

“To deliver the best for
looked after children,
the state must be a
confident parent . . .”

IN LOCO PARENTIS

Executive Summary

Celia Hannon

Claudia Wood

Louise Bazalgette

Executive summary

In media debate and policy discussions the care system is frequently described as failing. This negative view of care in England and Wales is closely related to how it is evaluated and the way that data on young people's outcomes is misinterpreted – both of which tell a misleading story about its impact. In reality, there is a dissonance between the evidence on the impact of care, and the public perception of the system. Currently, this stigmatisation of the care system, combined with concern about the upfront costs to the state, means that some children who might benefit from the care system do not do so.

Children enter care for a variety of reasons and go on to have very different journeys while they are there. If the care system is to be successful, it needs to be flexible and responsive enough to address the needs of individual children, their carers and their birth families. When the care system is used effectively in this way it can be a powerful tool for improving the lives of vulnerable children and young people.

A strong body of evidence and our own primary research shows the most positive experiences of care, and the best outcomes for looked-after children, to be associated with the following three factors:

- early intervention and minimum delay
- stability during care
- supported transitions to independence

In this report we will consider what the care system would look like if it were reconfigured to avoid the delay, instability and abrupt transitions that many young people still experience. We go on to show that this type of system could also be less costly to the state in both the short term and over the long term.

Section 1 The purpose and the impact of care

Broadly speaking, there has been a ‘pendulum’ movement in the history of the care system between two approaches. The first approach sees the purpose of care as supporting families and enabling children to remain with or return to their birth parents (a ‘preventative’ approach). According to the second approach, the purpose of care should be to safeguard children and provide them with permanency beyond the birth family (a ‘permanency’ approach). Both of these philosophies are rooted in the idea that children’s exposure to public care should be minimised.

In practice there will always be a group of children for whom prevention from entering care or permanent solutions such as adoption are not realistic outcomes. Instead of oscillating between these positions of ‘prevention’ and ‘permanency’ we should aim to use public care far more proactively to:

- provide support to families as soon as they need it rather than waiting until they reach crisis point
- achieve early permanency for those children who cannot return to their families
- provide stability for those children and young people for whom a permanent solution is not desirable or feasible

The care population

Children enter care for a variety of reasons and have very different needs and characteristics when they arrive. If we are to understand the many purposes served by the care system, we must be aware of the heterogeneous nature of the care population:

- Over the past 30 years, the numbers of children in care in absolute terms has gradually fallen. Between 1994 and 2004 there was a slight rise in the number of children in care; this was due to fewer children entering care but those that did tending to stay for longer.
- A number of factors indicate there is a high concentration of disadvantage in today’s care population.

- The care careers and placements of children vary considerably according to the age of the child and their age at entry, their reasons for entry, and their behaviour and needs.
- Many children entering care are over the age of 10, and many will only have a short stay in care. Consequently, a child's pre-care experience is one of the most important influences on their care journey. Evidence suggests that many of the children and young people who eventually become looked after already have a high level of mental and physical health problems at their point of entry to care.

The complex makeup of the care population reaffirms the range of purposes the system serves and the limitations inherent in pursuing a 'one size fits all' approach.

Does care 'fail'?

Society's view of whether care is, at the most simplistic level, 'good' or 'bad' exerts considerable influence over the use of care in practice. The mistaken belief that care consigns all looked-after children to a lifetime of underachievement and poor outcomes creates a culture of uncertainty, increasing delay and leading to instability later on. To challenge these misconceptions we need to recognise the following:

- The way that we measure and present looked-after children's 'outcomes' is flawed.
- There is now a substantial body of academic evidence that provides a longer-term and more nuanced perspective on looked-after children's lives, taking into account the nature of their pre-care experiences and comparing them with more appropriate control groups.
- This evidence shows that care can be a positive intervention for many groups of children.

However, care clearly serves some groups of children better than others. Rather than focusing on 'preventing' entry into care in cases where that might not be in the best interests of

the child, we should differentiate between types of care journey and identify the factors that do impact on children's wellbeing.

Section 2 What works for children in care?

Child development literature tells us that if children are to develop in a psychologically healthy way and develop the important character traits and skills they need to succeed in life (such as application, self-regulation, empathy and resilience), they need to experience:

- a secure attachment
- 'authoritative' parenting that provides a combination of 'responsiveness' and 'demandingness' (or warmth and consistent boundaries)
- stability

A care system that promotes stability, resilience and healthy psychological development for looked-after children, should be based around an early or decisive entry to care (where appropriate), stable and high-quality placements that provide good parenting and are responsive to the child's needs, and a supported transition to independent adulthood.

Early or decisive entry to care

Academic evidence shows that there is a strong association between children's age of entry to care, the likelihood that they will experience emotional and behavioural difficulties and their chance of achieving stability in care. Some groups of children whose entry to care is delayed by indecision or drift are at risk of experiencing:

- a longer exposure to pre-care adversity
- higher emotional and behavioural problems
- placement disruption and instability

These findings emphasise the need to avoid delay in intervening and to initiate permanency plans for children as early as possible if it is unlikely they will be able to return to their family, although it should be noted that entry to care at a younger age is clearly not appropriate in many circumstances.

High quality and stable placements

Stability can promote resilience for looked-after children in two respects: by providing the young person with a secure attachment (which can also reduce the likelihood of placement breakdown), and by providing continuity in other areas of the child's life, such as their school and their friendship group.

Placement stability and attachment

Attachment and placement stability are strongly linked. Evidence suggests that adoption provides children who are to be looked after in the long-term with the best opportunities to develop attachment. However, adoption is only suitable for a small proportion of looked-after children and most are placed with foster carers (73 per cent in 2009). Factors that contribute to children developing secure attachments with their carers and feeling stable and secure in their placements are:

- 'sensitive parenting'
- a combination of warmth and consistent boundaries being set

If residential care is to promote resilience and stability for children, it must promote opportunities for children to develop secure attachments. Influential research suggests that high ratios of staff to children and high turnovers of staff and young people are counterproductive. Other important relationships that can contribute to children's sense of stability and continuity include their relationships with social workers and with their birth families.

Stability and educational attainment

Being able to stay at the same school and avoid disruption to their education has a strong association with educational attainment for looked-after children. Care leavers who go on to higher education are more likely to have had stable care experiences, continuity in their schooling, to have been encouraged by their birth parents, and to have been assisted by their foster carers in their schooling.

Stability and mental health

Emotional and behavioural problems have a strong association with placement breakdown. Placements may disrupt if children's carers feel unable to cope with their challenging behaviour. Placement instability can then exacerbate children and young people's mental health problems, increasing their vulnerability to further placement breakdown. Children need to receive high quality emotional and professional support and stable placements from the start of their care journeys to address these problems and build their resilience.

Supporting stable placements

To reduce the risk of placement breakdown it is essential that adequate support is provided to looked-after children and their carers. Some adoptive parents may require a level of support that is comparable to foster carers. Forms of support valued by foster carers in our primary research included specialist training, social work support, and access to short breaks from caring.

Placement stability and quality

Stability is of vital importance but should not always be prioritised as an end in itself; in some cases a young person will feel that the benefits of moving to a more suitable placement outweigh the negative impact of instability and change. Children's wellbeing should be a higher priority than stability.

Listening to looked-after children

Ensuring that looked-after children's views are listened to and that they are able to influence care planning will make it more likely that children's placements meet their emotional needs and is also likely to reduce placement disruption.

