Safeguarding children in the UK: a longitudinal study of services to children suffering or likely to suffer significant harm

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ABSTRACT

This paper presents findings from a prospective longitudinal study which set out to track the progress of 105 children and young people newly identified as having suffered, or being likely to suffer, significant harm through maltreatment or neglect. Baseline data were collected on these children in four English social services departments. Descriptive data on the services and child outcome data were analysed on all the children between 12 and 18 months later, and on 77 of the young people 8–9 years after concerns were first identified. Forty per cent of the children stayed at home with a parent throughout, while the majority of children experienced either some or considerable disruption to their lives. Fifty-seven per cent experienced further maltreatment or neglect. Some children appear to have made good progress in spite of repeated moves, disruption and re-abuse. The paper examines the pattern of services to children and parents. Factors are explored which appeared to either help or hinder the children’s capacity to deal with the stresses and adversities faced over the 8 years. Implications for policy and practice are explored which may be more likely to promote positive outcomes for these high-risk children.

INTRODUCTION

The England and Wales Children Act 1989 introduced the terms ‘significant harm’ and ‘likely significant harm’ as thresholds for compulsory intervention in the lives of children who had suffered from parental or carer maltreatment or severe neglect, or were assessed as likely to do so if effective protective services were not provided to children, parents and carers. The first part of the study was commissioned by the English Department of Health as one of a series of research studies to evaluate the impact of different aspects of the new legislation. The legislation, which was accompanied by detailed guidance and an updated version of the multi-agency protocols for child protection work (Working Together to Safeguard Children, Department of Health 1999), strengthened court powers to intervene in cases of proven maltreatment, but also gave additional powers and duties to work co-operatively with parents and young people to encourage partnership-based working and avoid the unnecessary use of coercive powers.

This ‘safeguarding’ study was commissioned to identify whether the ‘balancing’ required by the Act was being achieved in a way which minimized risk and met the needs of the most vulnerable children so as to avoid future impairment to their development. It was, therefore, important to identify a total cohort of children newly identified as suffering significant harm, or likely to do so, in defined but diverse geographical areas and to study in detail how the family support and protective provisions of the legislation were
impacting upon them. One hundred and five children were, thus, identified in parts of four local authorities in England. The report was published as *Safeguarding Children with the Children Act 1989* (Brandon *et al.* 1999) and was summarized along with the other research in *The Children Act Now: Messages from Research* (Department of Health 2001). The 8-year follow-up reported in this paper was funded by the National Society for the Prevention of Cruelty to Children (Brandon *et al.* 2005).

For many of the children and families, the complex circumstances which had brought them into the arena of significant harm (referred to here as time 1), had not been resolved within the year’s remit of the early phase of this study (time 2). In over half of the cases, there were still problems which indicated that the child needed further help and 40% of the children had already experienced further maltreatment or neglect. By time 2, while the well-being of two-thirds of the children had improved to some extent, for the remaining third, there had been no change or even deterioration. The impetus for extending the study was, therefore, to see how the life course and life opportunities of these young people were unfolding as they matured (time 3). An 8-year follow-up was chosen to allow as long an interval as possible for changes in the well-being of the younger children to be observed, while not making it too difficult to trace files and seek interviews for those who were already in their teens when significant harm was identified.

At time 2, our predictions on the likelihood or otherwise of lasting improvements were influenced by the significant body of research which has identified the numerous and enduring risks to healthy development linked with child maltreatment (e.g. Cicchetti 2004; Ethier *et al.* 2004). For children maltreated in their early years, these include a number of difficulties in adolescence, e.g. school failure, drug and alcohol problems and a variety of emotional and behavioural problems including serious psychopathology (Egeland 1988). Fratter *et al.* (1991) and Thoburn *et al.* (2000a) also reported that early maltreatment was independently associated with higher disruption rates even when children were placed with well-functioning adoptive or permanent foster families.

Other potentially damaging consequences of living with abuse and harm can include additional losses and moves between caregivers some of which are brought about by the helping and protection process itself. However, it needs to be borne in mind that a return home after a period in placement can also threaten longer-term stability (Sinclair 2005). Disruption and lack of continuity is a cause for concern in relation to child well-being. The poor outcomes associated with repeated placement moves have been well documented (Jackson 2002; Department for Education and Skills 2003). Developmental difficulties linked with disrupted care include problems with educational performance and physical health, and problems with relationships, especially the ability to retain long-term attachments, and achieve positive emotional, behavioural and mental health. Consequently, a reduction in the number of placement moves was introduced as a target for local authority performance by the Department of Health initiative ‘Quality Protects’ in 1998 and ‘Choice Protects’ in 2002.

