Current trends in the use of residential child care in Scotland

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This research was approved through the procedures of the University of Strathclyde. The data from the questionnaires was anonymised before being passed onto the researchers. In the case studies the names of the subjects have been changed and some of the identifying details changed to preserve anonymity.

SECTION 1: INTRODUCTION

1.1 The practice context of the research

The survey was planned to examine how local authority residential care units were currently being used and to provide data relating to current issues in the use of residential child care. These issues were identified by Scottish Institute for Residential Child Care (SIRCC) staff as they provided training and development work with agencies across Scotland, and others have been part of wider professional and political concerns. They include matters such as the increasing numbers of children being admitted to care because of parental drug misuse. There is also anecdotal evidence about increasing numbers of seriously disturbed younger children having to be admitted to residential care because their difficulties preclude them being cared for in a foster home placement, or who had experienced a number of foster placement breakdowns. SIRCC provides a 'Placement Information Service' and over the past few years there has been a steady stream of enquiries from social workers looking for a 'therapeutic placement' for a younger child. There were also reports of sibling groups still being regularly split up on admission due to lack of places and a general reporting of a shortage of places.

Noteworthy also has been the continued high level of emergency placements. As there has been a gradual reduction in residential places over the past 10 to15 years and as residential care is perceived to be an expensive resource it is important to understand what kinds of admissions are putting such pressure on existing resources.

The survey therefore requested information about a wide range of topics related to admission to residential care including:

- age at admission;
- length of stay;
- previous placement;
- whether placement was planned or not;
- whether siblings groups were kept together or not;
- whether the child was in full-time education or not;
- the reasons for admission including parental drug misuse;
- whether the placement was the placement of choice of the social worker or residential services manager.

The survey also asked respondents to give a broad measure of the effectiveness of the placement.

It was hoped that the data might supplement the Looked After Children (LAC) statistics that are published annually by the Scottish Executive (SE), based on returns from local authorities. While the SE statistics give some information about residential services, much of the published data on 'Looked After Children' does not breakdown information by placement type.

1.2 Local authority children's units

All of Scotland's local authorities, with the exception of East Renfrewshire, have provided their own children's units, located within the authority boundaries and intended to serve children from within the local authority area and prevent unnecessary placement of children far from their parental homes and local communities. The structure of the residential sector has been continuing to change in a variety of ways in all of the countries of the UK over the past 10 to15 years, and this has followed a period of substantial reduction in the size of the residential sector that took place from the mid-1970s to the late 1980s (Skinner 1992). In England and Wales there has been a growing independent sector, including a major 'for-profit' sector, which has been almost completely absent in Scotland. Similarly in Scotland the residential school sector continues to play a larger role than in the rest of the UK, providing about half of the places for looked after children.

Thus the local authority units, although generally smaller in size than the past, continue to play a long-established role of being the point of admission to the rest of the residential sector; very few children go directly to a residential school placement. The children's units, as we will see, also continue to play a role in acting as an initial placement and as a safety net for other parts of the system, particularly fostering which has long been the placement of choice for nearly all children under 12 and for many older children as well.

1.3 Previous studies

While the survey was not a replication of any previous one it did draw on the approach developed by Kendrick (1995). Based on data from 1989 to 1993 this four-year study examined patterns of admission to out-of-home care in three Regional Council social work departments. It sought to explore '*the role of residential child care in the context of the integration of child care services*' (p.i) which at that time meant the integration of various types of child care services including fostering, day care and home support. The study drew heavily on the operation of field work teams to examine which children were placed in residential care as opposed to other placements, and drew its data mainly from social workers and their managers. The current study gathered data from residential unit managers, and their external 'line managers', in an attempt to gather information on all the children in the sample group of residential units.

In 1995 there was a major re-organisation of local government in Scotland and the previous 2-tier system, with Regional and District Councils, was replaced by a unitary system of 32 local authorities. Thus the previous 12 Social Work departments (nine Regions and the three Island 'all-purpose' authorities) were replaced by 32 separate social work departments of diverse sizes but most of which by definition were smaller than their predecessor authorities. The size of most social work departments means that, in general terms, they are too small to develop a range of their own residential resources, and often have to rely on 'out-of-authority' placements. Among other effects in most authorities there is a much smaller residential sector than

in the past with the consequence that there has been a dilution of the expertise that had developed in the Regional Councils in terms of the management and development of residential services.

There have been no systematic surveys of residential provision since the re-organisation of local government. The Children's Safeguards Review (Kent 1997) addressed issues of safe care practice and the prevention of abuse of children in residential care. This current survey, while limited in scope, allows for some exploration of trends in the use of residential placements in the context of the 32 authorities and provides some indications about the extent to which any trends are similar or different to those discovered by Kendrick (1995). The other major change that has occurred since the Kendrick study has been the passing of the Children (Scotland) Act 1995. One of the major changes of that Act was a tightening of the conditions under which social workers could apply for power to take a child into care without parental consent and without going through a Children's Hearing. Place of Safety Orders (PoS) were replaced with Child Protection Orders (CPO). These could only be authorised by a Sheriff and the intention was that they should only be used in serious emergencies where there was severe and imminent risk to the child and a lack of parental cooperation.

The other major study which has explored this subject in some depth was carried out by Jean Packman and Christopher Hall (1998) in England as part of the Department of Health-funded studies into the operation of the Children Act 1989. Packman and Hall's research, was based on an in-depth analysis of two contrasting local authority social services departments and had a particular concern to examine the use of accommodation provided on a voluntary basis in terms of Section 20 of the 1989 Act.

1.4 The point of this study

For many years now there has been considerable questioning by social work practitioners about residential care for children and there has been a long-established 'preference' for foster-placements when children, of all ages, have to be admitted to out-of-home care. This has led to residential care often being considered in practice, and sometimes in local authority policy, to be an undesirable form of care, only to be used in a 'last resort'. This preference has persisted despite authoritative attempts by Skinner (1992) and Kent (1997) and others to affirm the possibility of seeing residential care as a 'positive choice' and in Skinner's case trying to identify positive uses of residential care:

> *A residential home or school may offer the best placement in any of the following circumstances.*
>
> *a. When a young person needs care in an emergency, either because of a crisis in their own family's ability to provide care, or because they are at risk in their own home.*

> *b. When a young person needs longer-term care and a family placement is inappropriate. This may arise after a young person has had several family placements which have broken down, or when her or his need for longer-term care is not identified until she or he is well into their teenage years.*
>
> *c. When a young person needs care with additional specialist, therapeutic or educational services, provided on the same site.*
>
> *d. When a young person has complex special care and education needs, and her or his own family requires short-term support in sharing the care tasks.*
>
> *e. When young people and children require care which keeps them together and placement with substitute families would require them to be separated from each other.'*
>
> (Skinner, 1992, para. 1.10: 14)

It is interesting and relevant to note that these are very similar to the list of groups and purposes found by Curtis (1946), Strathclyde Regional Council (1979) and Short (1984).

