Seeing and Shifting the Roots of Opinion

Mapping the Gaps between Expert and Public Understandings of Care Experience and the Care System in Scotland

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Table of Contents

Foreword

Scotland is within reach of an enormous opportunity: a chance to reform and 'reframe' the way we support our most valuable and vulnerable members of society: children. Decades of research and experience have furnished carers, professionals and policymakers with critical knowledge about child development, human learning, and the links between childhood adversity and adult outcomes. If we can incorporate these insights into our systems and practice, all children could enjoy the best start in life, no matter what challenges they go through.

For children and young people who are, or who may be, in Scotland's 'care system', that change cannot come soon enough. While some children do thrive and succeed in care, for too many the experience is still marked by instability and insensitivity; another traumatic episode in lives already affected by adversity. But it does not need to be like this. The learning from research and practice can be reflected in how systems are organised and care provided. Being 'looked after' can be a second chance for a safe, nurturing and fun childhood.

The voices of care-experienced children and young people in Scotland have jolted politicians into action. Change is promised. However, real change can only come if Scottish society backs it, and if we can get people with no direct connection to the care system to understand its value, and to see the potential of the children and families who are part of it.

This report is part of our contribution to making that happen. By mapping the gaps between expert and public understandings of care experience and the care system in Scotland, we sought to better understand the way Scottish society sees 'care'. From that, we hoped to make sense of why some communities oppose new children's homes or raise concerns when looked-after children are enrolled at their local school. More generally, we hoped that the research would provide insight into why it proves so difficult to turn the evidence about what children need – and what works to meet those needs – into common practice.

By bringing to the surface the prevailing and deeply held cultural models through which people interpret and engage with issues about 'care', the FrameWorks Institute team have helped answer these questions and more. They have also highlighted the care we all need to take in our communications, if we are to avoid further entrenching unhelpful attitudes and beliefs among those we are trying to persuade.

We hope that this report will both stimulate and inform debate. We look forward to working with colleagues and care-experienced people in the testing of its recommendations as we start to build a new narrative about the system and the people who experience it.

The Robertson Trust
Life Changes Trust
CELCIS

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Introduction

All too often, children in care are seen as dangerous, delinquent or damaged goods. The circumstances of their early life, which are likely to include trauma, abuse and neglect, are commonly forgotten. Instead, we see communities protesting against residential care homes being built in their neighbourhood. We think children in care are there because they have somehow played a part in their fate. They've become a number, a case, a file.

'Children in Care Are Not Just Numbers: We Must Challenge the Stigma'.
Jimmy Paul, *The Guardian*, 8 March 2017

I still clearly remember my child psychiatrist giving me tablets after a nasty incident where I bit a teacher in primary school. As the state was my legal guardian – I was an unwanted child in care – no one ever checked with my parents. But the state was the sort of parent who exposed me to abuse, the kind of parent who never thought about a future for me beyond 18.

'I Was a Child in Care. We Needed Love, Not Chemicals.'
David Akinsanya, *The Guardian*, 23 August 2016

Children who experience the care system face a range of stereotypes and stigma.

These have a direct effect on the wellbeing of these young people, shaping identity and self-expectations in ways that impact on outcomes and life chances. This stigma also leads to isolation and constrains the opportunities available to these young people and the adults they become.

The effects of stigma exacerbate the trauma of entering the care system and add another layer of challenge onto the adversity that many experience while in the system.

But stigma also has less direct effects, leading people to undervalue the systems that support the complex needs of these children and young people.

The effects of society's views of children in care do not just accrue to the children in question. By compromising the potential of whole swathes of the population and increasing the use of social services and public resources, stigma has costs for all of society.

For those with care experience and those working for change on their behalf, the following two questions are of central importance:

- Why does the public think in these ways?
- How can we change these perspectives?

This report sets out to answer these questions.

In so doing we aim to equip those in the sector not only with explanations for the public's negative stereotypes and lack of support for the system, but also with ideas about how to shift these perspectives.

If we are to increase the salience and improve public understanding of the care system in Scotland and those involved in it, we have to start by seeing the deep and durable beliefs that shape how people think and talk about these issues. This report provides that information.

This work reveals a set of understandings about children, parenting and the care system that drive stereotypes and perpetuate stigma. The ways that people think about these subjects come together in a series of toxic combinations that reinforce stigma and denigrate the role and importance of the care system.

Perceptions of how child development works, what children need, what families provide, and what the system is (and is not) meet in the mind of the Scottish public to ignite and fuel perspectives that block both the efforts of those in the sector and the potential of those in the system. For example, if a normal childhood is seen as one free from significant worry and stress, and those in the care system are defined by such experiences, we can see why it is so easy to 'otherise' children with care experience and cast them aside as damaged. If children are characterised as unique individuals with variable needs and strengths, while the system is understood to provide standardised and impersonal care, it is easy to understand why we think it impossible for any child in the care system to develop in a positive way. And if parents are seen as exclusively responsible for protecting and nurturing children, and as immoral human failures when they struggle with these responsibilities, it is easy to see why parents might be the most stigmatised party of all. This stigma flows from multiple sources; children have to carry not only the stigma of being in care, but also the stigma of being from a family which couldn't look after them.

But there is a solution. It lies in recasting the understandings that the Scottish public uses to think about what children need, what families provide, and what the system can do. But it is only when we understand *how* people think that we can use our communications to open people up to these new ideas.

This report presents findings from a project sponsored by and conducted in close partnership with The Robertson Trust, Life Changes Trust and CELCIS (Centre for Excellence for Looked After Children in Scotland). It charts public understandings of childhood, parenting and the care system, and examines how these ways of thinking complicate, and occasionally facilitate, communicating about care issues. We identify strategies that the sector can use to build support for the changes necessary to improve the lives of care-experienced children and young people.

Communicating effectively about care experience and the care system in Scotland first requires a clear sense of the core ideas the sector wants to communicate. The report begins with a distillation of these points into an 'untranslated story' of care experience and the care system in Scotland.

These ideas represent the content that needs to be communicated to the public through a framing strategy.

After summarising these key ideas, we describe the deep, highly shared but largely unconscious patterns of thinking – what anthropologists call *cultural models*[1] – that inform how members of the Scottish public understand care experience and think about the care system. Working from over 1,000 pages of interview transcripts, we identify the powerful and predictable ways that people think about children, family, parenting and care, and how they draw on these understandings to make sense of the care system and those who experience it. Some of these ways of thinking are productive – they open people up to the ideas the sector is seeking to communicate. Others lead in less productive directions, reinforcing stereotypes about individuals with care experience and perpetuating negative ideas of the system itself.

Understanding why people think the way that they do about care experience allows us to develop framing strategies with the power to change public discourse and thinking about these issues. Shifting this discourse and expanding thinking are precursors to creating public will and generating demand for the programmes and policies that will ultimately improve the way we care for, support and protect young people in Scotland.

A description of the research methods used and demographic information about the interview sample can be found in the Appendix.

The Untranslated Expert Story of Care Experience and the Care System in Scotland

In this section we describe the themes that emerged from 18 hour-long interviews with researchers, advocates and practitioners (including individuals with care experience) working in the care system. The points presented below are also the result of two sessions conducted with members of the sector to gather further feedback and input. These sessions included individuals who themselves had care experience. In addition, Who Cares Scotland, a Scottish organisation working with care-experienced children, solicited feedback on emerging themes from a group of care-experienced young people. Below, we present a distillation of the themes that emerged from analysis of all the data gathered from these methods. These themes are organised around four broad questions:

1. Who is in the care system and how does the system work?

2. What are the consequences of being in the care system?

3. What do care-experienced children and young people need?

4. What can be done to better support care-experienced children and young people in Scotland?

Who Is in the Care System and How Does the System Work?

- **A child or young person has 'care experience' when the state has or had a formal role in bringing them up.** Experts explained that there are a wide variety of care experiences, including but not limited to living at home (subject to compulsory monitoring by a social worker), kinship care, foster care, residential care or education, and care provided in a secure unit.

- **Children and young people become involved with the care system when their parents are unable to provide adequate care or protection.** According to experts, exposure to childhood abuse, neglect, domestic abuse, parental mental illness or parental drug and alcohol misuse are common reasons why a child may enter the care system. Experts also pointed out that unaccompanied asylum seekers, children who have lost one or both parents, and those with complex health and behavioural needs are more likely to become involved with the care system than those without these experiences.

- **Poverty, social exclusion, chronic unemployment, poor housing and lack of community resources increase the likelihood that a family will become involved in the care system.** For

experts, these conditions reduce parents' capacity to attend to their own wellbeing and to create safe, supportive and nurturing environments for their child.

- **The children's care system is a collection of agencies, departments and individuals responsible for meeting the needs of children.** For experts, this involves coordination between social work services, education, health care, Children's Hearings and others.

- **The primary purpose of the care system is to support children's growth and development.** All care-experienced children have endured some form of trauma or adversity, but the ways in which they interact with the care system vary considerably across individuals. Experts therefore argued that the care system should be child-centred and flexible. It should not only address the effects of past experiences, but also support individuals to live full and productive lives. According to experts, the system's job is to support children to both 'heal and flourish'.

- **Young people begin transitioning to 'aftercare' at age 16 or 17 and need ongoing support.** Experts explained that for young people not in the care system it is rare to leave home at 16 or 17, and that when this does happen, there is typically continued contact with and ongoing support from family. This is usually not the case for care-experienced young people, who can be left with little or no support when leaving care.

What Are the Consequences of Being in the Care System?

- **Despite having the same aspirations as other young people, care-experienced children and young people are susceptible to a range of negative long-term outcomes.** Experts explained that these outcomes may result from the situation that led to their being taken into care, or from their experience in the care system, or both. These negative outcomes include disruptions to emotional and behavioural development, poor physical and mental health, lower educational and vocational achievement, homelessness, and involvement with the criminal justice system. Experts also explained that intergenerational contact with the care system frequently occurs – when young people who leave the care system become parents themselves, they are often not adequately equipped to care for their own children. This can be a result of their own developmental needs or because these wider structural factors inhibit people's ability to provide care.

- **Children and young people in the care system experience stigma and discrimination.** For experts, this stems from public misperceptions that care-experienced children are difficult, dangerous or antisocial. Experts pointed out that care-experienced children and young people are often subject to bullying at school and discrimination from adults, including teachers and other professionals. These negative attributions and experiences engender feelings of shame and loneliness and contribute to the social isolation and marginalisation of care-experienced individuals.

- **The poor wellbeing of children and young people in the care system has social and economic costs.** Experts explained that when society fails to provide adequate support for children and young people, communities and society pay the price, including increased costs to the health, welfare and criminal justice systems.

What Do Care-Experienced Children and Young People Need?

- **Supportive, nurturing, long-term and loving relationships significantly improve outcomes for care-experienced children and young people.** According to experts, such relationships can be formed with a variety of adults, including relatives, foster parents, residential caregivers, teachers, mentors and friends. They argued that the quality of relationships tends to be more important than the quantity, as one stable relationship may be sufficient to build resilience and lead to positive outcomes for children and young people in the care system.

