which has received surprisingly little attention from researchers.

Policies, planning and decision-making

The research findings with respect to policies, planning and decision-making are presented in point form here for the sake of brevity and clarity.

- The studies highlighted the need for improved national and local child-care statistics that will provide detailed information about the turnover of children and their care careers, allowing changes to be monitored.
- Managers should be aware that the fall in numbers of children placed away from home masks the workload caused by more frequent admission, discharges and changes in placement; it also hides the fact that many young children continue to be placed away from home for short periods.
- Residential care still plays an important role in child care. It must be adapted to current use, and the purpose and facilities of each establishment should be matched to the needs of the young people looked after.
- The central role of foster care continues to be that of providing short-term care for younger children. More resources for recruiting will be required to substantially increase short-term and/or task-centred placements for teenagers. The success of such placements depends in large part on the effective recruitment, preparation and support of foster carers.
- There is a need for more precise classification and differentiation of children and types of placement. This would assist appropriate allocation of resources and social-work input. Priority should be given to identifying racial and cultural differences.
- There are wide differences between authorities, which should lead managers to question their own priorities, and admission and placement patterns. If the differences are not identified and taken into account, they can lead to false conclusions being drawn from comparisons of numbers of foster placements, breakdown rates, and so forth.

- Studies of departmental structures suggest that improvements in practice are unlikely to flow from organisational changes. However, it is vital to ensure that policies, directives and guidance are known and understood by practitioners. It appears that staff are often unaware of policies and regulations. Channels of communication must flow freely to avoid the danger of far-reaching misunderstanding and errors.
- Planning for individual children is essential, and the needs of individual children should be aggregated into departmental policies. Effective planning requires:
  - written specification of what should be done, by whom and when;
  - long- and short-term goals for each child;
  - a contingency plan to cover crises.

It is vital that social workers involved in planning decisions have a sound knowledge of the research evidence on placement outcomes. Further, placement panels should specify the risks and countervailing factors and the reason for any placement which is made despite the presence of factors known to be linked with placement breakdown – for example, an 'own' child close in age to a young child being placed in a foster or adoptive home; or placement at home when changes in family composition have occurred during the child's absence. Finally, planning decisions must be informed by detailed knowledge about the history of both child and family.

Evidence-based practice

Despite the variety and differences in scope of the research studies, they were linked by a recurrent theme of profound importance: 'the whole question of evidence – how to gather, test, record and weigh it' (Department of Health, 1991d, p. 77).

The studies indicated that 'all the professionals involved in child care decisions would benefit from some rigorous training in the collection and use of evidence and should be challenged to examine the values on which their views are based' (Department of Health, 1991d, p. 76). Moreover:

> Without adequate evidence about existing needs and resources, strategic planning is a waste of time. Sound assessment of the problems and strengths of individual children and families must be based on clear, sufficient and well-recorded evidence about past and present functioning. Decisions can only be as good as the evidence on which they are based, and if evidence is distorted, ignored or not weighed up carefully, the

> decisions will be flawed. They may even be dangerous if risks and benefits are not analysed and balanced objectively.
>
> (Department of Health, 1991d, p. 78)

To be sure, social work is more than a science; it inevitably involves an emphasis on empathy, negotiation and building relationships. However, 'perhaps the most important message from recent research is that if progress is to be made in developing professional standards in the care of children, then more attention must be given to scientific disciplines in dealing with evidence' (Department of Health, 1991d, p. 78).

We come now to a discussion of the Looking After Children materials, which are designed to improve the parenting experiences of children looked after by local authorities and which identify a number of pointers for practice.

The Looking After Children project

The extensive child-care research undertaken in the 1980s and summarised in *Patterns and Outcomes* (Department of Health, 1991d) showed that the child-care system was failing badly when judged by the outcomes for children and young people. All aspects of their development – education, health, relationships, employment and identity – were found to be more problematic than those of children cared for by their own families or adopted at a young age.

A number of studies have since highlighted the extremely poor prospects of care leavers, 'who are many times more likely than their peers to experience illiteracy, homelessness, unemployment, early parenthood, problems with drugs and alcohol and imprisonment'. It may be further noted that the Education Reform Acts of the Conservative government mean that many looked-after children are in danger of being excluded altogether from the educational process (Jackson, 1998, p. 48). One research study showed that children usually bring their educational problems with them when they enter care or accommodation. Unfortunately, the experience of being looked after away from home all too frequently does little to ameliorate these deficits (Heath, Colton and Aldgate, 1989 and 1994).

Towards the end of the 1980s, the Department of Health and Social Security suggested that an independent working party be set up to consider the question of outcomes in child care (Parker et al., 1991). Specifically, the working party was asked to consider how the experience of being looked after in the public care system affects the quality of life and life chances of children and young people.

The working party identified the failure to specify outcomes as a significant weakness of the child-welfare system. As one member of the working party, Sonia Jackson (1998, pp. 48–9), succinctly puts it: 'there is no way of assessing outcomes if you do not know what you are aiming at'. Moreover, 'assessment of outcomes can only occur in relation to some kind of standard and someone has to set the standard'. The working party came to the conclusion that many of the shortcomings of the system were attributable to the fact that, in the majority of child-care cases,

> there was no one person monitoring the developmental process of the child in the informal and perhaps hardly conscious way that most parents do and taking corrective action if necessary. In devising the assessment scheme, therefore, we decided to base it on the aspirations and behaviour of 'ordinary' parents. What aspects of development are considered important by parents bringing up their own children? What do they do to try to promote good outcomes for their children?

The working party's deliberations resulted in the production of the Looking After Children (LAC) materials, which are designed to improve the parenting experience of children looked after by local authorities and other agencies. The first stage of the LAC project is reported in *Looking After Children: Assessing Outcome in Child Care* (Parker et al., 1991). This package of materials attracted widespread interest, which encouraged the Department of Health to engage in a programme of research and development into the application of the LAC materials to social-work practice and issues surrounding their use. This work is reported in full in *Looking After Children: Research into Practice* (Ward, 1995).

The research and development work included testing the materials with a group of 379 children living at home to establish whether the forms reflect the expectations held by families in the community for their own children. The acceptability and usefulness of the materials to social workers, caregivers, children and young people looked after away from home was also evaluated using a group of 204 children in care or in accommodation in five local authorities.

In the light of the results of research and development work, the original LAC materials were significantly revised. They were then launched by the Secretary of State for Health in May 1995. This heralded the start of a highly effective dissemination and implementation programme. Thirty-nine local authorities in England agreed to implement the LAC materials in 1995/96 with support from the Department of Health.

The materials have been widely adopted throughout the UK. It is estimated that by the end of 1998 the system was being operated by 90 per cent of English authorities and the majority of those in Wales, Scotland,

and Northern Ireland. The Central Council for Education and Training in Social work has promoted the use of the LAC material in Diploma in Social Work programmes and at post-qualifying levels. In addition, the LAC materials have been adapted or translated for use in many other countries (Jackson, 1998).

The LAC materials promote good parental care by identifying the experiences, concerns and expectations of children at different ages and stages through highlighting the likely impact of different actions. In a nutshell, they introduce ideas about the outcome of social-work practice.

They also facilitate discussion of the difficulties as well as successes in the lives of looked-after children and young people. The Assessment and Action Records (see below) assist with the planning of improvements to the quality of care that children receive, and with monitoring the extent to which these are carried out. However, the Records must be set within an overall framework of information-gathering, planning and review. Their purpose is to reinforce working partnerships between key people in the child's life and improve the allocation and clarification of professional responsibilities. This is particularly important in relation to multi-disciplinary work with health and education, where it is vital to improve current poor outcomes for children.

The materials are an integrated package which helps social workers and caregivers to set an agenda for work with children and young people, and ensure that these plans are acted upon. By assessing children's progress across a range of developmental dimensions including health and education, they direct attention to the ordinary everyday goals of parenting, and ensure that all essential information is recorded in one accessible place and is regularly updated. They encourage workers to listen attentively to children and young people and reflect on their successes as well as their problems and they strengthen partnerships between children and young people, parents, teachers and others. They rationalise documentation and create consistency across agencies, thereby facilitating improvements in the quality of care provided.

The LAC materials include *Planning and Review Forms* and *Assessment and Action Records*. The Planning and Review Forms are records which hold the essential information that is too often lost, for children who spend time in public care. They contain key details about the child's health and educational achievements, and his or her family. They also record formal agreements about placements and other issues appropriate to short- and long-term planning.

The Assessment and Action Records centre on the child's developmental needs, the quality of day-to-day care and the actions necessary to promote good outcomes. When used over time they enable agencies to assess

outcomes for children. They are designed around seven dimensions: health, education, identity, family and social relationships, social presentation, emotional and behavioural development, and self-care skills. It will be observed that these are the same seven dimensions as in the Child's Development Needs component of the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al., 2000).

Clearly, use of the LAC materials will help local authorities fulfil their responsibilities under the Children Act 1989. They set out explicitly what good parental care means in practice, listing the aims that any reasonable parents might be expected to hold for any child. Thus, they require those responsible to consider all aspects of children's lives, not only those that have resulted in the child's placement away from home. The materials rightly encourage partnerships between key people involved in the child's care, such as carers, social workers, families and others; they also promote continuity in the lives of looked-after children to avoid the damaging levels of disruption highlighted by previous research.

A new research programme, funded by the Department of Health, has been set up to show how 'the data contained in Assessment and Action Records can be aggregated and analysed to provide an overall profile of looked after children compared with their peers, and to reveal organisational risk factors which get in the way of effective service delivery' (Jackson, 1998, p. 53).

The LAC materials have been widely acclaimed and now appear to represent the mainstream of child-care practice. Although the field trials encountered some resistance from social workers, mainly on the practical grounds that the Assessment and Action Records were too time-consuming, there has been no serious challenge to the theoretical basis of the LAC model (Jackson, 1998).