It is important to note that, when consulted, children with experience of both foster and residential placements often express their preference for residential over foster care (Barry 2001; Emond 2002)

Undoubtedly a crucial element in the continued 'pro-fostering/anti-residential' bias of social workers and their managers has been the issue of cost. Residential care is more expensive than foster-care although detailed comparisons are very difficult to make. On the one hand it is very difficult to compare the needs of children in the different settings and there is also the problem of identifying all the headquarter and support costs associated with each service. Recently, in England, there has been an attempt to develop the kind of sophisticated cost modelling associated with different kinds of placements (Ward et al. 2004). Residential care has also been undermined by the presence of various 'outcome measures' which look at the conditions of young people, usually aged 16-18 who have emerged from the care system as 'care leavers'. While there is no doubt that many of these outcome measures, in relation to unemployment, educational attainment, mental health or early parenthood, are evidence of what needs to improve in the care system as a whole, they do not tell us about the outcomes of the very many children and young people who have shorter periods of time in residential care and return to the family home.

More fundamental however is the fact that social workers and their managers have, in the main, entrenched attitudes towards residential care for children, categorised as 'special pessimism' (Butler & Drakeford 2005). This has hindered the development of a more accepted place for residential care despite the official rhetoric about the positive role of residential care in successive central government reports. The persistence of this pessimism is

summarised by Packman and Hall in the final paragraph of their study (in a comment which related to both foster and residential care):

> *Finally, old attitudes die hard, and a 'last resort' stance is alive and well, despite the positive intentions of the Children Act. There are parents, and even some children, who value accommodation much more highly than the social services departments themselves do, and are frustrated by their gate-keeping policies. 'Last-resortism' can also prove to be self-defeating – social services' resistance can lead to family disaffection, more emergency admissions, hurried placements and belated planning. Improving the situation requires more than an attitude change: far more resources need to be made available.*
>
> *(1998, p. 270)*

These findings reflect those found in by Kendrick (1995) and concisely summarise why this research needs to be carried out to examine whether, and to what extent, such factors are still present within the Scottish system.

1.5 Funding of the research

The survey was carried out from 1st April to 30th September 2005. It was funded under the 'Sponsored research programme' of the Scottish Executive Education Department; Information, Analysis and Communication Division.

SECTION 2: RESEARCH DESIGN

2.1 Selection of authorities and homes

At the start of the survey there were 30 local authorities which were operating children's homes[1]. East Renfrewshire Council has never had its own units, and Falkirk Council at that point had no units and was in the process of opening a new unit. The homes are either directly provided by the local authority or in two cases by an independent sector provider on behalf of the authority.

For this survey it was decided to seek a sample of homes that were representative in the following ways. Firstly the authorities selected would be representative of the types of authority in terms of population size and urban/rural mixture. The second basis of selection was to use authorities which had different sizes of residential sector, i.e. number of homes.

Of the 30 local authorities who were operating residential units in April 2005:

- Eight authorities had more than five homes,
- Eight had between three and five homes, and
- 14 had only one or two homes.

The sample chosen therefore consisted of:

Two authorities with one or two homes; A (one unit) and B (two units);

Two authorities with three to five homes; C (three units) and D (five units);

Two authorities with more than five homes; E (six units) and F (13 units).

This selection thus also included a mixture of authorities in terms of urban/rural populations with a geographical spread across Scotland. All of the homes in each authority took part in the survey, except for F, where it was agreed that half of the units would participate. This was done to keep the overall sample to a manageable size given the scale of the survey.

The head of service in each authority was approached and agreed to take part in the research. Meetings were then held with the immediate external managers for the units and then with the heads of each of the units. It is perhaps worth noting that all the heads of service were keen to take part and felt that this information would be of interest to them. All participating authorities felt that they already gathered much of this data and that it would not be difficult to complete the questionnaires.

With one exception the units ranged in size from three places to nine places. The exception was a 14-bedded short-term reception unit.

[1] The term 'children's home' is adopted in this report as it is a generic term still widely used and recognised in official documents. Most local authorities designate their homes as 'residential units' or 'young people's centres'.

2.2 The scope of the survey

Questionnaires were devised to gather data on all admissions to the participating homes in the six-month period from 1st April 2005 to 30th September 2005. A total of **22 homes, with 151 places, in six local authority areas**, took part in the survey.

The number of homes represents approximately one-fifth of all the local authority children's units in Scotland. Data on all children's residential units is held on the SIRCC Residential Unit Database (RUD). Children's homes are classified as 'Residential units (without education)' in this database. There are a total of about 140 residential units in this category; about 115 local authority units and the remainder voluntary or private sector units.

Follow–up interviews

Upon analysis of the questionnaires telephone interviews were carried with six of the Unit managers and all of the External managers (6) to explore their understanding of the data and to provide qualitative material (including background information on illustrative case studies).

2.3 The questionnaires

For each admission a questionnaire, in two parts, was completed by the Unit Manager (UM). These were referred to as Q1 (Appendix 1) and Q2 (Appendix 2). There was also a Supplementary Questionnaire, also in two parts (Q1a and Q2a), which was completed by an External Manager (EM). (see Appendix 3 and 4).

Q1 was the 'Admission' Questionnaire and was to be completed for every child in residence at the start of the survey and then for every new admission. Q2 was the 'Discharge' questionnaire and was to be completed for every child who was discharged during the period of the survey **and** for all those still in residence at the end of the survey.

Q1 was the largest questionnaire and asked for a range of data on each new admission. Q2 was shorter and was concerned with information about where the child was moved to and a rating of the effectiveness of the placement. The Supplementary Questionnaires were briefer forms, with Q1a concerning admissions and Q2a completed at the point of discharge. It requested the EMs opinion on whether this was the preferred placement and also asked them to rate the success of the placement.

SECTION 3: RESULTS AND DISCUSSION

The following provides a breakdown of information relating to the children and young people. Not all figures will add up to the total number of returns as not all information requested was provided.

3.1 Sample size

We have returns on the admission of a total of **215 children**, who were either in residence at the start of the study period or who were admitted over the six months of the study.

Of those who provided information on date of admission:

129 children were in residence before 1.4.05 and

80 admissions were recorded in the six months to 30.09.05.

6 returns did not have a date of admission entered.

During the preparation phase we were informed that normally all beds in children's homes are utilised but nevertheless using this snapshot approach and asking for information about all those in residence on 1st April meant that there may have been some vacancies. We cannot be certain that we received returns on all children in residence on that date but units were followed up individually, and we are confident that the number of missing returns is low.

3.2 Gender and age

Gender representation in the study was almost evenly split with 52% being boys and 48% girls. Their average age at admission was ***12.5 years*** with 72% aged between 12 and 15 years.

Younger children in residential care
12% were under 10 years of age and 24% were under 12 years of age.

The SE 'LAC' figures for 2004 show that 53% of all children becoming looked after are under the age of 12 and comment that increasing numbers of younger children are becoming looked after. The published SE figures do not show the age distribution by placement. However the finding of this study that 24% of admissions in this period are of children aged under 12 is significant, given that many authorities, including 2 involved in this study, have explicit policies about keeping under 12s out of residential care if at all possible. (There is clearly a tension between conflicting objectives if residential care is seen as a place for over 12s only, and also a place for keeping sibling groups together.) It may be that a high proportion of the very short-term admissions (see section 7.2, p.21) were of younger children, who although initially placed in a residential unit following an unplanned admission, were quickly found a foster-care placement.

