Young People on the Edge of Care:

The Use of Respite Placements

Jo Dixon and Nina Biehal

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1. Introduction

This report presents the findings of a study of a supported respite service for families with children on the edge of care. The aims of the study, which took place between 2004 – 2006, was to explore how the service operated and assess its impact on outcomes for a sample of families receiving support from the service.

Rates of placement in care or accommodation are known to be high for older children and adolescents. Recent government statistics have shown that 40% of children starting to be looked after in England are aged 10-15. Over half (59%) of 10-15 year olds entering care do so for reasons of abuse or neglect, while the next most common categories of need are family dysfunction (11%) or acute family stress (8%). However, care episodes are relatively short for many of these young people, as almost half (47%) leave care within eight weeks and two-thirds remain looked after for less than six months (Department of Health, 2006). The high rate of placement indicates that child and family difficulties may be severe for this age group yet, since many return home quite quickly, there may be scope for developing services to support them in their families and so prevent family breakdown. This report focuses on one service which offers an innovative model of support for young people and families, the Hilltop residential respite care service.

Background to the study

The Children and Young Person's Act (1963) was the first legislation to set out a statutory duty to provide assistance to families to prevent the need for young people to enter care, or to remain in care long-term if they did enter. Since the early 1960s, research and policy attention to the prevention of entry to care has waxed and waned. With the permanency planning movement in the 1970s there emerged a related concern with the rehabilitation of looked after children with their families (Maluccio and Fein, 1983). In the UK these concerns with prevention and rehabilitation were fuelled by the findings of a number of research studies in the 1980s, which revealed that young people often 'drifted' in care for lengthy periods due to a lack of proper planning (DHSS, 1985). During the 1990s, researchers continued to find a laissez-faire approach to return and a lack of proactive planning for the rehabilitation of young people in care (Bullock, Little and Millham, 1993; Farmer and Parker, 1991; Sinclair, Garnett and Berridge, 1995). The lack of planning and support meant that any positive changes which resulted from a period in care were rarely sustained once a young person returned home (Farmer and Parker, 1991). Furthermore, outcomes have been found to be poor for many adolescents who left care at 16 and over (Biehal, Clayden, Stein *et al.*, 1995).

There is some evidence that a lack of any positive change in the family environment may contribute to poor outcomes for young people who return home from care (Quinton and Rutter, 1988; Thoburn, 1980). The implication of this is that direct work with young people should be complemented by work with their families during and after placement, which would necessitate a greater integration of placement and family support services. The development of respite care for young people at risk of

family breakdown is an innovative and creative approach to these dilemmas, maintaining young people in the community and facilitating work with them and their parents in the home environment, while providing planned relief from the stresses that can lead to family breakdown (Webb, 1990).

Support foster care is one example of an attempt to use respite care to support young people and families under stress (Brown and Howard, 2005). A small number of support care schemes around the country offer a series of respite foster placements over a period of several months for young people considered at risk of family breakdown. However, problems with the recruitment and retention of foster carers may limit the potential expansion of such schemes and, furthermore, foster care is not always able to contain 'difficult' young people. There is therefore scope for developing parallel innovative approaches in the residential sector. Indeed, these may be particularly appropriate for young people, since *adolescents* at risk of family breakdown typically have serious emotional and behavioural difficulties (Biehal, 2005; Sinclair, Garnett and Berridge, 1995; Triseliotis, Borland, Hill *et al.*, 1995). Such evidence as exists, suggests that children's homes are better able to tolerate difficult behaviour than even specialized foster care and may provide a good base for undertaking short-term work both with young people and their families (Cliffe and Berridge, 1991; Rowe, Hundleby and Garnett, 1989; Sinclair and Gibbs, 1998). It is therefore possible that, for some troubled and troublesome adolescents, residential placements in respite care may be particularly helpful.

However, there is very little existing research on respite placements for non-disabled young people to inform developments of this kind. The key British study on this topic focused on younger children being placed in respite foster placements, a different population to that in the proposed study (Aldgate and Bradley, 1999). In any case, given the indications that children's homes are often better at containing difficult behaviour than foster care, *residential* placements may be more appropriate for some 'difficult' adolescents. 'Shared care' schemes in the USA and the contact family service in Sweden represent alternative approaches to offering families support plus respite, but these interventions have not as yet been tried in the UK and have, in any case, mainly been used to support families with younger children (Andersson, 2003). There is an urgent need, therefore, to develop and test new methods of working with adolescents at risk of long-term placement.

The policy framework

Since the concept of prevention was first given statutory expression in the Children and Young Person's Act (1963), policy attention to this issue has fluctuated. The Children and Young Person's Act (1969) introduced Intermediate Treatment, which led to a great deal of preventive activity with older children and adolescents until criticism of its labelling and net-widening effects led to its decline (Thorpe *et al.*, 1980). From the mid-1970s, however, the principal focus of policy was on child abuse, following a series of inquiries into cases of child abuse. Policy attention to prevention, now referred to as a duty to offer family support, was clearly evident in the Children Act 1989 and in the refocusing debate that followed it (Department of Health, 1995). Some years later, the government Green Paper, *Every Child Matters*, proposed a three-tiered strategy for services to support young people and families including, in the third tier, services to support families where difficulties have emerged (Department for Education and Skills, 2004). More specifically, the recent

Green Paper, *Care Matters*, has emphasised the need for services to support young people thought to be 'on the edge of care,' in order to prevent the need for them to enter care in the first place or to rapidly return them to their families if they do enter (Cabinet Office, 2006). Clearly, attention to services to support children and young people thought to be at risk of care or accommodation is once again an important feature of the policy agenda.

The residential respite care service

This study focuses on a pioneering approach to working with adolescents at risk of entering long-term care. This creative approach integrates planned prevention, placement and rehabilitation services with a view to preventing family breakdown. The respite care service provides an integrated package of support involving residential care, the community support team and social work teams. It is located in a county with high levels of urban and rural deprivation, and where unemployment levels are well above the national average.

Based in Hilltop, a five-bedded children's home, the scheme offers respite placements to young people aged 12-16 years old considered at risk of long-term placement in care. It offers a series of planned short breaks (of one to three nights) over several months, provided under Section 20 of the Children Act (1989). At the same time, young people are allocated a worker from the community support team who works with young people and parents, alongside residential key workers and social workers, to resolve the difficulties that led to the respite placement and to offer short-term follow-up support.

Aims of the study

The aim of this study is to describe this innovative service, assess its impact on outcomes for young people and to explore the mechanisms by which it achieved its effects. It also aims to identify which young people, in which circumstances, might benefit from services of this kind.

This report will:

(1) Present a profile of the current difficulties and longer term problems these troubled adolescents and their families experience;
(2) Describe the organisational and practice characteristics of this innovative service;
(3) Consider how far the new service contributes to achieving positive outcomes for young people at risk of long-term family breakdown in terms of:

- ameliorating the specific problems presented at referral
- reducing the severity of their emotional and behavioural difficulties
- improving child and family functioning
- preventing admission to long-term care.

2. Methodology

Research design

A single group pre-test post-test design was used. Young people were recruited to the study when first placed at Hilltop and were followed up approximately nine months later. At baseline, young people, parents, residential workers, social workers and community support team workers were asked to complete postal questionnaires. Follow-up interviews were conducted around ten months later with young people, parents and the three social services professionals.

The study used mixed methods to evaluate the respite care service. Methodological triangulation of this kind allows for a complementary analysis, using quantitative and qualitative methods to ask different research questions, or to answer them in different ways. Quantitative methods were employed to evaluate the effectiveness of the integrated respite care/community support service. Qualitative methods were used to explore the views of participants and to investigate how, why and in what circumstances particular outcomes occurred.

Data triangulation was also employed, as a number of similar questions were asked of families and of the three different professionals involved. This enabled us both to gather different perspectives on the same issues and to compensate for gaps in the data in relation to certain factual matters (for example, whether or not the young person entered care or was excluded from school).

The pre-test post-test analysis of outcomes for the young people placed in Hilltop was complemented by the comparison of selected outcomes for this group with outcome data from an earlier study of 209 young people (Biehal, 2005). This earlier study evaluated outcomes for a similar group of 11-16 year olds at imminent risk of placement who were using either a community support team service or an ordinary area social worker service, but who were *not* provided with respite care, and employed the same outcome measures as the current study. The earlier study took place in seven local authorities, including the authority in which Hilltop is situated.

The sample

All young people newly placed in Hilltop between February 2004 – February 2005, and their parents were invited to participate in the study and a sample of 25 young people was recruited. The number of respondents at each stage of the study is shown in Table 2.1:

Table 2.1 Data collected at referral and at follow-up

	Number at referral	Number at follow-up
Young people	24	19
Parents	16	20
Residential workers	23	22
Support workers	13	07
Social workers	14	12
Total	**90**	**80**

In the chapters which follow, for reasons of confidentiality, the names of all the young people involved in the evaluation have been changed.