However, Knight and Caveney (1998) have recently criticised the Assessment and Action Records for imposing white middle-class assumptions about child development, for undermining the principle of partnership underpinning the Children Act 1989, and for blaming individuals rather than structural factors for deficiencies in the care system and poor outcomes. In reply, Jackson (1998, p. 45) welcomes critical scrutiny of the Looking After Children model. However, she contends that Knight and Caveney's views reflect a misunderstanding of the LAC approach and 'a classbound view of parenting which would deny looked after children the chance of a better quality of adult life than their families' experience'. Jackson accepts that implementing LAC is not an alternative to tackling widespread inequality and discrimination, but argues that the Assessment and Action Records increase the likelihood that social workers and caregivers will address key aspects of children's development; they also help

those responsible to understand better how their actions or inactions contribute to child-care outcomes.

Other principles of practice include attention to anti-oppression, not least in relation to race, sexual orientation and disability. These principles are discussed in Chapter 7.

Having discussed the principles underlying work with looked-after children, we come now to the selection of appropriate care options for them.

Selection of appropriate care options

A number of options are available to serve young people being looked after and few empirical data exist to help decide which option would best suit a particular child. Nevertheless, there are certain guidelines to aid in selecting a placement. One of these is the degree of restrictiveness or control which it is felt the child needs at that particular time. For example, living at home or with a relative is the least restrictive while being kept in secure accommodation is most restrictive. Other options, such as foster care and residential care, fall between the extremes on the restrictiveness continuum. In order, from least to most restrictive, placement options might be rated as follows:

Least restrictive	Living at home or with a relative (kinship care)
↕	Ordinary foster care
↕	Specialist or treatment foster care
↕	Group care
↕	Residential care
Most restrictive	Secure accommodation

Apart from restrictiveness, other guidelines focus on the best fit between the child's needs and the characteristics of the placement, taking into account the principle of family continuity.

Kinship placements are often preferred as they promote the continuity of relationships for the child in a familiar environment. They provide a placement within the child's own ethnic/cultural group and are less likely to be disrupted than placements with non-relatives. They are not appropriate if the relative cannot establish boundaries with the parent or is afraid of the parent, or there is any indication that the relative may have abused the parent or child or supported the parent's maltreatment of the child.

Family foster homes are preferred over group homes for the majority of children. For infants and preschool-age children, a family setting is almost mandatory except for those with very severe problems who require specialised care. For children who are able to participate in family life, attend local schools and live in the community without danger to themselves or others, family foster care is preferred.

Treatment or specialist foster homes are appropriate for children with emotional or behavioural problems that can be handled in a family setting. Specialised, highly trained foster homes that take medically vulnerable children and work closely with the hospital and medical team are appropriate for children with severe or multiple needs who might otherwise be hospitalised.

Group care is generally considered appropriate for adolescents who are unable to tolerate the demands and intimacy of family life but are still able to function within the community in terms of school or work. For some adolescents, small or family-type group homes in which the caregivers act as parent figures to a number of young people are a good solution. For others, group homes or cottages, where the caregivers act more as role models than as parent figures, work best. A few group or residential settings will accept both child and parent in placement, as will some family foster homes.

Residential care is recommended for young people who display behaviour that a family or community would not usually tolerate, perhaps acting in an aggressive way or posing a danger to themselves or others. Youths who have difficulty forming relationships with parenting figures because of past negative experiences may do better in a residential setting. For some parents, it may be more comfortable to see their children placed in residential care because they do not have to watch other 'parents' succeeding where they could not. Residential care is more commonly preferred in Europe than it is in the United Kingdom where practice is toward moving young people back from institutional settings into the community.

Having briefly described the various options, we will now explore each in greater depth.

Kinship care

As we have seen, the focus in the 1990s has turned increasingly towards family continuity. This concept emphasises the necessity for continuing important relationships across the lifespan and acknowledges that children need to be embedded in family and community networks. Even when children cannot live with their biological families and must move away from familiar communities, continuity can be maintained by involving their families in alternative living situations such as foster care, residential care and adoption. The importance of the continuity of kinship ties was emphasised by Joan Laird when she said in 1979:

> Human beings are profoundly affected by the family system of which they are a part. Kin ties are powerful and compelling, and the individual's

> sense of identity and continuity is formed not only by the significant attachments in his intimate environment but also is deeply rooted in the biological family – in the genetic link that reaches back into the past and ahead into the future. Ecologically oriented child welfare practice attends to, nurtures and supports the biological family. Furthermore, when it is necessary to substitute for the biological family, good practice dictates that every effort be made to preserve and protect important kinship ties. (Laird, 1979, p. 175)

Nowadays, we tend not to talk about 'substitute' parents or families. Even the term 'foster parent' is being replaced by 'foster carer' in recognition of the belief that parents in the foster family do not, and should not be expected to, replace the child's own parents: they are complementary not substitute adult figures in the child's life.

Ideas about what constitutes a 'family' are also continuing to change. In social-work practice, 'family' has often been synonymous with 'household' and, in the high proportion of cases where the household is headed by a single female, has sometimes come to mean 'mother'. Social workers might consider involved step-parents as 'family' but wider patterns of kinship are often overlooked. A recent study by Peter Marsh (Marsh, 1999) explored the definition of 'family' by young people leaving care, and compared the family tree constructed by the young person with the same family tree constructed by the young person's social worker. Cousins were the largest group of relatives in the family tree drawn by the young person, followed by maternal and paternal uncles and aunts, who together accounted for nearly one-third of the relatives named. Full siblings and other siblings counted for another third. There were some interesting differences in maternal and paternal kin groups, as maternal uncles and aunts accounted for 20 per cent of relatives but paternal for only 10 per cent. This pattern was repeated in other areas: for example, three times as many maternal as paternal grandparents were named. Young people were obviously more familiar with their mother's side of the family. Step-parents accounted for only 6 per cent of the relatives listed and sometimes included previous step-parents, who continued to be important figures for the child even when they were no longer the parent's partner. Other examples of unrelated people still looked on as 'family' included previous foster parents and family friends who had achieved the status of honorary aunts or uncles.

On average, family trees constructed by social workers contained just 40 per cent of the relatives named by the child. Social workers showed good knowledge of parents and full siblings but knew less about grandparents and even less about aunts and uncles. They fell down, too, when it came to identifying the most influential person in a child's life. They and the care leaver identified the same person in only 17 of the 41 cases: and only 3 of the 41 people nominated as most influential had attended the young person's last formal review.

Marsh remarked that 'potential family support for young people leaving care resembles a target' (Marsh, 1999, p. 13). At the centre of the target are 'key kin' who are likely to be proactive about involving themselves in the young person's life and are very important both emotionally and practically. The next ring contains kin who are not proactive but are willing to become involved if approached; and the furthest ring contains kin who are known to the young person but are unlikely to want to become involved. Although Marsh was talking about kinship involvement with young people leaving care, his model of the kinship support system as a target with a centre and inner and outer rings would be just as applicable to young people in care or being looked after. If we accept that social workers are unlikely to be familiar with kin in the inner ring – that is, kin who are not proactive but would be willing if approached – then it seems that a potential source of valuable support for young people is being overlooked.

To what degree kin support should be extended to providing a home for the young person – to what degree, that is, kinship care should be an accepted part of the foster-care system – is still a matter for debate. Advocates of kinship care point out that the trauma of placement may be minimised if children can be placed with extended family members. Keeping the child 'in the family' is likely to ensure that cultural traditions are maintained, particularly if the child is a member of a minority ethnic group and could not otherwise be placed with foster carers of the same cultural background. Ties to relatives will be strengthened and will serve to reinforce the child's sense of belonging and identity. Moreover, some studies have shown that kinship homes are less likely than non-related placements to be disrupted and more likely to keep children until they reach majority (Berrick, Barth and Needell, 1993). Thus, kinship care can satisfy both proponents of permanency and those who believe that family preservation should be paramount.

However, kinship homes can also have their drawbacks. If the kin home is in the same, sometimes quite disadvantaged community as the parental home, children will maintain their ties not only with relatives but with peers who are still engaging in the kinds of negative activities the child is now trying to avoid. In the same vein, kin may have shared with the child's natural parent a disadvantaged upbringing and may be struggling with many of the same problems which afflict the biological home. In addition, where contact with the natural parent is not advised – where continuing abuse is a danger, for example – kin may have more difficulty in denying the parent access to the child than would a non-related caregiver. From the social

worker's point of view, kin carers are less likely to see themselves as working for an agency. They are less aware of child-welfare policies and may be less interested in cooperating with agencies in the interests of the child. These characteristics make the home a more natural atmosphere for the child but may present difficulties for social workers. Thus, while kinship care is often a very appropriate placement option, safety and protection issues must be addressed through a careful assessment of the kinship home. In the United States, the Child Welfare League Kinship Care Policy and Practice Committee recommend consideration of the following factors in assessment (Child Welfare League of America, 1994, pp. 44–5):

- The nature and quality of the relationship between the child and the relative;
- The ability and desire of the kinship carer to protect the child from further maltreatment;
- The safety of the kinship home and the ability of kin to provide a nurturing environment for the child;
- The willingness of the kinship family to accept the child into the home;
- The ability of the kinship carer to meet the developmental needs of the child;
- The nature and quality of the relationship between the birth parent and the relative, including the birth parent's preference about the placement of the child with kin;
- Any family dynamics in the kinship home related to the abuse or neglect of the child;
- The presence of alcohol or other drug involvement in the kinship home.