Table 1: Age and gender

Age at admission (years)	Gender		Total
	Male	Female	
Under 1	0	2 (2%)	2 (1%)
1-4	5 (4.7%)	1 (1%)	6 (2.9%)
5-11	29 (27.4%)	12 (12.3%)	41 (20.1%)
12-15	69 (65.1%)	79 (80.6%)	148 (72.6%)
16-17	3 (2.8%)	4 (4.1%)	7 (3.4%)
Total	**106 (100%)**	**98 (100%)**	**204 (100%)**

n=204

Kendrick (1995) found that of the 61 initial placements into residential care in his study, the vast majority were aged 12 and over (89 %) and only seven were aged under 12 (11 %). A slightly larger proportion of the 188 residential placements covered in the 12 months of the study involved children under the age of 12 (14 %). These figures include all forms of residential care. 108 of the placements were in local authority residential homes and 22 involved children aged under 12 (20 %), a similar proportion to the current study.

Therefore, compared to the Kendrick 1995 figures this study is showing an increase of children aged under 12 being admitted to residential care. In the age band 5-11 years there were more than twice as many boys than girls admitted to residential care.

Local authority and age

In three of the authorities 89% or more of the admissions were of children of 12 years or over. In two other authorities while the majority of admissions were for those aged 12 or over, around a third of admissions were under 12. In the last authority the distribution of age was split almost equally between under and over 12, but this was significantly affected by the admission of a large sibling group with a number of young children.

Children under 1

The admissions data reveals that there were two children under the age of one. One of these was the child of a 14-year old looked after young person who had been placed in foster-care. Following the delivery of her baby she was adamant that she would not return to the foster-placement and insisted on being placed in a children's unit. The social work staff eventually agreed to this move and the child and mother continue to make good progress. The other child was part of a large sibling group of six children who were initially placed in a residential unit in order to keep them together.

3.3 Statutory basis of admission

Table 2 details the legal basis on which children were admitted and shows that over half were admitted under Section 25, i.e. voluntary admission, admission by parental consent.

Table 2: Statutory basis of admission

Legal basis	Number	Percentage
Accommodated under Section 25	114	55.6
Section 57 Child Protection Order	17	8.3
Section 66-22 Day Hearing Warrant	7	3.4
Section 70 Supervision Requirement [2]	58	28.3
Other	9	4.4
Total	**205**	**100**

n=205

The responses to this question were unclear in some cases suggesting that the respondents were unsure which section applied to the child in question.

This data does not tell us what kind of statutory basis was in operation throughout the placement and in many cases this will change; for example a Child Protection Order (CPO) may be replaced with a S.70 order and similarly, a child placed initially on a S.25 may come to be placed on a S.70.

These figures clearly show a decline in the numbers of children admitted to care via emergency statutory powers since the implementation of the Children (Scotland) Act 1995. Kendrick's study (1995) had revealed that 28% of all admissions were made under various forms of Place of Safety Order (see Table 4.4.1, Appendix, p.5) while the current study found that just over 8% were admitted on the basis of a CPO.

These figures also show the continuing major role of 'voluntary admission', that is admission with the consent of the parent or guardian.

3.4 Previous placement

47.6% of children were admitted from the family home and another 7.5% from a 'kinship' placement (other family member).

17.9% were admitted from foster-care and another 17.9% from other residential units.

Three admissions were noted from adoptive homes.

Three admissions were noted from secure units.

These findings illustrate the diversity of needs that residential care meets and its relationship to other parts of the 'care continuum'. The findings help illustrate the crucial role that residential care plays in terms of the foster system. Fostering is the placement of preference for the great majority of children becoming accommodated and yet, as has been well recognised for many years, there are many children who do not cope well with a foster placement (Skinner 1992). For some of these children, especially the older ones, the residential unit becomes a place of stability (Barry 2001). The current research study confirms that residential care plays an essential role in

[2] i.e. under the supervision requirement imposed by a Children's Hearing.

underpinning or providing a safety net for foster breakdowns. On a smaller scale, it also plays this role in relation to adoption breakdown.

Kendrick (1995) found a similar pattern: 45 per cent of children and young people entered placements in local authority residential homes from their own home; one-quarter (25%) came from foster placements and just under one-third (30%) came from other residential establishments.

In the interviews the issue of why so many foster placements broke down was explored. Nearly all respondents emphasised the difficulty that foster parents found in dealing with very challenging behaviour, especially as children got older. It was also recognised that sometimes natural parents worked against foster placements and sometimes children felt divided loyalties when placed with another family. Some respondents felt that foster parents would need much more training to support the levels of difficulty they faced. A unit manager made this important point about the nature of some fostered children's teenage 'rebelliousness', or 'challenging behaviour', and how this might be distinguished from 'normal' adolescent rebelliousness:

> *I've spoken to kids about this (foster breakdown) – there is this big thing about needing to know your birth family. Also sometimes pressure, birth parents sometimes sabotage foster placements, but kids themselves find them more difficult when thinking about family identity. The teenage years are a time of identity formation and teenagers in foster-care are rebelling, not just generally as many adolescents do,* ***but against what you see as not your true roots****.*' (emphasis added)

Residential care is also the place where emergency/unplanned admissions from the family home come. Some authorities do have an emergency foster-placement resource but in most places this is limited to younger and easier to place children. Residential care clearly is providing a service to older children requiring emergency placement.

3.5 Reasons for admission

The survey sought to explore the reasons given for the all the admissions. Given that many children are admitted to residential from another 'looked after' placement the questionnaire sought to gather information about both the initial admission and the admission to the current placement. Therefore the options for 'initial admission' closely follow the criteria for referral to a children's hearing, although recognising that children admitted under S.25 do not appear before the Hearing. The options offered in the question about reasons for 'current admission to care' included categories such as 'breakdown of previous placement'.

3.5 (i) Reasons for initial admission to care

In the tables that follow the numbers add up to more than 100% because respondents were able to tick more than one response.

Table 3: Reasons for initial admission to care

Reason for initial admission to care	Number	Percentage
Beyond parental control	95	44.6
Death of parent/guardian	6	2.8
Illness or hospitalisation of parent/guardian	21	9.9
Parent/guardian in prison	1	0.5
Respite care	35	16.4
Lack of parental care	89	41.8
Absconded or lost	16	7.5
Offence by child	15	7.0
Family homeless or accommodation unsuitable	10	4.7
Schedule 1 offences against the child	6	2.8
Drug misuse by parents or others	24	11.3
Alcohol misuse by parents or others	28	13.1
Substance misuse by child	15	7.0
Other	40	18.8

n=213

3.5 (ii) Reasons for current admission to placement

Table 4: Reasons for current admission to placement

Reason for current admission to care	Number	Percentage
Beyond parental control	77	36.2
Death of parent/guardian	4	1.9
Illness or hospitalisation of parent/guardian	14	6.6
Parent/guardian in prison	1	0.5
Lack of parental care	55	25.8
Absconded or lost	10	4.7
Family homeless or accommodation unsuitable	8	3.8
Schedule 1 offences against the child	4	1.9
Drug misuse by parents or others	15	7.0
Alcohol misuse by parents or others	18	8.5
Substance misuse by child	16	7.5
Parental mental health problems	17	8.0
Respite care	37	17.4
Breakdown of previous placement	60	28.2
Offending behaviour by child	28	13.1
Aggressive or violent behaviour by child	34	16.0
High risk sexual behaviour or vulnerability of child	19	8.9
Absconding behaviour	26	12.2
Other	55	25.8

n=213

Kendrick (1995) categorised reason for admission to care in a different way and had five categories: adoption; disability; family support; offending and behavioural problems; and child protection. The reasons for admission to the 108 local authority residential homes were: disability (1%); family support (4%); offending/behaviour (63%); and child protection (32%).