Movement in care is not inevitably associated with poor outcomes however. Jackson & Martin (1998) from their study of ‘high achievers’ in care and Schofield (2002) from a detailed follow-up study of young adults who had spent some time in a foster family, found that some ‘successful’ young people had experienced many moves. In the USA, Courtney *et al.* (2005) have found similarly.

Cicchetti & Toth (1997) state that while there is a documented risk of poor developmental outcomes for maltreated children, some come through with developmental competence. They attribute this to individuals’ inherent self-righting tendencies in combination with other protective factors sited in both the individual and in the environment (Cicchetti & Toth 1997, p. 338). Rutter similarly argues that it is possible to achieve relatively good outcomes despite living with major developmental risks (Rutter 2000).

To discern what might make a difference, Sroufe *et al.*’s (2005) longitudinal study of 180 children born into poverty over three decades, identified factors which protected maltreated children from repeating cycles of abuse as parents. These were emotional support from an alternative, non-abusive adult during childhood and a satisfying relationship with a male as an adult.

The extent to which interventions contribute to good outcomes and a good recovery from abuse is, however, difficult to gauge. Systematic reviews have established a body of international knowledge about the effectiveness of interventions. However, many children and their families receive services that do not meet the stringent requirements of systematic review and hence are not ‘counted’ as effective. Also systematic reviews consider specified interventions or programmes whereas most families receive a multiplicity of services concurrently or sequentially rather than (or in addition to) ‘intensive treatment’. Schofield and
Beek comment, for example, that there is no more intensive treatment than the provision of a responsive family environment that offers therapeutic care 24 hours 1 day (Schofield & Beek 2006, p. 1).

Thomlison’s (2003) review paper examined the characteristics of nine separate interventions for maltreated children. The services ranged from home-based interventions (like Olds’ ‘nurse family partnership’, and Webster Stratton’s ‘Incredible Years’ parent training) to out-of-home foster care services (in particular multi-systemic family treatment). While there was evidence of effectiveness from all interventions reviewed, stronger effects were found by targeting parents and the parent–child interaction, in the home setting, during early childhood.

Such review studies appear to leave a gap in relation to effectiveness for the more complex cases and ‘late’ rather than ‘early’ intervention. Utting et al.’s (2007) review of interventions for children at risk of developing antisocial personality disorder, concluded that the most needy, most challenging families were least helped by the programmes which emerge from systematic reviews as the most effective. Where there is a background of serious abuse and neglect, the outcomes are often least positive (Utting et al. 2007, p. 85).

In this paper, we describe the routes taken by 77 children whose progress we were able to track over 8 years (time 3), in conjunction with the level of services they received. These data are placed in the context of our baseline and time 2 data on the 105 children in the full cohort. The interim outcomes associated with the various routes are then outlined in brief. The adversities, disruptions and losses faced by the children are considered and examples of how some children have coped are given. We consider the factors which appear to be associated with successful ways of coping with life’s challenges.

**Methodology**

To summarize, the four participating areas (two inner city areas with multi-ethnic communities and two largely urban areas of mainly rural counties with mainly white British populations) provided data on all referrals of possible significant harm cases (n = 151) over an 8-month period in 1993–1994. The researchers used a template to identify from data available, (including information from those families willing to be interviewed) the 105 children for whom there was a *prima facie* case that they had suffered or were likely to suffer significant harm.

In all but four cases, a formal child protection conference (CPC) was held, and in 79 cases the CPC decision was that the child’s name should be entered on the child protection register (CPR) as a child in need of formal child protection services. For the remaining 26 cases, there was clear evidence that they had or were likely to suffer significant harm and a protection plan was put in place, but, exercising the discretion provided for in the new legislation, the agencies concluded that the more coercive route of formal child protection registration or court action was unnecessary because the parents or carers were willing to work with the agencies to secure the child’s future protection. The major form of maltreatment in respect of 33 children was neglect (42% of CPR categories included neglect).

Using a file data collection instrument, baseline data were collected from the records on the 105 children. This included information about early history and about the nature and extent of any abuse or neglect already suffered. An intensive sample was identified of 51 children whose parent/s were willing to be involved in the study. The children, one or more members of their families and key professionals, were interviewed shortly after significant harm was identified and between 12 and 18 months later. At time 2, factual data were collected, including data on any changes of carer and the nature and extent of any maltreatment known to have occurred during this period. (We recognized that some incidents will have gone unreported and unrecorded and noted when the types of maltreatment and those responsible for it might be different from those initially causing concern.) Information (including via standardized scales) was collected from the child and other family members, professionals and from records to gauge well-being and to discern the extent, nature and satisfaction with the services provided for the 51 cases in the intensive sample. ‘Researcher ratings’ (cross-checked by two of the four members of the research team) were made at times 1 and 2 with respect to all 105 cases on the extent of need in the child and family, and the likelihood of future maltreatment or future impairment to health and development of the child (including impairment resulting from deficits in the services provided, and alternative care arrangements). Ratings were also made of improvements or deterioration in well-being between time 1 and time 2.