When assessing kinship homes, social workers must be aware of their own biases. Kinship caregivers are typically grandparents or even great-grandparents, and while many are neither aged nor infirm, workers may feel that a home with a younger caregiver might be better. Kinship homes may involve predominantly members of ethnic minorities, who may be suspicious of 'the system', a situation requiring cultural competence on the part of the social worker in engagement and developing trust. Caregivers in kinship homes are often less well educated than unrelated foster carers and tend to have lower incomes. Workers may feel less comfortable with them than with foster carers who are known to the agency, have more financial resources and are better educated.

A genuine concern in placing children with relatives, particularly older relatives, is whether these adults have enough supports available in the community to help them in their efforts with the child. Use of an ecomap (see Chapter 4) can help to determine which supports are available and

which need to be provided. Meeting with the entire kinship network in a family conference often provides evidence that, although the carer's resources are limited, there are others close by who will provide respite care, transportation or other forms of support.

Sometimes, a family conference can be used not just to explore supports but as a decision-making tool. The Family Decision-Making Model in New Zealand has evoked wide interest in those working in family-based services. Although the model was originally developed for use with the Maori people of New Zealand as a way to honour the Maori culture, it has been used with other ethnic-minority peoples – for example, Aboriginal bands in Canada and the United States – as well as with members of the dominant culture. The model involves holding a conference of extended-family members following an investigation of child abuse by a child-protection worker or the police. The conference is facilitated by a specialist chairperson, takes place in a comfortable setting and may last for several days. Involved professionals share information with the family about factors that place the child at risk. Then the professionals leave the room, although the facilitator may remain available in a nearby room for consultation. The family develops a plan for protecting the child and providing a home within the kinship network. The facilitator records the decisions and accesses the resources needed for implementing the family's plan (Smith and Featherstone, 1991).

Adapting the family decision-making model to a UK setting raises a number of issues, including legal constraints regarding confidentiality, court processes and liability. A major issue is control. Child-welfare practice has traditionally focused on control by the social worker and it may be difficult for some social workers to engage in a process that hands control back to the family. Although a major thrust of the Children Act 1989 is towards partnership with parents, parents still often feel that they do not have equal decision-making power with social workers (Colton et al., 1995a) and some social workers still feel that parents do not have the expertise necessary to make decisions in the best interests of their children. For example, there is some debate over whether a kinship home should be required to meet the same standards as any other foster home or whether the standards should be relaxed somewhat, particularly if the home is going to be approved for one particular child and not for foster children in general. A kinship home selected through a family conference may fall short of accepted standards in many respects; and social workers may be reluctant to implement a family decision that they personally do not agree with.

Accepted standards include not only the level of care provided to the child but the level of training achieved by the foster carer. A high proportion of kinship carers are grandparents who brought up their own children

without any training in the art of parenthood and do not see why they should now need training to bring up their children's children – particularly as this training is likely to be provided by young professionals who have not themselves brought up children. The result is that kin carers are very often untrained and this leads to questions about the quality of care provided. After all, if training does not improve the quality of care, why are we spending money to train non-related foster carers?

Another controversy centres around financial support for kin carers. Some would argue that kin should not be paid for taking care of their own: they have a moral duty that does not apply to unrelated carers. In addition, fraudulent manipulation of the system may occur in cases where kin receive payment for children who are not really living with them and pass part of this payment on to the parents. On the other side of the debate, proponents of financial support point out that kin are often subject to the same economic conditions that affected the child's own parents and will probably need assistance with housing, respite care, support groups and special health and educational services to meet the needs of children. If they are not paid at the same rate and given the same support services as unrelated carers, it is the children who will suffer. Kin carers should not be used as a cheap substitute for unrelated carers but rather should be offered training, reimbursement and support in the same way and at the same level.

The argument about the government's responsibility towards kin carers is taking place both in a context of fiscal restraint and in relation to another controversy: whether the focus on family preservation, now over a decade old, is threatening the safety of children and should be discontinued. An article in *McCall's* magazine titled 'The Little Boy who Didn't Have to Die' told of the death of a child returned to his parents by the foster-care system. It said:

> Gregory appears to have been doomed by a decade-old national policy determined to patch up troubled parents and preserve families. Despite mounting evidence that family preservation programs aren't working, child welfare policy remains so focused on reuniting families that its original aim – keeping children safe – has become almost secondary.
>
> (Spake, 1994, p. 146)

Although it may seem that an article in a women's magazine should not determine the state of the nation, family-preservation proponents cannot afford to dismiss popular coverage as ill-informed, because public attention does influence policy formation and political controversy (see Sanders, 1999). Moreover, considerable divergence of opinion also exists between better informed researchers and practitioners. For example, Gelles (1993) calls for abandonment of the family reunification/family preservation model as both official and unofficial child-welfare policy. He writes:

> We are not sure under what circumstances family preservation is a penicillin and under what circumstances it is a poison. My most important argument is that family reunification and family preservation should not be the sole or even main means of treating and preventing child maltreatment. (pp. 558–9)

Gelles points out that it is unpopular to argue against family preservation because it draws support both from the Right, who want limited intervention into the private sphere, and from the Left, who think it consistent with their tradition of supporting disadvantaged families and children. Nevertheless, the unpopularity of an argument should not stop that argument from being made.

From a feminist perspective, the American writer Bernard (1992) examines the 'dark side' of family preservation, noting that the American family is one of the country's most violent institutions and a cornerstone of women's oppression. She cautions readers to:

> consider carefully the full implications of the family-preservation policy without buying into the nostalgia for and mythology of families that are presented by an administration that has consistently undercut the goals of equality and social justice. (p. 159)

Dore (1993) reminds social workers that family-preservation intervention is less effective with maltreating families characterised by extreme poverty, single-parent status, low educational attainment and mental health problems. She concludes that 'family preservation' can only (truly)

> occur when many families with children no longer struggle to exist at less than subsistence level, when poor parents are freed from anxiety and depression generated by raising children in hostile environments, and when it is widely acknowledged that the real cause of family breakdown is the failure of our society to value and support the parenting role.
>
> (p. 553)

Seader and Nelson (in Gambrill and Stein, 1993) argue that defining the treatment goal as 'family preservation' rather than 'the best interests of the child' necessarily changes the intervention. In many cases these goals conflict and it is the child who always seems to lose. Seider claims that there is no empirical evidence that family-preservation programmes are working and expresses concern that families may re-abuse their children when intensive 24-hour service is withdrawn.

On the other side of the debate, Seader also argues that it is not the family-preservation philosophy which is at fault but the way that services are provided. 'Services are limited because of agency biases, worker competencies, available community resources and so forth' (Gambrill and Stein, 1993, pp. 60–1). Also in Gambrill and Stein (1993, p. 65), Nelson argues that family preservation is not indiscriminately applied to all families entering the child-welfare system and that family-preservation workers themselves typically recommend placement outside the family in from 5 per cent to 50 per cent of their cases. Where family-preservation efforts are made, improvement in family functioning is an essential criterion for allowing the child to remain in the home.

Maluccio, Pine and Warsh (1994) acknowledge that family preservation is viewed as competing with child protection and in particular cases it may be incompatible. However, in its defence, they state, 'At the philosophical and policy levels, family preservation and child protection are complementary rather than competing values. In essence, the best way to protect children is to preserve as much of their families as possible' (p. 295).

Kinship care satisfies both camps in that it preserves the extended family if not the nuclear family and, at the same time, it is a placement which can ensure the safety of the child. However, the major issues associated with it, particularly standards and resourcing in comparison with those of non-related carers, remain to be addressed.

Before leaving kinship care, it is as well to say a few words about informal kinship care where the child-welfare system is not involved at all and the child merely goes to live with a relative. In these cases, the child may receive excellent care without the stigma that child-welfare involvement still seems to convey despite our best efforts to create a non-stigmatising system. On the other hand, no formal supports are available to the carer and the child may face the same risks that child-welfare legislation was designed to avoid: lack of permanency planning; lack of services to the child and family; and lack of pre-placement screening and post-placement supervision.

Informal care by kin is an integral part of many cultures and we do not know how many children are diverted from the formal system in this way, nor what befalls them. For some parents and kin, escape from state intervention and control may well outweigh the benefits, often meagre, which kin would receive were they part of the formal system. If we believe that the advantages of informal kinship care are greater than the risks, then we need do nothing to change this attitude. If, on the other hand, we believe that the risks are greater than the advantages, then it behoves us to offer more emotional and material support to formal kinship carers than we do at present.

Foster care

One type of foster care – kinship care – has been discussed above. However, when we speak of foster care, we tend to think of care by parent figures who are unrelated to the child, and indeed, most children looked after by local authorities are fostered by people unrelated to them.

Fostering is as old as human history in the sense that, through time, lost and abandoned children have been brought up by people who were not their birth parents. However, the origins of formal fostering have been traced to the wet-nursing system that developed in France around the fifteenth century. Formal fostering – that is, fostering sanctioned by law – came to Britain with the foundling hospitals of the eighteenth century but, as the name suggests, the children placed in foster homes under that system were babies. In the nineteenth century, a number of philanthropic organisations began to develop in response to the Poor Law and its perceived shortcomings in relation to the provision for children: there has always been a close association between poverty and the numbers of children requiring substitute care outside their families (Triseliotis, 1997). However, it was feared that the fostering of older children would undermine the deterrent element of the Poor Law, and thus, unlike in Scotland, older children were not fostered in England until after 1860. Indeed, mainstream fostering as it is currently understood was not introduced until the Children Act 1948. Prior to this, fostering was mainly a long-term arrangement, but the 1948 Act extended it to include fostering as a temporary service to children and families.

In the United Kingdom and Ireland, the vast majority of children placed away from home are living in foster care. In these countries, residential institutions have largely – and many believe, wrongly – become places of last resort, reserved for children whose severe difficulties make them unsuitable for foster care or whose foster-care placements have broken down. However, the balance between foster and residential care varies markedly across the European Union. In the southern states of the EU – Greece, Portugal, Spain – children living away from home are overwhelmingly placed in residential care. In Belgium, Germany and Italy, residential facilities also accommodate the majority of children in care. In Denmark, France and the Netherlands, roughly equal proportions of children are placed in foster care and residential care (Ruxton, 1996). It is thus apparent that the choice between foster and residential care is more a matter of philosophy than a reasoned decision about which setting would most benefit a particular child in his or her particular situation.