Case Study 1

The following example has been chosen because it represents the very traumatic background of some of the children who become looked after. It is the story of a 10 year old boy admitted to a short-term care unit during the study and shows the range of needs being addressed. It also shows how what was hoped to be a short-term placement has lasted for over a year and been very effective.

Case study 1 – Shaun

Shaun is 10 years old. His father took his own life when Shaun was a baby. Shaun's mum is drug-dependent, and has a 3-year old who is a step-brother to Shaun. When living at home with his mum and step-brother the social worker described Shaun as the 'main carer' in the house. Shaun's behaviour is very difficult, prone to outbursts and aggression. Sean was admitted to the residential unit from his Gran's. She had looked after him for a while after things broke down seriously at home, but her home was very over-crowded.

Shaun's Gran and other family members care about him, but the family is bitterly divided and there are drug problems in the extended family. Shaun's Gran is very angry about her son's suicide, and blames her daughter-in law, Shaun's mum. Shaun's behaviour has deteriorated since he found out about his Dad's suicide by overhearing a conversation between family members.

The social workers had hoped that Shaun could be placed with foster-parents rather than remain in the residential unit, however his behaviour is seen as far too difficult for 'mainstream' foster-parents. This authority does have some specialist, 'professional', foster-carers but they have been assessed for older children and it is felt that he would not be suitable for such a placement, and in any case he does not meet the normal age criteria for this scheme.

He is currently in a unit which is designated as a short-stay unit, one that often works closely with families with the aim of returning children home. The manager of the unit has seen significant improvement in Shaun's emotional state and behaviour since placement. It appears to have brought some stability into his life. The manager is frustrated because his unit is supposed to be very short–term but the authority has no longer-term units for someone of his age. However the Manager is also convinced that his behaviour would erupt again if placed in a family setting and he would quickly become unmanageable.

The care-plan is for Shaun to return to live with his Gran. Shaun has weekly contact with his Mum and Gran. However Gran is saying that she needs help with housing before this can happen.

3.6 Parental drug misuse

Respondents were asked to note whether parental drug misuse was a factor in either the reason for initial admission to care or to the current placement. Drawing together both this was a factor identified for **26 children (12.2%).** This is lower than was expected from anecdotal evidence. It may be that this reason is not always given in admissions records, even where it is a factor.

Follow up interviews indicated that one manager thought that the reason why these numbers were lower than expected was because of the development of services in the community for this particular group. Another manager said they had only ticked this item in one case because there was only one parent where it was definitely known and acknowledged but there was at least one other where it was strongly suspected but not 'proven'.

3.7 Education

Given the importance attached to the question of the education of looked after children in terms of current policy it was decided to gather some information about the education of the young people at the point of admission. No attempt was made to gather data about attainment.

Table 5: Education status at point of admission to current placement

Education status	Number	Percentage
Mainstream education full-time	123	58.0
Mainstream education part-time	11	5.2
Special education full-time	25	11.8
Special education part-time	8	3.8
Mainstream part-time, special education part-time	2	0.9
College/further education full-time	1	0.5
College/further education part-time	1	0.5
Not in education, employment or training	19	9.0
Other	17	8.0
Not applicable (including pre-school age)	5	2.4
Total	**212**	**100**

n=212

There have been concerns about the educational attainment of children in care and recent Scottish Executive guidance has sought to encourage social work staff to make a greater commitment to supporting the education of children while they are looked after and accommodated. There is no doubt however that many children have significant educational problems prior to admission to residential care as this survey shows. It reveals that nearly 30% were not in full-time provision at the point of admission. It should be emphasised however that over 36% of admissions came from other parts of the care system.

Case Study 2

This case study has been included because it illustrates the role of residential care in supporting older teenagers in need of long-term care. It also illustrates the very troubled family backgrounds of many young people, the failure of previous 'permanency' arrangements, the way that sibling groups are split up and the difficulties of reuniting siblings due to shortages of places.

Case study 2 – Mandy

This case study is told in the words of the unit manager of a home for teenagers which is described as a close-support, and longer-term unit.

Mandy has now left but we are still working with in aftercare. She is now 19 and has been away for 2 years, but we still have a lot of contact.

She was with us from age 14 to 17. She was admitted from secure, and before that she had been in another children's home with many problems such as self-harming, absconding, in vulnerable sexual situations with older men. She had been adopted at age 5. She has 2 sisters, one of whom is severely disabled, who were also adopted at the same time. The sisters were placed with 3 sets of adoptive parents.

Mandy initially had a settled adoptive placement, which all broke down at 12 with acting out rebellious behaviour and allegations of physical abuse against adoptive parents. The breakdown was also very associated with trying to find her birth mother who she hadn't seen between 5 and 13. She did find her. After the adoption broke down she had 2 short foster–placements. After the foster placements broke down she moved into the children's homes etc.

Why did we manage to work successfully with her? I guess what marked out our unit a lot at the beginning was about boundaries. She was in the throes of adolescence, in previous residential unit it appeared to be acceptable to go out and get drunk, stay out all night, come back and then go out again. The attitude was, 'we don't want you to do this but at the end of the day is your choice'. We didn't say that. If she got drunk we said she was not going out next night and kept her in physically if we had to. We had kept her in, physically stopped her from leaving. She responded to that very well. All she needed was being told 'no' rather than 'its' your choice'. Obviously building on her previous secure experience our aim was to have appropriate boundaries when she came to us. We did restrain if necessary - if you have justified reason then you have to follow it through. In my experience this only happens occasionally – you do have to be prepared to do it. Our restraint record is a bit higher than some to start with but usually drops to nothing. They want to be stopped and if they behave like this they may get locked up anyway, so if you do just let them go out it doesn't work out in any case.

The adoption of the disabled sister has been successful. But her other sister's adoption broke down in a similar way to Mandy's. It broke down at 12. She also had a spell in secure, could have come to us, but we didn't have a place. She had a long time in secure and is now going to a residential school. In her case she is more aggressive than self-harming.

After a pretty rough couple of years Mandy is now doing well. She has now stopped seeing her mother. Her mother had been a prostitute and tried to get Mandy into prostitution after she left the unit. She is also a heroin addict, the mother.

3.8 Sibling groups

One of the questions we were interested in was to determine the extent to which sibling groups were being split up on admission to care. This was because anecdotal evidence suggested that this was still a widespread practice and usually occurred not as a result of a deliberate plan based on the identified needs of each child but rather because of a lack of places that could keep brothers and sisters together.

To fully explore this issue would require a much more complex data gathering exercise. For example it would be necessary to determine in the first instance when siblings were being admitted together and when admissions only included one child from a sibling group.

Nevertheless the survey does provide some findings in this area.

58 young people had at least one other sibling admitted at the same time. Of these, just over **half** (52%) were all admitted to the same unit. In addition, in **seven** cases where there were more than two siblings admitted at the same time, at least one sibling *was* admitted to the same unit and at least one *was not* admitted to the same unit, as the index child.

Local authorities are under a statutory obligation to keep siblings together in out-of-home placements, 'if appropriate and practical'. (Children (Scotland) Act 1995, Statutory Instrument; Arrangements to Look After Children (Scotland) Regulations, 5(4)). The wording of the regulation clearly gives an easy 'get out' clause, but nevertheless indicates that placing siblings together is considered to be good practice. This research shows that residential care is at least on some occasions being used to meet this requirement, but in about half of cases siblings are being split up on admission to care.

