Home is where the care should be

Dr Joe Taylor reviews trends in the provision of residential services for looked after children, arguing growing demand requires innovation on the part of independent providers.
Provision of children’s residential services in the UK is in need of reform. The independent sector will likely see significant restructuring over coming years as commissioners focus on evidence-based outcomes and seek better value solutions to deliver system-wide economies.

Integration of education, health and social care provision for looked after children is nothing new, but co-ordinated delivery and funding has the potential to transform outcomes and differentiate the provider base.

The place of residential services within children’s care

Today, around 7,000 children are housed in residential services, which excludes foster homes. Placements are on average short so many more children will enter this type of placement in a given year. Use of this placement type has levelled off at 9%, meaning close to 1 in 10 children being looked after by their LA will be in a children’s residential home placement at any given time. Most children in such placements are teenagers, most of them boys and often from disadvantaged ethnic and social groups.

The pathway children take through the care provider space is diverse and, unfortunately, too frequently arbitrary – depending upon the agencies involved in their first point of contact and particular manifestations of their negative life experiences (figure 1).

Children will often have experienced a number of failed foster placements before entering residential care, they are universally vulnerable individuals with complex care and support needs. Placement stability remains a significant issue, with three quarters of children in such environments having experienced previous placements and nearly a third having been through six or more.

Too many children in need are identified by the youth justice system; looked after children and care leavers are disproportionately represented in our prison population. One in three boys in custody have spent time in care. There is a need to deliver a better standard of residential care that meets the aspirations of care professionals, reduces system-wide costs and is deserving of looked after children.

It is therefore important to ask ‘what is the purpose of residential care for children?’ Attitudes to residential care differ, with two principal models favoured: residential placement can either be viewed as a last resort to be used for the shortest time possible, or as a means of sharing parental care with families on an ongoing basis (figure 2).

The 2003 Stockholm Declaration asserted that institutional residential care should be used as a last resort and only as a temporary measure; a position endorsed by no less than the Human Rights Council of the UN General Assembly in 2009 where “family-based settings” were identified as the best environment for children’s care. However, this contention is increasingly being challenged:

- Residential care provision can deliver the mix of expert staff and intensive intervention that many vulnerable children need, providing them with a pathway to independent living as an adult
- Living in a residential placement need not be so different from a family environment; supervising adults and peer relationships with other children can foster both responsibility and support development of emotional relationships in a controlled and safe environment,
- Restriction of residential care for those for whom care has failed in other settings is itself a source of poor behaviour, as children can come to see themselves as irredeemable and the ‘worst of the worst’.

Residential care is an important component of the care provided for looked after children, and its place is unlikely to be further eroded as its value is better recognised and realised.

The current UK children’s residential service market

A mixed economy of local authority (LA), independent sector and voluntary organisation provision of residential care exists in the UK. Within the independent sector (figure 3), there is a long tail of small providers in this unconsolidated market (figure 4).

Since the 1980s we have witnessed an overall decline in the placement of children in residential care in developed economies, although significant differences in its use remain with English speaking countries tending to place far fewer children in residential care.

The availability of residential care placements is not matched to regional need, leading to many children being placed far from home and a disproportionate burden borne by recipient local services (figure 5). Whilst for some looked after children out of area placements are a good solution – maintaining their distance from disruptive and negative family and friendship influences – for many children living so far from family networks makes re-integration difficult.

Many children from the South East are patriated to residential care placements in the north of England, where operators’ costs are significantly lower. There are inevitable and significant knock-on effects for local statutory service provision; Children’s placement costs are met by the originating LA, but the true costs to statutory services extend far beyond those of the placements themselves:

- Policing pressure is a sad but inevitable consequence of a high density of looked-after children; these children’s backgrounds and life experiences make them much more likely to come into contact with the judicial system, which plays an important role in keeping them safe as well as protecting the community from inappropriate behaviour
- LA social services have an integral role in providing for the needs of children in residential placements beyond the home setting. When an area has many independent providers of care and takes a disproportionate number the money doesn’t follow and some social work teams are under significant burden as a result
- Looked after children also have healthcare and education needs that exceed those of other youngsters; these must be catered for and are often of the most expensive and challenging natures.
Children identified as having a care need but for whom existing guardianship arrangements continue are supported by LA social workers.