Smooth exit and supported transitions

There are four factors that can significantly improve a young person's experience of leaving care and give young people a chance of better adult outcomes: the age at which young people leave care; the speed of their transition; their access to preparation before leaving care and support after leaving care; and maintaining stability and secure attachments after leaving care.

The age at which a young person leaves care

Looked-after children who leave care early, for example at 16, tend to do less well than those who leave care later. Evidence suggests they have a higher instance of substance abuse, homelessness, unemployment and poor educational outcomes. Young people doing well with their careers tended to have left care later.

The speed of transition

If we are to promote resilience in looked-after children and young people, there needs to be more recognition of the nature and *timing* of young people's transitions from care, including the psychological space needed to cope with the significant changes taking place in their lives.

Preparation before and support after leaving care

A number of studies have associated positive outcomes for care leavers with:

- receiving adequate planning and preparation before leaving care, so they had developed strong life and social skills
- being engaged in education, employment or training

- having a positive sense of their own wellbeing
- having a network of informal support, including family and friends
- having access to ‘good’ housing on leaving care: those who failed to secure good housing arrangements early on tended to fare worse over the follow-up period
- having good-quality support in accommodation after leaving care

To support positive outcomes for care leavers and build their resilience, the care system must provide emotional preparation before they leave care and continued emotional support throughout young people’s transition to independence. The stress and depression reported by many care leavers may be linked to the rapid series of changes and the withdrawal of support that many experience at this time. Stable housing in particular has been identified as a critical element for a successful transition from care. Supported accommodation could provide care leavers with an important ‘middle way’ between care and complete independence.

Research suggests that some care leavers suffer from a ‘cluster’ of negative outcomes that are mutually reinforcing, for example substance misuse, emotional and behavioural difficulties and offending. Those with such difficulties will often face further problems in areas such as housing, career, occupation and general wellbeing. This suggests that support for care leavers once they have left care needs to be carried out holistically. Care leavers have identified holistic services, multi-agency leaving care teams and third sector ‘one-stop shops’ as a helpful and accessible type of support.

Stability and attachments

Stability and the maintenance of attachments with adults are vital factors in a positive care experience. Leaving care can represent an abrupt ending of a stable placement and break in attachments, which can impact negatively on care leavers’ resilience, self-esteem and sense of security. Maintaining links with care leaving teams, foster carers and family members can

provide care leavers with an important source of ongoing support.

Section 3 Areas in need of reform

As we outline in section 1, there is no 'typical' care journey; looked-after children's experiences before and during care are diverse and not *all* children will have experience of the issues outlined below. However, evidence from academic sources and our primary research shows that some poor care experiences are all too common and need to be addressed.

Delay in entering care

Pre-care experiences

Evidence suggests that provision of early family support remains patchy and dependent on the culture of individual local authorities, which have very different interpretations regarding the 'right' amount of support a family should receive before their child is placed in care, and indeed the 'right' moment at which a child should be taken into care. This means that in some cases children go into care because they have too little family support, when this might have been easily avoided, while in others *too much* emphasis on keeping the family together can lead to a delay of the inevitable.

The point of entering care - delays in the process

Taking a child into care is a complex administrative and legal process, which means delay can occur at a number of stages. Resource pressures exacerbate this problem. For those children coming from situations of abuse or neglect, such delays may result in an increased risk of mental health or emotional and behavioural problems. Children entering care at an older age are also less likely to be adopted or to secure a stable placement.

The role of our philosophical approach to care

The British cultural attitude to children and the family sees children as 'private goods' – the responsibility of the family and

the individual unit – while in some other European countries, children are seen as ‘social goods’ – part of society and its wider responsibility. This means taking children from the family normally only occurs when all other options have been deemed to fail. This philosophy of so-called ‘last resortism’ can create administrative delay in care proceedings as social work teams must prove beyond all reasonable doubt that a child had to be removed from their birth family. In some cases this may lead to children being taken into care too late, when significant problems have developed, and when their chances of a stable placement are greatly reduced.

Instability in the care journey

Multiple placements

In 2009 10.7 per cent of children had three or more placement moves in a year, while 67 per cent were in a long-term placement (defined as more than 2.5 years). There was significant local variation, with nine local authorities having 15–19 per cent of their children experiencing three or more placements in a year. In our interviews with children in care and care leavers, many young people reported having experienced up to ten placement moves, short term, emergency placements, and sudden unexpected moves. The frequency with which social workers changed was also felt to be destabilising. One study found that 43 per cent of placement moves were initiated and planned by the local authority, and were often resource or practice-led, as a result of a shortage of suitable placements or lack of planning.

Failed attempts at family reunification

Evidence suggests that a large proportion of children in care experience at least one failed return to their family, and a recent study found that 16 per cent of the children in their sample experienced two failed family reunifications. These reunifications may fail because they lack assessment and post-reunification support. Children who return to care following a failed reunification will rarely if ever be able to return to their former foster family, which creates further instability.

A lack of placement support

Many placements end in an unplanned way; this breakdown may result from lack of support, particularly mental health support. The support given by child and adolescent mental health services (CAMHS) to children in care – foster and residential care – and to adopted children is patchy, with many local authorities having no teams in place dedicated to helping children in care or those who had been adopted. This lack of coherent mental health support is particularly concerning when we consider that several studies have established poor mental health as both a cause and a result of children having unstable care journeys.

A lack of choice

The national shortage of foster carers and foster care placements means that some children do not have an adequate choice of placement. This can increase the risk of instability because placements that are not properly matched are more likely to break down, or because social workers may need to place children in short-term placements before an appropriate long-term placement can be identified.

Instability in residential care

The high instance of mental health problems in residential care may be due to the fact that in the UK residential care tends to be viewed as an ‘end of the line’ option for children and young people whose previous placements have failed. This can mean that the poor outcomes associated with residential care become a self-fulfilling prophecy as only most troubled children are ultimately placed there. However, it may be that for children for whom foster care is not suitable, residential care placements could be a valuable source of stability and opportunity to develop peer relationships. To improve the quality of residential care we need to address staff retention and shift patterns to provide young people with greater stability and continuity. Currently, the lack of availability of care homes also reduces choice, increasing the chances of a mismatch between the child’s needs and the home selected, which may lead to placement breakdown or a series of temporary placements.

An abrupt exit from care

The transition from care to independence is a critical period for young people, and needs to be handled carefully to prevent a traumatic break from the stability and attachments formed during care. The following areas are in need of reform:

An abrupt and compressed transition from care

Every year, around 6,000 looked-after children leave care for good; 21 per cent are 16, 17 per cent are 17 and 61 per cent are 18. This ought to be compared with the average age when young people leave home in the general population: 24. This means a significant proportion of young people are still leaving care prematurely to live alone in private accommodation, ill prepared for the realities of adult life. In addition to the departure from care being premature for many young people, the process itself is compressed. The speed with which a young care leaver finds themselves 'independent' has been reported to be traumatic for many, as they are ill prepared practically and emotionally for what this transition entails.

A lack of transition support

The 'cliff edge' style of transition from care is all the more concerning because care leavers are not given adequate practical, emotional and financial care and support once they leave care. A number of surveys carried out with care leavers found that many are in unstable and poor quality housing.

The importance of mental health support

There is a growing concern that care leavers living on their own display a range of emotional and psychological problems. Research suggests that local authorities tend to overlook the need for emotional and psychological preparation for those on the verge of leaving care and living independently, focusing instead on practical issues.