Given the importance of sibling relationships, which are typically the longest lasting relationship which any of us have, the significance of attachments, and the potential they hold for maintaining a degree of 'normality' for children taken out of their family home, it is disturbing to note the inability of authorities to place substantial numbers of siblings together and the apparent lack of priority accorded to this factor. It seems that the 'lack of places' is readily accepted as the reason why siblings are separated from each other. One external manager in a small authority made the interesting observation that they did in fact keep nearly all their sibling groups together because they had had a manager (in post for many years) for whom this had been a very important issue.

3.9 Planned and unplanned/emergency admissions

The Questionnaire asked respondents whether admissions were planned or unplanned and the following definition of planned was given;

> *'Planned (this implies some process; such as meetings or discussion several days in advance, not simply 24 or 48 hours notice).'*

The research shows that **55% of admissions were unplanned**. The great majority of these (68.1%) were unplanned admissions from the family home, with another 5.2% from kinship placements.

Kendrick (1995) found that the majority of admissions to residential care when children were received into care were described as 'emergencies' (82%); compared to 65% of the receptions into foster care. A smaller proportion of admissions from other care placements were 'emergencies': 43% of admissions to residential care and 29% of admissions to foster care.

Although the level of emergency or unplanned admission is lower in this study than in the 1995 one the fact that 55% of all admissions are unplanned must continue to be a cause of concern, especially as much anecdotal evidence would suggest that many of these children have been well-known to social workers. Planning of moves has long been held to be good practice in terms of purposeful social work intervention, and it is widely recognised that sudden removals from home and unplanned moves can be very traumatic for children. Interviews revealed that because there is great pressure on placements, (i.e. a lack of available places) and because social work seniors (in charge of admissions) are reluctant to use residential placements, the result is that most placements from home happen 'out of hours' or in the midst of a crisis requiring immediate action. One external manager explained it thus:

> *You might have someone trying to make a planned admission, and say a planning meeting has taken place, and a visit is proposed for a few days time, …however before you can make the planned move some other emergency placement has taken priority and the bed you were hoping to get for the planned placement is not longer there. Because this situation has persisted many social workers do not actually try to make a planned admission from home.*

The Child Protection Audit and Review Report (Scottish Executive 2002), also found that social workers were keeping children at home, even though they 'continued to suffer physical harm', on the one hand, because of their attachments to their families, but also because they believed that:

- *There was a lack of good quality foster homes and residential provision*
- *residential provision would not meet the needs of the child*

(4.13)

One consequence of this approach is that those children in longer-term care may be paying a high price in terms of having to live in units which are being used for the emergency admissions of very troubled children in crisis situations without planning and preparation. As we will see in the next section residential care is also being used for the longer-term care of a significant number of teenagers.

Comparison rates of emergency admission with other studies

The Packman and Hall study (1998) examined the question of emergency admissions and commented upon it in some depth. They categorised the admissions to accommodation as three different, though overlapping, groups of children; 1. the difficult adolescents, 2. those at risk (in need of protection), 3. the 'volunteered'. A categorisation often referred to as the 'villains, victims and the volunteered'.

> *The most striking feature of the accommodation of difficult adolescents was the predominance of emergency admissions. For 3 in 5 of these teenagers an unplanned admission took place without a prior planning meeting and within 24 hours of the referral or the precipitating episode'*
> *(p.78)*

These authors also make the connection to the diminished number of emergency orders which had followed reform of the legislation – the Children Act 1989 in the case of England and Wales.

> *The crucial point here is that, despite the dramatic fall in the use of emergency court orders since the Children Act came into force,…. the processes by which the troublesome young person was admitted - hastily, without prior planning, therefore in a potentially more traumatic and unsatisfactory way – have not changed at all. The use of emergency orders had diminished but emergencies had not.' (p.78)*

Packman and Hall also note the reluctance of social workers to offer accommodation where families are in severe conflict. This is sometimes because the social workers believe that it is the parents duty to support their children and the allied belief that there may not be much that a children's home or foster placement are able to do to improve relationships that have been difficult for along time. Packman and Hall acknowledge that social workers may be justified in some cases but that the overall result is that:

> *For a majority of difficult adolescents, their own precipitate actions or the desperate measures taken by their parents were magnified by social workers reluctance to offer accommodation as an appropriate resource. There may have been good ground for the families' sense of desperation on one hand and for social services reluctance to offer accommodation on the other. But the end result was admissions that were unplanned, hastily effected and far from the ideals of the Children Act Guidance. (p.82)*

Nevertheless our research did find that some planned admissions from home did take place (see Table 6).

Table 6: Planned admission and previous placement

Previous placement	Planned	Unplanned	Total
Own home	21 (21%)	79 (79%)	100 (100%)
Kinship placement	10 (62.5%)	6 (37.5%)	16 (100%)
Foster placement	23 (60.5%)	15 (39.5%)	38 (100%)
Other residential unit	33 (86.8%)	5 (13.2%)	38 (100%)
Residential school	2 (66.7%)	1 (33.3%)	3 (100%)
Secure unit	3 (100%)	0	3 (100%)
Adoptive home	1 (33.3%)	2 (66.7%)	3 (100%)
Other	2 (20%)	8 (80%)	10 (100%)
Total	**95 (45%)**	**116 (55%)**	**211 (100%)**

n=211

3.10 The uses of residential placement

In order to check out the extent to which residential care was being used purposefully, and to explore to what degree it might be considered a last resort rather than a positive choice, we asked questions about whether this was a placement of preference, and if not what the preference had been. Questions were also asked about the purpose of the placement of the children in the study. This was done through two questions which distinguished between the ‘purpose of placement’ and the ‘intended outcome of the placement’. There was also a question about the ‘intended length of placement at point of admission’. Drawing from these sources we report the following findings[3].

3.10 (i) Placement preference

The questionnaires asked both Unit Managers and External Managers whether they considered that the placement was ‘the preferred choice’ and gave options if the answer was ‘no’.

The UMs (Q1) said that in 74% (n=213) of cases it was the preferred choice and for 22% it was not. Half (55%) of those who said it was ‘not preferred’ expressed a preference for foster-care, and the other responses were mainly distributed between ‘other residential’, ‘residential school’ or ‘secure place’.

The same question was put to the External Managers (Q1a) to see if there was a similar perception between those who actually managed the units and those who had a more authority-wide overview, and who in some places were also responsible for other types of placement, such as fostering.

These External Managers said that 31% (n=203) of the residential placements were not the preferred choice and of these for whom we have this information 63% preferred a foster placement.

This is a significant finding given the context that we explained at the beginning about the ‘pro-fostering’ preference. We can see that there is a belief among the managers consulted here that they would have preferred a

[3] Some respondents selected more than one option.

foster placement in about 12% of cases but that in three-quarters of placements the residential placement was the preferred choice. External managers gave slightly higher figures and said that 19% of placements should have been in foster-care. As we see the findings in the section on the rating of the placement support the idea that the placement is both preferred and rated as relatively successful in the majority of cases.