- **Living in family settings tends to be the most positive experience for care-experienced children and young people.** Experts explained that kinship care can help children maintain existing attachment relationships to siblings and other family members and retain a sense of their own family identity. Kinship care can also offer greater stability and continuity in caregiving. For experts, successful family living environments, whether with kin or with a foster family, offer a sense of emotional stability and a familial structure that supports healthy development.

- **Complex trauma needs to be addressed directly.** Experts argued that care-experienced individuals need access to developmentally responsive, trauma-informed care that provides for reflection, nurtures trust, and recognises and contextualises trauma symptoms.

- **Long-term, stable living environments are critical.** Experts agreed that having a stable place to live can mitigate some of the challenges care-experienced children face when they enter the system, including adapting to a new school or community, losing contact with friends, and severing existing relationships with siblings and family members. Placement instability can exacerbate behavioural and emotional difficulties, making it even harder to rebuild relationships between children and the significant adults in their lives.

What Can Be Done to Better Support Care-Experienced Children and Young People in Scotland?

- **Invest in services that address early structural risk factors that make families more vulnerable to state intervention and provide targeted support for parents facing severe disadvantage.** Experts argued that addressing 'upstream' issues can prevent children from entering the care system to begin with. They pointed out that comprehensive interventions for vulnerable families who have not yet crossed the threshold for formal intervention are also effective.

- **Increase the stability and continuity of living environments by supporting carers to maintain stable, loving, authentic relationships.** Because of the strong association between frequent moves that disrupt relationships and poor outcomes, experts argued that the system should facilitate permanent or long-lasting living environments wherever possible. Providing greater support to caregivers, and assisting them in understanding and responding to child behaviour issues or listening to the wishes of the care-experienced child, will lead to more positive outcomes for both children and caregivers.

- **Ensure that the experiences and voices of care-experienced children and young people inform the system and the care it provides.** Experts agreed that government policies are most effective when they are shaped by the experiences and expertise of care-experienced individuals and their families. This is a key way for the system to adapt to and meet the needs of each individual child.

- **Prepare for and respond more effectively to the needs of care leavers.** Experts explain that currently the care system forces care leavers to undertake the transition to adulthood younger, faster and with far less support than their non-care-experienced peers. For experts, care leavers – especially those with complex needs – should be provided with continued housing, employment and financial assistance, and with support through ongoing loving and stable relationships.

- **Engage local communities to help support the care system to reduce stigma and marginalisation.** According to experts, building connections between people in the wider community and care-experienced young people can reduce the 'othering' that care-experienced individuals may feel. Connections with community can also build informal networks of support for both carers and children.

Public Understandings of Care Experience and the Care System

Background on Cultural Models

In this section, we present the *cultural models* – the shared but implicit understandings, assumptions and patterns of reasoning – that shape how members of the Scottish public think about those with care experience and the care system. This analysis was informed by 21 in-person, in-depth interviews with members of the public in the greater Glasgow, Edinburgh and Aberdeen areas (refer to the Appendix for more information about the sample and research methods).

It is important to emphasise that people have multiple ways to think about childhood, parenting and the care system. In everyday life, they toggle between these perspectives, drawing on different assumptions at different times. Some ways of thinking may be *dominant* – more consistently and powerfully shaping how people think and reason; others may be *recessive* – less top-of-mind and more easily pushed out of thinking when a dominant perspective is activated. And at any given moment, different assumptions may be primed through cues. This helps us understand why people can hold seemingly contradictory attitudes about the same issue, even within a single conversation.

It is also important to note that while our research suggests that the models described here are commonly held, there is certainly variation in how dominant or recessive particular models are for particular individuals or groups. It is the relative strength of these models that accounts for individual differences in opinion, rather than the absence or presence of these ways of thinking. The models we describe in this report are therefore accessible to all members of the public, even though individuals may vary in the strength with which they hold and use these perspectives.

In addition to these ways of thinking, our research finds one important *cognitive hole*. This is an area where members of the public lack well-formed or coherent ways of thinking about an issue.

Understanding the landscape of cultural models provides an important tool for communicators[1]. Some models may be more productive, facilitating a fuller understanding of care experience and the care system, and generating support for policies and programmes that experts recommend. Other models may be unproductive, shutting down thinking, reinforcing stigma, and depressing people's support for change and engagement with solutions. By identifying available models, the sector can frame messages to leverage productive models, push unproductive ones into the background, and fill in understanding where needed. This is the essence of a strategic framing approach to communications.

In the following section, we begin by describing the cultural models that members of the Scottish public draw upon to think about childhood, care, parenting and family. These ways of thinking underpin the public's views of the care system more broadly and shape opinions about those

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[1] This report uses the term 'communicators' as short hand for anyone who is speaking or writing about care, experiences of care, and the/a care system, whatever their professional responsibilities.

involved with it. We then directly explore the patterns of thinking that people rely on when asked to think about the care system. Finally, we outline the ways that people can think about improving the children's care system.

Cultural Models of Childhood and Care

Analysis of interviews revealed a set of assumptions about childhood, parenting and care that powerfully shape public thinking about the care system.

☐ The Weight of Worry **Cultural Model**

Across interviews, participants considered happiness and joy to be essential features of a 'normal' childhood. Childhood was understood to be a time when individuals should be unburdened by the kinds of roles and responsibilities that cause adults stress. Participants described these worries (for example, worrying about food, shelter or violence) as powerful inhibitors of a child's positive development, especially when they were seen as inappropriate for a child's developmental stage. This was described in metaphorical terms as like a 'weight', putting pressure on children and preventing them from being free to experience real joy and happiness. The experience of such worries and concerns was deemed 'abnormal' and in contrast to a 'normal' childhood, which above all else should be carefree and happy.

> **Participant**: On that journey of life, they're going to find out about external pressures, but they shouldn't have to deal with that at the age of four or eight or 12. They should just enjoy being children […] The simple pleasure that kids get of just playing and having fun. And not having the life-changing, life-threatening responsibilities, or not having to worry about money, mortgages, families, family feuds, death.
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> **Researcher**: What does it mean for a child to be well cared for?
> **Participant**: They look happy, they look healthy. They don't look anxious, worried. They're thriving.
> —
> **Participant**: You hear of people who go down a path of not really caring for themselves because they've not had positive experience as a child. They can end up being more prone to going into crime.
> —
> **Researcher**: Do you think there are things that children in care particularly need?
> **Participant**: Probably as close to a home environment as possible, but that's not always going to happen, is it? I guess safety and some sort of happiness and peace with less stress and fighting. Things like that.

This model holds mixed implications for the sector:

1. This model casts those who have faced childhood adversity or excessive stress as abnormal and fundamentally different – as 'other'. This understanding contributes to the stigma and discrimination faced by those with care experience. The model is also highly deterministic, suggesting that once a child bears the burden of developmentally inappropriate stress and worry, that child is scarred forever. These are clearly unproductive features of this model in relation to the sector's goals.

2. On a more positive note, the *Weight of Worry* model makes the detrimental effects of early stress powerful and salient in people's thinking. If the experience of severe, developmentally inappropriate stress is viscerally understood as bad and is seen to derail development, making the case for preventing such experiences becomes a relatively straightforward task.

In summary, communicators can cue this model to make the case for the importance of policies and programmes that prevent trauma. But such attempts should *always* be accompanied by efforts to communicate the potential for all individuals to experience positive change and the power of interventions to remediate the effects of early trauma and adversity. Communicators can use this model to increase the salience of early adversity and advocate the need to prevent these experiences, but they must put such messages in a larger frame of hope and of the potential to improve lives and outcomes for those who have experienced adversity.

☐ The *Every Child Is Unique* Cultural Model

Participants also shared the assumption that each and every child is different and has particular needs, proclivities and strengths. The assumption here is that no two children are alike. People bring this lens to thinking about a wide variety of issues surrounding childhood, from health to learning and (as we discuss below) care and the care system.

> **Participant**: I think everybody's different. Even within my family, I've got two girls. One girl is an outstanding sportsperson. Her sister came along and was 'less able' sports-wise is the polite way to put it, if you're being politically correct, until suddenly she realised she was more natural at that and suddenly she came out on her own.
> —
> **Participant**: People develop at different paces. So, some will be ready to take on responsibility earlier than others, but it's an adaptive process rather than a fixed process…. Everyone's different.
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> **Participant**: They've [social workers] got to treat the child as an individual. So, there might be stuff that comes up that wouldn't come up for any other child. Very individual… You just don't want a child to feel like they're being processed. And depending on whatever issues from their past or whatever issues they're having adjusting, needs to be asked there and then. So, you can't automatically say 'Right, you need to go to counselling', you might just give them a wee chance and see what comes up and see if they're appropriate for the counselling, or whatever.

Implications of the *Every Child Is Unique* Model

1. This model opens people up to the idea that supporting children and their development is a complex and dynamic process and needs to be individually tailored to each child. As these are ideas that the sector is attempting to communicate, this assumption is, at some level, a framing asset. It can be easily activated, and it helps people see that children's needs are complex and variable, and that care must be provided in a way that is sensitive to this variation.

2. Unfortunately, as we describe below, the assumption of individual differences comes into direct conflict with the most dominant way that people have for thinking about the care system. This points to the need to reframe public understanding of the system and its ability to provide responsive, individually focused and dynamic care. This is one of the most significant framing challenges facing the sector.

☐ The *Early Resilience* Cultural Model

Using this model, people understand young children to be relatively unaffected by negative experiences because they lack situational awareness, are incapable of experiencing 'real' (that is, adult-like) emotions, and are unable to form long-term memories. Together, these assumptions contribute to the perception that the younger a child is, the more resilient he or she is to adversity. This model most frequently emerged when participants discussed the experience of being taken into care. Participants reasoned that if a child does not remember the experience of removal from their family, he or she will not be affected by it.

> **Researcher**: Do you think it has a different effect on children at different ages?
> **Participant**: I think a baby is not going to be aware. A baby is not going to have that awareness. I'm not sure when a child becomes aware. Even a toddler might not be aware of the situation, but I think probably from five onwards they're a bit more switched on. They know what's happening. It might even be more difficult when they're in towards their teenage years because they probably had their roots settled and then suddenly taken away and put in a different environment, so it might be even more difficult for older children to deal with.
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> **Participant**: Sometimes you can get babies taken away if there's been physical or sexual abuse, and they'll be taken away quickly and placed with foster parents. As babies, as long as they're getting cuddles, shelter, food and interaction, that's all their needs met. They would notice a difference for a while, but, being that young they would forget and would know only what they're told through their own notes. The older the child, the harder it is really, I think.

This model is wholly unproductive and undermines efforts to communicate the expert perspective. It is likely to affect public thinking in the following ways:

1. This model obscures key aspects of the science of early childhood, which shows that supportive, nurturing environments in the first years of life exert *significant* effects on long-term outcomes. In doing so, this model leads people to see the quality of early care as less consequential than care later in life. The model also narrowly focuses understanding of young children's needs as being about physical protection and 'cuddles'. This makes it hard to get behind the sector's attempts to push for higher-quality early care services and preventative measures that focus on early childhood.

2. The model obfuscates the causes of later issues that children in care might experience. If early trauma is seen as relatively benign, it is hard to recognise that later behaviour and learning problems may not be caused by an individual's lack of commitment or willpower but, rather, rooted in early trauma. If people think that 'those kids' are wilfully bad or intentionally malicious, rather than seeing current issues as a result of earlier experiences of trauma, it is easy for them to stigmatise children in care, and hard to support the services and resources required to help them.