Sample attrition

In 20 cases, data was collected from families both at baseline and at follow-up. In 12 of these cases, both young people and parents provided data at both stages of the study and in a further eight cases, we were able to collect data at both stages either from young people (7) or parents (1).

Five of the young people included at baseline were lost to follow-up, as were three of the parents initially interviewed. However, seven additional parents, who had not participated at baseline, were interviewed at follow-up.

Unfortunately, in five cases it was not possible to interview either the young person or the parent at follow-up. One young person withdrew from the study due to the death of a parent. In the remaining four cases, both young people and parents felt unable to take part, either because of current difficulties (n= 3) or because the family felt settled and did not wish to dwell on the past (n= 1). However, in all four of these cases we were able to obtain some follow-up data from at least one of the workers involved.

In 11 cases, either a social worker or a community support worker or both took part both at baseline and at follow-up, and in 21 cases a residential worker participated at both stages.

To summarise, baseline data were collected on 25 families at baseline and on 24 families at follow-up. Although a complete data set was collected at both stages of the study in only two cases (i.e. young person, parent and all three workers), in a further 19 cases data was collected from a young person and/or a parent plus one or more workers. In the remaining four cases, follow-up data was provided by one or more of the workers.

Data collection

A document analysis and discussion with key managers was undertaken to situate the study in its local policy context and to gather basic descriptive information on the service.

Focus groups were held with residential staff and community support team staff. The focus groups explored perceptions of the aims and roles of the agencies within the overall respite service.

Baseline data collection

Residential workers invited all young people newly-placed in Hilltop to complete brief research questionnaires. At this point, questionnaires were also sent to parents. As some of the information collected at this stage was similar to the information routinely sought by residential staff shortly after admission, using residential workers to administer questionnaires helped to avoid duplication and over-burdening families with requests for information. Since these questionnaires were administered by social services staff, user views on services were not sought at this stage in the study in order to avoid potential bias.

At the same time, the young people's residential key workers, community support workers and social workers were asked to complete postal questionnaires. The questionnaires from young people, parents and the three types of worker provided the same baseline data as in the earlier study of community support teams (Biehal, 2005), including information on the characteristics and histories of the young people and families, the involvement of other agencies and the same measures.

Follow-up

The average time from baseline to follow-up was ten months. Follow-up times ranged from 7-13 months but both the mean and the mode follow-up period was ten months.

At follow-up, researchers conducted semi-structured interviews with parents and young people and telephone interviews with residential staff, social workers and community support team staff. These incorporated pre-coded as well as open-ended questions. Interviews with young people and parents included the self-completion checklists for the four outcome measures for young people and parents (see Measures section below), as well as questions to elicit developments since the first interview, services received and their views as to the helpfulness of these services. Interviews with professionals included questions on the nature of the interventions undertaken and on case events (such as duration of placement, re-admission to care, child protection investigations, school exclusion and any cautions and convictions for the young person). All interviews were tape-recorded and transcribed. All participating young people and parents were given a gift voucher for sparing time to help with the study.

The outcome measures

Some standardised instruments were incorporated into the questionnaires for young people and parents at both stages for use as measures of outcome:

- the Strengths and Difficulties Questionnaire, a measure of emotional and behavioural difficulties in young people designed for use with young people up to 16 years old (used with young people and parents) (Goodman, 1997);
- the General Health Questionnaire (GHQ-12), a measure of psychological distress/mental well-being (used with parents) (Goldberg and Williams, 1988);
- the Family Assessment Device (FAD), a measure of family functioning (used with young people and parents) (Epstein, Baldwin and Bishop, 1983) .

To complement these standardised measures, the Severity of Difficulties measure, designed for Biehal's earlier study, was also used. This was a self-completion checklist which aimed to measure change in the severity of a range of difficulties on which social work professionals might reasonably be expected to have some impact. Young people and parents were each invited to complete a version of the checklist when interviewed at referral and again at follow-up. They were asked to indicate the presence and severity of a range of issues: behaviour within and outside the home, staying out late, concerns about peers, parent–child arguments, parent-child communication and drug and alcohol misuse.
The study made use of these measures both as a means of collecting data necessary for assessment of outcome and progress within the sample and as a means of comparison with the samples from the earlier study.

Data analysis

Different perspectives on reasons for referral and placement and on the aims of the placement were explored to enable a rounded and detailed understanding of each 'case' and ensure robustness of the qualitative data through triangulation.

Quantitative analysis

Answers to pre-coded questions and self-completion checklists were analysed using the statistical computer program SPSS-11. All associations between variables that are reported are statistically significant at p= .05 or less, unless otherwise stated. As most of the variables were nominal, non-parametric tests were mainly used. Parametric tests were used where data for the dependent variable was normally distributed and was in the form of interval data. Details of the specific tests used in the analysis are given in footnotes.

The fact that there were potentially five respondents per case helped us to deal with the problem of sample attrition to some extent. Since the same *factual* information on *events* (such as placement, stays with friends or relatives, formal exclusion from school or contact with the juvenile justice system) was sought from all respondents, there were up to five opportunities to find out whether a particular event had occurred. Composite variables were derived from the source variables in up to five questionnaires at baseline and up to five interviews at follow-up, so that if any of the respondents indicated that, for example, placement had occurred, it was assumed that it had. Where responses appeared contradictory, the paper questionnaires for the entire interview set were scrutinised to establish what had taken place.

Two types of outcome analyses were undertaken. First, we investigated what change took place in the nature of the difficulties experienced by the 24 young people placed in Hilltop between placement and follow-up, as reported by young people, parents and professionals. In the 21 cases where both baseline and follow-up data was provided by either young people or parents, or both, we were also able to analyse change on the four outcome measures outlined above.

Second, outcomes for the Hilltop young people were compared to those for the sample of young people receiving similar interventions, but *without* the respite care component, in Biehal's earlier study. In order to ensure that this was a fair comparison, we controlled the nature and severity of problems of the young people in both samples (using baseline scores on the four outcome measures and baseline data

on current difficulties and histories of abuse, neglect and past placement common to both this and the earlier study). Outcomes for the two study samples were investigated in terms of any *change* in their scores on the four common outcome measures and in relation to rates of subsequent admission to care or accommodation.

Qualitative analysis

The in–depth interviews conducted at follow-up were tape-recorded and transcribed. Qualitative material both from the questionnaires and from the in-depth interviews were used to illustrate some of the issues uncovered in the quantitative analysis. Analysis of the in-depth interviews were principally used for individual case studies and to explore themes that emerged across cases. Qualitative data was also used to determine how, why and in what circumstances interventions appeared to be more, or less, successful in producing outcomes that young people and parents considered to be positive.

Using the computer program Atlas-Ti, qualitative data was coded and pen pictures of the circumstances and histories of each of the young people were also written, based on the data provided by all respondents in each case. One of the problems in analysing qualitative data in applied policy research lies in trying to grasp the complexity of each individual account while carrying out a cross-sectional analysis which can deliver useful insights across a range of subject areas. When data is first coded thematically and then analysed across cases, there is a danger that in the subsequent analysis these themes become detached from the context in which the fragments of text were situated. In order to avoid losing sight of a holistic appreciation of each case, while carrying out this cross-sectional analysis, data from respondents was always considered in the context of the pen picture describing the young person's circumstances and history and the views of the other respondents in that case. The aim was to build a cross-sectional analysis of the data based on a holistic interpretation of the interview transcripts.

In order to explore the question of how, why and in what circumstances positive outcomes occurred, cases where parents and young people both felt circumstances had improved and those where neither felt that circumstances had improved were selected from the qualitative sample for further analysis. All data (both quantitative and qualitative, collected at baseline and at follow-up) relating to each case was scrutinised to discover what were the ingredients in cases where outcomes were considered to be positive by family members or, alternatively, where they considered outcomes to be poor.

3. Profile of the sample

The 25 families who took part in the research were asked to comment on their current circumstances as well as on any previous contact with social services. Information was also collected on their current needs and difficulties. This chapter describes the characteristics of the sample and explores the level of need and general difficulties experienced by the families.

Characteristics of the young people

The service is available to young people between the ages of 12 and 18. This is reflected in the age-range of the young people taking part in the study, as shown in Table 3.1. The average age for the group, at referral to the study, was 14 years old.

Table 3.1 Age at referral of young people taking part in the study (n=25)

Age	%	Number
12	12	3
13	20	5
14	32	8
15	36	9

More boys (15) than girls (10) took part in the study (60% and 40% respectively). All were described as white.

Young people's health difficulties, disability and emotional and behavioural difficulties

Information on young people's health and the presence of a disability was collected from parents and workers at baseline[1]. Just over half of young people in the sample (13) were described as having health problems, including nocturnal enuresis, asthma and problems resulting from prescribed medication. One young person experienced a number of health difficulties related to their disability, (Spina Bifida), including neurological damage, problems with mobility and co-ordination and mild hydrocephalus. Three young people were reported to have mental health difficulties (depression, anxiety, self-harm and low self-esteem) and four had emotional and behavioural difficulties.