This reflects Kendrick's findings which were based on the opinions of field social workers. They would have preferred another placement in relation to 35% of foster placements compared to 55% of residential placements. However, in relation to two-thirds of residential placements where a different placement would have been preferred, a different residential placement was the preferred option. 'This means that out of the total of 188 residential placements, residential care was the preferred option in 80 per cent of cases' (Kendrick, 1995, p. 55)

3.10 (ii) The purpose of placement

Table 7: Purpose of placement

Purpose of placement	Number	Percentage
Assessment	46	21.6
Short-term care pending rehabilitation with family	66	31.0
Respite from other placement (residential or fostering)	5	2.4
Medium term to work on behavioural or emotional problems	22	10.3
Longer term care (over 1 year)	48	22.5
To keep sibling group together pending other placement	8	3.8
Provide stability in preparation for fostering/adoption	12	5.6
Preparation for 'independence'/care-leaving	33	15.5
Other	20	9.4

n=213

It is important to note that the biggest single purpose of placement was intended to be short-term work leading to family rehabilitation. In terms of future research if we are to evaluate the effectiveness of residential placements then it is important to find ways of evaluating these shorter term placements and not simply to concentrate on those young people who become 'care leavers'. The outcome measures have until now often been exclusively concerned with this population who are 17 or more when they leave care rather than the younger group who return home before their 16th birthday.

Kendrick (1995) found that the aims of 188 residential placements in his study were: assessment (34%); care/upbringing (4%); treatment (15%); education (9%) preparation of independence (9%); preparation for long term placement (3%); short term care – holding, respite, child protection (26%).

3.10 (iii) Intended outcome of placement

In 44% of placements the intended outcome was that the child would return to his/her own home. For a further 14% the intention was a move to a foster or adoptive placement.

For 26% of placements the plan was that the child would stay in the unit 'for the foreseeable future' and a further 16% were being 'prepared for independence/transition to care-leaving'. A further small number were awaiting or expected to move to a residential school.

Table 8: Intended outcome of placement

Intended outcome	Number	Percentage
Return home to own family (either parent or extended)	93	43.9
Remain in this residential placement for the foreseeable future	55	25.9
Move to other residential unit	6	2.8
Move to fostering or adoption placement	29	13.7
Move to placement in residential school	6	2.8
Preparation for 'independence'/transition to care leaving services	34	16.0
Other	10	4.7

n=212

From these kinds of intentions it is clear that a residential placement continues to serve a number of diverse objectives; a major one being relatively short-term while work is undertaken to reunite the child with their family. It is important however to note that residential care is also used to provide longer-term care for a significant number of young people. When the purpose of the placement is examined we can see that this is described as 'longer term care (over 1 year)' in 22.5% of cases and for another 15.5% it is given as 'preparation for independence/care-leaving'.

3.10 (iv) Length of placement

The data about the diverse purposes and intended outcomes of the placement is supported by an examination of the length of stay of those recorded in this survey. This data is separated into 2 categories; those who were discharged during the survey, and those still in residence at the end of the survey. Taking account only of the former the figures reveal a wide spread of placement durations from a few hours to a few years.

Out of the 88 discharges for whom we have this information 17 (21%) were placed for one day or night or less. A further 11 (13%) were placed for between one day and a week. Four children were resident for over a week but less than a month and a further ten were placed for between one and three months. The figures show 13 (16%) children who were resident for between 12 and 24 months and a further 12 were discharged after spending over 24 months in the home.

One of the possible lines of future enquiry would be to examine to what extent the purpose or 'intended outcome' matched the actual outcome in terms of the

length of placement. Manual scrutiny of the questionnaires suggested that a number of placements that were intended to be short-term became longer term, and this concurs with anecdotal evidence and professional experience.

Short- and long-term units
The interviews reveal that some authorities are trying to create separate longer and shorter–term units. The interviews however also reveal that it is very difficult in practice to hold to such worthy aims. One manager reported making an emergency placement in a long-term unit simply because there was no bed in the short-term unit. This short-term unit also had children who remained in it well beyond when short-term, assessment type work had been completed, simply because there was nowhere for them to go. Other authorities simply ran each unit with a mixture of short- and long-term placements which they acknowledged was sometimes at odds with a coherent Statement of Aims and Function (as required under the Children (Scotland) Act 1995), and especially reduced the quality of life for those in longer-term care.

3.11 Where the children moved to (destination placement)

It is important to note that this survey was mainly concerned with gathering information on *admissions* to residential care. It was also interested in data about the length and effectiveness of the placement. It did not set out to collect comprehensive data surrounding the *discharge* from the unit, which would have required a more extensive set of questionnaires. For those children who were discharged during the study we did ask where they moved to.

Table 9: Destination placement

Destination placement	Number	Percentage
Returned to parent (either)	41	46.6
Placed with other members of own family	1	1.1
Own accommodation with support from care-leaving staff	7	8
Foster placement	5	5.7
Residential school	12	13.6
Secure unit	4	4.5
Other residential unit	11	12.5
Other	7	8
Total	**88**	**100**

n=88

As the table above shows out of 88 discharges just under half returned to their family home. Another 8% left care for supported accommodation. The figures also show around a quarter moving to another residential unit or a residential school, while 4 children moved to secure care. This seems to indicate quite a high level of movement, and possibly placement instability. A degree of movement is inherent in a system where units are used for emergency admissions. Holding a child while a foster placement is sought is another recognised role for residential care although this survey shows only 5 such moves out of 88 moves. A figure of over a quarter of all moves being of a

'lateral' type to another residential unit or school, including secure care, does indicate a significant degree of instability.

Kendrick (1995) presents figures on 136 completed residential placements and the destination placements were: home (38%); independence (4%); foster placement (10%); residential school (13%); secure unit (9%); assessment/reception centre (8%); another residential home (18%). The current survey therefore shows a similar distribution to the 1995 study; with the exception of the 'return home' figure being slightly higher, at 47% against 38% in 1995, and slightly lower figures for fostering at 6% compared to 10% in 1995.

Table 10: Destination placement and age at discharge

Destination placement	1-4	5-11	12-15	16-18	Total
Returned to parent (either)	2 (100%)	5 (45.4%)	22 (43.1%)	6 (46.1%)	35 (45.4%)
Placed with other members of own family	0	1 (9.1%)	0	0	1(1.3%)
Own accommodation with support from care-leaving staff	0	0	1 (2%)	5 (38.5%)	6 (7.8%)
Foster placement	0	2 (18.2%)	3 (5.9%)	0	5 (6.5%)
Residential school	0	1 (9.1%)	9 (17.7%)	0	10 (13%)
Secure unit	0	1 (9.1%)	2 (3.9%)	0	3 (3.9%)
Other residential unit	0	1 (9.1%)	10 (19.6%)	0	11 (14.3%)
Other	0	0	4 (7.8%)	2 (15.4%)	6 (7.8%)
Total	**2 (100%)**	**11 (100%)**	**51 (100%)**	**13 (100%)**	**77 (100%)**

n=83

The spread of destinations for the under 12 group largely reflects the overall pattern, with the obvious exception of the move to independent living. The one child who was moved to a secure unit was aged 11.

3.12 Evaluation of placement

Both Internal and External Managers were also asked to rate the placement and give their opinion about whether it had achieved its 'main purpose'.

3.12 (i) Placement aims achieved

UMs considered that for 61% (49) of the children who had left the unit during the period of study (and excluding those who were still in residence) the placement had achieved its main purpose, while it had partly achieved it for a further 24% (19). For 15% (12) they considered that it had not met its main purpose.