Wagner (1988) argues that residential and foster care are most fruitfully conceived as complementary approaches for children and families. There

should be no question of which is 'better', but only of which is better for this particular child. For some young people, residential care is a positive choice rather than a last resort. For example, Triseliotis (1997) reports that an unresolved issue concerns the role foster care should play in the placement of adolescents. Some have claimed that the majority of teenagers prefer residential care. Others have argued that very difficult teenagers can be successfully fostered. Recent studies carried out by Triseliotis suggest that roughly half of young people and their parents prefer foster homes and half favour residential care. The same study indicates that teenagers' needs are responsive to a combination of care measures rather than 'either/or' solutions (Triseliotis, 1997).

Children come into foster care for a variety of reasons. One half (50.2 per cent) of the children who entered foster care in New York in 1990 were placed because of neglect and abuse. Another 20.9 per cent entered care because of parental conditions such as illness, death, handicap or financial hardship. A further 11.3 per cent entered because of offences such as running away, truancy or delinquent behaviour, while 12.5 per cent entered for other reasons such as parent–child relationship problems, a plan for adoption, or deinstitutionalisation. Only 1.9 per cent entered because of the child's physical, mental or emotional handicap (Tatara, 1993). While these figures are drawn from one American study, there can be little doubt that the major problems bringing children into foster care, in Britain as well, are not their own disorders but are related to parental dysfunction exacerbated by lack of social supports and severe environmental pressures.

There is also evidence which suggests that children entering foster care are tending to be older, less healthy, and more troubled than was formerly the case. In Ireland, for example, there is strong anecdotal evidence of increasingly challenging behaviour among children placed in foster care, and a growing risk of disrupted placements; there is also growing recognition of the implications of providing for a population of children who may have experienced abuse (see Colton and Williams, 1997).

In sum, foster care is no longer a system in which well-meaning and largely untrained women volunteer to take in babies and young children in difficult circumstances. It is fast becoming a set of systems in which trained professional carers supported by other trained professionals try to deal with children whose difficult circumstances have led to them becoming emotionally or behaviourally disturbed. The trend towards professionalisation in foster care parallels our general tendency to turn to 'experts' to 'fix' all that may be problematic in our lives, including our children and our family relationships; and we expect that such expert services will have to be paid for. The age of volunteerism is far from dead – many charitable organisations, for example, rely almost entirely on volunteers – but an increasing

proportion of women in the workforce has meant that fewer are available to care for children in their homes unless they receive as much for foster care as they would for other work.

With professionalisation has come an increasing diversity in the types and functions of foster homes. No longer is a foster home just a foster home. It may be short-term or long-term, ordinary, or treatment/special. In so-called ordinary foster homes, the carer is responsible for providing a nurturing environment for the child but is not responsible for the child's progress towards treatment goals. Responsibility for therapeutic progress lies with the child's social worker or therapist. Conversely, in treatment or special foster homes, the carer is considered part of the treatment team and accepts her share of responsibility for mutual goal-setting, implementing agreed interventions and measuring goal achievement. Short-term foster homes typically offer emergency care, respite care, assessment, and placement prior to rehabilitation, while long-term foster homes, as the name suggests, offer more permanent placements, sometimes until the child is reunited with parents, is adopted, or enters independent living.

Specialist foster carers may have particular skills in dealing with particular types of children or problems: for example, sexually abused children or children who are HIV positive. In general, they are more highly trained, better paid and better supported than ordinary carers, and their role is to work with the child until specialist care is no longer needed and the child is ready to move on to a more permanent placement. The distinction between 'specialist' and 'ordinary' has been the subject of much controversy. On the one hand, it is argued that specialist carers deal with more troubled children and more is required of them: they may, for example, be required to attend meetings and write progress reports in addition to day-to-day behaviour management and implementation of the child's treatment plan. It is only fair, therefore, that they should be trained, paid and supported at a higher level.

On the other hand, 'ordinary' foster carers also deal with highly troubled children and they too must work not only with the child but with the child's social worker and family, and often with a number of other professionals involved with the child. The traditional definition of fostering as 'looking after other people's children as if they were one's own' no longer applies in any sphere of foster care. The children are not the foster carer's own, even though a relationship with a foster carer may be one of the most significant in the child's life. Nor is the looking after a matter restricted to the carer and the child. 'Ordinary' as well as 'specialist' carers must work as members of a team, whose goal is achievement of the child's permanency plan and whose activities include sharing information, planning collaboratively, addressing issues of power and control, establishing specific plans with time frames, negotiating who will do what, managing conflict, making

decisions and evaluating team effort. 'Ordinary' as well as 'specialist' carers should be regarded as professional partners who deserve to be adequately trained, reimbursed and supported.

The argument here – and many would argue differently – is that separating foster carers into categories and treating the categories differently is unwarranted and divisive. Indeed, certain districts in Canada have abandoned the 'specialist' model after a period when bed shortage necessitated the placement of children wherever a bed was available rather than according to the best fit between carer and child. This unplanned 'experiment' revealed that, of children who would normally have been assigned to specialist care, those who were actually receiving specialist care did no better than those in ordinary – and much cheaper – foster homes. Of course, such after-the-fact results cannot be generalised to other settings and certainly do not indicate that specialist foster care has no benefits in comparison with non-specialist care. They do indicate, however, that more planned research needs to be done both with respect to process (What actually occurs in specialist as compared with ordinary foster care?) and outcomes (Do high-needs children do better in specialist homes?).

Separation issues

Children entering foster care have experienced a variety of situations but most have in common a background of insufficient parental nurturing, exposure to intra-familial or extra-familial violence, and a separation from attachment figures.

Our current focus is on the other side of the same coin: not on deprivation or separation but on the child's *attachment* to parenting figures. As previously mentioned, attachment commonly refers to a close emotional bond that endures over time. By the age of eighteen months, children are usually attached to more than one individual, with fathers and siblings sharing the attachment with mothers, who are usually the primary attachment figures. Preserving the attachment to parents, siblings and other kin is an important goal of contemporary child-welfare practice. Fahlberg (1991) has described the critical role of foster parents in nurturing the child's ability to attach, preserving the child's attachment to parents, and helping to build attachment with members of the biological family or with adoptive parents.

Closely akin to attachment is the concept of identity. Children's ideas about who they are and where and with whom they belong have a major impact on their adjustment in placement and on the success of efforts at reunification. To understand more about the identity issues of children in foster care, Weinstein (1960) interviewed 61 children five years old or older who had been in placement for at least one year. He found that continuing

contact with biological parents is important for the child's adjustment in placement and tends to have an ameliorative effect on the otherwise detrimental consequences of long-term foster care. It was also found that the child's predominant family identification is an important factor in his or her well-being in placement. On average, children who identified primarily with their biological parents had the highest ratings of well-being of any group in the study. Children who identified primarily with the foster carer or who had mixed identifications came significantly lower. Interestingly, the two most problematic groups were those children with mixed identification (who could not decide where they belonged) and those with foster-carer identification whose biological parents did not visit them.

Varieties of residential care

Some children are not able to tolerate the intimacy of family life and do better in a residential facility. Residential centres vary considerably in size, from large barrack-like institutions to small-group homes accommodating no more than three or four adolescents. Because of the trend towards strengthening foster care and maintaining birth families, the number of children placed in residential care has been declining. However, the needs of that number are greater than was the case, say, ten or twenty years ago because the young people now admitted to residential care are often those with serious difficulties, for whom foster care is not an appropriate placement, or for whom foster care has failed to produce the desired effect. Indeed, in the United Kingdom, one of the main tasks of the residential sector is to help deal with the aftermath of fostering breakdown. Even in the days when fostering was reserved for younger and non-problematic children, breakdowns sometimes reached 50 per cent (Triseliotis, 1997).

The historical antecedents of residential care in western Europe can be traced back as far as the Middle Ages. The roots of current approaches, however, are more readily found in the nineteenth century when very large residential institutions were erected in many countries. These institutions were usually administered by churches and charities and were characterised by regimented regimes founded on discipline, training and religion. Their purpose was twofold: to care for the destitute and abandoned, whilst protecting society from the perceived threat to social order posed by 'dangerous' children (Ruxton, 1996). As Hendrick (1994) observes, children play a dual role, both then and now: as 'victims' but also as 'threats'.

After a long period of stagnation, following the Second World War, there was renewed interest in residential care across Europe. Experiments were undertaken with democratic forms of communal living, with 'children's

republics' and 'children's communities'. Yet by the close of the 1960s, residential institutions were attacked for having repressive regimes and failing to provide individualised care. The following three decades saw the progressive decline of residential care in all European Countries. This trend has been fuelled by a corresponding growth in foster-family care. (Ruxton, 1996).

The decline of residential care across the European Union has been accompanied by an increasing movement away from large-scale residential provision towards smaller-scale units. However, although castles and other large structures are no longer fitted out for the purpose of accommodating separated children, the development of smaller living units in some EU countries has been slow (Colton and Hellinckx, 1993). Nor has the move towards a smaller scale resulted in the complete abolition of large institutions. Often, the older, large-scale structures have been split up into smaller units. Thus, several small-group homes may be located on one site. In addition, a large institution may serve as the operational centre for a network of smaller units dispersed throughout the locality. Whilst operating on a small scale does not by itself ensure successful outcomes, research suggests that small-scale homes are more conducive to child-oriented care practice than are large establishments.