⬜ The *Forever Damaged* Cultural Model

Rather than assuming that early adversity has minimal effects on a child, the *Forever Damaged* cultural model leads to the understanding that children are irreparably damaged by experiences of trauma. Thinking with this model, people reason that the experience of entering the care system is so profoundly traumatic that it invariably results in lifelong negative effects. Thus, care-experienced children are understood to be 'damaged goods' who have suffered emotionally and are affected for life.

> **Participant**: I think it [care experience] probably leaves a mark, a scar. You remember it, but you might know it. Although you mature, I think it would probably stick with you, because it's a traumatic event. If you were in that situation, I think it would stick with you.
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> **Participant**: You hear the kind of stories of children that have been in care and bounced around from place to place, family to family, not really had a stable environment. That leads to more issues later in life with their mental health, opportunities in life, job prospects, things like that.

This model was primarily focused on the trauma experienced during *entry* into the care system (which, as we discuss below, is a highly salient aspect of care experience). Participants explained that children who are placed in care experience a sense of abandonment and a loss of trust that affects them for life. They explained that care experience is likely to result in a range of negative outcomes stemming from this psychological damage, such as becoming involved with the criminal justice system, suffering from addiction, or experiencing significant mental illness.

Researcher: What do you think the effects are of being in care?

Participant: Sadly, I think there are effects. I think every child, regardless of what happened to your parents, there is going to be that bond with your parents. A child will be aware of being taken from the family home and then suddenly they're not in a family home. I think that's always going to affect them.

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Participant: Children would come out of the care system with a negative attitude towards society, will feel as though society owes them something. If they have been in a care environment where they have really come from a home that's abusive, that's carried on later in their other environments, they're going to carry on with that. It will come out into their interactions in society, whether they carry on abusing other people, whether they're in more violent crimes themselves, whether they are in sexual crimes because they believe 'Well, I was sexually assaulted so it's okay for me to do that as well'.

Implications of the *Forever Damaged* Model

This model poses an important challenge for communicators. By offering a highly deterministic understanding of the effects of early adversity, it makes it easy to label care-experienced children as 'damaged goods', with little hope for their success. If the experiences that bring them into the system or their experiences in the system are seen to damage and differentiate them, it is hard not to see them as permanent 'others', irreparably different from the rest of society.

☐ The *Effects of Adversity Are Emotional* Cultural Model

There was a common assumption among participants that the effects of adversity on a child are primarily, and perhaps *exclusively,* emotional in nature. These emotional effects include having trouble with trust, low self-esteem, difficulty feeling and showing love, and being unable to experience happiness. In contrast, the effects of adversity on cognitive development (such as problems with memory or attention) or health (such as heart disease, compromised life expectancy, obesity or substance use) were absent from discussions.

Researcher: What do you think are the effects of a child being in care?

Participant: I think you'd have some issues, abandonment, you don't know, you would blame yourself.

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Researcher: What do you think the effects are of children being in care?

Participant: Terrible. Kids should be able to expect a basic standard of care from their parents, and it's the first human interactions they have in the world, the people they should be able to trust, and they're just badly let down, and a lot will go through not trusting anybody in life after that.

Researcher: What's the effect of not trusting anybody?

Participant: You'll have a lack of empathy and sympathy for people and just find it hard to deal and cope with things in the manner expected by society. If you felt badly let down like that, of course you're going to kick out in society and look after number one and do whatever it takes.

This model is productive in highlighting certain impacts of early trauma, but unhelpfully pushes others out of view. If members of the sector want to be able to communicate about the full range of effects associated with care experience, and the multiple needs that must be supported, they will need to connect experiences of adversity with a wider range of outcomes.

The *Hierarchy of Care* Cultural Model

When reasoning with this model, people recognise that there are different types of care that children require and see these types of care on a hierarchy of importance.

There are two levels to this hierarchy. At the most basic level, participants argued that children have a set of material needs that must be met. This includes food, water, shelter and clothing. The emotional needs of a child − being loved and feeling cared for − occupied the next level of the hierarchy and were seen as a slightly lower priority. However, it is important to note that in this model, even though there is a hierarchy of importance, *both types of care are understood as essential for positive development.* In other words, people have a firm understanding that while children cannot survive without their basic needs met, they cannot thrive without having both their material and their emotional needs supported.

Importantly, participants understood that only family members are able to provide both levels of care. In contrast, they regard carers or contexts outside the family or home environment as only able to provide for material needs at best, and as unable to meet the emotional-needs level of the hierarchy.

> **Participant**: Caring can be the basics of making sure that person is fed, clothed and kept in a comfortable environment. Beyond that it's love and helping them develop in life.
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> **Participant**: I think children in care have the same needs as children in a normal family environment. They need the basics like making sure that they're clean, they're fed, they're warm. But they also need, maybe it's less likely they'll get it, that one-to-one nurturing and caring and loving. They need to build relationships with others. But they might not get as much one-to-one attention.

This model structured thinking about the kinds of care that a care system can (and more importantly cannot) provide. Participants assumed that care professionals such as teachers, social workers and doctors are simply unable to replicate the love, care and emotional support provided by a family. This led participants to reject the idea that individuals with care experience could have their emotional needs met within the context of a professional caregiving relationship.

> **Researcher**: Are there ways to demonstrate your caring professionally?
> **Participant**: Obviously it's more professional. You can't love them, but you try to implement the best you can, to see them as a person, do what you can to help them do what they can.
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> **Researcher**: Do you think that professionals can be that emotional support?
> **Participant**: There's boundaries that have to remain in place to remain professional and impartial, not to be biased.

Implications of the *Hierarchy of Care* Model

This model is problematic in two ways:

1. For communicators advocating greater resources and support for the children's system, the *Hierarchy of Care* model is challenging. If members of the public understand the system as *only* able to meet basic subsistence needs, and as fundamentally ill-equipped to fulfil social and emotional needs, key ideas that the sector wishes to communicate will remain poorly understood. For example, anything other than the provision of basic material needs will be seen as outside the system's purview and thus ill-advised as an area of investment. If the system is understood as fundamentally unable to provide nurturing, loving care, the public will struggle to support efforts and programmes designed to furnish these experiences.

2. More generally, the model obscures thinking about the range of necessary experiences that support the healthy development of children. By assigning emotional needs to a lower rung, it relegates this aspect of development to a place of lesser importance.

☐ The *Dependence and Care* Cultural Model

People understand independence in two ways. First, they assume that individuals vary in their level of (in)dependence. Interestingly, exposure to adversity is seen as a factor that explains individual variations in independence, with adverse experiences understood as building independence ('what doesn't kill you makes you stronger'). Second, independence is understood as a function of time – as children grow up, they become more and more independent and thus require less and less care. In our interviews, participants explained that children's dependence on parents or caregivers declines gradually but steadily from infancy to adolescence, and that once children become young adults, they need little – if any – care.

> **Participant**: Things change. We don't need as much care as we grow and we become our own people, into young adulthood.
> –
> **Participant**: With infants it's total dependence for pretty much every minute. Somebody in the family is always looking after them. With two to five it's more playtime. I think there is more chance to enjoy them. Then at primary school you see them grow and need less physical care, just being about and being able to take them places, chauffeur them about, be there when they need help. With teenagers, it's even less so. –

> **Participant**: I think it [the kind of care a child requires] depends on the age. Younger children wouldn't go into semi-independent housing because they don't necessarily have the means to care for themselves at that age. They may go into some kind of boarding school or foster home temporarily. I guess it depends on maturity.

The strength of this model helps explain why the challenges facing youth transitioning out of the system are *not* salient in public thinking. If older children are understood to acquire independence automatically as they age, then individuals on the cusp of adulthood are assumed to require few supports or services. Consequently, participants clearly did not see transitioning out of the system as important, struggled to think about why bridging services would be necessary, and were generally unsupportive of appeals to the importance of such supports.

Implications of the *Dependency and Care* Model

The *Dependency and Care* model undermines support for key supports and services. Assumed connections between independence and care, and variations in independence, can dilute support for robust services, comprehensive care and continuing support for children in the care system.

1. The idea that individuals vary in their level of independence, and that those who are more independent require less care, is dangerous for those communicating about the care system. This assumption allows people to justify low levels of care for some children who are deemed 'more independent'. In this situation, a child who may be seen as independent because of experience navigating difficult situations might be seen as requiring *less* support and being fine with lower levels of care. The logic of this argument is particularly worrisome. If exposure to adversity creates independence, and independence is assumed to require less care, then the very children who need the most support are likely to be seen as requiring the least.

2. The *Dependency and Care* model erects a barrier to seeing the need for robust services that accompany children as they transition out of the system. If independence increases with age and more independence correlates with fewer care needs, then youth who are ageing out of the system should be fine with minimal if any services. This is a challenge for the sector in communicating about the needs of transition-age youth and in advocating more, rather than less, robust services during this period.

☐ The *Awareness + Control = Responsibility for Outcomes* Cultural Model

According to this model, the level of individual responsibility for your own life and outcomes is the product of your awareness of what is going on around you and your ability to control yourself and make rational decisions.

When discussing younger children, participants questioned individual responsibility, because they saw one or both of these conditions as being in question. For example, they would explain that very young children are neither aware of their surroundings nor able to make decisions to advance their own interests in a controlled or rational way. However, older children, and certainly young adults, were seen as meeting both these criteria of responsibility and were thus judged as responsible for their own circumstances.

This model figured prominently in participant discussions of children in care, and it underpinned the predictable way participants held older youth responsible for outcomes but absolved younger children of responsibility. The criteria for responsibility came particularly into focus when the determination of responsibility was harder to establish – in children who were not yet seen as young adults but were not clearly categorised, and in young children. In such cases, participants evaluated (implicitly) both situational awareness and control over behaviours to assess responsibility for outcomes.

This model goes a long way in explaining why members of the public have dramatically different reactions to younger and older children in the care system. As soon as children are seen as having awareness and the ability to control their own decisions and actions, people are quick and willing to hold them responsible for being in care situations.

> **Participant**: You've got to take a part of the responsibility as well when you get to a certain age. They can continue the cycle or they can break it.
> **Researcher**: Can you just explain a bit then about what might be going on for that child to be able to break that cycle?
> **Participant**: Again, if they're aware of what's going on and they're at a certain age now where they're [inaudible] and they can see, they could do things differently or try and do things differently.
> —
> **Researcher**: When you say some may be ready or mature at a different age from others, what does that look like? How would I identify that that person was now into their adulthood?
> **Participant**: They would be responsible, have the responsibility and pressures of life, whether that would be financial, relationship, everything else that you need to cope with as an adult. Some will have been more exposed at a younger age.

Implications of the *Awareness + Control = Responsibility for Outcomes* Model

The implications of this model are unequivocally negative for members of the sector seeking to communicate with the public about the care system and those in it. It allows people to establish responsibility for outcomes in a way that hides the role of context, for which children in the care system are clearly *not* responsible. As soon as situational awareness and control over behaviour have been established, people are quick to hold children accountable for being in the care system. This pushes out of mind the factors beyond children's control that shape their outcomes and explain their experiences with the care system. This assumption also leads people to attribute near-total accountability to older children in the system. Communicators must not allow people to get into the mode of evaluating individual responsibility on the grounds of situational awareness and control. Every effort must be made to highlight the contextual and situational features of the lives of children in care, and to connect these variables concretely and directly to outcomes.