In this paper, these earlier data, as well as ‘time 3’ data, will be drawn on with respect to the 77 children whose records could be traced 8 years after ‘significant harm’ was identified. Information about the progress...
of these children and young people, aged between 8 and 23, was drawn from structured searches of 76 social services files and from semi-structured interviews. Interviews took place with 22 of the young people (Steele & Steele 2000), 13 parents (eight birth mothers, one adoptive mother and four birth fathers) and eight carers (two sets of grandparent carers, one aunty carer, two foster carers and one young person’s advocate). Standardized scales were administered to 20 of the young people (Strengths and Difficulties Questionnaire, Goodman 1997) and to 18 of the parents and carers (Rutter Malaise Inventory, Rutter et al. 1970). Table 1 shows that, with respect to age at time 1, the 77 followed up were broadly similar to the 105 cohort children.

The follow-up sample was also broadly similar in terms of ethnicity (60% white British in the time 3 sample and 56% in the time 1 cohort, but with the different minority ethnic groups being represented in similar proportions in the two samples). The largest among the minority ethnic groups comprised African-Caribbean children (14% at T1 and 15% at T2) and black children of mixed heritage (10% at T1 and 7% at T2). Rather, more of the 77 were initially placed on the CPR (77%) than was the case for the full cohort of 105 children (73%). The cases followed up were similar in respect of the categories of abuse for the 77 initially registered cases, although more of the ‘physical abuse’ cases were ‘lost to the sample’.

**FINDINGS**

We concentrate in this paper on the findings with respect to outcomes for the young people. In doing so, we describe the experiences of the children their parents and carers during the intervening 8 years and the services received. More detailed findings are available in the full report (Brandon et al. 2005).

We triangulated all the information to achieve a rating of the young people’s well-being and the overall success of the intervention, taken as a whole, and including the contributions of the young people and their parents and carers, at time 3. This was arrived at using a protocol based on whether the child was safer than when initially referred; future risk of significant harm/impairment of development; extent of the child’s or young person’s problems at time 3, and a ‘change over time’ measure of their overall well-being based on all the data available at time 3 compared with time 1. Researcher ratings (with inter-rater checking for reliability) were then used to allocate each case to one of four outcome groups: ‘successful outcome’, ‘moderately successful outcome’, ‘little change’, ‘slightly worse’ or ‘worse’ than the time when significant harm was first identified.

**Patterns of intervention**

When referring to interventions, we concentrate on interventions by local authority social services departments who are given the lead role in the protection of children. There was information on file to indicate that the task of protecting these children and supporting their families was in some cases carried out in multi-agency groups or through referrals to other agencies for protective services. The extent to which this happened was extremely variable. Almost two-thirds of the children received long-term social services intervention over a period of many years, defying the ‘quick fix’ philosophy of much service planning (see Brandon et al. 1999; Department for Education and Skills 2004 and Thoburn et al. 2000b for detailed accounts of the ‘processing’ of child and family cases referred to social services departments during this period).

A substantial number of these cases (29) were still ‘open’ with social work help being provided to the child 8 years after significant harm was first identified. Just over one-third of the children’s cases (26) had been closed relatively early; however, either within 1 year of the initial identification of significant harm, or shortly afterwards and according to our searches, they stayed closed. In eight of these ‘closed’ cases, the files revealed that further problems for the child or family...
resurfaced but they did not reach the threshold for social services intervention. It is unclear whether they received the help they needed from other sources (Table 2).

Overall, there was a surprising degree of continuity in the interventions from social services, with more sustained long-term work than sporadic bursts of short-term services. In spite of this, few children experienced continuity of social worker. As one young person said, bearing witness to the need for continuity placed into focus by a government report (Department for Education and Skills 2003):

Say they know that a person is going to be on a care order, they know this person is going to be with them for a long time, let's give them a social worker that we know will be there for them.

Family changes and placement patterns

The complexity of the interventions and the changes in the children's residence arrangements over the 8 years is summarized in Fig. 1. This illustrates some aspects of service provision and varying degrees of continuity or disrupted care. Further details are provided in Table 3.

Route 1: children who stayed at home (30)

Thirty children stayed at home with a parent or parents throughout. Most of these cases were closed relatively early (20), after the provision of family support services, although a third received long-term social services help and five children were still getting help at time 3. Further neglect or maltreatment was recorded for one-third (11) of the children and for seven of them, concerns about neglect or maltreatment persisted (these were the children and families who received long-term help). Although three quarters of these children had a good or moderately good outcome, a-quarter had not fared well. An example of a child staying at home included a baby who had received a serious physical injury (fractured limb) following an isolated outburst by her father. The case remained closed after a brief but successful family support intervention and continuing support from extended family.