In addition to size, residential provisions can be classified in terms of the age of the youngsters accommodated or the particular type of service offered. One of the major types of residential care throughout Europe is 'children's homes', which look after children who do not have behaviour problems, or whose problems in this respect are not severe. Children's homes range from relatively large, multi-purpose, facilities to smaller hostel and family-group provisions.

A few years ago, a key function of residential institutions was to act as 'assessment centres'. Such centres used to accommodate children of all ages for short periods of time, usually with the aim of observing the child's behaviour to ascertain what sort of help was required. Over the last fifteen years or so, this form of residential care has been severely criticised. It is argued that, rather than being undertaken in 'artificial' residential environments, assessment should take place in the family unit. Further, it is difficult in practice to separate care and treatment from assessment, and many children remained in assessment centres for lengthy periods. Although a number of countries, including Denmark, have retained assessment centres, they have been closed in the UK.

Group care

Group homes are small residential units in which five or six children, usually adolescents, are cared for by house parents who work in shifts. A group

setting has a number of advantages. It can allow greater variation in behaviour than a family unit and the impact of difficult behaviour – acting out – is reduced because it is diffused among a series of adults, who do shift work rather than being on duty 24 hours a day. The young person has an opportunity for a variety of interpersonal relationships with different adults and with peers who share the same experiences day by day. A broad range of remedial and therapeutic programmes and group activities can be brought together in the home and made available for planning positive daily-living experiences. The accessibility of the child to the staff facilitates his or her diagnosis, observation and treatment. Therapy for emotional problems, remedial programmes for learning problems and controls for behavioural problems can be integrated and related directly to the young person's daily life. The consistent routine of group care can contribute to a sense of continuity, regularity and stability for a disturbed youth. Many young people requiring group care come from very disorganised home environments and need structure to help them learn impulse control.

Specific approaches used in a planned, therapeutic, group environment include individual psychotherapy, behaviour modification, play therapy, art therapy, group work and a positive peer culture. Although individual psychotherapy was dominant in earlier times, it has largely been replaced by various forms of group work and behaviour modification as preferred models of treatment. In all such approaches, an attempt is made to use the everyday living environment as a therapeutic tool. Staff have the task of making desired behaviours and consequences explicit to residents and of managing the system of rewards and punishments necessary to reinforce expectations. Common techniques include token economies, in which young people work for points or tokens to attain various levels of privilege.

Group-work approaches have emphasised social and peer supports and sanctions as a means of establishing new patterns of behaviour. Youths are given selected responsibilities for the day-to-day running of the house and for governing their own and each other's behaviour. In some cases, recreational challenges such as camps and nature trips are used to strengthen young people's perceptions of responsibility to the peer-group goals.

Despite the many advantages, certain problems are common to most group homes. One is resistance from individuals and groups in the neighbourhood. Neighbours may be afraid that the presence of the group home will threaten the peace, safety or property values of the neighbourhood. In addition, group homes are open systems and must function in cooperation with a number of constituencies such as schools, police, and community recreational and other facilities. Thus, community relations are of prime importance and must be proactively built and maintained. Useful strategies include efforts to involve the community in every stage of planning before

the home is established, through advisory groups led by key community members, and ongoing consultation when the home is in place. Involvement of the young people in the local community, individually or collectively, can also have benefits.

A second problem has to do with the difficulties inherent in group living. There is always a lack of privacy. Because of the number of people involved, opportunities to make personal choices may be compromised. If appropriate supervision and controls are not provided, acting-out behaviours by some residents may jeopardise the welfare of others. It may also be more difficult to involve young people's families in their care and treatment since there is no one foster carer to provide the personal touch and assume the leading role. A variety of approaches have been developed in this regard in the United States.

Before leaving residential care, it is as well to say something about the problem of abuse of children in care, since much controversy has centred around the abuse of children in residential facilities.

Abuse of children in care

Over the past 10 years the public care system has been rocked by numerous highly publicised controversies surrounding the abuse of children, particularly those living in residential institutions. The report of the National Commission of Inquiry into the Prevention of Child Abuse (1996, p. 19) notes:

> the catalogue of abuse in residential institutions is appalling. It includes physical assault and sexual abuse; emotional abuse; unacceptable deprivation of rights and privileges; inhumane treatment; poor health and education.

The abuse of children in residential institutions is particularly disturbing, given that many such children have already been deeply harmed prior to being placed away from home. It is estimated that between a third and two-thirds of those in residential institutions have been abused before entry (National Commission of Inquiry into the Prevention of Child Abuse, 1996).

One of the most publicised cases of abuse of looked-after children was 'Pindown'. This term was coined by the senior manager directly responsible, to denote the regime he established in children's homes administered by Staffordshire County Council. Increasing public and media interest was reflected by a Granada Television *World in Action* programme shown nationally on 25 June 1990. Four days later, an independent inquiry was set up by the besieged local authority (Levy and Kahan, 1991).

In the conclusion to their report, the members of the inquiry, Alan Levy QC and Barbara Kahan, relate:

> the vast majority of children who underwent the regime perceived Pindown as a narrow, punitive and harshly restrictive experience. We think their perceptions were correct. ... The children who were in Pindown ... suffered in varying degrees the despair and the potentially damaging effects of isolation, the humiliation of having to wear night clothes, knock on the door to 'impart information' as it was termed, and of having all their personal possessions removed; and the intense frustration and boredom from the lack of communication, companionship with others and recreation. ... Pindown contained the worst elements of institutional control: baths on admission, special clothing, strict routine, segregation and isolation, humiliation and inappropriate bed-times.
>
> (Levy and Kahan, 1991, p. 167)

The official response to the Pindown scandal included a special review of residential care in England by the then Chief Inspector of the Social Services Inspectorate, Sir William Utting (Utting, 1991; see also, CCETSW, 1992; Department of Health, 1992; Howe, 1992). His report identified the lack of qualified staff as a central problem underlying the poor quality of children's homes. Only 22 per cent of non-supervisory staff had any relevant qualifications. Further, many officers-in-charge were found to be unqualified. Essentially, what emerged from the report was a picture of a system in which children with the most severe personal and social problems were being looked after by staff who had the least experience and training in child-care matters. Young, inexperienced, isolated and untrained staff were often left to tend, and work with, the most problematic clients.

Since Pindown, an attempt has been made to improve care, training, management, and inspection and complaints procedures. But it is highly questionable whether the scale of this effort is sufficient. Moreover, of late, confidence in the public care system has been further eroded by repeated revelations concerning the sexual abuse of children in the system.

While extra-familial sexual abuse is by no means limited to the public care system, much controversy has centred on the threat posed to children in residential care. The care system has repeatedly been shown to have failed to protect youngsters in children's homes from sexual abuse by paedophiles operating alone or in semi-organised 'rings' associated with a number of residential homes. Many of the perpetrators have sexually abused children and young people in their care and, in so doing, have betrayed positions of special trust. It appears, therefore, that rather than being protected by their special status, children living away from home are often exposed to greater risk (Colton and Vanstone, 1996).

Major child-abuse inquiries have been undertaken involving clusters of children's homes in North Wales and Cheshire (House of Commons, 2000). It has been estimated that over 350 children were sexually abused while in care in these areas. Most of the victims are now young adults. It is anticipated that the compensation bill paid by the Criminal Injuries Compensation Board will ultimately exceed £40 million.

Of course, the cost in human terms is incalculable. Child sexual abuse can have far-reaching adverse consequences for victims, and has been linked with short- and long-term emotional and behavioural problems, such as general psychopathology, anxiety, depression, aggression, low self-esteem, sexual problems, physical symptoms, cognitive disability, developmental delay, poor school performance, 'acting out' disorders, and suicide (Colton and Vanstone, 1996). Significantly, at least 12 suicides of former residents in children's homes in North Wales have been linked to the abuse they suffered as children in care (NCH Action for Children, 1996).

Sir William Utting recently prepared a second report for the Department of Health, based on a review established in 1996 in response to ongoing disclosure of abuse suffered by children living away from home (Utting, 1997). The report confirms that Britain is failing to provide adequately for children living away from home. Far fewer children are now placed in residential care than was the case 20 years ago. Moreover, residential homes are much smaller today, with an average of 10 child-care places per home. Nevertheless, Sir William argues that the danger of child abuse remains an ever-present threat. The report finds that over a third of children in residential care are not receiving an education; it also condemns inadequate staffing and the placement of vulnerable children alongside other youngsters who are likely to bully them. Whilst acknowledging that the care of children looked after by local authorities has improved, the report contends that progress is unsatisfactory and greater regulation is necessary.

The quality of foster care is also criticised. This includes the inadequate regulation of foster carers, whose difficulties in coping with complex and stressful tasks can result in abuse or bullying.

Sir William's main criticisms on the quality of care for children placed away from home were: inappropriate residential-care placements, poor standards of health and education in residential care, inadequate regulation of foster carers, no inspection of residential special schools, and children in prison sharing accommodation with adult offenders.

To ameliorate these problems, Sir William recommended a comprehensive strategy for residential care, legislation to regulate private foster care, extending the Children Act 1989 to include regulation of all boarding schools, linking residential and foster care to facilitate more choice of placements, giving greater attention to the educational and health needs of

children placed away from home, and improving the regulation of the recruitment of staff working with children.

Maggie Charnock (1998, p. 2), a member of the steering group for the feasbility study by the National Voice for Young People, argues that many people are unconcerned about the abuse of children and young people in care, including professionals, members of the public, the police, insurance companies and even a number of local authorities. She believes that this attitude is born out of 'careism' – a term which denotes prejudice against young people on the grounds of their care status. To tackle the abuse of children and young people in care, she recommends that 'careism' should be recognised and abolished. She also recommends that a national organisation should be set up to give a voice for young people in care and that those responsible for abuse, including local authorities, should face criminal prosecution.