□ The *Troublesome Teen* Cultural Model

According to this model, adolescence is understood as a time of conflict and difficulty as adolescents rebel and push back against their parents and other symbols of authority. The dominant image of an adolescent in the public mind is of a difficult, risk-taking rebel with a high potential of getting into trouble and even causing harm to others.

> **Researcher**: Is there anything you think explains those wrong decisions? Is it just down to them as individuals or is there something else going on here?
> **Participant**: Peer pressure, perhaps. I don't know. Probably because a lot of these decisions are made when they're young, 16 to 19, it could be a bit of peer pressure there. Maybe just not believing that there are very real and bad consequences, like I started smoking when I was 14, never once thinking I'd be addicted, and I didn't stop until I was 37. If I started at 14 and someone said, 'You'll still be smoking at 37', I wouldn't have believed that. You think you're invincible as a teenager and 'that won't happen to me'.
> –
> **Participant**: I guess you've got puberty, when puberty hits, and you've got sullen, sulky, spotty teenagers, obviously they're growing up, they're hanging out with their friends, they think themselves to be adults but they're not quite…. I did a few daft things when I was a teenager, but I'm sure teenagers these days are doing just the same if not worse.

Participant discussions of care-experienced children and youth focused on adolescents. Analysis showed that this focus was due at least in part to the assumption that because adolescence is an inherently risky time, adolescents' risk-taking and rebellion means they can fairly easily find themselves in trouble and in the care system. As with the model of responsibility discussed above, this way of thinking about adolescents led to a logical conclusion: that if someone of this age ends up in the system, it is a product of his or her own decision to take risks and break rules.

> **Researcher**: Are there different reasons why a child might be taken into care at different ages?
> **Participant**: I suppose as you're going into your teens, if you're becoming troublesome and running around with the wrong crowd and things like that, getting involved in drinking, drugs, crime, poor behaviour. –
> **Researcher**: Do you think there are stages or ages of childhood where children are more likely to be taken into care?
> **Participant**: I think young babies, but also when they start hitting adolescence, because children start developing in different ways when they go through puberty. And that can lead to problems, which means they might be more likely [to be taken into care].
> –
> **Participant**: For a younger child to go into a care situation they'd be more desirable to fosterers, and in turn to the adoption process. They're more mouldable, I suppose. They can slot into a family, they're more impressionable. Whereas once they go into their teenage years they might have really been through the system and struggled their way through it and maybe had experiences of rejection from people in foster care and stuff like that. The demands and the needs might be more complex because they need to be given more responsibility and freedom, but it may not always be appropriate.

The model puts responsibility for entry into the system squarely on the shoulders of the adolescent in question. Understood as aware of their surroundings and in control of their behaviours, adolescents who rebel and take risks are seen as accountable and responsible for their decisions. As the most recognisable example of a child in the care system, this image creates the sense that care experience most typically occurs when children wilfully disobey parents and authority figures or choose to take risks for which they must be held accountable. This focuses responsibility on the child, and away from the situations and other individuals who play a role in system involvement.

Cultural Models of Parenting and Family

Analysis also revealed several models of parenting and family that shape how people think about the care system and those with care experience.

☐ The *Pure Love of Family* Cultural Model

This model has two constituent assumptions.

First, participants shared an understanding that a family is the *only* context in which children can be 'properly' raised and have a 'normal' childhood. This assumption became clearly visible as participants pushed back against the idea that non-family situations could fully support children and their development. Such situations were seen as unable to give children what they need to develop well and turn into well-functioning adults.

> **Researcher**: Do you see that foster parent role as being quite different from the role of staff in a care home?
> **Participant**: Yes. I think the foster parents… They're not seeing it as a job, I think. They've gone into it for different reasons, I think, and I would like to hope that it's through the love of children that they're there. But no, I think staff in foster homes[…] not all of them, but some, will just be seeing it as a job. It's a job, it's something to do. And again, I would say that what you're picking up in the media, some of them just aren't in it for what they should be in it for, which is caring for the children. Some will be, but I get the feeling that too many don't care. It's nine-to-five or whatever shift they're on, yes.
> –
> **Researcher**: What explains why some children are well cared for and others not?
> **Participant**: It depends on the parents. And how much the parents care for them.
> –
> **Participant**: Parents give children their first moral code, in the sense that parents are the ones that are there to tell children what is right and what's wrong, and that's based on their ideologies and their principles. So that can work both ways, in the sense that it can be quite good morals, or it can be quite bad ideologies that they instil into their children.

The second part of the model is a strong association between family and love. Participants reasoned that family members are the only individuals who are able to provide children with the unconditional love and warmth that children need (a pattern of thinking consistent with the

Hierarchy of Care model discussed above). Non-family contexts, and professional carers in particular, are seen as unable to provide this warm, responsive and loving care. This is largely because they are understood as professionals, and thus it is understood that their primary motivation is performing a job rather than having true love for the child in question.

> **Participant**: Looking after somebody. Looking after their needs, so it could be that you have to help them, it could be an older person who needs help with their shopping or their personal care, getting washed and dressed and things like that. Financial care as well. Sometimes older people need help. I think caring is loving as well, you're loving someone, if it's your family and you're looking after them.
> –
> **Participant**: Well, parents are the primary care providers because they're the parents. Then the extended family will be pretty similar to that, but not have the [laundry] to do every evening. Then I guess care professionals at nurseries will care for your child, but that's more of a looking-after role rather than a loving and family role. But then teachers are taking care of the education of your child, the wellbeing of your child, when your child is at school. And then coaches and the likes… I mean, that's a bit of a teacher role, but at the same time it's a training role, totally different. Parents obviously are… You [can't] really call it most caring, but for your own child I guess it is. And I've got two nephews as well. I love them, they're great, but totally different relationship to what I've got with my own son. It always will be, I guess.

It is important to note that people's understanding of family and a family's ability to provide loving support was not restricted to the birth or nuclear family – it was relatively expansive and included multiple definitions and permutations of 'family'.

Implications of the *Pure Love of Family* Model
This model holds mixed implications for communicators:

1. The model sets up an understanding that children who are cared for in non-family contexts are unable to experience healthy, positive development. This is clearly a negative implication, as it is likely to contribute to the stigma faced by care-experienced children and those in non-familial living arrangements.
2. More optimistically, the model can be evoked to increase public support for family-based care settings. People see such settings as important, and it is easy to activate this perception. However, a key challenge is to ensure that messages about the importance of family do not denigrate non-family-based care, casting youth in these settings as damaged goods, lost causes and forever-abnormal others. We discuss this framing challenge in greater depth in the conclusion of the report.

☐ The *Opportunity Filter* Cultural Model

According to this model, parenting is understood as a process of filtering: parents keep negative and detrimental influences at arm's length, while simultaneously granting children access to positive experiences that contribute to healthy development. This model positions parents as an active and responsible agent (the 'filter'), but also makes salient the need for environments where positive experiences and opportunities are available to pass through the filter.

> **Researcher**: Anything else that you want to say about what the word 'children' conjures up for you?
> **Participant**: Children for me, it's a need to be protected in terms of giving them the best opportunity to develop. I think about our education system and what could be better about it so that they've got the right environment, and in the current climate I think parents are having a difficult time and how we get a supportive network in to support parents to bring them up as well.
> –
> **Researcher**: Okay. So why are your kids now the epicentre?
> **Participant**: That's fundamentally what I think is the parent's fundamental job, their fundamental role, to look after the kids and bring the kids up as well as you can, give them every opportunity. And I don't know if that stems from a belief that you have growing up, it's that classic combination of nature versus nurture. So, what you have can sometimes be a driver, but equally what you don't have can be a driver. So, if you don't have the best start then you want to give your kids exactly everything you didn't have to avoid them going through that.

Implications of the *Opportunity Filter* model

The *Opportunity Filter* model has generally positive implications for communicators. It opens people up to the importance of context and community as sources of resources and opportunities. This is important in garnering support for many of the preventative solutions advocated by the field. If people can be attentive to context, systems and resource availability as factors that can improve outcomes for children in general and children in care in particular, a host of preventative solutions can be seen as important and effective. When cuing this model, it is important to frame community and context not only as a source of opportunity that parents are responsible for filtering, but also as sources that can support parenting.

☐ The *Selfless Parent* Cultural Model

People assume that being a good parent is fundamentally about being selfless – that it requires making sacrifices for your children and putting their wellbeing before your own. People believe that some parents are either naturally incapable of prioritising their children's wants and needs or are immoral in deciding to put their own happiness and wellbeing before that of their children.

> **Researcher**: So why are some children well cared for and others not? What explains that?
> **Participant**: I think initially it depends on the parents. And how much the parents care for them. And that's also multifaceted in the sense that unfortunately the way the world works is if a parent has less money they might not be able to provide for their kid in the same way. It doesn't mean they care less, because they could still try and divert every extra penny towards their child, which in my view is a parent still trying to care for their child to the nth degree.
> –
> **Participant**: Unless the parents are willing to kick their [drug] habit, then it's not an environment to bring up a child. There probably are lots of children being brought up in that environment and new parents are coping, but it's quite a selfish thing. It's maybe easy for me to say that because I've never taken drugs or been an addict, but I think when you make a decision to have a child […] you have to become selfless.

This model has a clear class component. Participant discussions showed that working-class parents are understood to be more likely than their middle- and upper-class counterparts to be innately or intentionally selfish, and as a result to neglect their children.

> **Participant**: But then there are parents who just neglect children and neglect their development for whatever reason to cater to their own desires. I think to be a parent you should be a parent when you know you're able to provide for a child.
> –
> **Participant**: But if you can't afford to look after them, don't have five [children]. If you can afford to look after one, have one. And then maybe things will get better and you can afford this and that, but don't have children if you can't afford to look after them. I don't mean iPhones and things like that, I mean actual basic needs. It doesn't mean you've got to have five children and you've got to have five iPhones. You've got children that can be fed and clothed and be happy, so that's what you've got to be able to provide.

Participants drew heavily on this model in thinking about the care system. When responding to open-ended questions about why children enter the care system, 'selfish parents' was a predictable response. Analysis of these responses showed that there was an underlying assumption that to be a good parent is to be selfless, but that some parents choose not to meet this fundamental criterion of good parenting, and as result their children enter the care system.

Implications of the *Selfless Parent* model

This model presents significant challenges for those communicating about why children enter care, and for those looking to build support for preventative solutions:

1. The model is highly moralistic, stigmatising parents with care-experienced children. If a child's involvement in the system is attributed to a parent's inability to be selfless, or to wilful selfishness, then parents are likely to be heavily stigmatised. In turn, this makes it hard for the public to support the idea that reunification with family may in many cases be the best way of supporting a child's development and wellbeing. This stigma not only attaches to parents but also sticks to children who come from families involved in the care system.