Route 2: children who returned home and stayed home (14)

Fourteen children returned to live at home after a period of time away, in foster care or with relatives, and were still living at home when we last collected information. Five of these children's cases were 'closed early' and five more received long-term social services intervention, but their cases were closed at time 3. The remaining four children were still getting help from social services. Over half of the children who were restored home suffered one or more further episodes of neglect or abuse (8). For five of the children, the abuse or neglect persisted. There was evidence that these five were 'unprotected' children and all had a poor outcome. This included two children who were found to be experiencing maltreatment at all three time points despite being on the CPR for most of the 8 years. For half of these children (7), the outcome was moderately successful, while for half it was poor.

Table 2 Patterns of social services intervention

<table>
<thead>
<tr>
<th>Summary of 77 cases</th>
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<tbody>
<tr>
<td>Closed 'early' i.e. within 1 year of 'significant harm' or shortly thereafter</td>
<td>26 (34%)</td>
</tr>
<tr>
<td>Long-term case now closed</td>
<td>22 (28%)</td>
</tr>
<tr>
<td>Open case</td>
<td>29 (38%)</td>
</tr>
<tr>
<td>Total</td>
<td>77 (100%)</td>
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</table>

Figure 1 Placements and interventions for the 77 children 1993–2001 (adapted from Masson et al. 2004, p. 138).
Case example. Andrew, who had global developmental delay and learning difficulties, spent 6 months in foster care because of neglect and physical abuse, but returned home at the age of 2 and was not re-abused. Initially, his mother and stepfather refused to co-operate with social services, but the multi-agency team managed to establish good relationships and Andrew made steady progress at home with continuing, well-coordinated support from a number of agencies.

Route 3: children who left home and stayed away (20)

Twenty children left home without returning. All of these young people’s living circumstances had some formal oversight. Three of the children who left home without returning were adopted as babies and their cases were closed early. Ruth whose adoption broke down, was 8 years old at time 3 and in long-term foster care with severe mental-health problems. Seven teenagers received long-term help but their cases had been closed. Ten other young people’s cases are still open to social services, eight of whom have care orders in place or were previously subject to a care order. Another young adult was in a long-stay mental-health setting and the last young person was living in a residential unit for young people with a learning disability and high-risk behaviour.

Half of the children who left home and stayed away suffered one or more episodes of neglect or abuse during the 8-year follow-up period. For most, this was in the period before leaving home although one young woman was repeatedly abused during contact with her father. The 10 children who were not re-abused had already moved away from home within 1 year of the initial identification of significant harm.

Most had successful outcomes overall, but four did not fare well. Nine children in the study stand out as having the best overall outcomes and all but one took this route. Their circumstances are discussed in more detail later.

Route 4: children who returned home but left again and stayed away (10)

Ten children who returned home within 1 year, but then left again, have not subsequently gone home to live. Most of the children had multiple moves and disrupted care but three had settled with grandparents. All the children received long-term services and eight of them were still getting social services help 8 years on. The two closed cases include an 8 year old living with grandparents with a residence order in place (this family did not want help), and an adolescent whose whereabouts were unknown. All 10 children had experienced further episodes of abuse or neglect. In spite of the shuttling to and fro, seven of the 10 children appeared to have at least a moderately successful outcome.

Case example. Terry had numerous moves between home and foster care before settling with his current foster carers 2 years previously at the age of 14. He had experienced neglect and sexual abuse while at home. Terry was still having family contact but said that visits home often included witnessing bouts of domestic violence between his mother and stepfather.
There had been episodes of serious self-harm for Terry, but this was improving. At school, his Special Educational Needs statement had recently been removed and he was doing reasonably well and was about to take GCSE exams. He planned to join the army.

**Route 5: children already in care**

Three young people were already being looked after by the local authority when significant harm was first identified and they stayed away from home throughout. All stayed in care for many years, experiencing multiple moves and all received leaving care services once they were living independently. Two young women had babies while teenagers (one whose first baby was adopted kept her second child) and both were offered services to support their parenting. All three young people were in the ‘moderately good’ outcome group.

**The incidence of stability and disruption**

It has already been made clear that the children lived in a variety of circumstances: with parents, with relatives, living independently or permanently or temporarily looked after by the local authority or adopted. These configurations also changed over time as Fig. 1 demonstrates. In addition to the 30 children who stayed at home, just over a-quarter (27%) experienced a reasonable level of stability only moving between caregivers between one and three times, including some teenagers who left home or left care. Over 40% of the children however, like Terry, experienced considerable disruption and 10 of these children each had more than eight moves between carers.