Section 4 The cost of care journeys and later life outcomes

The failure to provide looked-after children with a stable, high quality experience of care will not only result in a less positive care journey for them, but can also lead to escalating costs to children's services. To illustrate this problem we have modelled and costed two exemplar care journeys, which typify the best and the worst of the current system. They do not attempt to prove that certain care journeys *cause* certain outcomes, so it is important to note that we have not attempted to prove causality at any stage. These exemplar journeys are therefore only designed to illustrate the costs associated with two experiences at each end of the spectrum.

One journey is designed to reflect the experience of the very top range of 5–10 per cent of children in care who are fortunate enough to have long-term, stable placements and supported transitions; the other reflects the 5–10 per cent of children who have a journey characterised by instability, disruption and abrupt exits. We drew on DCSF data from the Department for Children, Schools and Families (DCSF; now the Department for Education) about looked-after children to build these journeys, and used a number of small scale academic studies to identify the associations (but not causality) between the factors of late entry, poor mental health, instability and late exit.

In comparing the costs to children's services for two exemplar care journeys ('child A' and 'child B') we found the following:

- The variation in costs is significant: the stable care journey cost £352,053 over a 14-year period, while the unstable care journey cost £393,579 over a 7-year period (a difference of £41,526).
- This translates to a much larger difference in annual costs per year (£23,470.20 for child A and £56,225.57 for child B) once their length of stay in care is taken into account (15 versus 7 years).
- There is a cost of £32,755.37 more per year for child B's care journey than for child A's

Some of this variation can be attributed to the additional social worker time needed to make a larger number of placement

moves, but more importantly, we identify a cyclical escalation of poor care experience and costs: a child with a delayed entry into care is less likely to maintain a stable placement, which is associated with poorer mental health and potentially behavioural problems, which in turn may undermine placement stability. This cycle leads to a need for increasingly costly support. Of course, it is also important to note that children will enter care for a range of different reasons and have widely differing personal characteristics – child A's journey would not be applicable in many instances.

We also went on to consider the adult outcomes that might be associated with each scenario (again causality was not proven) to estimate their possible costs to the state up to age 30:

- Child A leaves care at 18, following a stable placement, with good qualifications.
- Child B leaves care at 16½, has no qualifications, and has mental health problems.

Rather than starting their adult costs at different points, the analysis begins at age 16. This is because although both children are still technically in care at this point, their costs to the state (as distinct from the costs of their care to children's services) begin at 16, as this is the end of their compulsory schooling. Assumptions about adult outcomes for child A and child B:

- We assume child A lives outside London, where she stays at school to 18, then attends a university to age 21, living away from home. On graduating, she finds a job and is employed at an average starting salary.
- We assume child B also lives outside London. She leaves school at 16 with no qualifications, and moves out of her care placement at 16½. We know from her care journey (above) that she is likely to have mental health problems. Based on a range of national data, we are able to estimate the risks of child B being unemployed during her life, and a range of costs associated with this.

By collating the costs of these very different adult outcomes, we have calculated the estimated costs to the state of each young person from age 16 to age 30.

- ‘Child A’, may cost the state £20,119.10 by age 30 if she goes on to university and secures a graduate job.
- ‘Child B’ may cost the state £111,923.99 if she experiences unemployment, underemployment and mental health problems.
- Between age 16 and age 30 there is a difference between Child A’s and Child B’s costs to the state of £91,804.89.

The difference here can be attributed in large part to the very different mental health and educational attainment outcomes associated with the two care journeys. The main costs of child A are associated with a young person attending university after care, which only happens in the minority of cases.

In reality, most children in care will experience something between these two extreme examples of care journeys. However, in demonstrating the significant range of care journeys and types of outcomes that the current care system is capable of producing, we hope to show not only that there is considerable room for improvement, but more importantly that this improvement is eminently attainable.

With this in mind, we should consider the range of adult outcomes than can be achieved by today’s care system, from those children who have a positive, nurturing care experience and go on to university and a successful life, through to those who end up more or less dependent on the state and health services. In total the difference could be £133,330.89 per child to age 30 if we take both the costs of the care journey and outcomes into account. As there are currently nearly 61,000 children in care, the contrast between the two creates a powerful argument for investing in good care experiences to avoid greater costs now and in the future.

At whatever age a child enters care, greater stability and improved mental health can reduce *immediate* costs to the local authority by reducing social workers’ time, use of expensive agency and residential placements, and therapeutic support. These are not distant cost savings beyond the budgetary cycle, but in this case amount to an average of £32,755.37 saved per child each year while that child is in care. This difference in cost between a stable and unstable care journey should be borne in mind in section 5, where we present our recommendations.

Section 5 What next for care?

While recent reforms have done much to improve the framework and legislation surrounding the care system they have not gone far enough in tackling the parenting deficit in the lives of many looked-after children.

What must care achieve?

Although children come into care for different reasons, at different ages, and for different periods of time, there is no reason why all children, when living away from their families, should not benefit from warm relationships and a sense of stability. It is for this reason that we differentiate between *permanence* (which would imply a permanent care solution or adoption) and *stability*. While the latter may be delivered effectively through the former, we should also bear in mind that when a permanent care solution is not viable, stability can and should still be sought.

Drawing on best practice and case studies, the following recommendations, therefore, all seek to create permanency (where appropriate), stability of good quality placements and continuity of support. These can be achieved in very different ways at each phase of a care journey – from entry, during and at exit. Given the current fiscal climate, we have not included a number of recommendations that would have been more costly, and we have instead focused on changes that we believe would provide a high impact for the costs involved. In some cases recommendations are close to cost-neutral. Given the escalating spending associated with poor care journeys we believe that the relatively modest investment we propose in particular areas makes economic sense, and will help to make the care system more sustainable in the future.

Systemic reform

The poor usage of public care can be linked, in part, to society's belief that the care system is destined only ever to be a poor second to the quality of care provided by any birth family. This points towards a self-fulfilling prophecy: a lack of confidence in

the care system to generate positive outcomes leads to its poor use, and its poor use is associated with poor outcomes. Poor outcomes reinforce the underlying lack of confidence in the system. However, in spite of popular misconceptions, the care system as it currently stands can and does create stable, nurturing environments. To promote positive outcomes more consistently for young people Demos believes that the following shift in our approach to care is necessary:

1 A more pro-active, positive use of care

Demos urges the government to adopt a more confident stance on the capacity of the care system to achieve positive outcomes. We should create a new virtuous circle – one where care is used earlier and more effectively and in turn becomes more effective.

2 Care as family support and early intervention projects

Corporate parenting and birth parenting should not always be seen as mutually exclusive. The state should be recognised as capable of acting as a ‘parallel parent’ for children and families who need such ongoing support. The government must embark on a concerted effort to destigmatise care as a form of family support. We set out in our specific recommendations below how parallel parenting could work in practice for some families with packages of ‘support care’.

3 Improved data on children in care

We currently compare children from backgrounds of deprivation, neglect and abuse with children from stable family backgrounds, and attribute the difference in outcomes to the care system (in which children may only have stayed for a matter of months.) By failing to take into account or controlling for background characteristics, we generate a fundamentally flawed picture of the care system. Demos recommends that outcomes data relating to children in care must adopt a ‘value added’ approach that is able to take children’s backgrounds into account. Rather than publishing annual data ‘snapshots’, the Department for Education (DfE) should publish analysis of

longitudinal data that links looked-after children's pre-care and in-care experiences to their later life outcomes.