Drivers of entry into care

- Family breakdown resulting in uncertain or inadequate guardianship
- Emotional, physical or sexual abuse at the hands of a guardian
- Physical or psychiatric disability making care impossible for the guardian.

Statutory children’s care services

- Foster care placement
- Adoption or shared care arrangement
- Residential care

Exits from children’s care

- Independent living outside of formal care structures
- Continuation of care arrangements in the context of EHC plan or local arrangements
- Entry into adult long-term care
- Engagement with judicial system.

Sources: Candesic analysis

**FIGURE 1: CARE PATHWAY FOR LOOKED AFTER CHILDREN IN RESIDENTIAL PLACEMENTS**

**FIGURE 2: ALTERNATIVE ROLES FOR CHILDREN’S RESIDENTIAL SERVICES**

Duration of placement:  
- Long
- Short

- A temporary refuge for children until a better alternative is found
- A home where children can be brought up as an alternative or adjunct to family life
- A therapeutic setting where children receive treatment for problems resulting from adverse life experiences

**Dominant model in the UK**

“Residential placements are seen as a last resort, we try other placements first whenever possible and look to move children on quickly.”

*Social worker, UK*

“Children’s homes can provide a safe and stable environment for children, whilst issues in the family environment are addressed and parents take a break.”

*Social worker, Germany*

“We design specific programmes to address behavioural issues. We hope they will return to their families better able to cope with their destructive emotions.”

*Service provider, USA*

Sources: Public Health England, New psychoactive system; Candesic analysis
There is increasing pressure being felt by net recipient LAs, and this is translating into limitation of the support those regions can offer. To achieve the best and most cost-effective outcomes for vulnerable children the geographical spread of provision will need to change.

Outlook for residential services

It will be necessary to rebalance the market in order to meet the needs of local commissioners, and improve the quality and focus of provision to secure better outcomes.

The closure of in-house LA provision of residential services was driven by analyses demonstrating it was less expensive to purchase places from independent providers. However, since the 1990s prices in the independent sector have risen and authority staff have come to perceive many independent providers as delivering low-quality services, demanding additional social work support and resulting in ongoing long-term support needs.

Frequently, the base cost model offered by independent providers is significantly increased through additional service modules, such as therapeutic interventions and specific educational elements. In reality, independent provision has not been the cost-saving model many LAs envisioned it to be. Independent providers of residential care are financially incentivised to maintain children in higher acuity service packages, and the perception abounds that they claim higher support requirements than are appropriate in order to increase fees. High acuity independent placements cost around £6,000 per week, and even a small number of such placements can put huge financial pressure on an authority.

Proactive LA commissioners are fastidious in their monitoring of placement requirements, and take steps to reduce care costs within existing placement as well as support transition into less expensive non-residential services. However, it is challenging in the absence of robust outcome measures for social work teams to assess the appropriateness of residential services.

In this market, those who can demonstrate good outcomes and cost-effectiveness in their services will succeed in maintaining service activity volumes. Providers need to both deliver and prove the quality of care they are delivering and the positive long-term outcomes achieved.

An improved model for residential care

Children most often move into residential care after having lived in traumatising and challenging family environments; this does not mean that their poor long-term outcomes are acceptable. The quality of residential care in the UK needs to improve, alongside further integration of services with other models of support.

The problem is that commissioners are judging poor quality and expensive residential placements against an under-supported and ineffectively delivered foster care sector. Going back to basics and considering what elements of care can support looked after children in residential placements is the best starting point.

Integration of health into residential placements

The Children & Families Act 2014 ushered in Education, Health and Care plans (EHCPs) as a statutory mechanism to join up budgets and activity across these three domains. In reality, tripartite funding arrangements long preceded EHCPs.