Several young people we interviewed talked about the impact of being constantly uprooted, including the detrimental effect it had on their education.

I don’t have enough fingers and toes, there were that many, [moves]. I believe, and the school I went to believe, that if I had not been moved about as much as I did I would’ve sat down and concentrated and done really well. However, because I was swapped about . . . I wasn’t concentrated on anything else (Buddy aged 22, Route 5).

I started going into foster care, and I started running away, kept going to different foster carers. I went to The Limes. I was taking all drink, drugs, all from bad stuff, all from that first time they took me. I’ve also been in young people’s prison as well, secure units. I’ve been everywhere in Scotland, Devon, Birmingham, London, Essex, everywhere (Kerry aged 18, Route 3).

In contrast, and in common with many of those responding to a large-scale survey of looked-after children (Timms & Thoburn 2006), many other young people who left home, after the initial disruption, valued the stability and predictability they achieved with the same set of carers, over a number of years. Benito (aged 17 at time 3) had spent 7 years with the same foster carers and it seemed likely that he would remain part of that family as he moved into adult life.

I was just happy (coming into care) because I knew I just didn’t want to be in that situation any more, getting beaten now and then, I didn’t like it. Once I went I knew he [father] couldn’t do it again so I was glad about that (Route 3).

For another young woman, stability was achieved by spending 8 years at the same school, boarding during the week and going home at weekends. This was as a voluntary arrangement between her parents, the Education Department and the Social Services Department, with no order in place. The predictability and security of the school environment appeared to provide a refuge from acrimony and rejection at home:

The atmosphere at home is tense – I suppose that would be the word. I’ve had many confrontations between myself and my parents and of course as you grow up the atmosphere would’ve been very difficult. Being away from home has taken me out of that a lot, it’s allowed me to develop more as a person, my own individual character rather than what my parents want (Route 3).

This young person experienced good nurturing as well as stability at her boarding school, although her permanent family was still her home base with her parents. The school experience seems to have helped her to cope better and to withstand recurring parental rejection.

**Re-abuse related to continuity and stability**

In identifying the different service groups, we have already mentioned that some in all groups experienced further episodes of maltreatment. Further episodes of abuse or neglect were noted on the files of 57% of the children after actual or likely harm was first identified. For most of the 33 whose names were placed on the register following the original episode, there was an ‘on-off’ pattern of registration, but six were still registered as in need of a formal protection plan at time 3. The changing categories of abuse and registration with respect to these six provide a bleak reminder that registration in itself does not protect children or necessarily promote a better outcome.

In some of the six cases which ‘drifted’ on and off the register, the files revealed a preoccupation with decision-making (whether or not the child was listed...
on the register, and in what category) rather than helping. In one case, entrenched maternal problems (alcohol misuse and depression) were never tackled and the child’s well-being and safety remained poor throughout. In another case, the ‘on-off’ pattern of registration appeared to serve a useful purpose, being linked to bouts of serious maternal mental illness when the child was unsafe and needed additional services (including foster care at times). In this complex case, an array of multi-agency services, as well as the social worker and the school, provided consistent and long-term support to the family. The head teacher understood the reasons for the child’s very difficult behaviour at school which the parent valued: ‘they are really good and really supportive and had it been any other kid they said they would have been excluded’.

The following variables were statistically significantly associated with re-abuse.

- Children who suffered further episodes of abuse or neglect were significantly more likely to have experienced disrupted care.
- Children who continued to experience maltreatment were more likely to have conduct problems at home and school. Indeed overall, we found a higher rate of conduct problems (60%) than in Meltzer et al.’s study of the mental health of looked-after children, where 37% had clinically significant conduct disorders (Meltzer et al. 2003, p. XII).
- Children experiencing further episodes of maltreatment were more likely to have received intensive social services intervention throughout the period of the study than those not known to have been re-abused or neglected in the period since referral. This was in most cases the result of targeting resources on the children and families who needed them most, but in some cases a combination of poor decisions and poor practice was associated with poor outcomes. In an important minority of these cases, there was a pattern of difficulties in engaging one or both parents or stepparents, often in families with a pattern of domestic violence. On occasions, cases were (temporarily) closed, even though there were still concerns about the children’s welfare, because of the inability of workers to engage the parents in services which might have prevented further impairment of the children’s welfare.