4 A better understanding of placement and care journey costs

Value-added and longitudinal measures of children's outcomes may help change perceptions of the care system, but will not drive real reform unless spending decisions at local level change. To achieve this, local authorities need a better understanding of the outcomes of different types of care placement, *and* of the costs associated with these placements. We suggest local authorities look to the cost calculator for children's services (CCFCS)¹ developed at Loughborough University to break down their costs more accurately.

However, annual budgeting may make it difficult to take into account longer term outcomes or attribute cost savings to them, and may also make it difficult for authorities to understand how placement delays generate costs over time. There are reports that some children's services departments have already shifted to multi-year spending plans (in line with the comprehensive spending review) allowing annual budgets to be carried over from year to year. Multi-year spending plans are an important step in the right direction, and where appropriate other Local Authorities should use these to manage annual budgets more flexibly for looked-after children. Some children's services departments have already shifted their annual budgets to multi-year cycles, in line with multi-year children and young people's plans and the comprehensive spending review, which is an important step in the right direction.

Demos is also making a number of targeted recommendations, set out below.

Recommendations for early intervention and less delay

- 1 Demos recommends there should be a government audit of local authority policies on managing their care populations and research into associated child outcomes.
- 2 Demos recommends the 'tapering' of the care system for families in need of occasional support, for example by local authorities

making ‘support care’ arrangements matching foster carers and families more widely available.

- 3 Demos recommends there should be a statutory duty on local authorities to offer family group conferencing.
- 4 Demos calls for the government to provide seed funding for concurrent planning in local authorities wishing to pilot the service.
- 5 Demos calls for a renewed government focus on adoption timeliness and a DfE review of the 12-month target.
- 6 Demos recommends that all local authorities consider establishing permanency planning tracking panels.

Recommendations for stability

- 7 Demos recommends that the DfE makes mental health assessments of children entering care mandatory, using a standardised multi-disciplinary measure.
- 8 Demos calls for the Children’s Workforce Development Council (CWDC) to include mental health training in training standards for foster and residential care workers.
- 9 Demos recommends that primary care trusts commission on-site CAMHS support for children in residential care and residential staff.
- 10 Demos recommends that local authorities make short breaks and placement support workers available to foster carers on request.
- 11 Demos proposes introducing social pedagogy training in CWDC standards in order to spread existing good practice in residential care work.
- 12 Demos calls on the DfE to amend care planning guidance to ensure there are fewer failed reunifications, and to introduce better resourced and time limited reunification plans.

Recommendations for supported transition to independence

- 13 Demos recommends that looked-after children teams and 16 plus teams shadow one another before and after transition.
- 14 Demos calls for local authorities to use personal advisers at an earlier age and for CWDC to outline specific training requirements.

- 15 Demos urges the government to raise the care leaving age to 18 and asks the DfE to support flexible approaches to allow young people to stay on in placements to 21.
- 16 Demos recommends that DfE amends transition support guidance to prioritise emotional and mental health support.
- 17 Demos recommends that DfE guidance explicitly applies the resilience model to transition planning, and independent reviewing officers are trained accordingly.
- 18 Demos calls for the wider availability of supported accommodation through commissioning and active promotion by government and local authorities.
- 19 Demos recommends floating support services are made more readily available by local authorities, and calls for the government to create a statutory ‘right to return’ for all care leavers.

Conclusion

Every child is different and will need something different from the care system; from a short break away from home to a lifelong adoptive placement. By no means do we underestimate the difficulty of meeting the needs of each individual child, and of making the right decisions at key moments in that child’s life. Nevertheless, a shift of resources and investment to the beginning of a child’s care journey could have real long-term benefits for that child, and minimise the costs associated with unstable placements.

In the context of the immediate resource constraints confronting central and local government, the interventions and recommendations outlined in this publication should be seen as part of a long-term, ongoing project to raise standards in the care system. But we also believe that the escalating costs associated with poor care journeys and placement disruption have short-term resource implications for local authorities, meaning there are cost savings attached to better care journeys in the here and now.

Of course, intervening earlier through focused family support or placements away from home is not always possible or

appropriate, and so we must also focus on the key ingredients proven to make a difference at any stage of a care journey, namely a high quality stable placement and a supported, smoother transition to independence. The edges of the system also need to be 'tapered'; entering care should not be seen as an all-or-nothing intervention to be used only when all else fails. Recognising that care can, and often does, succeed enables us to be more ambitious for the system as a whole, and by extension for the children and young people who pass through it.

Extracts from Section 4: Care journeys and costs

In the last section we described some of the weaknesses in how the current care system is used at entry, during and when leaving care. However, we must be clear that the care system certainly does not deliver poor experiences universally, but that it is *patchy*. Children's experiences vary hugely, and not just between local authority areas. Dozens of separate decisions and events, made by several different individuals, may fundamentally change a child's care journey and future outcomes. And of course, the intrinsic characteristics of the child themselves and their needs will influence the path they take through the care system. It is for these reasons that the same care system is able to produce successful, university educated adults, as well as some of society's most disadvantaged and vulnerable young people.

To illustrate the full scale of this variation, the following section models the costs of caring for two children who have contrasting but realistic experiences at the two extremes of the care system, from the time that they first enter care, until age 18. We then go on to compare the costs to the state of the later life outcomes they might go on to experience in adulthood.

10 The cost of care journeys

We originally sought to explore whether care journeys that are poorly planned, initially under-resourced and increasingly unstable work out to be more expensive as a result of the poorer later life outcomes with which this is often associated.

Unfortunately, a lack of publicly available longitudinal data linking looked-after children's experiences in care to their later life outcomes makes it extremely difficult to establish this relationship of cause and effect between good care and good later life outcomes and poor care and poor later life outcomes.

However, a number of small-scale academic studies have demonstrated that there is a correlation between a child's:

- age of entry to care and their level of emotional and behavioural difficulties
- level of emotional and behavioural difficulties and potential for a stable or unstable experience of local authority care
- experience of instability in care and a higher risk of poor behavioural outcomes, poor educational outcomes and early exit from care
- age of exit from care (and level of support in transition to independence) and educational attainment and employment outcomes

But as the majority of these studies lack controls, and the different factors of age of entry to care, stability in care, and age of exit from care tend to be interrelated and mutually reinforcing, it is not possible to isolate the impact of these individual factors from one another and identify a causal relationship in each case. It is important to note that we have, therefore, limited our analysis to variables for which we can find a *correlation*.

Purpose and scope of illustrative care journeys

In order to negotiate these data limitations, we have drawn upon the national statistics on looked-after children published by DCSF, and a number of small-scale academic studies, to construct two exemplar care journeys that demonstrate how a child's age of entry to care, experience of stability or instability, and age and type of exit from care are interrelated and often mutually reinforcing.

The first care journey illustrates how a 'good' care journey, characterised by entry to care at an early age (associated with lower mental health needs), a stable and high-quality placement in long-term foster care, and a supported transition from care at 18, is frequently associated with the young person experiencing better mental health outcomes and educational attainment.

The second care journey illustrates how a 'poor' care journey, characterised by entry to care at a later age (associated with higher mental health needs), a number of unstable and low quality placements and several unsuccessful returns to her birth family, and a premature exit from care aged 16½, translates into escalating costs to social services and is often associated with that young person experiencing worse mental health outcomes and poor educational attainment.