2. Relatedly, this model's heavily individualised focus on parents, morality and decision-making obscures the wider role that context plays in shaping families' lives. This make it difficult to engage with multiple elements of the sector's story, including the role that structural inequalities play in care involvement and the importance of addressing these factors preventatively.

☐ The *Community Values* Cultural Model

In this cultural model, children who live in poverty are understood as more likely to have care experience, not because of financial issues, but because poor communities lack moral values. People assume that low-income communities have different norms and values about what is 'right', 'moral' and 'proper', which in turn shape a range of choices and behaviours. These choices and behaviours

are seen in turn to lead to parenting decisions and child behaviours that increase the chances of involvement with the care system.

> **Participant**: Through personal experience I've found that where there's a lot of social housing and housing schemes there's a lot of social problems. It's a culture that can form, and I think it's really important to intervene and take that child out of it when there's a real drug culture or crime culture or something like that. –
> **Participant**: I think a lot of it has got to do with a vicious circle. If somebody has a child when they're 16, and you see this situation of their child having a child when they're 16 and then they're a granny when they're 30. This is the vicious circle that a lot of people get into, how does that happen? Something's got to break the mould here. Somebody's got to stop that and say, 'That's probably not the best thing to do if you're wanting a good future'. I think a lot of it is to do with poverty.
> –
> **Participant**: Education for people before they have children, sex education, obviously the younger kids, more harsh sex education.
> **Researcher**: What would you see as being the focus of that? Having a baby?
> **Participant**: So they know it's not a fashion accessory. In poorer areas there's nothing to do but have them. You'd hear that.

Implications of the *Community Values* Model

The *Community Values* model has similar implications to the *Selfless Parent* model. If people view whole groups of individuals as morally deficient, and connect this deficiency with decisions and actions that lead to a child's involvement in the care system, parents will be blamed and stigmatised, problems will seem inevitable (what can we do to change something as deep and pervasive as community values?), and people will easily see the issue of children in care as an issue about 'them' and not 'us' (it is a problem of people who are low-income and lack morals and values, not a *social* issue). The sector should be particularly wary of discussions of community 'values' that are not carefully framed to avoid activating the assumption that care involvement is the result of some groups simply having deficient values.

▢ The *Financial Constraints* Cultural Model

The core assumption of this model is that the ability to care for a child is influenced by a family's access to financial resources. Financial resources are seen as determining a family's access to food, housing and other necessities. Therefore, having money is understood as an essential part of ensuring that a family can provide and care for a child. In this way, people assume that a family's socio-economic status increases or decreases its risk of coming into contact with the care system.

When reasoning with this model, people are attuned to the way that financial resources shape parents' ability to provide for their children and assure their wellbeing. From this perspective, the public is able to recognise that living in poverty, especially severe poverty, makes it more likely that a child will enter the care system.

> **Participant**: I touched on child poverty before. If the parents don't have much resources to start with, it makes it more difficult for them to look after their children.
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> —
>
> **Researcher**: Can you explain the link between unemployment and poverty and the likelihood that a child will be in care?
>
> **Participant**: I think because the parents don't have the finances or the wealth to help the children with needs like food, clothing, heating. If they can't afford to do those three simple things, then they may have to go into care because the parents haven't got the money to be able to provide for their children. So, when government comes in and says this is a poverty-stricken child, they try and help them in some respect. They may go into care until things improve, or they may never improve.

However, our analysis shows that this cultural model is recessive. Attention to financial resources was easily interrupted by the more dominant models of *Community Values* and *Selfless Parents*.

Implications of the *Financial Constraints* Model

The *Financial Constraints* model is promising from a communications perspective, as it enables the public to think systemically about effective parenting and care. This model is highly consonant with the expert perspective. When active, it allows people to see that we are shaped by what surrounds us, and to identify the ways that resources are connected to an individual's actions and behaviour. However, the *Financial Constraints* model is recessive and easily displaced by other, more dominant models that blame 'bad' parents or deficient community values for a child's lack of care. Future research should explore ways to cue this model and expand it to focus thinking on nonfinancial ways in which contexts affect families and thus how the provision of other supports and resources might improve family and child outcomes.

Models of the Care System and Its Effects

Participants drew on a number of cultural models to think about the care system and its implications for individuals within it.

☐ **The *Where the Family Ends* Cultural Model**

There is an overarching understanding in which the care provided by the system is seen as fundamentally different from that provided by families. Participants reasoned that being 'in care' means, by definition, *not* being in a family. Discussions about care were dominated by distinctions between the care system and care provided by family.

> **Participant**: I guess 'in care' would mean living somewhere other than with family.
> –
> **Participant**: When you talk about a child 'in care', the phrase 'in care' means that they're in the care of somebody else other than the family. So 'child in care' would be child in the care of the government.

This model was so dominant that even participants who knew *factually* that children could be in care while residing with their family (or a family) did not see a child in this situation as being in the care system. This way of modelling the care system as fundamentally different from family is vital to understanding public thinking and opinion about this system and those who are involved in it.

Implications of the *Where the Family Ends* Model
This way of thinking about the care system makes certain care situations – group homes or residential care – easy to identify, but other situations – supervised family care or kinship care – difficult to see as part of the care system. This limits people's understanding of what the care system truly entails, the supports that it offers to children and the range of services it provides.

☐ **The *Standardised and Cold* Cultural Model**

There was a highly dominant understanding of the care system as standardised, impersonal and cold – providing the same basic care to all in its purview. The system was described as faceless and machine-like and. in many ways. compared to medical care. It was seen as fundamentally unable to provide individualised care or the love, emotional attention and warmth that children are understood to require. Family care, on the other hand, was seen as the opposite of this blunt-edged, cold system, and was defined by its ability to meet the specific needs of particular children and attend to children's emotional requirements.

> **Participant**: I think a care system that engages with young people, in the sense that it's not just, 'You're into care, let's just put you on a conveyor belt', but a system that tailors what it does to each individual's needs, which is easier said than done, but I guess you can dream.
> –
> **Participant**: It's trying to make it genuine, isn't it? This is what I'm struggling with, how to make it genuine, and how do you make it individual? And how do you generally care for them?

This way of thinking about the care system likely derives from a more general model of government and public systems in which people understand government programmes as impersonal, standardised and generally inefficient.

> **Participant**: If it's run like everything else in the UK, then it probably doesn't work very well, if I'm being honest. It probably lacks funding, probably a lack of resources. In fact, I can probably tell you that there probably is a lack of resources and a lack of funding in the care system in Scotland, judging by the way that the show is run. I wouldn't say it's run very well, but that's just a guess.

Implications of the *Standardised and Cold* model

1. This model helps explain why people have such generally negative views of the care system. If people model children as individually unique and requiring warm and emotional support, then they will be unsupportive of what is understood as a one-size-fits-all system that lacks the ability to provide loving care. This perception of the system is perhaps the most formidable challenge that those in the sector face in increasing understanding and turning back the stigma that currently so strongly attaches to those with care experience.

2. The *Standardised and Cold* model also cues a more general unproductive model – of government and public services as ineffective and ill-equipped to provide high-quality services. This likely leads to a lack of support for public services that spills and seeps into different domains (for example, education, criminal justice, health care and so on). Communicators must actively avoid cuing this model, even unintentionally (for example, in efforts to challenge this misperception). Instead, future research should focus on finding a suite of strategies that can supplant this understanding of the system with a more accurate and productive sense of what the care system is, how it works and what it does. This is a communications priority.

☐ The *Bad Apples* Cultural Model

Participants frequently voiced opinions that the care system is not able to provide children with adequate care because individuals working in the system are failing in their responsibilities. People see two main types of 'bad apple' in the system:

1. Carers who deliberately perpetrate abuse and use their power to prey on vulnerable children. These discussions were informed by high-profile cases in the media of abuse and exploitation by people in positions of responsibility.

2. Carers who are incompetent and lack the skills, training or interest to be able to perform their jobs effectively.

> **Researcher**: Why do you think people end up being carers?
> **Participant**: Because they gravitate towards children. I guess the fact that, say you're a paedophile, you want to live near a school, you want to get a job as a lollipop person, it could be a man or a woman, you know,

that's the ones that do the school crossings. Simple things like that, that's what they gravitate towards. Well, it's going to be an easy target if somebody is in care and they're an abuser, because who do they go to? Nobody. They can't go to their parents. They've got nobody to go to.
–

Participant: But the people [professionals within the care system] would need to be people who care about other people, and not who are just doing a job. It's got to be people who are caring and nurturing, because looking after other people's children is a huge responsibility.

Implications of the *Bad Apples* model

This model is problematic from a strategic communications perspective. It reinforces people's understanding that the care system is unable to provide high-quality care. However, rather than understanding that the system itself is fundamentally flawed, this model lays blame at the feet of individual actors who are understood to be failing in their responsibilities. Unlike the *Standardised and Cold* model, the *Bad Apples* model presents a situation that is decidedly more open to remediation. If we can weed out maleficent carers and provide better training to those who lack skills, the system will improve. This is a significantly more efficacious perspective, albeit one that assigns responsibility for systemic failures to individuals and thus may take attention away from systems reform.

The *System as Removal and Entry* Cultural Model

In discussing the care system, participants' focus was overwhelmingly and predictably on the point at which a child is removed from his or her family and enters the care system. This is called a *prototype model* – it constructs an understanding of a complex thing through one and only part or type of it. In the same way that we share a common prototype when someone says the word 'bird', the experience of entering the care system comes to stand in for and be used as a mental image of the entire system and all of its complexity.

> **Researcher**: Do you have any ideas of how it is that children end up in care?
> **Participant**: Again, maybe if the parents couldn't cope or if they were taking drugs, or if the children were unhealthy, or unclean. There are examples of little kids that have died recently that had been really badly treated and stuff like that.
> **Researcher**: How did you feel it would result with a child going into care?
> **Participant**: It's a difficult job for the social worker to pick up on these ones. Maybe these are the ones that get to school age and you get a teacher seeing them every day that can maybe point… Again, maybe nursery staff to an extent. Maybe children that are born into care maybe get flagged up to social work.
> –
> **Participant**: To me the definition of 'in care' is a child has been taken away from the parents for whatever reason and put somewhere for their own safety. That's my definition, that's my understanding of in care. And if someone looks after a child, then they look after it to the best of their ability. And to me that would be a supportive environment which would include all the elements I spoke about earlier.
> –

Participant: To be in care would be in a home that's not your own. Being looked after by people who aren't your family. You've been taken away from your family for whatever reason, they can't look after you so you're looked after by someone else.

Implications of the *System as Removal and Entry* Model

1. If the traumatic experience of being removed from family and entering the system comes to stand in for the whole system, the system – and all those in it – becomes coloured by a highly negative set of feelings and emotions. This is yet another feature of public understanding that perpetuates the stigmatisation of the care system and those who have experience with it.

2. The focus on this one event distracts from thinking about what is actually going on and needs to happen *in* the system, making the majority of the sector's ideas difficult to communicate.

☐ The *Trauma of Removal* Cultural Model

There was strong and widespread assumption that involvement with, and entry into, the care system is an inherently traumatic experience. Participants understood, fundamentally and powerfully, that removal from a family was a negative and likely life-altering event.