Further integration of support and funding will be required to achieve the...
best outcomes, and local arrangements need to be augmented and integrated in the context of EHCPs. Many LAs are struggling to develop adequate local offers and providers should be supportive of them in shaping the future of combined care and support packages.

Continuum of care
Residential placement is most often one of a number of models of provision children will encounter in their journey through statutory care, support and protection. Every care modality transition is challenging for looked after children, for commissioners of care and for the social workers charged with children’s protection.

Some residential care providers have their own step-down foster care families able to provide specialist support to enable children to step-down from residential placements into more long-term mainstream provision models. Providers able to integrate their packages into other services will be preferred by commissioners.

Family engagement
England has a limited range of residential placement models, compared against other European nations where the part-time and shared-care arrangements have driven a diversity of provision types.

The majority of children who leave care will continue to have contact with their families, and nearly all will have a psychological need to make sense of that relationship. Ensuring support for contact and integration back into family life when children are in residential care is a key factor in supporting positive long-term outcomes for looked after children.

Provider models that emphasise parent engagement have been demonstrated to improve both within-care metrics and support long-term goals. The UK is behind the curve in this respect, and there is resultant opportunity for innovation.

Therapeutic intervention
Looked-after children are five times as likely to have a mental health disorder than their peers, and those in residential care have an even greater prevalence of psychological disorders, with two-thirds reported as having a conduct disorder and a fifth psychotic symptoms. These are children with significant and persisting care needs.

In the UK we have a relatively poorly qualified workforce to deliver the needed high quality care and support in residential care environments. As important as formal programmes and interventions are, the key to placement success rests on the qualities and commitment of the people delivering care and support within them. There have been repeated calls to raise the minimum levels of qualification, training and support for those working in residential care, inline with many continental European countries.

In the US, ‘residential treatment centres’ have been established to support children with emotional and behavioural problems with a therapeutic focus on improving both short and long-term outcomes.

The therapeutic residential placements offered in the UK are few in number and hugely expensive (c. £6,000 per week). Providers able to appropriately staff their services with the plurality of qualified, dedicated and professional individuals needed will continue to stand out from the crowd.

Psychological support
Local designated child and adolescent mental health services (CAMHS) support workers are effective in ensuring children in residential care receive the services they require within the wider service network. However, CAMHS services are
under significant pressure, and waiting lists are often long.

Addiction to legal highs has become endemic amongst the looked after children population, but services have not kept pace with evolving pharmacology and legislation. Previously, many looked after children would have developed a relationship with marijuana and ecstasy, but one senior social worker described to Candesic how "the situation with legal highs is spiralling out of control". Historically, children in care have not had the financial means to develop significant drug-dependencies, but the low cost of legal highs makes these accessible.

Unlike many other countries, England does not have specific residential treatment placements for children with substance misuse disorders. There were, in fact, only 1,264 inpatient beds for children with mental health problems in 2014.

Now is the time for providers to address this challenge and meet market demand for supporting looked after children who have become addicted to this pharmacopeia.

Conclusions
There has been a process of ‘deinstitutionalisation’, but have we now stripped the system of the type of provision that best serves the needs of children? There are circumstances in which residential care is not only required, but also preferred.

Reconfiguration of residential care provision can support the aims of commissioners and deliver the standard of care looked after children deserve and need to meet their long-term goals.

Providers able to deliver a comprehensive service that supports children through their education, psychosocial development and healthcare requirements will be the preferred choice for commissioners.

Dietrich Bonhoeffer wrote that "the test of the morality of society is what it does for its children". Providers and commissioners can work together to ensure we pass this fundamental test.

Dr Joe Taylor is education practice lead at Candesic, a boutique consultancy working across health, education and social care to support commissioners, investors and operators in building high quality assets.
jtaylor@candesic.com / 020 7096 7680 / www.candesic.com