It is important to establish at this point that this study does not purport to prove that one particular type of care journey has an inevitable impact on young people's outcomes. Studies consistently show that young people's personal characteristics, level of resilience, and opportunity to draw on the support of secure attachments, determine how well they are able to cope with challenging life experiences.²⁵⁰ Equally, it is important to establish that this research does not attempt to identify a 'one size fits all' recipe for a good care journey. As the first chapter of this report demonstrates, children come into local authority care for a variety of reasons, at different points in their lives, and with a variety of different needs. We cannot, therefore, recommend child A's care journey (below), entering care at age 3, for the many children whose family situation dramatically changes in later childhood, which then necessitates them going into care. Nevertheless, for many children who experience a history of

abuse and neglect from early life, child A's care journey represents something to work towards.

The 'good' care journey: child A

When constructing child A's care journey, we sought to establish:

- an aspirational care journey for a child who is looked after away from home in the long-term (from age 3 to 18), but is not adopted
- a realistic care journey, representing the current experience of between 5 per cent and 10 per cent of looked-after children
- a care journey that facilitates stability and permanence and provides the opportunity for a secure attachment
- a care journey that would be most likely to produce 'good' outcomes such as good mental health and good educational outcomes

Box 4 Journey outline – child A (female)

One period in care and two stable placements

- *enters care aged 3*
- *care proceedings to obtain a care order*
- *short-term foster care placement for 1 year*
- *long-term foster care placement for 14 years*
- *leaves care aged 18 with good mental health and with good qualifications*

Child A's care journey (box 4) was constructed on the basis of several data sources, which can be found in more detail in appendix 1. These data, including academic studies and DCSF statistics, were used primarily to establish a 'realistic' care journey for child A, and where possible to bring her care experience in line with between 5 per cent and 10 per cent of the current care population in relation to age of entry, number of

placements and periods of care she experiences, and age of exit.

We also used these sources of information to explain why child A's stable care journey could be associated with good educational attainment and mental health. Although causality cannot be proven, we drew from various studies which demonstrate a clear correlation between stable care journeys and better mental health and educational attainment. These include UK studies, such as Biehal et al, and academic evidence from the US which found that children who had a stable care experience had a lower probability of experiencing behavioural problems (controlling for pre-care experience and other characteristics).²⁵¹

The 'poor' care journey: child B

When constructing child B's care journey, we sought to demonstrate:

- a flawed and poor quality care journey for a child who is looked after away from home from age 11 to age 16½
- a realistic care journey, representing the current experience of around 10 per cent of looked-after children
- a care journey that is characterised by disruption and instability and does not provide opportunities for the child to develop a secure attachment with a carer
- a care journey that is therefore more likely to produce 'poor' outcomes such as emotional and behavioural problems, poor mental health and poor educational attainment

Box 5 Journey outline – child B (Female)

Three periods in care and ten placements

- *enters care aged 11 (voluntarily accommodated)*
- *emergency foster care placement (1 week)*
- *short-term foster care placement (12 months)*
- *reunified with family (6 months)*
- *emergency foster care placement (1 week)*

- *short-term foster care placement (6 months)*
- *reunified with family (6 months)*
- *re-enters care and legal processes are undertaken to obtain care order*
- *three foster care placements over 12 months*
- *placement with agency foster carer (12 months)*
- *short-term residential placement (1 month)*
- *residential placement (11 months)*
- *exits care at 16 ½ and lives in independent accommodation until 18*
- *has poor mental health and no qualifications*

Again, we used several data sources to compile child B's care journey. We used data, often from DCSF, to ensure the age of entry and exit, number of placements and types of placement reflected the experience of around 10 per cent of children currently in care.

We also used studies such as Sempik et al and Dixon et al²⁵² to establish a negative escalation in child B's experiences; from late entry to care, leading to greater risk of instability, leading to emotional and behavioural problems, which in turn gives rise to a greater numbers of placements. We also used various studies to establish a correlation (again, causation was not established) between child B's journey and poorer outcomes on leaving care –poor mental health and educational attainment. The full range of data and studies we used can be found in appendix 1.

Calculating the cost of child A and child B's care journeys

To estimate the total costs of the care journeys experienced by child A and child B we have worked in partnership with Harriet Ward, Jean Soper and Lisa Holmes from the Centre for Child and Family Research (CCFR) at Loughborough University, who have developed a cost calculator for children's services. This tool is able to calculate and aggregate the cost of children's care

journeys by bringing together data on the children's characteristics, their placements and other services they receive with the unit costs of social care activities.²⁵³

The methodology underpinning the cost calculator is outlined in Ward et al's book *Costs and Consequences of Placing Children in Care*.²⁵⁴ As an earlier study by Harriet Ward and Lisa Holmes explained:

*It is possible to cost children's pathways through care, first by identifying and developing unit costs for the specific social care processes, and then by identifying the numerous variations and their causes. The frequency and duration of processes incurred over a specific period can then be calculated and the cost of each one aggregated to build up a cost pathway covering all or part of the care episode.*²⁵⁵

Ward et al calculated their eight 'process costs' in consultation with staff from social service departments in six different local authorities.²⁵⁶ The table in appendix 2 outlines these processes and the estimated costs attributed to each one.

The cost calculator for children's services is able to aggregate the costs to social services that would be incurred by child A and child B's care journeys, according to the social service activities that would need to take place:

- deciding that child A and child B needed to be taken into care and finding suitable placements
- initiating legal proceedings at the appropriate times for each child
- maintaining their placements in foster care, residential care or independent accommodation
- finding any subsequent placements that are necessary
- undertaking the necessary review and care planning activities (with the frequency prescribed in the Children's Cases (Amendment) (England) Regulations 2004²⁵⁷)
- exiting care on the two occasions when child B returns to her birth family
- the transition to leaving care services, which is undertaken by child A at 18 and by child B at 16½

In addition to the process costs outlined above, we believe it is likely that child B would need to receive some form of mental health support during the later phases of her care journey. At the time when child B is placed with an agency foster carer for 12 months (from age 14 1/2 to age 15 1/2) we have therefore factored in the cost of a weekly session with a clinical psychologist for 12 months.²⁵⁸

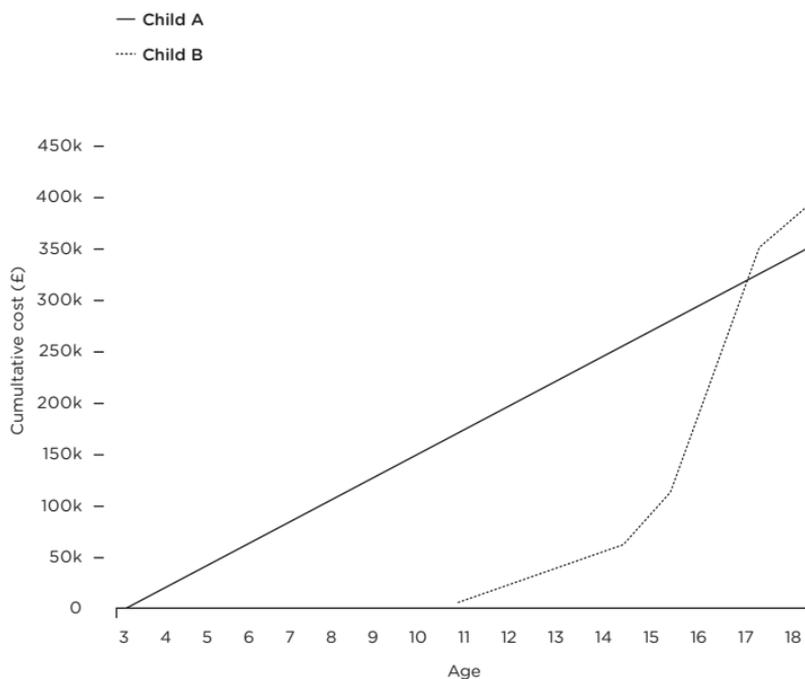
Using the cost calculator to match the costs of the above processes to the two care journeys outlined above, we found that in total:

- the cost of child A's care journey over 15 years, up to age 18 is £352,053, which translates to £23,470 *each year*
- the total cost of child B's care journey over 7 years, up to age 18 is £393,579, which translates to £56,226 *each year*.