> **Researcher**: What do you think the effects are of being in care?
> **Participant**: Sadly, I think there are effects. I think every child, regardless of what happened to your parents, there is going to be that bond with your parents. A child will be aware of being taken from the family home and then suddenly they're not in a family home. I think that's going to affect them.

Participants made sense of the effects of this trauma by oscillating between two conflicting cultural models of adversity. As described above, one of these models allowed them to at least partially dismiss the effects of such traumatic experiences, reasoning that young children would be relatively less affected by such situations because of their inability to remember and their general unawareness of their experiences (the *Early Resilience* model). This way of thinking was only evident when discussing very young children. The other model, by far the more dominant of the two, led to the understanding that these experiences have unavoidable long-term, negative effects (the *Forever Damaged* model).

Implications of the *Trauma of Removal* Model

This is another model that supports the stigmatisation of those with care experience. The model tags those who are identified as being or having been in the system with the mark of trauma. In tandem with the *Forever Damaged* model, this leads to the logical conclusion that all children who enter the system (and experience the trauma of family removal) are damaged goods, forever.

ADVERSITY

Weight of Worry

Early Resilience

Forever Damaged

Effects are Emotional

DEVELOPMENT

Every Child is Unique

Hierarchy of Care

Dependence and Care

Awareness + Control = Responsibility

Troublesome Teen

PARENTING

Selfless Parent

Community Values

Financial Constraints

Pure Love

Opportunity Filter

SOLUTIONS

Govt. Step UP

Education

Family Financial Support

Fatalism

Care System & Care Experience   THE CARE SYSTEM

Where the Family Ends

Standardized and Cold

Removal and Entry

Trauma of Removal

Bad Apples

⬜ A Cognitive Hole: Experiences in the System

As discussed above, there was an overwhelming focus on and preoccupation with *entry* into the system. This is the image of care experience in people's minds. Analysis showed, however, that people have little understanding to draw from in thinking about a child's experience *in* the system and the effects of such experiences.

Implications of the Cognitive Hole

The hole in people's thinking about what actually goes on in the system, the way it provides services, and the effect of these services on children's lives – not to mention the ways these services can be improved – presents both a challenge and an opportunity.

At one level, the lack of understanding about what the system looks like and how it works makes it difficult for the field to engage the public in its ideas. Without a solid starting place, communicators cannot assume an understanding of how the system actually works and what it does. But from another perspective, the absence of firm and durable understandings of how the system works means that the sector can focus its communications on *filling in* understandings, rather than on having to do the more difficult work of finding frames that push existing ideas out of the way before information and ideas can be introduced.

Thinking about Solutions

Participants' dominant cultural models informed their thinking about how to address issues within the care system. This link between the understanding of an issue and the perception of appropriate and effective solutions is well documented, both in Frameworks' research and in the work of other scholars in a range of social science fields. Below we outline the solutions that participants consistently generated, and we tease apart the thinking that they drew on to generate and justify these solutions.

⬜ Solution 1: Government Must Step Up and Protect

Members of the public find it easy to see the government's responsibility to step in when parents are unable to adequately provide care for their children. Drawing on the *Protector* model, participants' first answer to questions about improving the care system was that government needs to step into its protective role. Importantly, however, using several of the models described above, participants saw this government responsibility in relation to physical safety and material needs, and did not extend it to emotional support or love. Drawing on the *Standardised and Cold* model, participants saw the idea that government might be responsible for providing emotional support as inappropriate and ineffective. In short, multiple models come together to provide people with a clear way of seeing that government is responsible for protecting children, and that it needs to do more to ensure that it meets this obligation – even though the services it was seen as providing were relatively basic and limited.

> **Researcher**: Who is responsible for providing for children in care?
>
> **Participant**: Local councils and things like that. Obviously, the people who care for them as well. But I think, ultimately, they are controlled by circumstance, which is created by the government.
>
> –
>
> **Researcher**: Who is responsible for addressing the needs of children in care?
>
> **Participant**: I think the Scottish government or UK government. Education, where children are being educated. Because we live under the government rule, they have responsibility to us as their patrons to look to them for support. They want to be in power, so if they want to be in power then they should really be giving something back to the people that they're governing.

When participants reasoned with the *Bad Apples* model, they added that the government should also act as protector by increasing oversight and vetting care professionals, to make sure that the 'wrong people' do not get into care jobs.

> **Participant**: I don't know enough about it, but what seems to be the problem with the system is there are people who are maybe not recognised abusers. These people get through the loop somehow. The obvious one would be to not let these people in in the first place. They've got to be identified, they've got to be recognised as problems. But if they're not recognised then nobody knows.
>
> –
>
> **Researcher**: So, what would be a really good care system?
>
> **Participant**: It would be an army of people who were able to take the children into their own homes and look after these children in their own homes, but you'd need an awful lot of people to be able to do that, and an awful lot of vetting would have to be done to be absolutely sure of the people that could do it. That's the only way.

Implications

It is promising that people are so easily able to attribute such substantial responsibility to government. At the same time, the fact that this sense of responsibility is so narrowly applied to protecting children's physical safety and providing for their material needs poses a challenge to communicators.

☐ Solution 2: Increase Financial Support for Families

Applying the *Financial Constraints* model, some participants suggested the need to address social inequality in order to prevent children from entering the care system in the first place. When this model was active, participants argued that providing a more robust set of services to a wider section of the population was necessary to improve the care system and the outcomes of those who experience it.

> **Participant**: I'm quite a firm believer in the fact that if you're on benefits and you've got kids, it's not enough to get by on. That's just from watching documentaries, and if you know enough people like that, I don't think it's enough to get by on. I think there needs to be more financial assistance for people with kids in general.
>
> –

> **Researcher**: Do you think there are any ways that we could reduce the number of children who are in care?
> **Participant**: Parents and the families around them need more support to help them and look after them properly. It could be as simple as helping them to have a stable house, so you'd need more houses.

Implications

The public's recognition that providing resources and services to families can address issues with the care system is an asset for those in the sector. The fact that the *Financial Constraints* model paves the way for this type of thinking suggests that this is a strategically valuable model for communicators. If the sector can find ways of more consistently and powerfully activating this model through its messaging, support for a host of family supports and social benefits – and preventative measures more generally – will increase.

☐ Solution 3: Increase Education and Awareness

Members of the public think that one of the reasons why children enter the care system is because of a parent's inability to make good decisions. They thus assume that if parents knew better, they would make better decisions and there would be less involvement with the care system. In the public mind, greater education for parents can build greater understanding of how to be a good parent, which leads to better parenting decisions and fewer children in care. Participants discussed a variety of ways to educate parents and build better understanding – for example, antenatal classes, information on the risks of alcohol and drug use, and education on managing a household budget.

> **Researcher**: What could be done then to decrease the number of cases?
> **Participant**: I think education and showing people if they've got kids don't abuse alcohol and drugs. You shouldn't really have to tell them, but tell them that it is their basic right to provide food, shelter and accommodation. Maybe highlight the role of a parent to parents, even if it's antenatal classes and running through the basics to help the parent and make sure they're providing a safe home, because they might be unaware that they are not providing the right things for the child. So just getting through to them what is required.
> –
> **Participant**: I do think parenting classes should be compulsory for some parents. Also, I think any young parent that are under the age of 24 to 25 would also benefit from it.

Implications

Improving parent education may be part of reducing the number of children who enter the care system. However, focusing on this solution sets the frame at the individual level and traps people in thinking that better individual decisions are all it will take to address this issue. This draws attention away from the ways individuals are affected and constrained by the systems in which they are embedded, and the power of policies to change these contexts and alter individual circumstances and outcomes.

☐ Solution 4: There's No Solution

As we have noted, a number of cultural models contribute to the understanding that little can be done to improve the care system or prevent children from entering it. For example, if the Scottish care system is perceived as a standardised, impersonal bureaucracy that is able to meet only basic material and protective needs, it is difficult to envisage how it could supply children with the full range of supports they need to thrive. Similarly, if the public assumes that individuals are irrevocably harmed by their experiences of trauma, then the value of interventions following adversity is easily obscured.

> **Researcher**: What needs to change [about the care system]?
> **Participant**: People? [Laughs.] How can you change it? I don't know, you can't change people that much. You can educate people to whatever level and just hope that they become good people, I guess.
> –
> **Researcher**: So, we've flung everything out and we're starting again, brand new clean slate. Magic wand, blue-sky thinking, what kind of things should be in our new shiny care system that we're going to create in Scotland for children?
>
> **Participant**: Bloody hell. I don't know enough about the existing care system, as I've mentioned. There's got to be carers, there's got to be responsible people or managers who've got their teams of people who are caregivers, be it foster parents or in care homes […] you've got to have a good education, you've got to have… I don't know. It's just an impossible question to answer.

Implications

Fatalism is a major hurdle for communicators. If addressing issues within the care system is seen as a futile endeavour, support for systemic reforms will be impossible. We recommend that future framing work should focus on providing a more accurate and constructive way of thinking about the system of care in Scotland – what it actually does, and what it is capable of providing for children in its care.

Toxic Combinations

Some of the most important findings from this research can only be seen once we a have a sense of the full set of cultural models that people can bring to thinking about care and those with care experience. There are important ways that the models described above come together to help us make sense of public opinion of the care system and those who experience it. Unfortunately, these constellations of assumptions have negative implications for those in the sector.

That negative opinions are supported not by a lone model, but by cognitive scripts that pull together multiple models, helps us understand the strength and perniciousness of negative opinions about the system and individuals with care experience. Below we summarise the three most significant *toxic combinations* and discuss their effects in shaping public thinking.

Toxic Combination 1:
Every Child is Unique + Standardised and Cold = the System Is Destined to Fail Children and Produce Broken Individuals

This pair of models was frequently used together, and consistently resulted in highly negative, deterministic views of the system and its potential to support children. If children are characterised by individual variability, and the system of care is understood and defined as standardised and impersonal, people see little or no hope that it can provide for the needs of children or produce positive outcomes. Any individual who is in the system is thus seen as destined to fail, as unique needs cannot be met by a one-size fits all system.

Toxic Combination 2:
System as Removal and Entry + Trauma of Removal + Forever Damaged = the System Breaks Children Forever

This is the most important string of assumptions in understanding why individuals with care experience are stigmatised. If the system is defined by its entry point, this entry point is assumed to be deeply traumatic, and trauma is understood to indelibly mark an individual and her or his life chances, then any individual in the system is understood as broken. This string must be snapped. Key in the breaking this script is remodelling people's understanding of the system, as well as providing a more robust sense of individual plasticity and the ability of interventions to address trauma and improve outcomes.

Toxic Combination 3:
Hierarchy of Care + Pure Love of Family + Where the Family Ends = the Care System Is Fundamentally Unable to Adequately Support Children

If people think that the care system is only out-of-family care, and that such care cannot provide children with the things they need, then the care system is, by definition, unable to support full and

positive development. Again, this string of models helps us understand why children with care experience are so heavily stigmatised, and why the system of care is viewed as so futile.

Mapping the Gaps: Key Communications Challenges

In this section, we review the overlaps and gaps between expert and public perspectives, and the important communications challenges and opportunities that they present.

Overlaps

There are important points of overlap between expert and public understandings of the care system and individuals with care experience. These overlaps represent common ground and strategic starting places that the sector can build on to communicate its key ideas.