The external managers reported similar proportions. They considered that for 69% of children who had left the unit the placement had met its main purpose, and had partly done so in a further 23% of cases. While for 8% they felt it had not achieved its purpose.

Kendrick (1995) found that there was an association between placement type and achievement of aims of placement. Social workers considered that 58 per cent of residential placements had achieved their aims and 27 per cent had partly achieved their aims; this compared to 68 per cent of foster placements achieving their aims and 25 per cent partly achieving their aims.

> *When the particular aim of the placement was taken into account this association disappeared. Thus, foster placements and residential placements were equally successful in achieving their specific aims.*
> (Kendrick, 1995, p. 61)

3.12 (ii) Rating of placement

The respondents were asked to rate the benefit of the placement to the young person by giving a score of between 1 and 5. The guidance in the question said 'A rating of 1 equates to no benefit, and a rating of 5 means great benefit overall'. They were also invited to make comments on this question and given the prompt that they might want to consider a range of factors ' for example, education, family relationships, offending, emotional well-being'.

Table 11: Benefit of placement – Unit Manager

Score	Number	Percentage
1	6	7.7
2	8	10.3
3	15	19.2
3.5	1	1.3
4	22	28.2
5	26	33.3
Total	**78**	**100**

n=78

From a total of 78 young people who had left the unit the unit managers gave a large number of 4s (22) and 5s (26), and only a few low scores 1s (6) and 2s (8). This suggests that the UMs feel they are generally doing a good job despite operating in a situation where over 50% of placements are unplanned. The view of the external managers becomes important here as their view should be to some degree more objective or at least has the benefit of knowledge of a range of units for comparison.

Table 12: Benefit of placement – External Manager

Score	Number	Percentage
1	6	7.2
2	6	7.2
3	24	28.9
4	27	32.5
5	20	24.1
Total	**83**	**100**

n=83

As the Table above shows overall the EMs are also very positive about the benefits of residential placement. They gave a lower number of 5s, but more 3s and 4s, and less 1s and 2s, than the UMs.

SECTION 4: CONCLUSION

Limitations of the survey

This survey did not examine admissions to the residential school sector which accounts for about half of the places available for 'looked after and accommodated children' in Scotland.

The survey did not investigate admissions to services that were primarily for children with disabilities; either respite services or longer stay services including special schools. It should be noted however that there are many children with different forms of disability in residential services. Some evidence for this can be found in the education question in this survey which found that 16% of all admissions were in either full or part-time special educational provision.

Conclusions

1. Residential child care is used for diverse purposes and there is a very wide range of length of stay.
2. Significant numbers of children stay for short periods of a month or less, 21% of all admissions in this survey were for one week or less.
3. 55% of all admissions were unplanned.
4. In contrast it is also a home and place of stability for many other children. Of the 88 children discharged over the survey period 13 had lived in the placement for between one and two years and a further 12 for over 2 years, over a quarter of the total.
5. Although previously a service mainly for teenagers, it is clear that across the country residential care is being provided for some younger children; 24% under 12 in this study.
6. Parental hard drug misuse is widely believed by child care professionals to be a major factor in a large number of admissions, although this survey shows only 12% of admissions being for this primary reason. Further research may well be indicated and the development of clearer admission categories in LAC paperwork may be helpful as many respondents noted that 'drug and alcohol' concerns are often categorised together.
7. Residential care is used to a limited extent as a placement which will allow some sibling groups to be kept together, especially if it is a group of two. However almost half (47%) of the sibling groups in this sample were separated on admission.

   Given the lack of places available generally – the pressure on the placements which do exist and the rapid filling of any single vacancy as it arises, it is difficult to see this situation changing. Siblings are likely to continue to suffer unnecessary separation from each other unless new strategies are developed by local authorities; such strategies will necessarily involve expansion of provision or the development of residential or foster resources which are staffed on a flexible basis, so that places can be kept free to accommodate sibling groups should that be necessary.

8. Both the Unit Managers and External Managers felt that a minority of children and young people were placed in the units inappropriately. The main preference was foster placement. However both sets of managers felt that the units were achieving the aims of placement in the majority of cases and that the residential placement was beneficial.

Issues arising from the survey and questions for future research

1. All agencies reported a shortage of resources but none had any plans to increase the size of their residential sector. Some authorities reported reliance on the independent sector, although authorities often see the level of expenditure on out-of-authority placements as undesirable. Taken together this indicates a lack of planning and strategic thinking. The sector seems to be at the whim of budgetary pressures and hopes by local authorities that they will be able to increase the number of foster recruits or improve retention rates. Despite its perceived expense there is a continued strong demand for residential placements. Very few vacancies existed for any length of time in the authorities taking part in this survey.

2. This seems to point to the need for regional or national planning otherwise residential services will continue to be seen as a 'marginal' resource in terms of planning, though consistently used in practice.

3. Significant numbers of children are being inappropriately placed and in consequence receiving a poor service; in particular those who are part of a sibling group admitted at the same time. This is despite the existence of specific Executive guidance contained in the S.I. on the Arrangements for Looked After Children. New strategies, plans and procedures will need to be developed to turn this guidance into a reality.

4. The mixture of short and long-term use of residential care indicates that any authority providing residential care needs different types of facility and good links between them. However many local authorities seem unable or unwilling to operationalise this level of differentiation. If an authority only has a small number - say one or two - units then it is very difficult to adhere to a well-defined remit. What seems to happen is that an authority will try to operate a short-term unit but then discover that they do not have enough places available to move on a child who is assessed as needing a longer term placement. The result is that some children end up staying for long periods in short term units thus undermining the function of the unit, and not getting the kind of care that they are assessed as requiring.

APPENDIX 1

ADMISSION TO RESIDENTIAL CARE QUESTIONNAIRE (Q1)

Please complete a separate form for 1.) Every child in residence on 1st April.
2.) Each new admission in the research period 1.4.05 – 30.9.05.

Once the admissions data has been completed please **copy and post (or e-mail)** this form to: Ian Milligan, SIRCC, University of Strathclyde, 76 Southbrae Drive, Glasgow, G13 1PP
ian.milligan@strath.ac.uk

1.

Name of Person Completing Questionnaire	
Designation	
Tel	
Date of Completion	

2. Unique Identification code – please insert new identifier for each child (**then write this identifier on Discharge Questionnaire (Q2), and on the Supplementary Q1a.**

Local authority: R

Unit: O

Child: (e.g. child's initials)

Background data

3.

Date of birth	

4. Sex

Male	
Female	

5. Reasons for initial admission to care (accommodation). (Tick as many as apply):

Beyond parental control	
Death of parent/guardian	
Illness or hospitalisation of parent/guardian	
Parent/guardian in prison	
Respite care	
Lack of parental care	
Absconded or lost	
Offence by child	
Family homeless or accommodation unsuitable	
Schedule 1 offences against the child	
Drug misuse by parents or others	
Alcohol misuse by parents or others	
Substance misuse by child	
Other	

6. Under which Statute was the Child received into care?

Accommodated under Section 25	
Section 57 Child Protection Order	
Section 66 – 22 Day Hearing Warrant	
Section 70 Supervision Requirement -specify	
Other – specify	

Admission Data

7.