One-sixth (4) of the young people had been diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD). This compares to less than 2% of 11-15 year olds in the general population who have been diagnosed with hyperkinetic disorders[2] (Meltzer, Gatward, Goodman *et al.*, 2000). The extent of health difficulties and disability within the group is shown in Table 3.2:

[1] Health difficulties can be difficult to define and responses from those asked to comment on health difficulties varied for individual young people. Young people were recorded as having a health difficulty if one or more respondent indicated this to be the case. Also, some young people had more than one type of health difficulty or disability and therefore appear more than once on Table 3.2.

[2] The term Attention-Deficit Hyperactivity Disorder (ADHD) is commonly used in the USA and UK, however, the official term in the UK is Hyperkinetic Disorder.

Table 3.2 Presence of health difficulties and disability amongst young people (n= 25)

	%	Number
Physical health problems	52	13
Mental health problems	12	3
Emotional Behavioural Difficulty (EBD)	16	4
Learning disability	24	6
Physical disability	4	1
Medical diagnosis of ADHD	16	4

One-sixth (4) of the sample experienced more than one type of health difficulty and/or disability and one in four were reported to have either emotional and behavioural difficulties or a learning disability (or both). Clearly, parents were likely to experience a degree of stress in caring for these young people.

Special Educational Needs

Given the extent of disability and behavioural difficulties within the sample it was not surprising that a number of young people had been assessed as having special educational needs under the Education Act 1981. Over a third (36%, 9) of young people in the sample was found to have a statement of Special Educational Needs (SEN). This proportion seems high in comparison with other recent studies of similar groups of vulnerable children and young people, including those looked after in public care, which suggest that around a quarter of this vulnerable group have a statement of SEN (Berridge, Beecham, Brodie *et al.*, 2002; Biehal, 2005).

Consistent with national figures, more boys had received statements of SEN than girls (40% of boys compared to 30% of girls). Those who had a statement of SEN were more likely to have multiple health or behavioural difficulties than those who did not (p=.002). Although the reasons for the statement were not given for all the young people, five of those who had a statement of SEN were reported to have a learning disability, three had mental health problems and three had a diagnosis of ADHD. Other reasons given for the SEN statement were physical disability, dyslexia and literacy problems.

Family composition

Young people were referred to the service from a range of family settings, the most common forms being step-family and lone parent households, with around one-third living in each of these household types. As Table 3.3 indicates, just over a quarter of the young people in the group were living with both birth parents at referral. Of those living with other relatives, one young person was living with a grandparent and another with an uncle. Families were far more fragmented than for young people in the wider population, where 65 per cent live with both birth parents (National Statistics, 2003).

Table 3.3 Young people's family composition at referral (n= 25)

Carer	%	Number
Birth mother and step-parent	32	8
Both birth parents	28	7
Birth mother only	28	7
Birth father only	4	1
Other relatives	8	2

Duration of difficulties

The duration of young people's difficulties were explored, as previous research suggests, young people whose difficulties emerged at an early age might be a particularly difficult group to help. A variety of longitudinal studies have indicated that the origins of persistent youth aggression and violence are to be found in early childhood (Scott, 1998). Where children display behaviour problems at an early age, usually before the age of five, these are more likely to persist into adulthood. This persistence is considered to be to some extent related to parent-child relationships (Rutter, Giller and Hagell, 1998). One quarter of the parents reported that behavioural difficulties had emerged during early childhood, as shown in Table 3.4:

Table 3.4 Age of child when parent became concerned (n=19)[3]

Age –range	%	Number
0–4	26	5
5–9	32	6
10—12	26	5
13-16	16	3

Around one quarter of the young people had been of concern to their parents during their pre-school years and almost a third had started to exhibit difficult behaviour between the ages of five and nine years:

> *'I can remember going to the playschool and them saying "If you don't tell him to calm down and listen to what we're saying" …..Right from being sort of four years old he was excluded from different schools'* (mother of Adam, aged 13 years).

> '*When I think back I have always had significant problems with him from when he started school, he struggled with school and that's when I should have had all the help but they never recognised it, the seriousness of it*' (mother of William, aged 14 years).

A high proportion of parents in Biehal's earlier study of troubled adolescents also reported long-standing behavioural difficulties, with 40% of that sample reporting that difficulties became apparent when their child was under ten years old (Biehal, 2005). In the current study, three-quarters of the parents reported having been concerned

[3] This table includes data from follow-up interviews, where three additional parents mentioned age at onset of problems.

about their child for at least three years and several reported even longer-term concerns, in four cases ten years or more. Overall, the average duration of concern for the group was five years prior to the current referral to the service.

History of contact with social services

Few of the young people were new to social services, as other studies of social work with adolescents have also found (Biehal, 2005; Sinclair, Garnett and Berridge, 1995; Triseliotis, Borland, Hill *et al.*, 1995). Parents, young people and workers were asked about any contact with social services regarding the young person, prior to their current referral. The majority (88%, 22) of young people had received some previous social work intervention. Over one-quarter (7) of the young people studied had been known to social services long–term, that is, for three or more years.

Reasons for past contact

The main reasons for previous contact were provided by social workers and community support workers. As Table 3.5 shows, for some young people multiple difficulties had led to past referrals:

Table 3.5 Reasons for previous social work contact (n=22)

Reason for past contact	%	Number
Young person's behaviour	77	17
Potential/actual abuse	23	5
Neglect	9	2
Breakdown of relationship between yp and family	68	15
Parent unable to provide care	27	6

In over three-quarters of cases, the young person's behaviour was cited as one of the main reasons for contact with social services. For one-fifth of the total sample (5), past contact had been partly or wholly due to concern about abuse and for two young people past contact had been prompted by concerns about neglect.

Care history

In some cases, earlier contact with social services had involved a period of being looked after. Information on previous care episodes was sought from young people, parents and the three workers. However, data was patchy, as not all cases supplied full information and in several cases there was some discrepancy amongst the different sources of information. Young people were considered to have had a previous care episode if they, a parent or one of their workers, indicated that this was the case. In most cases, reports of previous placement in care were confirmed by more than one respondent.

Ten of the young people (40%) had previously been looked after on at least one occasion, a higher proportion than in Biehal's earlier study of community support teams, which found that 25% had been previously looked after. Three indicated that they had been looked after on more than one occasion (ranging from two to four times). For some, the experience of care was quite recent as one-sixth (4) of them had been looked after at some point during the six months prior to the current referral.

To sum up, in most cases young people's difficulties were not new, as the vast majority of the young people using this service had experienced difficulties in the past. For over one-quarter, contact with social services had begun over three years earlier, so difficulties were clearly long-term. One quarter of them had been looked after away from home at some time in the past. If we add those with previous experience only of respite care of some kind, the proportion whose difficulties were severe enough for them to require a break from their families rises to 40%.

Parents' circumstances and difficulties

Parents face many challenges in caring for and responding to the needs and demands of their children and these may be amplified during the young person's adolescent years. Coping with the task of parenting adolescents, particularly more troubled or troublesome adolescents, may be made even more testing for parents who are coping with additional stresses and difficulties of their own.

Parental health and disability

The extent of parental ill health is possibly underestimated, as only two-thirds (16) of the parent group completed questionnaires at baseline. Of the 16 parents who responded, around one-third (6) reported having health or mental health problems, a disability or sensory impairment. Two indicated that they or their partner had a serious health problem; three reported a physical disability and one was partially sighted. Health difficulties experienced by parents included hypoglycaemia, back and leg problems, and asthma. Information gathered from young people showed that 41% (10) had concerns about parental illness.

Parental mental health

Parental depression was particularly common amongst the group. The majority (81%, 13) of parents reported often feeling depressed and two mentioned other mental health difficulties. For five of these parents, mental health difficulties had persisted for more than three years, whilst for the remainder (8) this had been the case for the past year only. Furthermore, just over half (13) of the young people reported concerns about parental depression. Workers reported evidence of current depression in relation to the parents of over one-third of the young people (9) and evidence of a psychiatric illness (excluding depression) for the parents of one quarter (6) of the young people.[4]

We used the General Health Questionnaire (GHQ-12) as an objective measure of parental mental health. The GHQ is a standardised measure designed for use as a screening instrument to detect psychiatric disturbance in community settings. It is normally used to detect breaks in normal functioning rather than lifelong traits and focuses principally on detecting symptoms of depression and anxiety (Goldberg and Williams, 1988). Since a substantial minority of parents in this study suffered from poor health and/or a disability, the cut-off score used to indicate anxiety or depression was increased from three to four in order to control for the influence of physical illness, as recommended by Goldberg and Williams 1988.

[4] This is based on combined data from social workers and community support workers. However, because of limited responses from workers we do not have information for all young people and families taking part in the study. The reported figures may therefore underestimate the extent of these difficulties.