Total costs of the care journeys of child A and child B

As these figures demonstrate, higher expenditure alone does not necessarily generate a better care experience. Indeed, as Harriet Ward and Lisa Holmes have observed of similar types of care journey, child B experiences 'an inverse relationship between costs and outcome'²⁵⁹ in that the points at which child B's costs escalate (when she has three local authority placements in one year, when she is placed with an agency foster carer and when she is placed in residential care) are also the points at which her emotional and behavioural difficulties become more severe and her chance of achieving stability in care recedes (figure 4).

Mapping costs in this way demonstrates that care journeys built around earlier intervention, stability and gradual transitions are not only better for children's wellbeing, they are also likely to be less expensive to the state. This is not to understate the sheer difficulty of 'getting it right', which should not be underestimated in the case of child A. There is no doubt that the involvement of skilled practitioners would be necessary, along with all of key decisions and processes being undertaken swiftly in order to lead to such a care journey; something which is not always easy to achieve in practice.

Figure 4 **Care journey costs for child A and child B**

The next section of the report will go on to consider example cost implications for child A and child B's later adult lives, taking into account their educational attainment and mental health on leaving care.

11 Later life costs: the cost of outcomes to age 30

As we have seen with our example care journeys, 'child A' leaves care at 18, following a stable placement, with good qualifications. 'Child B', on the other hand, leaves care at 16½, has no qualifications, and has mental health problems.

Rather than starting their adult costs at different points, the following analysis begins at age 16½. This is because although both children are still technically in care at this point, their costs to the state (as separate from their care costs) begin at 16, as this is the end of their compulsory schooling. The choice of child A to stay in school means she will be eligible for education maintenance allowance. The choice of child B to leave school means she is at a high risk of being NEET. Both of these scenarios represent costs to the state which are not included in the care costs outlined in the previous section, but which are included in the following calculations.

Child A

Assumptions

We assume child A lives in Coventry, where she stays at school to 18, then attends a university (not in Coventry, but outside London) to age 21, living away from home. On graduating, she finds a job and, between graduating and age 30, we assume she earns in the top 30 per cent of average salaries for her age. We take this to be a reasonable and conservative estimate given the lack of data regarding average adult earnings linked to qualification levels. Our assumption is supported by two broad reference points: analysis by the Institute for Fiscal Studies in 2002, which found that 55 per cent of the Labour Force Survey's top decile earners in the 25–34 age range were graduates; and DCSF

analysis of the Labour Force Survey in 2008, which shows that women working fulltime with Level 4 qualifications, equivalent to a degree or higher degree, had gross hourly earnings 28 per cent higher than the average for all women working full-time, and 55 per cent higher than those with Level 3 qualifications.²⁶⁰

Additional costs associated with a care leaver with this life course

Having a low household income, child A may well be eligible for education maintenance allowance at the highest rate (£30 per week), but will not be claiming housing or other benefits as she is still living at home with her foster family at this point.

At 18, on entering university, all students are entitled to a range of loans and grants. These include student loan, maintenance loan, maintenance grant and bursaries, which should cover child A's accommodation costs. Coventry also pays for the accommodation of care leavers during university vacations so they can return to Coventry during these periods.

In appendix 4 we have presented the full range of costs associated with going to university outside London. These demonstrate that in total child A would cost the state £40,480.10 from age 16 to 21, if she chose to continue her education, or around £8,096 per year (table 3).

Table 3 **Total costs of child A ages 16–30**

Education age 16–18 (education maintenance allowance)	£3,120.00
Student grants	£12,818.00
Student loans	£20,361.00
Accommodation support	£4,181.10
.....
Total costs child A age 16–30	£40,480.10

After 21, we can assume that child A's costs are in line with the average working population, recouped by government from

income and other taxes. Child A has no *additional* costs associated with her path beyond age 21.

However, we should bear the following points in mind:

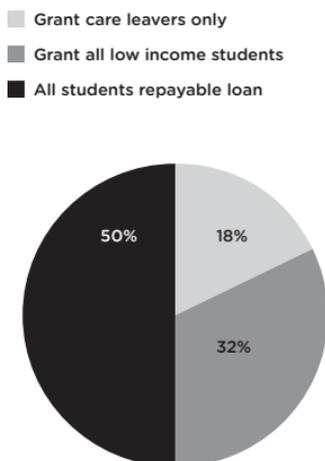
- 1 £20,361 of this sum is a repayable loan, which child A will be paying back through her working life (although in practice this is not necessarily entirely cost free to the state because of the subsidised interest). The remaining £20,119.10 is non-recoupable, so in reality, child A would actually cost the state £6,706 per year while at university.
- 2 A large proportion of these non-recoupable funds are given to *all* low income students. Overall, £12,838 is provided to other students who may have low incomes or caring responsibilities, or are lone parents.
- 3 Therefore, only £7,281.10 of the total £45,872.50 costs would be generated *specifically* because child A is a care leaver, and not just because she was from a low earning family or vulnerable in some other way. This cost would be made up of £2,000 care leaver grant plus £4,181.10 in housing costs to the local authority, and £1,100 bursary cost to the university (figure 5).

Gains of child A

Having graduated, child A can potentially generate gains for the government, thanks to her increased earning potential. She might well start work at 21 on an average starting salary of £19,677 per year,²⁶¹ which is substantially above the median salary for 18–21-year-olds in full-time work.²⁶²

As outlined above, we have assumed that throughout her working life child A will earn in the top 30 per cent of salaries between graduation and age 30, given her level of qualification. We believe this is reasonable and conservative, using a 2002 IFS analysis of the Labour Force Survey as a broad reference point.²⁶³

So, if child A were to be in the top 30 per cent of earners, the government would receive more in income tax and national insurance contributions (NICs) on this higher salary. These gains are calculated in box 5, but are an underestimate of true gains as

Figure 5 **Child A's costs ages 16–30**

we exclude employer NICs and focus on the gains provided directly by child A.

Box 5 Increased tax and national insurance contributions above national median

The average salary of a 22–29-year-old female, working full time in the 70th percentile of earners, is £24,920.²⁶⁴ The overall average for this group is £21,008.²⁶⁵

The difference between the income tax and NICs received by the government of these two salaries is £1,212.72 per year, therefore:

- Child A would pay the state £52,209 in tax and NI contributions between the age of 21 and 30 (based on an average salary across all years).
- This means she would pay £10,914.48 more in tax and NI contributions over these nine years than if she were on average wages.

Child B

Assumptions

We assume child B also lives in Coventry. She leaves school at 16 with no qualifications, and moves out of her care placement at 16½. We know from her care journey (described above) that she is likely to have mental health problems. Based on a range of national data, we are able to estimate the risks of child B being unemployed during her life, and a range of costs associated with this.