Alternative forms of residential care

Recently, attempts have been made to develop new, creative forms of residential care. These include 'communes' in Germany, which offer shelter to young people who volunteer to live together, and attend school for vocational training. Similarly, in many EU countries, houses located in residential communities provide accommodation for groups of young people. Although adult care workers facilitate some of these groups, in many cases the group is exclusively comprised of young people, who receive a minimum of adult supervision.

In Germany, small autonomous units have formed networks with one another to provide a wider range of programmes and activities, which can be shared by youngsters from all the units within the network. This pooling of resources makes for economies of scale, and helps to overcome the high costs which otherwise discourage the development of smaller units.

In view of the evidence that residential care is increasingly reserved for more challenging children and young people, there is an obvious need for small-scale facilities which offer effective help to such youngsters. In Germany and Ireland, small-scale, specialised facilities have been set up for children and adolescents with severe behavioural difficulties. A number of projects have been developed in Germany for young drug addicts and runaways. Residential workers in Germany have given increasing attention to the problems experienced by girls and young women, in particular those who have been sexually abused. In the UK, attempts have been made to improve practice in relation to overcoming the special difficulties encountered by children and young people from different ethnic backgrounds (Colton and Hellinckx, 1993).

Alternatives to residential and foster care

Recognition of the heterogeneous nature of children in the care system, in terms both of their needs and of possible ways of meeting them, together with the high costs of residential care and the criticisms levelled against it, have fuelled the development of community-oriented alternatives. The key objectives of such provision are twofold: first, to prevent entry into residential or foster care; and secondly, to maintain the young person in his or her own social environment. The most common alternatives to residential and foster care in the European Union are: day centres, centres for independent living under supervision, and home-based treatment schemes. All three approaches are widely used in the Netherlands (Colton and Hellinckx, 1993).

Day centres are places where children and young people in need can go after school. The child, family and school are all involved in the intervention programme. Day centres focus help on young people who are at risk of being placed away from home. Parents gain respite and support, whilst maintaining the care of their children.

Centres for independent living under supervision typically involve young people living in apartments, either by themselves or in small groups. They are usually supervised by care workers based at larger residential establishments, or by workers specialising in this form of care. The goal is to provide young people with the opportunity to develop the skills essential for an independent life, including practical household skills. This type of care tends to focus on the young people themselves, and parents are often left out. However, the involvement of young people's families is important in the transition to independent living. Such a finding is not surprising when we consider the difficulties often experienced by young people from supportive homes who have never been in care, when they first venture into independent living. Many cannot manage at first without help from parents in cash or kind and some return home several times before they are finally able to establish independence. For youngsters leaving care, the situation is fraught with additional practical and emotional difficulties. At a practical level, they may have educational deficits which contribute to a lack of readiness for employment, as well as scant survival skills in such areas as finding accommodation, budgeting, cooking and general household management. At an emotional level, the separation from the child-welfare system, which did offer some support and protection, may cause the child to re-experience the original loss of parenting figures and the subsequent losses inherent in changing placements. Before the move to independence, there was the social worker and perhaps a foster carer or child-care worker. Now, unless the child has a supportive relative

or friend or has maintained contact with a former foster carer, there is no-one at all.

A third alternative to foster and residential settings is *centres for home-based treatment*, which offer intensive help in the child's family home. Several times each week, family members receive training in relation to the practical and social aspects of family life. This intervention addresses the parenting process as a whole rather than focusing on specific, isolated problems; on family relationships, rather than on individual family members.

Secure accommodation

Secure accommodation is the most restrictive placement option available and there are strict criteria governing its use. A local authority may only restrict the liberty of a child that they are looking after if it can be shown:

(a) that –
  (i) he has a history of absconding and is likely to abscond from any other description of accommodation; and
  (ii) if he absconds he is likely to suffer significant harm;

(b) that if he is kept in any other description of accommodation he is likely to injure himself or any other persons.

(Children Act 1989, Section 25(1))

Where these criteria are met, a child may be kept in secure accommodation for a maximum of 72 hours without a court order, although the direct authority of the Secretary of State is required before children under the age of 13 can be placed in secure accommodation. If the local authority wishes to restrict liberty for more than 72 hours, or more than a total of 72 hours over a period of 28 days, they must obtain a court order.

The restrictions on the use of secure accommodation do not apply to children detained under mental-health legislation. However, they do apply to all children in residential care, nursing or mental nursing homes. Further, children in voluntary and registered children's homes cannot be kept in secure accommodation. It is important to note that any person with parental responsibility may at any time remove a child in accommodation whose liberty is being restricted.

Except for those remanded into accommodation as a consequence of committing criminal offences, applications for secure accommodation are made to the family proceedings court (or the County Court or the High Court). If made, the order may be for up to three months. This may be renewed on application to the court for periods of up to six months.

Applications for children on remand are made to the youth or other magistrate's court, and, if granted, last for the duration of the remand or for a maximum of 28 days.

Where an order for secure accommodation is granted, the local authority must hold a review within a month, and thereafter at intervals not exceeding three months, to (a) establish that the criteria for placing the child in secure accommodation still apply, and (b) determine whether an alternative form of accommodation would be appropriate.

The child must be legally represented in all secure-accommodation proceedings, unless he or she has refused such representation. A guardian *ad litem* must be appointed in non-criminal proceedings to keep a child in secure accommodation, except where the court considers that this is not necessary in the interests of the child (Ball, 1996).

The report of the National Commission of Inquiry into the Prevention of Child Abuse (1996, p. 20) reports that children placed in secure units may be at 'increased risk of bullying and violence'. It further notes the lack of 'comprehensive annual statistics on what *behaviour* has caused children to be placed in secure accommodation' and cites recent research indicating that a third of children placed in secure accommodation are 'locked up unnecessarily'. The report also makes reference to other research which showed that over 90 per cent of those sentenced to long-term detention had suffered abuse and/or loss as children. Unfortunately, 'most had not received effective help to enable them to come to terms with their experiences'.

Adoption

The adoption of children dates back to antiquity. References to adoption can be found in the Bible and in the legal codes of the Chinese, Hindus, Babylonians, Romans and Egyptians. Its purpose has varied considerably by country and era: for example, to cement relationships with foreign powers; to make possible the continuance of religious traditions; to overcome difficulties in recognising an out-of-wedlock child; and, more recently, to provide permanent homes for children in need of them.

Modern adoption has it roots in the Victorian foster-care system where babies, often illegitimate, whose mothers could not care for them were found homes with other families. However, adoption legislation was not passed until as late as 1926 in England and 1930 in Scotland. The delay in developing a legal framework around a common practice partly resulted from attitudes concerning the possible inheritance by adopted children of 'bad blood' and criminal tendencies from their biological parents (Triseliotis, 1997). Not only might 'the apple not fall far from the tree', but

this rotten apple might then stand to inherit the worldly goods that decent adoptive parents had worked so hard for. Attitudes have changed since then and in 1993 the total number of adoptions in England and Wales was 6,859 (811 in Scotland), with step-parent and relative adoptions comprising roughly half the total. However, these figures are less than half the total for 1977: a fact which might be explained by improved contraceptive techniques, policies which encourage single mothers to keep their babies, and an emphasis on maintaining links with biological families.

The evolution of adoption in the United Kingdom

According to Triseliotis (1997), there have been three distinct periods in the evolution of adoption in the United Kingdom since the introduction of adoption legislation a little over seventy years ago. The first period occurred in the 1920s and 1930s, between the two world wars, when adoption was mainly practised by working-class people who were relatively unconcerned about heredity and inheritance. Adoption concentrated on older children, rather than infants, and sometimes included children with disabilities. Triseliotis argues that, except for the post-1970s, this period was the closest that adoption policy and practice have come to their modern purpose of 'providing a home for a child' (Triseliotis, 1997).

The second period, after the Second World War, ran from the early 1950s to the early 1970s. For various reasons, adoption became popular among the middle classes, and was seen as a way of offering children to childless couples and as a solution to the problem of out-of-wedlock births. Thus, adoption during this period focused less on 'providing a home for a child' than on 'providing a child for a home'. Bowlby's research on the adverse effects of separation and institutionalisation on children had a strong influence on adoption policy and practice. His claim that children over two years of age should not be adopted appeared to support the view that placement of children with disabilities or 'dubious' social backgrounds should be avoided (Triseliotis, 1997). The inescapable inference here is that, if a child is to be provided for a home, it should be a child worthy of the honour, not a child who has been damaged in some way by unfortunate previous experiences.

The third period in the evolution of adoption began towards the end of the 1960s. Between 1969 and the beginning of the 1990s the number of infants and very young children adopted by non-relatives fell from around 21,000 to about 4,500. For example, the 1993 figure (6,859 children adopted in England and Wales) is less than half of the figure for 1977. This fall in the number of children adopted reflected factors such as the wider availability of contraception, increased access to abortion services, and a

reduction of the stigma associated with births outside marriage, which meant that more single mothers kept their children. Ruxton (1996, p. 347) reports:

> Statistics from several northern European countries from the end of World War II onwards ... show how the fall in the number of babies available for adoption went hand in hand with improvements in the standard of living and, in particular, with improved welfare provision to single parent families. ... Experience in today's Europe shows a progressive and sustained decline in the number of healthy babies offered for adoption in each country.

Consequently, adoption agencies in Britain turned their attention to the placement of children with 'special needs'; that is, older children with emotional and behavioural problems or with mental and physical disabilities (Triseliotis, 1997).

This shift in perspective back to 'a home for a child' drew on research suggesting two things: first, that there were large numbers of children in care who required new permanent homes since they had little chance of being reunited with their birth parents; and, secondly, that with an enabling family environment, older children could overcome earlier psychological adversities and do well. At the same time, the idea of psychological or social parenthood was becoming accepted: proponents of social parenthood argue that effective parenting depends not on a biological connection with the child but on positive psychological and social interactions day by day. All these factors encouraged people to adopt. It might also be noted that transferring children from the care system to adoptive homes was financially attractive to local authorities, 'who otherwise would have faced many years of funding residential or foster care placements' (Triseliotis, 1997, p. 334).