Despite the fact that a relatively high threshold score was used for detecting psychological difficulty on this measure, it was evident that over three-quarters (13) of the parents who participated in the study at baseline were experiencing high levels of psychological distress. This was similar to the rate of 72% found among parents in Biehal's earlier study, but is far higher than the proportion that would be expected in the wider community, since an international study evaluating the GHQ found that the mean prevalence of mental disorder in the general population was 24% (Goldberg, Gater, Sartorius *et al.*, 1997).

Parental lifestyle

There was some evidence of substance misuse amongst parents, although it is difficult to be accurate about how extensive this was as respondents may choose not to report behaviour that is considered socially unacceptable. Equally, professionals may not always be aware of these problems. Workers indicated that at least one-sixth (4) of the parents had problems with drug use and three of them had problems with alcohol misuse. Similar questions of accuracy arise in relation to the reporting of involvement in crime. Workers reported that at least two parents were involved in offending.

Social isolation was a problem for at least one-fifth of the parents, which was similar to the finding in Biehal's earlier study that one quarter of the parents had no-one to turn to for support. This may have contributed to parents' ability to cope with their children's behaviour and, more generally, with family stress, since other research indicates that social support systems can mediate the effects of stressful life events and depression (Goldberg and Huxley, 1992).

Financial and housing difficulties

Parents were asked about their main source of family income. Three-quarters of those who responded indicated that they were in paid work, whilst a quarter relied on income support, as shown in Table 3.6:

Table 3.6 Main source of family income at referral (n=16)

Source of income	%	Number
Wage	31	5
Wage plus family credit	43	7
Income support	25	4

Financial problems may often lead to increased family stress. Information from social workers, community support workers and parents indicated that over one quarter (7) of the participating families were experiencing financial problems. Four parents reported serious money worries related to being on benefits or on low income, and two reported serious debt problems.

Problems with accommodation can also add to overall family tensions. One quarter of the parents who responded, reported serious problems with their housing situation. For example, one highlighted serious problems with overcrowding, while another described how she was unable to secure suitable accommodation due to being unable to find the required rental deposit. Two parents were unhappy with the location of their home, as one felt isolated from her family, while the other felt unsafe.

Neighbourhood problems may arise as a consequence of local tensions and conditions or, as a result of problem individuals or families. Young people, parents and workers were asked about any neighbourhood difficulties which had affected the family. Information from young people and parents suggested that over a third (9) of the families felt that people in the neighbourhood made life difficult for them or their child. Problems included the local presence of drug pushers and the prevalence of crime in the area, providing an environment in which the risk of anti-social behaviour was exacerbated by anti-social peers or '*the wrong crowd*', as one parent put it.

To sum up, many of the parents experienced considerable strain. Over three-quarters of those who participated in the study at baseline experienced poor mental health, some had chronic health problems or a disability and one-fifth were socially isolated. A number were experiencing financial and/or housing difficulties and a few were known to be involved in substance misuse or crime. In addition, as we shall see in the following chapter, there was also some evidence of domestic violence. Young people were clearly aware of this parental stress, as over half of them (14) reported feeling worried about a parent. One-third reported that they had been worried about a parent just during the past year, but one quarter indicated that they had been worried about their parents for more than a year, so in these families, difficulties were clearly not of recent origin.

4. The nature of the supported respite service

As the previous chapter has shown, young people referred to the service presented with a range of difficulties. These difficulties were often accompanied by significant, and in some cases, long-term need across several life areas. Support to address their needs had been provided by a range of professionals, including those involved in the respite service.

This chapter looks at support provided by the respite service. It presents a description of the service, its aims and objectives. It also looks at the ways in which the service offered support to families, from the perspective of young people, parents and workers. Finally, the chapter considers the range of wider formal and informal support received by young people and parents at baseline and during the follow-up period.

The supported respite service

The overall service provides a supported respite care scheme to families and young people in need and at risk of entering full-time care. Its innovative approach integrates planned prevention, placement and rehabilitation services with a view to working with the family to resolve difficulties. The service involves a collaboration of three key groups of professionals: social workers, the community support team; and staff at the Hilltop residential unit.

Young people are referred to the respite service by a social worker. They are also allocated a worker from the community support team who works with them and their parents, to resolve the difficulties that led them to the supported respite service. Importantly, young people are offered a series of planned, short breaks (respite) in Hilltop of between one to three nights per week over several months, under Section 20 of the Children Act 1989. Hilltop works specifically with male and female 12-18 year olds who need a break away from home, in order to prevent their usual living situation breaking down. Up to five young people can be accommodated at Hilltop at any one time.

Aims and approach of the service

The overall aim of the supported respite service is to prevent long-term family breakdown and '*prevent the young person from coming into care*' (Community Support Team Focus Group). More specifically, Hilltop aims '*to provide high quality accommodation services which are firmly focussed on the needs of the child'* and '*to ensure effective partnerships within* (their) *own organisation and with other agencies* (and) *work in partnership with the Community Support Team, Social Workers, young people and their families and others… to achieve positive outcomes'* (Hilltop Statement of Purpose Document).

The service is holistic in approach '*looking at the whole picture… a combination of all sorts of family and environmental factors*' (Hilltop Focus Group). There is no single therapeutic approach, both Hilltop and the community support team focus on the individual and '*tailor* (support) *to the needs of each child'* (Hilltop Focus Group).

A key objective of the supported respite service is to provide opportunities to young people in order to help them achieve their full potential, including addressing any health, education or leisure needs, and to facilitate and maintain positive aspects of relationships with family and friends, '*We address the issues and difficulties within the home and try and put some strategies in place to get it working again, and get them* (young people) *back into education, try to encourage them'* (Community Support Team Focus Group).

Duration of the service

The respite service offers respite stays of up to three nights per week over a planned period of weeks. On average, young people in the sample attended Hilltop on 36 occasions over the follow-up period. The number of visits ranged from four to 96 visits. Generally, the number of days young people attended per week decreased as the support progressed towards completion. However, a small number of young people were re-referred to the service during the follow-up.

In most instances, parents and young people were happy with the amount of time spent at Hilltop. However, it was apparent that some parents would have valued more of a break from their child – either by increasing the number of days respite or reducing telephone contact whilst at Hilltop. In a few cases, parents expressed a wish for long term care, '*I couldn't cope any longer with her aggressive defiance and stealing. I left her at social services and told them to keep her'* (mother of Joanne, aged 14 years).

Admission to the respite service

Almost 300 referrals had been made to the respite service in the three years prior to the research ending. Admission to the respite service can be made on a planned or emergency basis. The admissions process generally consists of a referral to Hilltop by the young person's social worker, followed by a planning meeting.

If a respite care placement is considered appropriate, the social worker provides relevant information, including the initial risk assessment, care plan and reports to the manager of Hilltop. Where an urgent or emergency placement is required the young person's social worker makes contact with Hilltop via the duty referrals system and staff assess the appropriateness of a placement.

Prior to a decision to offer a placement to a young person, an assessment is carried out on their compatibility with the young people already accommodated in Hilltop. This involves a consideration of the likely effects of a young person's admission, '*upon the existing group of residents or alternatively, how the current resident group may impact upon them. The placement must be appropriate to the mix of ages, sexes, and personalities of young people already placed in the home and is not likely to significantly adversely affect any of these young people already in residence'* (Hilltop Statement of Purpose Document).

The final decision rests with the manager and is based on consideration of relevant documents (plans, needs assessment, risk assessments, etc.) and discussion with the young person, parents and social worker. The manager, social worker, young person and parents then form an agreement about the placement, and the young person is allocated a community support team worker (if they do not already have one). This plan forms the basis of the written placement agreement, a copy of which is given to

the young person and their parents and Hilltop. Each plan becomes the subject of continuous monitoring and evaluation and also regular review.

Before a new placement begins, the young person and family are invited to meet the respite team and other young people in Hilltop.

Roles of the professionals providing the service

Whilst each of the three services has a distinct role within the overall provision, there is also a degree of flexibility in order to encourage a seamless and effective service, *'you don't want to be overlapping work so when you come together you have to look at what each* (agency) *are doing, like* (residential) *are doing a specific piece of work but social work will do another piece of work and it will all be linked together to meet the objective, though we work in different ways, you need to manage it quite well'* (Community Support Team Focus Group).

Social workers

In addition to having responsibility for referring families to Hilltop and processing the initial paperwork, social workers are primarily responsible for the statutory areas of work, including investigating any child protection concerns that come to light and arranging support from agencies that only take referrals from social workers. Information from the research participants suggested that in many cases, the social worker took a step back from direct work with the family as the community support team and Hilltop became involved. However, this was not always the case. A number of families commented on the wide-ranging and on-going support they had received from their social worker. For example, the mother of David (13 years) described some of the help she had received:

> *'I suppose it was like having a partner there to give you another opinion…because she could stay calm and unemotional and evaluate the situation, explain it to me …like I'd be hysterical on the phone to her and she would stay so calm and just talk us down…looking for avenues to sort of rectify the situation….sort of finding the different avenues for David,….activities scheme, Hilltop, CAMHS….sort of David's behaviour (and) how to rectify it pointing me in the right direction… finding parenting classes. Sometimes she was just there to calm us down'.*

Community support team workers

The Community Support Team (CST) is a multi-disciplinary team consisting of 12 members of staff. Staff have a range of experience and expertise, including backgrounds in residential care, foster care, social work, youth and community work and the police. The CST's role in the provision of the respite service involves working in partnership with Hilltop to support the families. This involves a contract or '*worker-family agreement*' where the CST and family agree certain areas of work *"three or four areas that we are going to focus on* (and) *we share that with* (Hilltop) *so that they know our aims and objectives and hopefully work on that, work in partnership'* (Community Support Team Focus Group).