- Both groups recognise that poverty and unemployment make it difficult for parents to provide adequate care for their children, increasing the likelihood that children might go into care. However, this is a much more salient idea for experts than for the public, which has other, more dominant ways of thinking about why children enter the care system that focus on selfishness and poor values.

- Experts and members of the public alike recognise that removal from a family and entry into the formal care system are deeply traumatic experiences and create complex needs.

- Both groups recognise that care experience can have negative long-term effects for children.

- Experts and members of the public agree that care within family-based settings is powerful in supporting positive child outcomes.

- Both groups appreciate the importance of loving, warm relationships for positive and healthy child development.

- Both groups recognise the potential of prevention and the need for stronger benefits to support families living in poverty and to reduce the number of children in care. However, this way of thinking is significantly more dominant among experts than among members of the public, for whom competing models can obscure the importance of preventative, context-based strategies and instead focus attention on individuals, poor decision-making and deficient morals.

- Experts and members of the public agree that the government and local authorities have a duty to protect and care for children whose parents cannot adequately fulfil these roles. However, this overlap morphs into a gap at another level, as there are important differences in the specific types of care that these groups see the government as responsible for and able to provide.

Gaps

In addition to these overlaps, there is a set of gaps between expert and public understandings of care experience and the care system. Efforts to reframe these issues need to address these gaps and shift and expand public thinking about individuals with care experience and the care system.

1. **Image of the care system: a varied and complex system versus a prototypical event.** Experts understandably have a rich perspective on the various types of care that make up the system, and on the trajectories that individuals take within it. The public, on other hand, has a mental image of the system that is dominated by one particular experience: children being removed from their families and placed in non-family care. This image stands in for a system that in reality is multimodal in its provision of care and where care experience changes over time.

2. **Types of care provided: in a family versus non-family care.** According to experts, children can be 'looked after' across a range of different care settings, including those where children live with their parents under a supervision order from social workers. By contrast, members of the public assume that care experience means by definition that children are removed from their birth parents and family home.

3. **Orientation of the system: child-centred and caring versus uniform and cold.** Experts argue that even though improvements are necessary, the care system *is* able to provide individualised, emotionally supportive and loving care. In contrast, the public views the system as fundamentally uniform in its provision of care and unable to provide love. This is a stark gap in understanding the system, what it does and what it can be.

4. **Goal of the care system: supporting development versus providing protection and material needs.** Experts see the main purpose of the care system as supporting children's physical, emotional and psychological development while helping address trauma. Members of the public, on the other hand, assume that supporting a child's emotional development is the role of the family, and that the best care professionals can do is to provide safety and meet children's basic material needs. This is a significant gap which is likely to undermine support for key reforms to the care system.

5. **Children in care: positive potential versus irreparable damage.** Experts argue that children in care have the same potential and aspirations as all other children. Furthermore, they believe that with the right supports and services, children in care have the potential to lead full, healthy and productive lives. Meanwhile, members of the public, using multiple models, see children in care as having suffered irreparable damage. Having been deprived of a happy, joyful and carefree childhood, and having suffered trauma, they are not – nor can they ever be – 'normal'. This gap contributes to the stigmatisation of children in the care system, and also makes it difficult for the public to think how their situation can be improved. It is a top-priority gap to address.

6. **Stigma: recognised versus perpetuated.** Members of the sector see the stigmatisation of people with care experience as part of the reason why so many experience negative outcomes. Such stigma leads to a host of issues, ranging from increased social isolation to difficulty in securing employment, and psychological issues stemming from shame and loneliness. Members of the public hold models that lead them to negative stereotypes of individuals with care experience. In short, experts recognise the existence and negative effects of stigma, while members of the public show this concern to be well founded as they clearly stigmatise individuals with care experience.

7. **Early childhood: a critical time versus little lasting effect.** Members of the sector recognise early childhood as a significant time in development when experiences in general and adversity in particular can have long-term impacts. Ironically, while the public generally sees trauma as seriously detrimental to life chances – to the point of determinism – it views early childhood as the time of life when such experiences pose the least danger of long-term negative consequences.

8. **Adolescents: in need of significant support versus independent and requiring minimal care.** Experts understand that children and young people of all ages need support and care, even though these needs differ across development. They cite adolescence as a particularly sensitive developmental window when the provision and quality of services and supports is of utmost importance in shaping long-term outcomes. The public views adolescence paradoxically as a time when trauma can have particularly resounding effects but when individuals are highly independent and thus require little formal support.

9. **Transition services: must be robust versus can be minimal.** Experts emphasise the need for significant support to individuals as they age out of the system. This is an idea that members of the sector view as having the potential to dramatically improve outcomes for children with care experience. Members of the public, on the other hand, view individuals at this age as having situational awareness, the ability to control their behaviours, and a degree of independence sufficient to assume near-total responsibility for their lives and actions. For the public, this time thus requires relatively little support from the care system.

10. **Inadequate care in the home: social load versus individual and moral failings.** Experts emphasise that parents have trouble adequately caring for children when facing stressful conditions such as poverty and unemployment, and that these pressures are even more significant when they lack support from social networks and government programmes. Employing some of their most dominant models for thinking about parenting, members of the public assume that children enter the system because parents fail to be selfless, or that parents lack morals and values.

11. **Social costs: front-of-mind versus out-of-mind.** For those in the sector, the broader social costs of issues in the care system are a front-of-mind consideration and a good part of the reason why changes must be made. For non-experts, these larger social costs and effects – with the exception of increased criminality – are simply not part of thinking about the care system or individuals with care experience.

12. **Improving the system: achievable versus impossible**. Experts believe that the care system can be improved by listening to the voices of care-experienced children and young people. Through these and other actions, they feel that positive change is possible. Members of the public think that even with additional financial resources, there is little chance of making the system do more or work better than it currently does.

Mapping the Gaps

Sector		Public
A varied and complex system	IMAGE OF THE CARE SYSTEM	Prototypical event
In a family	TYPES OF CARE PROVIDED	Non-family care
Child-centred	ORIENTATION OF THE SYSTEM	Uniform and cold
Supporting development	GOAL OF THE CARE SYSTEM	Providing protection and material needs
Positive potential	CHILDREN IN CARE	Irreparable damage
Recognised	STIGMA	Perpetuated
A critical time	EARLY CHILDHOOD	Little lasting effect
In need of significant support	ADOLESCENTS	Independent and requiring minimal care
Must be robust	TRANSITION SERVICES	Can be minimal
Social load	INADEQUATE CARE IN THE HOME	Individual and moral failings
Front-of-mind	SOCIAL COSTS	Out-of-mind
Achievable	IMPROVING THE SYSTEM	Impossible

Initial Recommendations and Future Research

Communicators face serious challenges in addressing stereotypes and stigma and cultivating public support for the changes needed to improve the care system in Scotland. This much is clear. Having an equally clear understanding of *why* these barriers persist is the first step in addressing them.

The analysis presented in this report reveals a set of broadly shared, deep and subconscious ways of thinking that block the public's ability to engage with the expert perspective. These assumptions and patterns of reasoning make it challenging for people to get behind the sector's calls for meaningful change to the care system and more support for those who experience it. These ways of thinking structure a belief that, in reality, meaningful change is simply impossible.

The public's dominant models of care assume that only family can provide children with what they need, and that the care system is the antithesis of family care. They see individuals within the care system as having experienced significant trauma with irreparable long-term effects. They see individuals with care experience as dangerous 'others' with profound psychological scars and abnormal childhoods. They see the problem as selfish parents trapped in morally deficient communities – neither of which are amenable to change. They recognise the importance of love and care in a child's development but see a system that is fundamentally unable to provide this.

Alongside these perspectives are more productive ways of thinking that can be engaged to realise the potential of care-experienced individuals and build a care system that helps achieve our goals as a society. The power and potential of family-based care, the ability to see context as a precipitant of care involvement, the understanding that trauma has serious effects, and the unquestioned way that people hold government responsible for caring for children are all assets that the field can use to move ideas and bend the public discourse in positive directions.

Considering these both unproductive and productive cultural models reveals a set of recommendations that the sector can use immediately to more effectively communicate its key ideas and advance the public discourse. Even as further research is necessary to develop and test specific frames and strategies to address the gaps detailed above, the following recommendations can be used to guide communication efforts.

☐ **Tell stories, and develop a rich and varied – but shared – set of examples that target specific framing needs.**

The sector can shift public thinking by developing and sharing examples and case stories framed in particular ways.

- **Tell systems stories and use structural examples.** Given the public's tendency to think about the children's care system in individualistic ways – as being about selfish parents, badly behaved children or incompetent carers – it is vital to foreground the systemic and structural dimensions of this issue. Communicators should tell stories about care experience where the characters are resources, systems and contexts, not just individual children and their families. When individual stories stand alone, they lead people to see individual-level causes and obscure systemic and environmental ones, thereby reducing support for the systems-level changes recommended by the sector. Telling resonant stories that feature systems can move people away from individualistic perspectives and towards more contextual ones. This helps foster a more structural level of thinking and build support for systems change.

- **Develop examples that show how the system provides individualised care and meets the full spectrum of children's needs.** The public needs help seeing what it looks like for the care system to provide warm and loving support to children, both in and out of family settings. The sector should generate – and repeat – a number of stories and examples that highlight the care system's ability not only to protect and provide material support for children, but also to effectively meet children's emotional needs. Hearing such stories again and again in the context of discussions of the care system will help people move towards a new set of understandings about what the care system is and can be. This is the best way to counter the *Standardised and Cold* model. Whereas explicitly pushing back against this model is likely to have the unintended effect of feeding and strengthening it, it is important to develop and tell stories where the system has the capacity to flex and adapt to meet individual needs in dynamic and personalised ways.

- **Use stories and examples to show how interventions can improve outcomes for children who have experienced trauma, to counter the public's determinism and fatalism and to fight stigma.** Reversing stigma and erasing negative stereotypes is less about arguing that they are not true, right or fair, and more about altering the way the public thinks about individuals with care experience. A good part of doing this deeper understanding work is providing people with concrete examples that show that trauma experience does not guarantee negative life outcomes. In particular, the sector should develop a set of stories and case examples that show – and importantly, explain – how interventions address trauma and lead to positive outcomes. People need to see that such change is possible, but they also need to understand how it happens.

- **Avoid over-reliance on stories of family removal and system entry.** Communicators should be cautious and parsimonious in their use of family removal and system entry stories. While resonant, stories like this stand in for and cast a negative shadow over the entire system. Instead, communicators should develop a suite of examples and stories that show *different* aspects of the care system and provide people with a sense of the multiple ways it supports children and families.

Emphasise the importance of the family, but explain and show how non-family care situations can be effective.

This is a fine line to walk, as the importance of the family can easily move people to a view where any alternative is destined to fail children and result in poor outcomes. The perceived importance of family can be a tool for the sector, but great care and attention must be paid to keep the door open for the appropriateness and effectiveness of non-family care options in certain situations. Communicators should make sure the public has positive and identifiable examples that show what non-family services look like, how they work, and that they are important in supporting children and young people.

 Explain principles of child and adolescent development.