**Overall ratings of outcomes for the young people**

A summary of the outcomes for the children (a rating which drew on the different aspects of well-being discussed above) is provided in Table 4. If we add the closed cases (in all of which at the time of closure there was evidence of a reasonably positive outcome, at least in terms of safety) to those where the children were rated as having moderate or good outcomes, it can be concluded that, despite episodes of further maltreatment for some, 56 of the 77 children (almost three quarters) had been protected from significant impairment to their health or development during the intervening period. These young people were rated as having a moderately good or good chance of overcoming the worst of the adversities that had drawn them to the attention of the child protection services by the time they reached adult life. However, for many of the children who returned or stayed home, and also no doubt some of those whose cases had been closed, some concerns remained. The data indicate that for around a-quarter the long-term outcome is likely to be poor. There are important implications for follow-up services, community support and the transition to adult services for these young people, most of whom seem to be carrying their vulnerability with them into young adulthood and potentially into the next generation.

**The most successful cases**

A group of nine young people (each of whom had, with their parents and carers, received a substantial amount of services) stood out as showing evidence of significant improvement and good well-being over a number of years. For these young people, the outcome at this stage looked promising. Each had been helped to cope with extreme adversity and with the serious problems which surrounded, or stemmed from the circumstances which brought them into the child protection arena. Six of these nine children were interviewed and the additional detail this provided helped

<table>
<thead>
<tr>
<th>Summary of outcomes for the children</th>
<th>9 (12%)</th>
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<tr>
<td>1. Now protected, child good well-being at T3</td>
<td>9 (12%)</td>
</tr>
<tr>
<td>2. Protected at T3 but still some concerns</td>
<td>20 (26%)</td>
</tr>
<tr>
<td>3. Closed cases (indication from file of group 1 or 2)</td>
<td>26 (34%)</td>
</tr>
<tr>
<td>4. Still concerns about well-being. No clear improvement since T1</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>5. Still serious concerns about child’s well-being/well-being deteriorated</td>
<td>19 (24%)</td>
</tr>
<tr>
<td>Total</td>
<td>77 (100%)</td>
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to illustrate how and why these young people appeared to show many signs of resilience.

When we examined the quantitative and qualitative data about these nine young people, we discovered that the positive attributes they seemed to show could be set against key domains used in outcome evaluation in child mental-health treatments. Fonagy et al. (2002) describe four outcome domains, which for these nine young people translated into:

- the absence of symptoms of mental ill health (all nine had good scores on the Strengths and Difficulties Questionnaires);
- a good adaptation to the psychosocial environment (all coped well at school or college and with peers);
- strong cognitive and emotional capacity, which helps the child’s adaptation and probably links to the absence or significant reduction of symptoms (all of the children and especially the older young people showed the capacity to reflect on their experiences and resolve difficulties, all had developed good relationships with carers); and
- transactional aspects of development, or the ability to cope with individual developmental changes alongside changes within their environment (all had adapted well to new circumstances, like changing school and leaving school).

A common factor for these nine young people was that all had experienced long periods of security and stability over the 8 years, developed good relationships either with family or with carers and also good social relationships with friends and at school. Three of these nine children were living on a permanent basis with relatives (two with a care order and one a residence order in place). One child lived with a parent. Four children were permanently placed, away from birth families (three were in foster care and one had been adopted as a baby). The ninth young person was at boarding school and waiting for ‘A’ level results before going to university, but with very fragile family relationships. All but one of the nine came from the group of children who left home and stayed away (Route 3).

This group of nine ‘successful’ children shared the crucial common characteristic of a very high level of commitment from family or carers. A grandparent described how she set clear boundaries for her granddaughter and was guided by strong religious principles. She said that her granddaughter, Latisha, is aware of these rules and codes. Latisha described herself as ‘sensitive, kind, loving, quite confident, ambitious’ and ‘a good friend’. She talked about her relationship with her grandmother saying:

At first it was hard because she wouldn’t let me out. Now I’m more honest. I used to lie a lot and didn’t trust anyone because of what happened to me. Now I trust my grandparents. I know my grandmother is there for me – like when my boyfriend dumped me and I felt bad and all used up – I love her a lot.

None of these ‘successful’ children were from the group of older adolescents at the time significant harm was identified. Three were babies at the start of the study and the others were in their middle years (aged between 5 and 11). In terms of ethnicity, three of the young people were black (two African Caribbean and one African) and the remaining six were white British.

**Moderately successful cases**

For a larger group of 20 children, the outcome was rated as ‘moderately good’. They had enough of the characteristics of the first group to give some confidence about their future but also had more areas of potential vulnerability. This group included five of the 19 who were adolescents at the beginning of the study. Twelve of these young people had had long-term or permanent placements (including one later adoption, and three young people who had left care and were currently living independently).