The CST work directly with the family in their home environment to introduce effective parenting strategies for managing challenging behaviour, setting and re-enforcing appropriate boundaries within the family and for communicating with

young people. One parent explained how her CST worker had helped her to increase her confidence and parenting skills:

> *'He made us realise just how much progress we made. He would say look this is where you were when I first met you and now you're here. This is a problem you've got now, how about you use this strategy then?" talking rather than shouting, although the shouting would come every now and then cos it's hard to change behaviour. I mean, I'd just learnt not to smack them ….so instead of smacking I was shouting just as bad. So then* (CST worker) *came along and taught us how to sort of, even if I was angry take the tone down a bit and...communicate'* (mother of 13 year old boy).

Another explained how the CST worker had acted as a mediator for the family:

> *'When* (CST worker) *was here we would talk… be a bit more open with each other…so we got things off our chest…I think it was with someone else being present it didn't end up a screaming match'* (mother of Catherine, aged 13 years).

CST workers also worked with the young person to address elements of their behaviour and manage the inter-relationship with parents, family members and peers, *'We can address a lot of issues, sexual education, anger management, peer pressure, self-esteem, relationships, communicating with each other, boundaries'* (Community Support Team Focus Group).

Young people also commented on the helpfulness of their CST workers:

> *'She was good her, because she like used to come and see the whole family and like talk to us individually and set targets. I had to like wash up and tidy the house a bit. Just sitting in and talking like and she'd tell us things to do and it did work'* (Joanne, aged 14 years).

The CST is also involved with sourcing other support services for the family. A key element of their role is to, '*empower the family to access their own local resources to find out what's going on in the community, to introduce the young people to other areas so that when we do close they have got other resources to access. It's about empowering them to deal with their own situation*s' (Community Support Team Focus Group).

CST workers work with parents and young people separately and as a family unit, depending on the needs of the family. Visits can vary from three times a week to less frequent support when the service to moving to a close. The CST worker also offers short-term, follow-up support after the period of respite has ended.

Residential workers at Hilltop

Hilltop has a multi-disciplinary team consisting of 15 members of staff, including residential care workers and support staff. A key worker is assigned to a young person. Attempts are made to match the needs and preferences of the young person with the experience and skills offered by the staff. A co-worker is also assigned, in consultation with the young person.

All residential staff are checked in compliance with Schedule 2 of the Children's Homes Regulations 2001 and all employees undertake an appraised induction programme; followed by a six month foundation programme; leading on to a period of consolidation in NVQ level 3 in Child Care. The key focus of the residential worker role is to work directly with the young person to address their difficulties and wider needs, as described in detail below.

Interventions by Hilltop staff

The inclusion of respite residential care within the family support service represents a new way of working with families and young people in crisis. This section looks in more detail at the specific role and approach of Hilltop.

As outlined above, Hilltop offers time-limited, planned respite to young people who are experiencing difficulties. Respite not only gives young people and their families 'time out' or time away from each other, but also provides an opportunity for residential staff to carry out some focused work with young people to help them resolve or cope with their difficulties. Residential staff work with young people across a range of key areas. To enable us to understand more about the focus and scope of their work, residential workers were asked to indicate, from a list of activities, which areas of work they had undertaken with the young person they were supporting. Responses for 22 cases are presented in Table 4.1:

Table 4.1 Types of work undertaken by residential workers with young people (n= 22)

Area of work	Number	%
General support		
Co-ordination/case management	12	55
Providing financial/material help	3	14
Providing practical help/services (e.g. family aide, transport)	11	50
Help with housing problems	1	5
Providing advice or information about services or benefits	16	73
Advocacy/obtaining services from other agencies	16	73
Support with yp's behavioural, emotional & social needs		
Teaching techniques for dealing with problem behaviour	16	73
Teaching new patterns of behaviour (e.g. anger management)	16	73
Work on emotional problems (e.g. anxiety, grief, self-esteem)	18	82
Work on drug or alcohol problems	11	50
Work on mental health problems	3	14
Work on young person's social skills/life skills	18	82
Work on sexualised behaviour, sexual health or sexuality	13	59
Group work	3	14
Supporting family interaction and communication		
Mediation between parent and child	15	68
Improving parent/child communication	16	72
Counselling on marital/partner relationship	0	0
Exploration of underlying causes of family problems	10	46
Support to improve parental care (e.g. in cases of neglect)	3	14
Mobilising social support (from relatives/friends)	3	14

The areas of work fall into three distinct spheres of support: general support; support to enable young people to address emotional, behavioural and social needs (including risk behaviour and general life skills); and support to develop wider family relationships and communication. The extent to which all of these tasks featured in the work of the residential staff reflects the holistic nature of their work and supports the aims of Hilltop to address and meet *individual need*. It also suggests that whilst providing a broad spectrum of support, the key focus of their overall work lies in supporting young people to address their emotional and behavioural problems (73% and 82% of cases respectively), develop skills in behaviour management and basic life skills (73% and 82% of cases respectively) and promote more effective communication between parents and young people (72% of cases).

Evidence from the accounts of young people, parents and professionals provide some indication of the particular methods employed by Hilltop in supporting young people and their families.

Helping young people to change their behaviour

A key focus of the work at Hilltop is assisting young people to address their behavioural difficulties. This includes support to develop strategies to avoid negative behaviour. For example, anger and aggression had featured heavily amongst the reasons for young people entering the respite service. Many young people commented on support they had received from Hilltop with anger management techniques and strategies to avoid or defuse confrontations or volatile situations. Leanne, aged 15, described one of the techniques she had been taught by staff:

> '*They talked to us see, if I started to feel angry, just told us to go out the room for about half an hour, an hour and then go back and try and talk calmly to them*'.

Another young person commented:

> '*At the time I was in an angry mood so we did loads of like anger management work, doing the deep breaths and stuff like that..…..Before I went to Hilltop, like every ten minutes we were arguing ….and from there it's learnt me loads of stuff how to walk away from the argument…and that's helped me make things really good at home*' (William, aged 14).

William's mother agreed:

> '*Hilltop definitely helped ……they were spot on, that's what they are trained to do, so they probably dealt with it (argumentative behaviour) a hundred times before so they were in a far better position to deal with it than I was…I mean we still argue, but who doesn't with teenagers but it's not as intense*'.

A small number of parents felt that their child struggled to put these new techniques into practice at home. Stephen's stepmother told us:

> '…..*because young people are so aggressive these days it's unbelievable….they* (Hilltop) *were trying to get him to be nicer to people …if you treat people the way you want to be treated sort of thing you know, but it didn't work, not here* (at home) *it didn't work anyway*'.

Helping young people and parents to negotiate boundaries

Hilltop staff also supported young people to develop an understanding of the need for boundaries, thus complementing the work of CST workers who focused on assisting parents to agree and maintain boundaries. A residential worker outlined the nature of the work they had undertaken with 16 year old Emma:

> '*The main focus of the work was to deal with boundaries in the family home, time to go to bed, appropriate language. Initially she was not receptive to this but as time went on she became accessible to it. The staff would always reinforce what was said, for instance the time she had to be in at night, the boundaries were always reinforced*'.

The environment within Hilltop helped to promote a sense of routine and structure in a neutral and non-threatening manner. Hilltop staff, for example, implemented clear house rules for young people attending Hilltop, including times to be in, to go to bed, and for conducting themselves with staff and other residents. In doing so, they established familiarity with boundaries and routine. Leanne's social worker commented on the ways in which Hilltop had supported the young person:

> '*Well I think one of the things that I find with Hilltop is they're very consistent. All the workers have a very clear agenda, what's expected of the child, what's not expected, what's inappropriate….so they have very clear boundaries and that really works with most of the young people coz often they haven't had that*'.

Reinforcing positive behaviour

Hilltop also undertook work to reinforce positive behaviour through use of rewards and incentives. Young people were able to earn activities by improving their behaviour at home and in Hilltop. Leanne told us, '*if you were naughty during the week with your parents, you weren't allowed to go on any of the trips out'*. Alex's mother explained how this approach worked for her 15 year old son:

> '*It was absolutely wonderful, especially the occasions …when he was enjoying it, when he's earned an activity that he was looking forward to. He was told that the next week he could go, he could choose an activity and he actually made me ring them early and ask if he could go, so when it worked it worked wonderfully*'.