Additional costs associated with child B's life course

We considered three main variables in child B's life – unemployment, underemployment and mental health problems. Using various data sources including the International Labour Organization (ILO), Annual Survey of Hours and Earnings, Labour Force Survey and others, which can be found in more detail in appendix 3, we were able to estimate the length of time child B might be NEET between 16 and 24, and unemployed between 25 and 30, based on the fact that she left school with no qualifications. As she also has mental health problems, however, we believe our calculations may well be an underestimate. We then calculated how much these periods of inactivity would cost the state.

We also considered the average salary of adults with no qualifications compared with the average, and calculated child B's 'underemployment' costs – the cost to the state of child B not fulfilling her potential (or at least, not being able to earn an average wage). Finally, using data on costs of mental health from the King's Fund,²⁶⁶ we were also able to add child B's costs for being treated for depression. Appendix 3 provides evidence to justify our choice of depression as child B's principle mental health problem.

Total costs – summary

We have calculated the costs of each of the variables above, which can be found in detail in appendix 4. A summary of the costs for child B's life course are shown in table 4.

Table 4 **Total costs of child B ages 16–30**

Unemployment- welfare benefits	£25,172.86
Unemployment -foregone tax and NIC revenue	£20,208.61
Housing benefits during periods of inactivity	£35,493.12
Underemployment - foregone tax and NIC revenue	£26,984.90
Mental health treatment costs	£4,064.50
<hr/>	
Total costs child B age 16 to 30	£111,923.99

What haven't we included?

We should bear in mind that the costs for child B are likely to be a significant underestimate. We have only included direct welfare costs and tax revenue and NIC loss resulting from child B's lack of qualifications. Even then, we have underestimated welfare costs – for example, we have assumed, perhaps optimistically, that child B will be employed full time when she is employed. In reality, she may well work part time, which could make her eligible for income support. We have not included tax credits because of the complexity of calculating their interactions with other benefits.

We have also excluded a range of additional costs that might arise from child B becoming pregnant. We know female children in care are 2.5 times more likely to become teenage mothers than average,²⁶⁷ and low educational achievement and social exclusion also increase the risk of teenage pregnancy.²⁶⁸ However, we considered pregnancy to be a cost associated with a large proportion of the population and so therefore not an 'additional' cost associated with child B's life course specifically.

We have also excluded the possibility of other, more costly, mental health problems in addition to depression, and the potential costs associated with the higher risk of offending behaviour of child B, which could be associated with having poor educational attainment, and low income is also associated with this. Again, this would substantially increase child B's costs to the state.

Table 5 **The total costs of child A and child B ages 16–30**

Child A	
Education support age 16–18	£3,120.00
Student grants	£12,818.00
Student loans	£20,361.00
Accommodation support	£4,181.10
.....	
Total child A costs 16–30	£40,480.10
Child B	
Unemployment – welfare benefits	£25,172.86
Unemployment – foregone tax and NIC revenue	£20,208.61
Housing benefits due during periods of inactivity	£35,493.12
Underemployment – foregone tax and NIC revenue	£26,984.90
Mental health treatment costs	£4,064.50
.....	
Total child B costs 16–30	£111,923.99

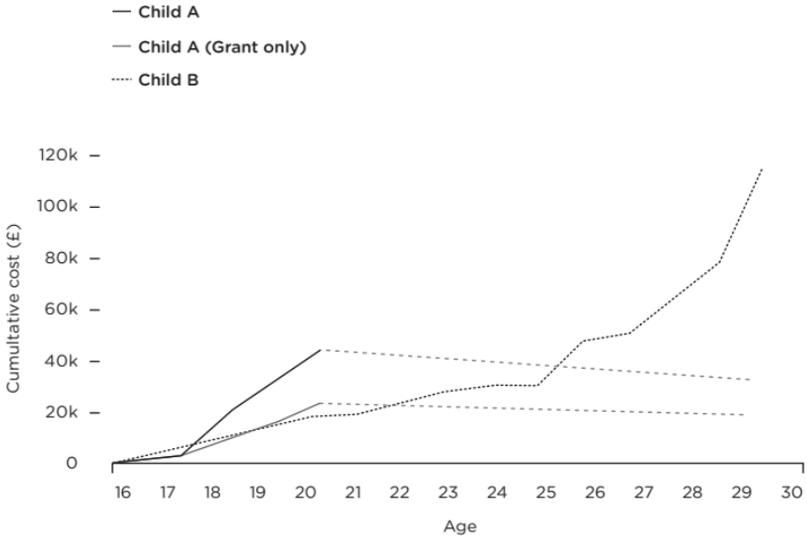
Comparing the costs of child A with those of child B

The difference between the additional costs associated with child A and child B up to age 30 is £71,443.89 (table 5). This does not take into account gains in tax revenue and NICs made by the state as a result of child A's better salary, which at £10,914.48 over and above a median earner, would reduce her additional costs to the state.

However, it is clear that additional costs associated with child A's life course (going to university) end at 21. After this age, her net costs to the state are in line with the average tax payer (or perhaps slightly less given that she will pay slightly more in tax and NICs as a graduate, and assuming she has no underlying health conditions).

Child B, on the other hand, will have ongoing *additional* costs over and above the 'normal' tax payer for the rest of her life (though we only illustrate these up to age 30).

We can see from figure 6 that child A's line stops at 21 as we have no additional costs to calculate. Child A's life course *appears* to have considerable 'up front' costs. However, we should bear in

Figure 6 **Costs of child A and child B over a lifetime**

mind that only the lighter shaded line actually counts – the darker shaded line includes student loan costs, which are paid back by all graduates who then earn a salary of more than £15,000 per year (although subsidised interest rates may mean the government does not recoup full costs of these loans, we are assuming full repayment over a lifetime here). As we have seen, child A is likely to pay her student loan off at a rate of £900 per year immediately after graduation. Looking at the green line, even by the age of 20, child B’s costs have almost met child A’s.

Furthermore, from 21 onwards, the government will have nothing but ‘gain’ from child A – her costs will be in line with the national average, but she will be paying more tax thanks to her increased income, and paying off her student loan. This also does not count other potential gains that have been associated with higher education levels (eg lower risk of offending behaviour and improved mental health).

This possible onward life cost journey is reflected in the dotted lines on the graph, continuing the darker and lighter

shaded lines, which suggest that in child A's active year (before motherhood or old age) child A may well be cost neutral, or indeed a net contributor to the state. This is slightly more apparent with the darker shaded line, as we include child A paying off her student loan here. Child B's life course, on the other hand, sees escalating costs, because of the cumulative costs of unemployment and underemployment throughout her working life. We would not expect these to decrease particularly beyond age 30.

Child A and child B – conclusions

In attempting to cost two young people's care journeys and subsequent adult outcomes up to age 30, we have made some interesting discoveries:

- 1 It is possible to model a care journey which is both more beneficial for the child, *and* more cost-effective. In contrast, a poorer care journey seems, at points, to be correlated with increased cost due to higher levels of instability. Although time in care is longer for child A, her overall costs are lower – as intervening early is usually associated with more stable journeys, fewer costly placements and a reduced risk of needing specialist intervention or mental health support.
- 2 Decisions at the outset of a care journey can set in motion a domino effect of positive or negative outcomes, with costs accumulating over a lifetime. Although, of course, making the 'right' decision when a child or family is first known to social services is easier in theory than in practice.
- 3 Stability has cost benefits at any stage, even for those who only need to enter care at adolescence. It is important to note that these journeys are not intended to 'prove' from a cost perspective that children should necessarily enter care earlier – clearly this is not appropriate in many cases. However, stability or permanency will have benefits at all ages.