The outcome of the drive to place children with special needs in adoptive homes appears to be mixed. On the plus side, thousands of children have gained permanent families. New knowledge and skills have been developed with regard to the preparation, matching and post-placement support of adoptive families and children. On the debit side, however, this new knowledge has not been applied by all agencies. Further, some adoptive families have been unable to cope with the level of emotional and behavioural problems manifested by the children adopted. As a result, some children have experienced yet more disruption and unhappiness (Triseliotis, 1997).

Research indicates that the stability of adoptive placements can be as high as 85–90 per cent, especially for children placed with their adoptive families before the age of nine. However, the breakdown rates for older

children are sometimes as high as 50 per cent, and there is a close association between increasing age and higher breakdown rates. Because it is felt that many older children who might require adoptive families are more psychologically damaged than was previously the case, agencies are now more cautious about their placement. They are tending to place such youngsters with permanent foster carers, or with foster carers with a view to adoption later on if things work out (Triseliotis, 1997).

An essential condition for the adoption of any child is the consent of the biological parents or a legal termination of parental rights so that the child is free for adoption. Termination of rights may occur either by the consent of the biological parents or involuntarily, following a finding that they have failed to exercise their parental responsibility. A number of areas of uncertainty exist regarding parental consent which may call into question whether a particular child is in fact free for adoption. For example, if the birth mother consents but the birth father does not, should the birth father's rights prevail even if he has had no contact with the child at all? Once consent has been given, should it be irrevocable and, if not, how long should the birth parents be given to change their minds before the adoption becomes final? Further, since consent must be given by children of a certain age to their own adoption, should the child's wishes override those of the parents if there is a difference of opinion? Another area of uncertainty in modern times concerns which of the parents has the right to consent to or block the child's adoption when the child has been created through artificial insemination or surrogate parenting.

An adoption is not made final until the child has lived in the adoptive home under the guidance of a social-welfare agency for a certain period of time, usually a year. Waiver provisions give flexibility so that courts can shorten the time if doing so is in the best interests of the child. Once the adoption is finalised, it is 'for keeps' and cannot be abrogated because the birth parents wish to withdraw their consent or the adoptive parents decide they do not want the child. Adoptive parents may lose their children in exactly the same ways as biological parents: they may relinquish their right to the child or the child may be removed if allegations of neglect or abuse are upheld. With the increase of adoption of children with special needs, more adoptions are dissolving, causing some people to advocate more humane ways to undo these placements legally so that children can move on to more appropriate placements without feelings of failure.

Open adoption

Triseliotis (1997, p. 335) argues that mistakes were made in the past when placing children with special needs, including the revivalist approach with

which the policy was pursued, the introduction of time limits, the use of the law to assume parental rights and thus stop parental access before placing the children with new families, and the severance of important emotional links between older children and their birth families.

Two of the 'mistakes' identified by Triseliotis (1997) included lack of parental input before the child was placed with an adoptive family, and severance of ties with the child afterwards. The notion that confidentiality is preferable for all three members of the adoptive triad – birth parents, adoptive parents and children – is termed closed or confidential adoption. It rests on the 'fresh start' principle whereby it is deemed better for the child to start again with a fresh family and without the emotional 'baggage' that continued contact with the family of origin might compel the child to carry. However, in recent years, this closed model is increasingly giving way to an open or cooperative adoption model. As fewer infants have become available for adoption, birth mothers have found more leverage in the process of relinquishment and preferences about adoptive parents. Agencies have learned that mothers are less concerned about confidentiality than with helping to select the adoptive parents and with maintaining some kind of connection with the child after the adoption. Adults who were adopted as infants, for their part, have begun assertively to seek to have their sealed records opened and have demanded the right to know about their biological origins.

The movement to place for adoption children with special needs (those children hitherto considered 'unadoptable') has also changed adoption practice dramatically. These children are often older, have memories of their birth parents and siblings, and have ideas of their own about maintaining ties. Adoptive parents of such children have often thoughtfully considered their motives in seeking adoption before approaching the agency: they know what kind of child they might be able to help and they want full information about potential adoptees, sometimes including a meeting with the birth family. Since it is difficult to recruit parents who are willing to face the difficulties inherent in adopting a special-needs child, agencies' attitudes towards such parents focus less on 'screening out' (the common attitude towards people who want to adopt infants) than on helping parents in every possible way to achieve satisfaction in their adoptive parenthood. Many adoption agencies today have revised traditional 'closed' practices towards varying degrees of openness. These changes may include planned communication between the adoptive and birth parents prior to the placement. In the case of a baby, all the parents may have face-to-face meetings before the birth, at the time of the agreement for placement and at various times after the birth. At such meetings, the birth mother and the adopting parents may share first names, photographs, addresses and telephone numbers. The information exchanged may include ethnic and religious backgrounds, level of education, aspects of personality and interests, physical and medical characteristics, and other matters of common interest. These options are agreed when birth and adoptive parents, with the help of an agency social worker, discuss the extent of 'openness' in the present and future. Such arrangements are usually entirely voluntary on the part of both parents and adopters, as courts would be very reluctant to attach contact requirements as part of an adoption order.

Inter-country adoption

By contrast with their counterparts in northern and western European countries, British adoption agencies and practitioners took a stance against inter-country (and transracial) adoption, preferring to concentrate their efforts on the placement of own-country special-needs children (Triseliotis, 1997). Until 1990 only about 50 adoption orders a year in England and Wales concerned children from other countries, and many of those children were related to the adopting parents. However, the number has increased since 1992. This owes much to increased public awareness of the appalling conditions suffered by children in residential institutions in Romania and other eastern European countries. There is ongoing interest in adopting from Central and South America, India, South-East Asia, and China (Ruxton, 1996).

However, some argue that inter-country adoption, which is driven by the demand of childless couples in the West, has created an unregulated market involving the one-way movement of children from poor to rich countries. Proponents of this view say that much more should be done to provide support for such children in their own countries. Some cases entail 'child trafficking', with babies smuggled illegally and large profits made by 'go-betweens'. It is further held that these adoptions occur at the expense of domestic placements for older children and those with disabilities. Evidence is also cited of high placement breakdowns, resulting in admission to the public care system (Ruxton, 1996).

Conversely, others insist that inter-country adoption is successful in that children are saved from poverty, institutionalisation, and a life on the streets; they experience loving family life and significantly improved life chances. It is pointed out that many of the children concerned are rejected in the country of their birth, and that inter-country adoption is encouraged by the governments of many so-called 'donor' countries. In addition, child trafficking and badly prepared placements are consequences of lack of regulation, which can be rectified through cooperation between countries (Ruxton, 1996).

Such an approach is reflected in the principles underpinning the Hague Convention on Intercountry Adoption (29 May 1993), which prescribes that inter-country adoptions should only take place after the best interests of the child have been properly assessed and in circumstances which protect his/her fundamental rights. Birth parents or others responsible for consenting to adoptions should understand what they are consenting to and its implications. They should be objectively counselled and should not be offered financial or other inducements. Agencies acting in intercountry adoptions should be suitably staffed and supervised. No-one should derive improper financial gain from adoption. Finally, adoptive parents should be carefully and objectively assessed for their suitability (Ruxton, 1996, p. 352).

The Convention will establish a framework whereby the sending country is responsible for the assessment of the child's circumstances, needs and interests, and for transmitting to the receiving country the information that shows this has been done. Receiving countries are responsible for arranging the assessment of the adoptive parents and transmitting the results to the sending country. Adoptions carried out between each ratifying country, in accord with the Articles of the Convention, are known as 'Convention Adoptions' (Ruxton, 1996). The Draft Adoption Bill, published by the British government in March 1996, contains provisions that would enable the United Kingdom to ratify the Hague Convention on Intercountry Adoption.

Same-race placements

Within the EU, few children from ethnic minority groups are placed in adoptive families of the same ethnic origin, despite the fact that in some countries such children comprise a majority of those entering care and requiring adoption. Agencies in the UK appear to have done more than their counterparts in other EU countries to place a child within his or her own culture. However, even here progress has been slow. The reason usually given for not placing ethnic minority children with same-race adoptive parents is that insufficient numbers of ethnic minority families come forward to adopt (James, 1986). However, Ruxton (1996) argues that this is partly because inadequate emphasis is given by many agencies to proactive recruitment of such families (see also, Gambe et al., 1992).

Adoption by single people

Another issue which has attracted much debate in recent years is whether single people should be allowed to adopt. Whilst such adoptions are not possible in all EU member states, a recent review of adoption law in the UK pointed to highly successful adoptions by single people, with particular reference to those involving older children and those with disabilities. It is argued that abused children often experience difficulty coping with one close relationship at a time, let alone the several relationships involved in joining a family with a mother, father and perhaps other children. The single parent is able to focus exclusively on the child because there are no competing demands from a spouse, and thus, may provide a more appropriate placement than a couple could. Studies show that single adoptive parents are more likely to be women who have occupations and skills that lend themselves to understanding children's special issues. For example, nurses, social workers and teachers are highly represented among single adoptive applicants. They usually have extended family back-up and a high percentage were themselves brought up in single-parent homes (Feigelman and Silverman, 1983).

Adoption by gays and lesbians

If adoption by single people is controversial, adoption by homosexuals is far more so. Although it has been argued that lesbian households may be safer for a child than heterosexual ones because no men are present, public opinion in the EU – as measured by a survey in 1993 – seems to be against such placements. To be sure, the great majority of people in countries like Denmark, the Netherlands and Spain do believe that gay and lesbian people should enjoy equal rights to those of heterosexual couples in relation to marriage and inheritance. However, only in the Netherlands did the proportion in favour of homosexuals having the right to adopt children (47 per cent) exceed the proportion against (40 per cent) (Ruxton, 1996).