However, there was some concern that providing access to activities and to some extent attending Hilltop per se, could send an ambiguous signal to young people. William's mother commented:

> '*When we got help for Will, everyone centres on him, and they didn't think how it was affecting his younger brother…it was apparent, Will seemed to get rewarded for bad behaviour, he was taken, like for instance, he'd go go-carting with* (the activities scheme) *or he'd go for trips out and yet he had been absolutely horrendous to live with that week and then he would have this great weekend* (at Hilltop)'.

Hilltop staff attempted to prevent such situations by establishing regular contact with parents to discuss how things had been at home during the week prior to attending Hilltop. This enabled staff to discuss the most appropriate means of responding to

negative behaviour, including the withdrawal of privileges, such as activities or addressing incidents as a focused piece of work with a key worker. Residential workers explained:

> '*We have on occasions had to remind parents that we're not here as the punishment…we have to work with the parents in how to discipline the child for behaviour they have displayed at home*'.

> '*We would, on a regular basis, contact parents before their child comes here and say "What they been like at home? Have they had a good week? Have they been going to school?" and stuff like that. Then we say, "Well maybe you'll get an activity, something pleasant". But when a young person walks in and, and you say, "Oh, you've had a bad week then? I've just been talking to your Mam or your Dad" or whatever, they think, oh I'm not going to get away with it at home and then come here and don't mention it, keep it quiet, you know.*'

Promoting positive activities and positive self-esteem

Encouraging positive activities and peer group culture forms a significant part of Hilltop's work. The aim is to increase skills, self-esteem and divert young people from risk behaviour and negative peer group influence.

Whilst at Hilltop, young people are encouraged to broaden basic living and self-care skills by contributing to domestics tasks, such as cooking, washing-up and laundry. Young people are also encouraged to attend group meetings and individual sessions with key workers. Although their time during their respite stay at Hilltop is often structured and occupied, young people also have some 'free time' where they have access to a range of activities, such as puzzles, games and a computer, which can be used for home study. Alternatively they can opt for quiet time, watching TV and DVDs or interacting with staff or other young people.

As a means of encouraging participation in positive activities in the community, Hilltop offers and arranges a wide range of activities, including sport, dance, street art, music workshops and trips out to the cinema, museums, libraries or places of interest. Young people are also encouraged and supported to participate in after-school activities, sports clubs, and hobby clubs in their local area, including activities that encourage the development of creative and interpersonal skills.

The supported respite service has particularly good links with a local activity scheme, which provides a broad range of personal development activities to young people referred by social services, youth offending teams and other agencies. Around half of the young people in the sample had attended the scheme, which involves support from trained instructors who are able to plan and prepare specific activity programmes for individuals and groups. The scheme works in partnership with young people, their parents, social workers and other professionals to ensure that '*personal change is maximised'*. Instructors undertake ongoing assessments of young people's personal and social performance and attainment and provide pastoral and personal care. As one social worker explained, '*it's about self-esteem, group work, relying on other people. There are times when they do family work as well, where young people can go with parents and siblings as well*'.

Hilltop's planning of opportunities and activities is undertaken at both a group level, in young people's meetings, and in young people's individual Planning and Review meetings to ensure that activities match their interests and needs. There is also a strong recognition that some families may have limited resources to encourage ongoing participation in positive sports and activities after respite has ended, indeed one parent noted, '*there's no way we can ever afford to take the children, take them all to these big places but Hilltop can'* (mother of Victoria, aged 15). In order to support the involvement of young people in activities both during their respite stay and whilst at home, Hilltop is involved in a local partnerships with leisure departments and Arts and Libraries (initially funded through *Quality Protects*) to offer subsidised access through a local *leisure card*. This increases young people's opportunities to access leisure facilities and activities in their local area.

Such opportunities to develop new skills, in a positive and supportive environment, can make a significant difference to a young person's self-esteem and behaviour. Douglas came from a troubled 'dysfunctional' family and presented with multiple difficulties, including truancy and offending at referral to Hilltop. His social worker believed that attending Hilltop had made a huge difference:

> '*He was very well behaved there. He was very positive and the staff there gave him some excellent positive feedback that he wasn't getting at home. They even reinforced… that deep seated belief in himself, that he was a really nice young person, intelligent, hard working and it was a very positive experience. Praised him to the hilt and he took it on. He was a young person that needed this self-esteem building cos at home he's just not appreciated*'.

Developing positive relationships and communication

Providing access to positive activities is an important factor in increasing young people's self-esteem and resilience and forms part of Hilltop's commitment to meeting the emotional, physical and social needs of the young people. Also important, is building relationships based on mutual respect and trust between young people and residential staff. Certainly the value of having a safe, neutral environment where young people feel able to talk about their difficulties or circumstances, relax and interact with others cannot be underestimated. Thirteen year old David looked forward to staying at Hilltop, he described a typical visit:

> '*At Hilltop I would go out with them and talk about how things were going at home. Sometimes it was helpful. When I arrived I would get a cup of tea and go on the computers. I would stay the night and the next day go to school or go home. There was a couple of groups. I talked to anyone. They were all really nice people over there like. I was able to get out my anger there, talk about it. It helped a lot*'.

Many young people, parents and workers commented on the willingness of young people to just sit and chat to residential staff. Indeed, for some young people it had been the first time they had been given such an opportunity. Leanne's social worker noted:

> '*Hilltop workers will, you know, sit and chat to the young people, and certainly that was the case with Leanne. She felt able to talk, obviously about how she felt about things…(they) try to like not be too in your face, just very gently …helping*

her to sort of talk about how she felt and why she was doing the things' (social worker of Leanne, aged 15 years).

Leanne clearly valued this time. She told us that residential staff, '*were lovely, they were easy to get along with and they would help us in any way I like needed'*. Stephen's social worker told us, '*he could go there and feel respected and he was able to, you know, talk to the staff about his thoughts and feelings*'. Stephen found this helpful and described his key workers as:

'Like my two best friends. You had your key worker sessions to talk to you and say "How are you doing?" and that… they don't give you a hard time at all they talk to you, they are always there for you'.

Of course effective communication between the parent and young person is also important and both Hilltop staff and the CST team worked to improve this. One CST worker told us a key focus of her work was, '*keeping them communicating, because usually what you find is that they do want the same things, they just don't know how to tell each other, they have never sat down and spoken about it*' (CST focus group).

Encouraging participation in education

As we have seen, at referral many of the young people had considerable problems with schooling. Only half were in mainstream school and one in eight were refusing to attend school. The majority had truanted during the six months prior to referral and most displayed behaviour problems at school or in their alternative educational provision.

The supported respite service places a high premium on encouraging educational participation and attendance, where consistent with the young person's assessed needs. Hilltop promotes a positive culture in relation to education with, '*a strong expectation that individual educational achievement will be pursued and encouraged in order to improve the young person's self-esteem and life chances'* (Hilltop Statement of Purpose). Hilltop arranges transport to take young people to and from their school on the days that they attend Hilltop, thus minimising any disruption or delays resulting from the increased distance. Hilltop also provides a study room for after school use and for use by young people who are excluded during their respite stay.

Fifteen year old Stephen had been excluded from school and had a history of truanting. Whilst at Hilltop he attended a pupil referral unit. He told us that his educational attendance had improved whilst at Hilltop, with the help of incentives and rewards, *'they helped us with that as well, They used to try and get us to go to school, persuade us to go to school…pay us to go and I went there'*. At follow-up Stephen's parents reported a reduction in truancy, although his general behaviour at school remained a problem.

Victoria explained how Hilltop used activities as incentives to encourage her to attend school, '*you could only go out if you went to school and behaved yourself, if you didn't go to school you weren't allowed out on trips'*.

Of course, promoting participation in education involves developing effective links with local schools and specialist educational provision. There was some feeling amongst residential workers that educational professionals could play a greater role in the planning and review process for young people, '*I do lots of* (review) *meetings and I can rarely…recollect….few educational representatives being there. We have to attend…I just think it needs to be balanced throughout all of the services'*. Hilltop also worked with the Educational Psychology Service and with the Education Department's ACCESS service[5]. In addition, Hilltop has an Education Liaison Worker who actively promotes education within Hilltop.

Work on health and risk behaviour

As outlined earlier, risk behaviour was evident amongst young people in the sample. Nearly two-thirds reported a degree of substance misuse. Around one quarter of the young people had reported major problems with alcohol use and one-third reported major problems with drug use.

An important focus of Hilltop was promoting young people's wellbeing and addressing risk behaviour. As part of promoting a healthy lifestyle, young people are actively discouraged from smoking, using alcohol and illegal substances. A looked after children's nurse provides guidance to staff and young people on a variety of matters, including help to access services for young people with specific health care needs. The risks associated with substance misuse, sexual activity and offending are addressed in both individual and group work sessions with Hilltop staff and in workshops conducted by relevant professionals. For example, a Health Liaison Worker and relevant health professionals are available to provide guidance on these matters, including information about safe sex and all the health risks associated with unsafe behaviour.