A comparison of total costs and costs per year is given in table 6 and figures 7 and 8 these figures combine costs to the

state *and* costs to children's services. Note that the difference in annual costs for child A and B during care is larger than the total costs, as the time child B spends in care is significantly less (7 years compared to 15 years for child A), so total costs are spread over a shorter period.

We should also bear in mind that as child B entered care later, overall annual costs are also compressed in a shorter period – 19 years, compared with 27 years for child A. So child A's combined costs to children's services and the state is on average £13,784.15 per year for 27 years, while it is £26,605.42 per year for 19 years for child B. As a result of the nature of child B's outcome costs (see above), we would expect her costs to continue accumulating throughout her life, so the difference between child A and child B would grow larger with each year.

The difference between the total care journey costs of child A and child B is £41,526, even though child A's care journey is

Table 6 **A comparison of total costs and costs per year for child A and Child B**

	Child A	Child B	Child A average cost per year	Child B average cost per year
Total care journey cost from entry to exit	£352,053.00	£393,579.00	£23,470.20	£56,225.57
Total outcome cost from 16 to 30	£20,119.10*	£111,923.99	£1,437.00	£7,994.57
Total costs from entering care to age 30	£372,172.10	£505,502.99	£13,784.15	£26,605.42

*excluding student loan

Figure 7 **Total costs from entering care to age 30**

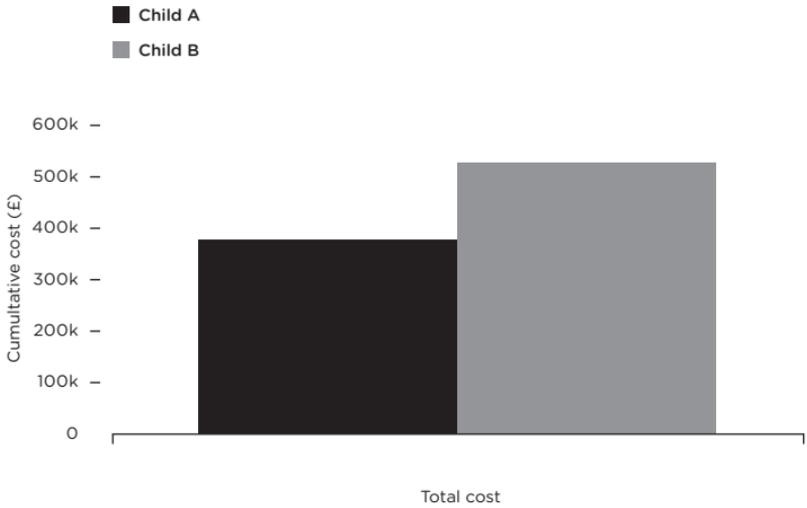
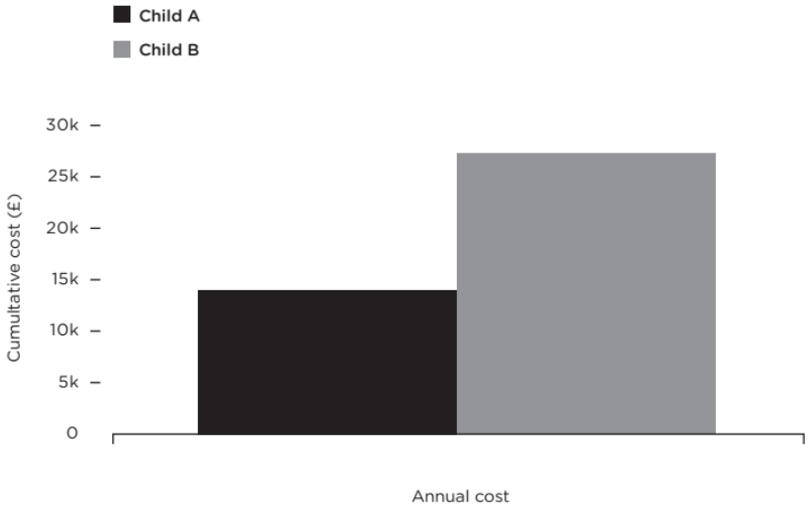


Figure 8 **Average annual costs from entering care to age 30**



longer. And ultimately the difference reaches £133,330.89 when the total costs to the state are included up until age 30. Although these are only examples and we have not proved that the respective care journeys caused these outcomes, they point to the existence of real potential cost savings for local authorities in the short term, and to the state in the long term, of investing in high quality care journeys for children.

Of course, all children are different, and enter care with specific characteristics and needs which may have costs associated with them (for example a disability). And it is important to note that many children enter care in later childhood not as a result of delay or indecision, but rather because care was simply not needed before that time (eg if they entered care after a parent died). Others may only need to stay in care for a matter of months. For these children, lifetime costs associated with indecision and delay may not be relevant. Nevertheless, even in these circumstances, local authorities should strive to avoid some key elements of child B's journey. Stability, timely decisions and effectively supported transitions can benefit *all* children in care – regardless of when they come into care and how long they need to stay for.

The difference in costs between a stable and unstable care journey should be borne in mind in section 5, where we present our recommendations. We are aware that we are entering a period of unprecedented fiscal constraints. Children's services are likely to experience substantial reductions in funding, and as local authorities must meet their statutory safeguarding commitments, cuts will have to be made elsewhere. In such circumstances, it is understandable that local authorities may 'firefight' to deal with child protection cases and urgent needs, rather than invest in approaches that may save costs over the long term.

However, we hope that by costing an unstable journey, we have demonstrated that timely care decisions along with stability and better mental health can reduce *immediate* costs to the local authority by reducing social work time, use of expensive agency and residential placements, and therapeutic support. These are not distant cost savings beyond the budgetary cycle, but amount

to an average of £32,755.37 in the difference between the two journeys, which could be saved each year while that child is in care.

With this in mind, we should consider again the range of adult outcomes that are experienced by young people who come into contact with the care system at some point, from those who have a positive care experience and are in the minority that ultimately go on to university,²⁶⁹ through to those who become more or less dependent on the state and health services into early adulthood. Combining both the costs of the care journey and the outcomes, the difference could be £133,330.89 *per child* from entering care to age 30. Given the current care population is nearly 61,000 children, the contrast between the two creates a powerful argument to invest to save in both the short term and the long term.

Comparisons between looked after children and the rest of the population have consistently shown that care leavers are one of the most vulnerable and disadvantaged groups in society. But assuming that the care system is wholly responsible for this disadvantage, and is therefore 'failing' all those who enter care, is both overly simplistic and counter-productive.

Through an in-depth review of existing data and research studies, *In Loco Parentis* shows that there are a number of factors that influence outcomes among children in care, not least their pre-care experiences; and that looked-after children, far from being a homogeneous group, enter care for a variety of reasons and have very different needs. Using new quantitative analysis of the costs associated with good and poor care journeys, *In Loco Parentis* demonstrates the significant gains to be made by minimising delay and drift, promoting stability in placements and supporting young people's transitions to adulthood.

Drawing on primary research with looked after children, care leavers and foster carers as well as case studies of good practice cross the UK, the report sets out recommendations to de-stigmatise care as a source of family support and 'taper' the edges of the system so that care is not used as an all-or-nothing intervention. The report demonstrates that what matters most is building a care system which is sufficiently proactive and responsive to provide the right kind of support for children and their families at every stage.

Celia Hannon is head of the Capabilities Programme at Demos. Claudia Wood is an associate of Demos. Louise Bazalgette is a researcher at Demos.

ISBN 978-1-906693-46-6 £10

© Demos 2010