Adoption by foster parents

Foster carers are another relatively recent group of adoptive applicants. Although there have always been some foster carers who have adopted their foster children, the practice has not been encouraged. In the 1960s and 1970s, adoption by foster carers was termed 'the back door to adoption', a route whereby carers could 'try on' children until they found the one they wanted to adopt. Social workers tended to feel in general that this was harmful to children since the carers' prime purpose was not to do the best for the child in the context of a temporary placement but to evaluate the child as a candidate for adoption. It was felt that people who wanted to adopt should apply for adoption, people who wanted to foster should apply to foster, and there should be no overlap between the two, particularly

since children whom their foster carers wished to adopt might not be free for adoption. This attitude has recently been seen as unrealistic since foster carers grow fond of their charges, the affection may be reciprocated and, in cases where the child is free to be adopted, the continuance of an established and positive relationship may be the best option for the child. Difficulties may arise with respect to changed relationships with the child's natural family: permanent adoption is a very different proposition from temporary fostering. However, the recent trend towards open adoption may go some way to alleviate these difficulties, as may supportive pre- and post-placement work by the adoption agency.

Inter-country adoptions, same-race placements, and the placement of children with homosexual, single, or foster-care adopters are all issues which seem likely to represent an ongoing challenge for adoption agencies and professionals. Triseliotis (1997) considers that other challenges include: recruiting new families for some 'very "damaged" and problematic' youngsters against a background of increasing numbers of reconstituted families which are themselves having to care for children from more than one relationship; developing more uniform and better informed preparatory and matching methods; improving training of adoptive (and foster) parents in relation to managing problematic behaviours; organising more uniform post-placement services; and developing skills to manage open adoptions.

The legal framework

Now that we have considered some of the practice issues related to adoption, it is time to consider the legal framework. Local authority social workers may be involved in adoption in three ways: first, because adoption is being considered for children on their caseload; secondly, because they may have to prepare the detailed report required by the court in an adoption case under Schedule 2 of the Adoption Rules 1984; and thirdly, because the Adoption Act 1976 places on all local authorities a statutory duty to:

> establish and maintain within their area a service designed to meet the needs in relation to adoption of:
>
> (a) children who have been or may be adopted,
> (b) parents and guardians of such children, and
> (c) persons who have adopted or may adopt a child, and for that purpose to provide the requisite facilities, or secure that they are provided by approved adoption societies.
>
> (Ball, 1996, p. 98)

Besides local authorities, a number of other adoption agencies are approved by the Secretary of State for Health (Ruxton, 1996, p. 362).

Because the making of an adoption order has such a profound impact on the child's legal status, strict requirements are laid down for all stages of the adoption process. An adoption order can only be made by an authorised court; that is, the magistrates' family proceedings court, the County Court or, in certain circumstances, the High Court. The statutory provisions and procedural rules are contained in the Adoption Act 1976, the Adoption Rules 1984, the Adoption Agencies Regulations 1983, and the Adoption (Amendment) Rules 1991 (Ball, 1996).

As previously mentioned, applications by single people are allowed, but there is a strong presumption in favour of married couples. Moreover, unmarried couples are not permitted to apply jointly. The birth parents' agreement to the adoption is necessary. However, if this cannot be obtained, either because their whereabouts are unknown or because they will not agree to adoption, an application may be made for the court to dispense with the parents' agreement. Usually, the grounds for such a course are that the parents are withholding consent 'unreasonably' – for example, because there is no reasonable prospect of them being able to resume care of the child (Ruxton, 1996).

Before the court considers the application, a comprehensive report must be compiled which provides detailed information about the child, the birth parents, prospective adoptive parents, and the role and involvement of the agency concerned. The court may appoint a 'guardian *ad litem*' to represent the child's interests.

The welfare of the child is the first consideration of the court. Section 6 of the Adoption Act 1976 requires that:

> the court or adoption agency shall have regard to all the circumstances, the first consideration being given to the need to safeguard and promote the welfare of the child throughout his childhood; and shall so far as is practicable ascertain the wishes and feelings of the child regarding the decision and give due consideration to them, having regard to his age and understanding.

It may be that the child's welfare can be safeguarded by a less drastic change in his or her legal status than that effected by adoption. Under the Children Act 1989, the court may make orders other than those applied for – such as a residence order instead of an adoption order. Residence orders may be made by courts hearing adoption applications irrespective of whether or not the parents have agreed to adoption. In addition to determining who the child lives with, the residence order gives the person in whose

favour the order is made parental responsibility for the duration of the order. The court can also add any conditions it considers necessary to the order. By contrast with adoption, residence orders generally cease to have effect when the child is 16, but may not do so if the court considers the case exceptional; the child's name can only be changed with the consent of all those with parental responsibility, or on the direction of the court; moreover, those with a residence order cannot appoint a guardian for the child in the event of their death, or indeed, consent to the child's adoption (Ball, 1996).

Where either the child is already in the care of the agency and the question of parental consent is in doubt, or the mother wishes the child to be adopted before any specific application is ready, the agency may apply to the court for an order freeing the child for adoption. The parents must consent to the order, or their consent must be dispensed with. Such an order removes existing parental responsibility and vests it in the agency, which will hold it until an adoption order is made. Unless they have signed a declaration that they do not wish to be further involved, after a year the birth parents will be informed if an adoption order has been made, or the child has been placed for adoption. If they have not signed the declaration and the child has not been placed, the birth parents may apply for revocation of the freeing order. Applications for freeing orders have been subject to long delays; further, once freed, the children concerned are, in effect, placed in a legal limbo until adopted (Ball, 1996).

The publication in March 1996 of the Department of Health and Welsh Office's paper *Adoption – A Service for Children,* with a Draft Adoption Bill for consultation, represented the culmination of a lengthy review of adoption law. The Draft Bill seeks to bring adoption legislation in line with the Children Act 1989, in particular by providing that the child's welfare must be the court's and the adoption agency's paramount consideration. It would also replace the process of 'freeing for adoption' by an entirely new framework for placement for adoption, with or without parental agreement, and involving the court before placement in cases of dispute. In addition, the Draft Bill would make it possible for step-parents to obtain parental responsibility without making an adoption application, and includes provisions which would allow the United Kingdom to ratify the Hague Convention on Intercountry Adoption – discussed earlier in the chapter (Collier, 1996). This Draft Bill has so far not been taken forward by the Labour government.

In this chapter, we have discussed the placement options available to children who are being looked after. We will go on now to look at anti-discriminatory and anti-oppressive practice, in the next chapter.

Case example

Case example 6.1 John

John (aged 12 years, 5 months)

John comes from a family of five children. He has an older brother (14) and an older sister (13), and two younger sisters (10 and 9). He is the only child in the family who is of mixed parentage. The three oldest children have had a number of care episodes, in all three cases beginning when they were twelve years old. The older brother and sister no longer live at home, but live with different relatives in the rather large extended family surrounding John. His mother comes from a family of eight children. There are lots of aunts, uncles and cousins in the family.

John's parents (Mike and Mary) are married to each other, but the relationship has been very turbulent. Mike frequently comes home drunk on payday, and gives the remainder of his salary to Mary, which is usually insufficient for the family to buy food, clothing and other necessities. When Mary confronts him about this, he becomes violent and on two occasions has caused her to have broken limbs. She has been in the local refuge on two occasions, but after each she has gone back after about six weeks away.

Another source of tension in the relationship is that Mike suspects that Mary is having relationships with other men. He had no suspicions about this until John was born. John, who was conspicuously not Mike's son, is aware that he is not Mike's child, but has no knowledge of who his biological father might be. He has never discussed this with his mother, nor has she broached the issue with him.

John's difficulties appeared to begin after a very turbulent first year in secondary school. He has always had racial taunts from children at school, but when he went to secondary school, it seemed to become much worse. He was assaulted on his way home from school in his second week, by a group of about five or six older children at the school. Since then, he has been very reluctant to go to school, but managed to attend with cajoling and persuading. In his second year this has been much more difficult, and he has only attended school about 40 per cent of the time.

Since the beginning of the second school year, John's behaviour at home has become much more difficult as well. There are frequent rows with his mother. When things calm down, he is unable to explain to his mother why he is so angry with her. She is finding it very difficult. Finally, she approached the social services saying that she was not able to have him at home anymore.

Although reluctant to provide accommodation for John at first, the social worker agreed to try a plan of respite, in view of the very severe difficulties at home. John was admitted to the local children's home for the first time for a two-week period, a week last Friday. The plan is to use the experience to work out how to improve the relationship between John and his mother. The social worker, however, is concerned that given the experience of the older children in the family, John's respite arrangement might drift into something more permanent. From the social services' perspective, this is something to avoid.

Questions

1. We know that children of mixed heritage are placed away from home in disproportionate numbers. What effect might John's mixed heritage have on the social worker's thinking?
2. A continuing controversy centres around whether the focus on family preservation is threatening the safety of children and should be discontinued. Bearing this controversy in mind, do you think that the social worker's initial reluctance to provide accommodation for John was justified under the circumstances?
3. If John's respite arrangement does become more permanent, this might be something to avoid from the perspective of social services. Is it something to avoid from the perspectives of John and his family? Why, or why not?
4. If John is placed away from home, what kind of placement might be most appropriate for him? Keep in mind the restrictiveness continuum and all you have learned about the advantages and disadvantages of different types of placement for different types of children.
5. Preserving the attachment to parents, siblings and other kin is an important goal of contemporary child-welfare practice. Do you agree that this should be an important goal? Why, or why not? What steps might be taken to preserve John's attachment to his family if he were to be placed away from home? What would be the probable result if these steps were not taken?