Mental health problems were also apparent amongst young people in the sample and Hilltop staff commented on difficulties in both accessing Child and Adolescent Mental Health services (CAMHS) and also in young people's willingness to engage with mental health services, '*The* (waiting list) *is very high…and there's a barrier that young people, they're not really forthcoming using these services'*. As a consequence, some Hilltop staff took on the role of supporting young people with these difficulties, although some expressed discomfort at taking on such a responsibility, '*they are not willing to go to the qualified people so we've got this work…it's a frustration for us because we are not qualified to do that type of work with them*' (Hilltop focus group).

Other sources of professional support

The focus of the research lies primarily in exploring whether the supported respite service helped young people and families to resolve their differences and difficulties. However, it would be misleading to assume that any changes subsequent to placement at Hilltop should be attributed to the work of social services support alone. As previous research has shown, young people who come into contact with social

[5] The LEA's Access Service provides in-class support, group work, homework support, out of school hour's support, age phase transition support, Year 11 GCSE revision, counselling, support and mentoring arrangements.

services are often already, or subsequently become, involved with a number of other support agencies (Biehal, 2005).
Information gathered from young people, parents and residential workers showed that most families had contact with a range of support professionals, in addition to support from a social worker, CST worker and Hilltop, over the follow-up period:

Table 4.2 Young people's contact with other professionals (n=25)

Professional	Number of young people at baseline	Number of young people at follow-up
Educational Welfare officer	18	16
Mental Health Worker (CAMHS, Educational psychologist, child psychiatrist or psychologist)	16	17
Youth Offending Team	16	13
Drug/alcohol worker	8	13
Young carers group	4	1
Youth worker	12	7

Information collected at baseline suggested that most young people had been in receipt of professional support in the six months prior to referral to the supported respite service. As Table 4.2 shows, most commonly young people had received support from mental health workers, education workers and the youth offending team.

The majority of young people in the sample (22, 80%) had some contact with one or more 'other' professionals over the follow-up period. Again, support came mostly from mental heath, education and youth offending teams. All but one of the young people in the sample had received some support from an 'other' professional either prior to, or during, the follow-up period. Some young people had been in contact with several support agencies. Most often, young people were in contact with three professionals at follow-up, with a third (8, 32%) having had contact with four or five professionals in addition to the social worker, residential worker and community support team.

As discussed earlier, many of the parents had difficulties of their own, including mental health problems, substance misuse, domestic abuse and debt or housing problems. Not surprisingly therefore, parents also reported contact with a range of other professionals over the follow-up period, including counselling services, adult social services and parenting support schemes. One parent had been referred to parenting classes by her CST worker, but commented on a lack of support for parenting adolescents, '*I did classes for the young ones, into the young peoples behaviour and....psychology...but....finding parenting classes for teenagers, its nigh on impossible in this area. It's an avenue that really needs to be looked at*'.

In summary, the supported respite service provides a holistic and innovate approach to working with troubled young people and their parents. Whilst there is some distinction between the different roles of the three professionals involved, social workers, CST workers and residential staff generally work together to provide a seamless service. The overall focus is to work with families and young people to establish and agree boundaries, resolve difficulties and improve communication skills. Whilst the CST workers and social workers specialise in developing positive

parenting skills, residential staff are able to utilise the short breaks within the residential unit to work directly with young people on overcoming difficult behaviour and addressing individual difficulties and need.

On average, young people attended the unit on 36 occasions over the follow-up. Whilst at Hilltop, young people are supported with health and wellbeing, education and positive activities to increase their abilities, opportunities, self-esteem and resilience.

In addition to support from the supported respite service, it was evident that families were receiving support from a range of other professionals, demonstrating the level of need amongst the group.

5. Residential respite care: practice issues

The supported respite service represents an innovative approach. Respite care is well established for families and young people with a disability and is also increasingly used within foster care settings to provide a short break away from parents or from substitute carers. To date, however, there is little evidence of using respite for *troubled adolescents* within a *residential* setting.

There are two key differences in comparison with more common types of placement provision. First, respite care has more commonly been provided in foster care settings, so the provision of a respite service in a residential setting poses particular challenges. Second, unusually for residential care, young people move between home and the placement during the course of a week and staff are working with a constantly shifting resident group. This chapter draws on the views expressed in our focus groups with Hilltop staff and CST staff to examine the practice issues that arise in the provision of a residential respite service.

The use of relationships

Developing effective relationships between staff and residents and amongst the resident group is an important part of working effectively within a residential setting. However, given that the young people using the supported respite service come and go and only stay for short periods, we questioned how far it is possible to build up relationships and engage and work with young people effectively. Residential staff agreed that building relationships remained an important aspect of their work, and this view was supported by comments from young people, parents and professionals (presented in later chapters). They acknowledged, however, that there were important differences due to the nature and aims of the support. One member of Hilltop staff explained how the overall aim to maintain young people in the family home and the subsequent temporary nature of the placement had an impact on the use of relationships in their work:

> '*It's very difficult in fact, because in a child, say in a mainstream children's home, where you want that child to stay there and flourish, be happy and get on with their education and build up a really strong relationship with the staff to do that, our remit is different. We don't want to do that. We have to have a relationship but we don't have to have the same relationship because we want the child to go back home. Not to be reliant on the system. So there's a balancing act between having an effective working relationship with a young person and not getting too close, to get the young person so they're dependent on the system, the system that we try to avoid them getting into*' (residential worker).

Another residential worker highlighted the importance of developing a good relationship with the parent so as to facilitate a joint and consistent approach to the young person both in the family home and in Hilltop:

> '*It depends on the relationship you've built up with the parents as well, cos in that sense if you can get a good rapport going with the parents so that the young people can see it as a two way communication that tends to work better. It's when*

your parents just, you know, they're off with you, you know, they don't want to know what's going on whilst (the young person's) *here. That's when you know that there's a good chance it's going to be longer lasting than you'd like it to be*'.

Building an effective relationship with the parent can also facilitate a smoother and more successful reintegration when the young person returns to the family full-time. This was something that residential staff and CST staff worked on together. One CST worker explained how a phased return to full-time home life was managed for a young person she was supporting:

'*I was working with a person who was in Hilltop I think three nights, because it was quite an intense situation at home and then they reduced it to two and then they reduced it to one and then they phased back to his return home really and that gives the parents as well as the young person time to get used to it again*'.

The use and impact of group culture

Traditionally, residential units often use the group as a way of working with young people, for example by trying to develop positive peer cultures and trying to bring about change in individuals through group work and activities. This was certainly the case within Hilltop, despite the fact that residents only stayed there for part of the week. Through its strategy of trying to place the same group of young people together when they returned week after week, staff were able to make the best possible use of the value of congregation. Residential staff attempted to manage group dynamics by carefully planning which nights the young people would attend Hilltop:

'*We look at who we have in on that particular night cos we also have to bear in mind that sort of risk assessment through the night, so we're always really conscious of who we place where and with whom. Vulnerability and stuff like that, that's bearing in mind*'.

By promoting and supporting a positive peer culture, the group can have a positive impact by reinforcing acceptable behaviour. As one residential worker explained:

'*There was a culture being developed over quite a long time at Hilltop that when a child, they may be aggressive and they may be violent, then they walk into Hilltop they see that other children aren't like that. So they think well that's not the norm. That's not the way things are done and we reinforce that obviously, so that it has a positive roll on effect that children pass on to each other*'.

Other members of staff noted that whilst they do not necessarily use the group to work on specific aspects of an individual's behaviour, the overall group culture can have a positive impact on behaviour:

'*You do have occasions where you would say that the behaviour of someone is more challenging than the others but you don't make it a group issue. You will talk to (the individual) about their behaviour, and the effect upon the others and things like that you don't tend to bring the others involved*'.

'*What we do try and encourage, is tolerance of other people, you know,*

acceptance. We sort out little problems that obviously occur from time to time within a group by negotiations and having respect for people and getting it back'.

The group setting also provides an opportunity to work on young people's difficulties in forming relationships with their peers. For example, 12 year old Liam explained how his key worker had, '*helped us fit in with the young people there and make more friends*'. Another positive aspect of the group setting was to help young people to develop negotiation and decision-making skills by the use of young people's meetings. A residential worker explained that:

'*We have young people's meetings on a regular basis and we have them all sit down and we discuss issues…their likes and their dislikes. We give them the opportunity to give their opinions. You know, what can be changed or not, and that tends to work well, with the group, sitting down with them*'.

However, within a residential group there is always the danger of the contamination of behaviour. Negative peer influences within the group can influence, or pressurise, other young people to develop negative behaviours they have not previously displayed. Children and young people may begin to run away or become involved in offending for the first time, or established patterns of running away and offending may be reinforced instead of weakened (Biehal and Wade, 2000; Sinclair and Gibbs, 1998). For example, one member of staff noted:

'*Sometimes we'll get one young person who comes and he doesn't smoke, or hasn't smoked, but once they come in here in a certain group, he might start smoking. So that's a prime example, you know*'.