Date of admission into current placement in Unit:

8. Was the placement planned or unplanned?

Planned (this implies some process; such as meetings or discussions several days in advance, not simply 24 or 48 hours notice).	
Unplanned/emergency	

9. Where was child admitted from (by type of placement?)

Own home	
Kinship placement (i.e. other member of extended family)	
Foster placement	
Other residential unit	
Residential school	
Secure unit	
Adoptive home	
Other (please write in)	

10. At the point of accommodation was the young person

In mainstream education		Full-time		Part-time	
In special education		Full-time		Part-time	
Attending college/ further education		Full-time		Part-time	
In employment		Full-time		Part-time	
Not in education, employment or training					
Other (please write in)					

11. Reasons for admission into **current** placement:
(tick as many as apply)

Beyond parental control	
Death of parent/guardian	
Illness or hospitalisation of parent/guardian	
Parent/guardian in prison	
Lack of parental care	
Absconded or lost	
Family homeless or accommodation unsuitable	
Schedule 1 offences against the child	
Drug misuse by parents or others	
Alcohol misuse by parents or others	
Substance misuse by child	
Parental mental health problems	
Respite care	
Breakdown of previous placement	
Offending behaviour by child	
Aggressive or violent behaviour by child	
High risk sexual behaviour or vulnerability of child	
Absconding behaviour	
Other (please write in)	

Purpose of placement

12. What is intended *outcome* of placement, at point of admission?

Return home to own family (either parent or extended)	
Remain in this residential placement for foreseeable future	
Move to other residential unit	
Move to fostering or adoption placement	
Move to placement in residential school	
Move to secure placement	
Preparation for 'independence'/transition to care-leaving services	
Other please specify	

13. What is intended length of current placement, at point of admission?

Less than 1 week	
1 to 4 weeks	
2- 3 months approximately	
4- 6 months "	
7-12 months "	
Over 1 year "	

14. What is the main *purpose* of placement?

Assessment	
Short-term care pending rehabilitation with family	
Respite from other placement (residential or fostering)	
Medium term (3 months to 1 year) to work on behavioural or emotional problems	
Longer term care (over 1 year)	
To keep sibling group together pending other placement	
Provide stability in preparation for fostering/adoption	
Preparation for 'independence'/care-leaving	
Other, please specify	

15. In your view is this placement the preferred choice to meet the needs of the child?

Yes	
No	
Don't know	

16. If the answer to the above is 'no' what was the preferred placement type?

Other residential unit	
Residential school	
Secure place	
Foster placement	
Other, please write in	

17. In your opinion was this placement the preferred choice of the social worker responsible for the admission?

Yes	
No	
Don't know	

18. If the answer to the above is 'no' what was the preferred placement type?

Other residential unit	
Residential school	
Secure place	
Foster placement	
Other, please write in	

19. If this placement had not been available (for example if unit was full) what other options were available?

Please write in:……………………………………………………………………

Sibling Status

These questions refer to any brothers and sisters, under the age of 18 years, with whom the child or young person has been living in the family home, prior to current period of being looked after and accommodated. Siblings in this context include 'step' brothers and sisters.

20. Give gender and age of each sibling

	Age	Gender M/F	Already accommodated
Sibling 1			
Sibling 2			
Sibling 3			
Sibling 4			
Sibling 5			
Sibling 6			

21. Number of siblings admitted at the same time: ………………………………

22. Were siblings admitted to same unit: YES…….. NO…..

23. If no, which type of placement were they admitted to:

Other residential unit	
Foster placement	
Kinship placement	
Other- please write in type of placement	

Once this section is complete please copy and return to Ian Milligan.

Thank you for your help in conducting this research.

APPENDIX 2

ADMISSION TO RESIDENTIAL CARE QUESTIONNAIRE (Q2)

Please complete a separate form for 1.) Every child discharged from the unit in the research period.
2.) Each child still in the unit on 30.9.05.

Phone Ian Milligan with any queries: 0141-950-3623

Discharge data

Please complete this section of the questionnaire as soon as the child has left the unit. Please copy the form and post or e-mail to: Ian Milligan, SIRCC, University of Strathclyde, 76 Southbrae Drive, Glasgow, G13 1PP ian.milligan@strath.ac.uk

Unique Identification code – please insert same identifier as on front page.

Local authority: R

Unit: O

Child: (for example, child's initials)

24.

Date of discharge from unit	
Still in unit on 30.9.05	

25. Length of Stay in Unit (in months, or weeks if less than 2 months, or days if less than 2 weeks)

26. Was the move out of this placement planned or unplanned/emergency?

Planned	
Unplanned/emergency	
Still in unit on 30.09.05	

27. Destination placement type:

Returned to parent (either)	
Placed with other members of own family	
Own accommodation with support from care-leaving staff	
Shared care-leaving/hostel accommodation	
Foster placement	
Adoption placement	
Residential school	
Secure unit	
Other residential unit	
Other – please write in	

28. Did the placement achieve its main purpose?

Yes	
Partly	
No	

29. **Overall** how did you rate this placement in terms of its overall benefit to the child or young person? Please give a score of 1,2,3,4 or 5

A rating of 1 equates to no benefit whilst a rating of 5 means great benefit overall.

Rating	

Please comment briefly on key aspects of the placement that informed the rating you have given. (For example, education, family relationships, offending, emotional well-being)

Please copy and return to Ian Milligan as soon as form has been completed.

Thank you for your help in conducting this research

APPENDIX 3

ADMISSION TO RESIDENTIAL CARE
SUPPLEMENTARY QUESTIONNAIRE (Q1a – Admission)

This form should be completed by a senior officer or manager who is responsible for authorising admissions

Once the admissions data has been completed please copy and post (or e-mail) this form to:
Ian Milligan, SIRCC, University of Strathclyde, 76 Southbrae Drive, Glasgow, G13 1PP
ian.milligan@strath.ac.uk

Unique Identification code – please insert same identifier as on questionnaire 1.

Local authority: S

Unit: B

Child: (for example child's initials)

Planning information

1. Was this placement the placement of choice?

	Yes
	No
	Don't know

2. If the answer to the above is 'no' what was the preferred placement type?

	Other residential unit
	Residential school
	Secure place
	Foster placement
	Other, please write in

3. Please give an account of the factors which affected your decision to use this placement. (For example, the risk to the child, availability of places, purpose of unit, was it an emergency or out-of-hours placement etc.)

Please complete this part (Q1a) of the supplementary questionnaire as soon as the child or young person has been admitted, and copy or forward it to SIRCC.

The placement evaluation questions on the next page (Q2a) should be completed after the child or young person is discharged, or at the end of the research period, 30/9/05.

APPENDIX 4

ADMISSION TO RESIDENTIAL CARE
SUPPLEMENTARY QUESTIONNAIRE (Q2a - Discharge)

This form should be completed by a senior officer or manager who is responsible for authorising admissions

Unique Identification code – please insert same identifier as on questionnaire 2.

Local authority: S

Unit: B

Child: (for example child's initials)

Outcome information

4. Did the placement achieve its main purpose?

Yes	
Partly	
No	

5. **Overall** how did you rate this placement in terms of its overall benefit to the child or young person? Please give a score of 1,2,3,4 or 5.

A rating of 1 equates to no benefit whilst a rating of 5 means great benefit overall.

Rating	

Please comment on key aspects of the placement that informed the rating you have given.

Please copy and send this form to Ian Milligan

Thank you for your help in conducting this research

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