**Worst outcome cases**

At the other end of the scale were the 21 children whose outcome was poor or little different to the time when significant harm was first identified. These were the children where files, and where available, interviews and standardized scales, indicated considerable problems with behaviour and relationships. Indeed, these young people demonstrated difficulties across the four domains where the nine most successful children had shown positive attributes. Interestingly, however, only four of them had experienced multiple moves and seven of them had never lived away from home, showing that movement is not the only issue in determining the lack of security and stability associated with a poor outcome. At time 3, 13 of them were living at home or were living independently and eight were in placement.

There was a wide spread of ages for the 21 young people with the worst outcomes. Eight were aged 5–11 years at the time significant harm was first identified, five were aged 1–4, four were under 1 and four were adolescents. In this study, therefore, age at onset of abuse did not appear to be a factor in predicting outcome.
EXPLANATIONS/LIMITATIONS OF THE DATA

The study on which this paper is based is essentially a descriptive, longitudinal study of interventions in the lives of the children, their families and carers over an 8-year period. There were a number of factors about the data which need explanation. Firstly, it was easier to track information about children where social services had been involved for considerable lengths of time, than about children whose cases had been closed early. This means that we have more detailed long-term data about the high-threshold cases where children were looked after or subject to a care order, or where there were persistent levels of risk to the children’s healthy development. There is less information about closed cases where successful outcomes may have been located, and the data are ‘richer’ and more robust about the majority of children who received long-term services. Potentially, we have tracked the children who have been most damaged by their experiences of significant harm and other subsequent adversities. The loss to the sample of more of the youngest children placed early in stable substitute families (data were not available on five of the nine adopted children) or protected by the departure from the family home of a potential abuser, means that in the data on child outcomes the less successful cases from the 105 original cohort cases are likely to be over-represented among the 77 followed up.

A further limitation of the data was the quality of information available on some social services files. Some files, especially those on cases that had been closed early, contained little information, or, as with the children placed for adoption, good-quality data were available for only a short period of time. While a few files were in complete disarray, there were some excellent examples of clearly ordered files with relevant information, including a full account of the child’s own views over time. Using the experience within the research team of front-line child and family social work and management, alongside government guidelines on recording, the researchers rated the information in over one-third of the files as ‘good’, in almost half as ‘satisfactory’ and in the remaining 15% as seriously deficient. Because of this, and as some families received a short-term, low-intensity service, the extent of re-abuse is likely to be under-reported and under-recorded. Limitations of file recordings and the absence of interviews with practitioners at the latest stage of the study also made it difficult to report in depth on social work practice and models of intervention.

Even with the limitations identified below, outcome data are more robust than in many studies and for a proportion of the cases are extensive. Given the fact that a large proportion of the children received a long-term, or episodic service, and that detailed records have in some cases been supplemented by an in-depth, triangulated, interview process, descriptive data on services are more robust than is often the case. What our research can not do, given the many variables about the children, their differing experiences of maltreatment, and the complexity of the services provided over time, is to draw causative inferences between outcomes for the children and particular aspects of the service they received. We believe that the richness of our data does, however, allow us to explore possible explanations in the section which follows as to why some had more positive outcomes and others did less well.

Discussion: evaluating the safeguarding service to the 77 children

We have noted above (Table 4) that the outcome was positive or moderately positive with respect of 72% of the children and poor for 28%. All of the children in our study lived with the consequences of neglect or abuse, or, if removed early, of being born to parents who were incapable of meeting their needs and having to understand why they were not living with their birth families. Many also suffered parallel adversities and disruptions of family life, like loss, separations and repeated moves.

Rutter (2000), however, notes that stress and adversity are not passive experiences but an active process by which people deal, to a better or worse extent, with their environments. In these circumstances, it is helpful to have a repertoire of coping strategies for life’s challenges and we have demonstrated how this appeared to work for the nine young people with the most successful outcomes. For these and other young people, it may be that their own qualities and personalities had as much to do with positive outcomes as did any help they had (or had not) received. However, we noted that coping strategies could be nurtured by carers or relatives who provided responsive care and ‘a secure base’ for the child. These carers needed good support in return, since as we have seen, the children’s behaviour was often oppositional and difficult, as would be expected with maltreated children. Not all of the children living with extended family had carers who were well supported. In keeping with Hunt’s study (in Sinclair 2005), family carers we interviewed...
complained about a lack of financial support from local authorities.

Looking at changes over time, there was evidence that the well-being and life chances of 24 children (31%) had improved at least to some extent, and that the well-being of 19 (25%) had deteriorated. For 34 (44%), the evidence indicated that there had been little change to the children’s well-being 7–8 years after significant harm was identified. In some of these cases, there were not, at time 1, concerns about the child’s health or development as action had been taken before the child had suffered harm (these were mostly babies). In other cases, preventing deterioration could, in the light of the difficulties the child was already experiencing, be regarded as an achievement.