To reframe the care system and shift public attitudes about those with care experience, communicators need to build public understanding of the following principles of early childhood and adolescent development.

- Members of the public need help realising that experiences in early childhood can have considerable lifelong effects. Prior FrameWorks research on communicating the science of early childhood can be immediately helpful. Specifically, explanatory metaphors such as *Brain Architecture*, *Toxic Stress* and *Serve and Return* can make key developmental concepts more explicit – particularly the ideas that early experiences matter, that exposure to adversity can have long-term negative effects on development (but these effects can be buffered through supportive relationships), and that reciprocal interactions between children and caregivers are critically important.

- The public requires a better understanding of the biology of plasticity. Brain and biological systems stay malleable throughout life but are particularly sensitive to environments and experiences during early childhood and adolescence. This results in heightened sensitivity to the negative effects of trauma and adversity, but also in increased responsiveness to interventions and supports. Including concepts from this science (although perhaps not the term 'plasticity') may be productive in countering the *Forever Damaged* cultural model and the stigma that it drives.

- By communicating about the science of adolescent development, the sector can help the public understand that this is a period of active change requiring specific forms of developmentally appropriate care, supporting adolescents to acquire increasing independence and autonomy.

☐ **Activate the *Weight of Worry* model, but always in association with ideas of plasticity and examples of change.**

The *Weight of Worry* model − the idea that childhood stress is a major inhibitor of positive development − has productive effects on public thinking. However, its negative implications − that children who are under the weight of significant adversity cannot have normal childhoods and are affected for life − must be managed. Two strategies for managing these negative implications are to (1) always include messages about the possibility and potential for positive change, and (2) employ examples of positive change following experiences of adversity. This model can be used to supply messages with urgency, but communicators must always supply a measure of efficacy − the possibility of change.

☐ **Explain *how* social factors influence whether a child will become involved with the care system.**

Explaining the causal links between social factors, lack of adequate care in the home and involvement in the care system is critical for expanding public understanding. For example, communicators might explain − in a step-by-step fashion[2] − how poverty makes it more likely for a child to enter care. Communicators must make each link in the causal chain explicit: for example, how poverty not only makes it harder for parents to buy what their children need on a daily basis, but also leads to a lack of social capital and social support; how these in turn increase parents' daily levels of stress, worry and isolation; how this affects parents' decision-making and focus in the short term, and their physical and mental health in the long term; and how these conditions leave little or no room for the provision of adequate care to a child, who as a result becomes more likely to get involved in the care system. By using causal chains to explain the role of social determinants in children entering the care system, communicators can deepen the understanding of this role.

☐ **Provide detailed descriptions of ways the care system can be changed and improved.**

Communicators should stress the idea that positive change *is* possible by explaining the details of how programmes and policies can lead to better outcomes for care-experienced children. In general, effective solutions messages must have the following three characteristics:

- **The solution must fit the scope of the problem.** In other words, do not let the sense of the problem outweigh the scope of the proposed solutions. A problem that seems inadequately addressed by a proposed solution will just make people more fatalistic.

- **The solution must provide a sense of efficacy.** Demonstrate that a larger issue can be fixed and show how public systems are empowered to fix them.

- **The solution must be presented with sufficient explanation.** Show exactly how the solution was achieved and how it positively affects outcomes.

Further reframing research is needed to identify communications tools and strategies capable of overcoming the deepest and most challenging gaps identified in this report. In subsequent research – which would include both qualitative and quantitative frame tests – FrameWorks could develop and test a comprehensive framing strategy for the field to use to translate the expert perspective on looked-after children and the care system. This work would culminate in a unifying narrative framework for those communicating with the public.

This unifying narrative would require developing communications tools of varying types. *Values* are likely to be needed to broaden the public's sense of responsibility for improving the care system and promoting a sense of collective efficacy. Explanatory metaphors and explanatory chains can build public understanding of why children enter the care system, and the kinds of supports they need within it. *Exemplars* may be useful in broadening the public's mental prototypes of care-experienced individuals and their developmental trajectories. Further research is needed to identify and test the effectiveness of these types of communications tools with the Scottish public.

☐ **Below we present a to-do list for future framing research. Frames have to be able to take public thinking:**

- *From* 'outcomes are set in stone and irreversible', *to* 'individuals are plastic, and outcomes can always be improved'

- *From* 'the care system is incapable of providing individualised, warm, loving care', *to* 'we can create a system that provides the full spectrum of care that children require'

- *From* 'care involvement is the result of poor individual decisions and a lack of morals', *to* 'care involvement is the result of a combination of individual and contextual factors'

- *From* 'care needs decrease over time', *to* 'individuals have an evolving set of needs and require support throughout development'

- *From* 'difficult, complex problems like this are nearly impossible to fix', *to* 'change is possible, problems can be prevented, the system can be improved, and outcomes for individuals with care experience can be positive'

- *From* 'the care system affects *those kids*', *to* 'the care system is relevant to and affects us all'

- *From* 'children in care are damaged, abnormal others', *to* 'children in care are invested with potential and have the same goals and aspirations as everyone else'

We believe that the first two of these shifts represent top framing priorities. Without giving people a different view of the care system and helping them see that positive change, despite trauma, is possible, public thinking on this issue will not move forward.

We encourage the field to make use of these findings and recommendations. While change is difficult because culture is deep, durable and strong, it is possible because culture can and does change. And it does so in response to the stories that we tell.

Appendix: Research Methods and Demographics

Expert Interviews

To explore experts' knowledge about the core principles and social determinants of health, FrameWorks conducted 18 one-on-one, one-hour phone interviews with participants whose expertise included research, practice and policy. Interviews were conducted from July to September 2017, and with participants' permission were recorded and transcribed for analysis. FrameWorks compiled the list of interviewees, who reflected a diversity of perspectives and areas of expertise, in collaboration with The Health Foundation.

Expert interviews consisted of a series of probing questions designed to capture expert understandings about who is in the care system and how the system works; what the consequences of being in the care system are; what care-experienced children and young people need; and what can be done to better support care-experienced children and young people in Scotland. In each conversation, the researcher used a series of prompts and hypothetical scenarios to challenge experts to explain their research, experience and perspectives, break down complicated relationships and simplify complex concepts. Interviews were semi-structured in the sense that, in addition to pre-set questions, researchers repeatedly asked for elaboration and clarification and encouraged experts to expand on concepts they identified as particularly important.

Analysis used a basic grounded theory approach.[3] Researchers pulled common themes from each interview and categorised them. They also incorporated negative cases into the overall findings within each category. This procedure resulted in a refined set of themes, which researchers supplemented with a review of materials from relevant literature.
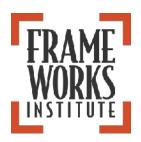
Cultural Models Interviews

The cultural models findings presented in this report are based on a set of interviews with members of the public. To understand the Scottish public's current thinking, FrameWorks conducted 21 in-person, in-depth interviews with members of the public in September and October 2017 in the greater Glasgow, Edinburgh and Aberdeen areas.

Cultural models interviews – one-on-one, semi-structured interviews lasting approximately two hours – allow researchers to capture the broad sets of assumptions, or *cultural models*, which participants use to make sense of a concept or topic area. These interviews are designed to elicit ways of thinking and talking about issues – in this case, issues related to care experience and the care system. Interviews covered thinking about childhood and care in broad terms, before focusing more specifically on children in care and the care system. The interviews touched on who care-experienced children are, why children enter the care system, what effects that might have on them, who is responsible for care and the care system, and how the current standards of care in Scotland might be improved. The goal of these interviews was to examine the cultural models participants used to make sense of the care system, so researchers gave them the freedom to follow topics in the directions they deemed relevant. Researchers approached each interview with a set of topics to cover, but left the order in which these topics were addressed largely to participants. All interviews were recorded and transcribed, with participants' written consent.

The sample included 12 women and 11 men. Of the 23 participants, 19 self-identified as 'white' (for example, English, Welsh, Scottish, Northern Irish or British Irish), one as 'mixed/multiple ethnicity' (for example, white/Black Caribbean, white/Black African, white/Asian or other), and three as 'Asian' (for example, Indian, Pakistani, Bangladeshi or Chinese). Six participants described their political views as 'Labour or left-leaning (on the Left)', four as 'conservative (on the Right)' and 13 as 'middle of the road (moderate)'. Eleven participants reported living in a suburban or rural area, and 12 in an urban area. The mean age of the sample was 43 years, with an age range of 23–60. Education was used as a proxy for socio-economic status: five participants held a GCSE (or equivalent) or below, eight participants held A levels/Highers, five had completed university studies, and five had completed postgraduate studies. Fifteen were married/living as married, and 17 were parents of at least one child.

Findings were based on an analysis of these interviews. To analyse the interviews, researchers used analytical techniques from cognitive and linguistic anthropology to examine how participants understood issues related to care experience and the care system.[4] First, researchers identified common ways of talking across the sample to reveal assumptions, relationships, logical steps and connections that were commonly made but taken for granted, throughout an individual's talk and across the set of interviews. In short, the analysis involved patterns discerned from both what *was* said (how things were related, explained and understood) and what was *not* said (assumptions and implied relationships). In many cases, analysis revealed conflicting models that people brought to bear on the same issue. In such cases, one of the conflicting ways of understanding was typically found to be dominant over the other, in the sense that it more consistently and deeply shaped participants' thinking.

Analysis centred on ways of understanding that were shared across participants. Cultural models research is designed to identify common ways of thinking that can be identified across a sample. It is not designed to identify differences in the understandings of various demographic, ideological or regional groups (which would be an inappropriate use of this method and its sampling frame).

About the FrameWorks Institute

The FrameWorks Institute is a think tank that advances the non-profit sector's communications capacity by framing the public discourse about social problems. Its work is based on Strategic Frame Analysis®, a multimethod, multidisciplinary approach to empirical research. FrameWorks designs, conducts, publishes, explains and applies communications research to prepare non-profit organisations to expand their constituency base, build public will, and further public understanding of specific social issues – the environment, government, race, children's issues and healthcare, among others. Its work is unique in its breadth, ranging from qualitative, quantitative and experimental research to applied communications toolkits, eWorkshops, advertising campaigns, FrameChecks® and in-depth study engagements. In 2015, it was named one of nine organisations worldwide to receive the MacArthur Foundation's Award for Creative & Effective Institutions. Learn more at www.frameworksinstitute.org.

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Endnotes

1 Quinn, N. & Holland, D. (1987). Culture and Cognition. In D. Holland & N. Quinn (Eds), Cultural Models in Language and Thought (pp. 3–40). Cambridge: Cambridge University Press.

2 For advice about how to construct effective step-by-step explanations, see for example L'Hôte, Fond & Volmert (2017). *Beyond Awareness of Stigma: Moving Public Understanding to the Next Level. Mapping the Gaps Between Expert and Public Understandings of Mental Health in Colorado*. Washington, DC: FrameWorks Institute.

3 Glaser, B. & Strauss, A. (1967). The Discovery of Grounded Theory*: Strategies for Qualitative Research (*Observations*). Chicago: Aldine; Strauss, A. & Corbin, J. (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage.

4 See Quinn, N. (Ed.). (2005). Finding culture in talk: A collection of methods. New York, NY: Palgrave Macmillan.