A key but extremely complex ‘effectiveness’ question, is whether outcomes (in terms of well-being or any changes over time) can be linked to protective intervention, and even more so with any particular aspects of intervention. When describing the three ‘outcome groups’, we have made reference to the patterns of services provided, particularly with respect to placement patterns. Although they are interlinked, it is possible to look separately at the different aspects of the social casework or therapy services to parents, carers and young people and at the decision-making aspects of practice. Is this child in need of protective services? Is compulsory intervention necessary? Should the child be cared for by relatives or outside the family? Should he or she be placed permanently with adopters or permanent foster carers or, as with one of our ‘successful cases’ in boarding education with aspects of a shared care arrangement? These are just some of the decisions on which the parents, carers and young people interviewed at time 2 and time 3 expressed their views. In the full report (Brandon et al. 2005), we provide descriptive data on the components of the social work and other services provided, insofar as it was possible to gain this information from the records or from the young people and carers interviewed. Here we consider the service as a whole.

We have already noted that contrary to the pattern of service provided to the majority of children referred to English local authorities (e.g. as reported by Thoburn et al. 2000b and Gibbons et al. 1995), the majority of these cases in which harm or likely harm was substantiated received a long-term service, though the intensity of service for both long- and short-term cases varied. Some children in each of the three ‘outcome groups’ received long-term and intensive services. The records and our interviews evidenced skill, creativity and commitment in many of those who provided these services, although only a minority of the young people were able to develop a trusting relationship with the same social worker over a period of years. Those who did greatly appreciated it.

Six of the nine children in the ‘good outcomes’ group (including the baby who was adopted) moved to their current carers, where they have all remained, within 3 years of the initial identification of significant harm. All of these six children received an intensive social work service, which with the exception of the adopted child lasted without interruption, over many years. The other three children had short-term or episodic social services over the years. Five of the nine children’s cases were still open at time 3.

Each of the group of 20 young people in the ‘moderately good outcomes’ group had received a substantial amount of social services help. They were either still in receipt of such services or had experienced either high-intensity, or long-term low-level services. The pattern of service for the worst outcome group was similar, with some cases open throughout the period. However, more of them received an ‘episodic’ service.

In terms of placement patterns, there were good outcomes for many of those who were permanently removed from the care of birth family members, as well as for some of those who remained at home. In the five routes identified, outcomes tended to be less positive for children who were restored home. This was in keeping with other UK foster care studies where it was found that returning home could work against stability in the longer term (Sinclair 2005). On the other hand, as other studies have found, a period back with their parents may have helped some of the children to see the necessity of ‘cutting their losses’ and helped them to settle with grandparents or alternative carers (Thoburn 2003). Seven of these 10 had good or moderate outcomes compared with only half of those who went home and stayed home. Within this sample, the role of extended kin, both in providing temporary refuge as well as long-term care, seems to have been particularly positive but some needed to know first that the possibilities of the children’s parents providing safe care had been exhausted.

CONCLUSIONS
In conclusion, this longitudinal study has demonstrated that, with the possible exception of the early
placement of infants with respect of whom there is clear evidence that the parents are incapable of meeting their needs, there are no ‘quick fixes’ when children are abused or seriously neglected. Even where cases are closed early to social services, children may struggle to achieve reasonable standards of overall development.

We have identified, with the aid of hindsight, a group of children who would have gained from having been removed earlier and placed with substitute parents. In most of these cases, in the light of their existing relationships an element of continuing birth family contact would have been necessary though not easy to manage. In other cases, especially those involving highly conflicntal relationships between adults, children whose behaviour was already difficult to manage, and ambivalence about accepting help, the level of skill needed by those intervening (and the continuity of service and worker needed) was inadequate to the demands of the case. That some of those in long-term care, including some in ‘shared long term care’ arrangements, did well, is an important reminder that the negative impact of care should not be overstated. We cannot, from our data, attribute the success in some cases and the negative outcomes in others to competent or incompetent practice. But we can say that these are fine judgements requiring highly skilled professionals to work together with each other, and with parents, carers and children, to achieve the positive changes that we saw for some of the children who remained at home and others who entered long-term care.

The role of the social worker in these complex cases is to try to ensure that effective decision-making takes place but not solely as a case manger at the expense of a relationship-based, helping service that seeks to promote close relationships between children and their parents and carers. Social workers need to persevere in their relationships with difficult and even hostile children and families. To do so they need backing, and supervision from their own agency as well as shared responsibility with the multi-agency team. In this way, social workers are more likely to provide a consistent, responsive and sensitive service and to know when preventative work or attempts at rehabilitation is not going to secure the child’s well-being or safety.

REFERENCES


Safeguarding children in the UK M Brandon and J Thoburn