There was some sense of similar concerns amongst a minority of parents. One parent was concerned that during his time at Hilltop, her son was being '*contaminated*' by the behaviour of other young people, and for this reason she eventually stopped him going there. Despite this, she felt that the placement had been very useful at times:

'*It was absolutely wonderful, especially when he went there for two nights…..but it didn't work most weeks. I didn't think things could get any worse but little did I know they could, because he was mixing with other young people in Hilltop. It was worse behaviours than what he had and he was loving it. It got out of hand and we asked for him…not to go any more*' (mother of Patrick, aged 14 years).

Generally, it was felt that such instances could be avoided by carefully matching the young people attending Hilltop on particular nights. One CST worker commented that a young person they were working with had to be matched carefully:

'*Hilltop look at what backgrounds they come from …and said sorry, we can't put them two* (young people) *together because one might make the other one stray and their personalities would clash*'.

Caseloads

Using a residential unit to provide respite, rather than continuous care, naturally means that residential staff must work with a large group of young people. As a

result, respite residential staff have much higher caseloads than would be usual in a residential unit. Although Hilltop was limited to five young people per night, the changing population through the week meant that staff could be working with up to 25 young people in a month. This not only meant that staff had to work hard to engage a much larger group of young people, but high caseloads resulted in increased administrative work in relation to maintaining young people's case files and preparing for statutory reviews. As one residential worker explained:

> '*The paperwork…it's massive. Although we're a respite home, each person has to have an individual file. Whereas most of our staff are working with three, four, five young people, that's to look after maximum. We could be working with say 25. Last January, we worked with 25 so we had 25 files with loads of information, you know, so our workload has sort of quadrupled basically*'.

Staff felt that paperwork could be reduced if the problem of duplication was addressed, '*sometimes you have to write the one thing in about three places and send information over and over again*'. This was particularly the case in relation to young people who required medication whilst in respite care:

> '*It's very difficult to convince managers that to tackle that problem, particularly when it comes to important things like medication. To give a child a controlled drug, one tablet, it has to be recorded four times in four different places. But with …..maybe three children, if they were all being medicated it may be something of a task*'.

Staff were in agreement that a more streamlined system of collection and recording information on young people would free up considerable time.

The importance of collaborative working

Since the Hilltop service worked closely with both the CST and social workers, collaborative working was essential. At the beginning of the evaluation (2004/5) there was a sense that the joint working of the respite service and CST was still undergoing some development, '*we are still feeling our way'*, explained one residential worker. However, residential staff agreed that one of the key strengths of the service was '*working together'*. Successful collaborative working depended on a range of factors.

First, access to information about young people and families was important. Although at the time of the research, each team had access to the social services information database, Hilltop staff had only just started to be trained in accessing this information. This had, in the past, resulted in some difficulties and delays. Residential staff also felt that having copies of the Family Agreement between CST workers and the families and regular communication through reviews or data sharing was crucial to understanding the focus of the work and to ensure the co-ordination of their own work with that of their colleagues. A Hilltop worker commented:

> '*The biggest thing is actually, we're expected to work together and share experiences and find out, you know, what's happened to* (young people) *before* (so

that) *we get the overall picture. If we get the whole picture we work in a holistic way with them*'.

CST workers agreed that shared information improved efficacy and efficiency. CST workers now enter details of the work carried out with families onto a database that can be accessed by social workers, '*all our contact sheets are now put onto the system…..so the social workers can see exactly what we've done* (with the family) *that week'*.

Second, good communication between the teams was essential. A CST worker explained how communication was important to avoid duplication of work:

'*You don't want to be overlapping…what Hilltop are doing, and we say we are doing this specific work and social work will do another. We also get details of who* (families) *have worked with before to ….see if we can continue a piece of work*'.

A third issue related to reaching agreement on timescales. Residential and CST staff commented that on occasion there had been discrepancies in decisions over when respite should cease for individual cases. This had resulted in one or another service *'pulling out'* too soon. Equally, the timing of social work and CST withdrawal could pose problems, as one CST worker explained:

'*Sometimes the social worker will remain continually involved just in case…or close at the same time* (as CST), *which is unprofessional*'.

One obstacle to effective working was a perceived lack of sufficient staff. One residential worker commented on difficulties resulting from the high turnover of social workers in the area. As a result of this shortage of social workers, those social workers who were in post were unable to see families as often as they would have wished:

'*We have more communication with CST than social workers…cos there's been a high rate of agency social workers and a lot of people moving on, not being replaced…..so it can lead to sort of …things not kept up to speed*' (Hilltop worker).

'*There have been cases I have been on and I have phoned social workers and they have said "*(the file is) *on my desk and I haven't been able to see the family"*' (CST worker).

There was also a feeling that in some cases, due to staff shortages, high rates of sickness and the consequent pressure of work, allocated social workers would sometimes '*step back*' once CST and Hilltop became involved with a family. Residential and CST staff worker commented that:

'*Once social workers see young people in the looked after system they are out of their hair, well they* (young people) *are safe and contained elsewhere so they don't need the time and attention and* (social workers) *have new clients coming in, they can move onto someone else*'.

'*I have had a couple of young people who have felt really unsupported by some of the social workers and they felt they have never bothered getting in contact, it's mainly been myself rather than the social worker*'.

Overall, however, staff felt that the integrated respite service was working well, and were pleased with the continued increase in referrals as the service became more established. Staff estimated that around 260 young people had used the service in the two years since it opened. Good collaborative working was thought to be an essential ingredient of this integrated service:

'*But also, it all depends on ….community support work, if, their work is going well, ours will go well……If the teamwork between Community Support and us does well, you know, there's definitely a likelihood of a positive outcome at the end…I think the results show it all, that multi-agency does work and it works well*' (residential worker).

Finally, good working relationships with other agencies (for example Health and Education) and a shared approach to effectively supporting the young person were also thought to be important. There was some concern, however, that working relationships with Education staff needed to improve. For example, there was strong feeling amongst residential staff that educational specialists should attend reviews, '*we attend their education reviews but they don't attend the other way round, it's quite rare for, to get a representative from a school*'.

There was also some concern that a lack of a shared strategy of support from other agencies could destabilise the work undertaken by the supported respite service. For example, residential staff were concerned that young people attending Hilltop may be more likely to be excluded from school:

'*A young person comes in here and all of a sudden they find out they're in this environment, it's OK, we'll exclude them, they can go back to Hilltop…. because there's somebody here during the day…. That kind of thing does happen and it's getting across, that is more detrimental to the young person because it is a rejection thing happening*'.

To summarise, traditionally, respite care has been used for young people with a disability and is increasingly used within foster care settings to provide a short break away from parents or from substitute carers. To date, however, there is little evidence of using respite for *troubled adolescents* within a *residential* setting. Staff identified a number of practice issues related to the provision of residential respite care. Several issues arose from the short-term nature of the placement and the fluid nature of the resident group. For example; although staff were able to work on building relationships with and amongst the resident group, it required careful management so as not to create a dependency on the care setting. Also, staff noted a higher number of cases than traditional long-term residential care. Staff also attempted to manage the group dynamics to maximise the chance of positive peer influence and minimise the possibility of 'contamination' or negative peer influence.

An important aspect of the overall supported respite service was successful collaborative working. Joint procedures and good communication between the three

services was subject to on-going development and considered essential. Workers from the three core services were also keen to highlight the need for developing closer working relationships and procedures with other agencies including education, youth activity schemes and health.

6. Child and family difficulties at referral

Reasons for referral

In most cases, it was an accumulation of problems that led to referral to social services and then on to the community support team and to Hilltop. In many cases the community support team initially tried to help the family resolve their difficulties and then the referral was subsequently made to Hilltop. Young people and parents were asked for the specific reasons for their current referral to the respite service. Their responses fell into three categories of difficulty: the young person's behaviour within the home, their relationships with their parents/carers, and wider problems outside of the home.

Young people and parents were each asked to complete a Severity of Difficulties checklist to indicate whether a list of potential child difficulties constituted a 'major problem,' a 'moderate problem' or 'not a problem at all' in the past few months. They reported a wide range of difficulties, as shown in Table 6.1:

Table 6.1 Difficulties rated as 'a major problem' in the past six months

Nature of difficulty	**Parents n=16 % (*n*)**	**Young people n=24 % (*n*)**
Child's behaviour at home	0 (0)	24 (6)
Parents' concern about young person's friends	19 *(3)*	28 (7)
Stays out late	13 *(2)*	24 (6)
Parent/child arguments	13 *(2)*	12 (3)
Child/parent 'doesn't listen'	37.5 *(6)*	12 (3)
Child/parent 'can't talk things over'	37.5 *(6)*	20 (5)
Drug problems	25 *(4)*	24 (6)
Alcohol problems	19.*(3)*	36 (9)
Offending	24 (6)	32 (8)

Surprisingly, young people were more likely than parents to rate their own behaviour, communication problems with their parents and substance use as 'major' problems. In Biehal's earlier study, a far higher proportion of parents reported 'major problems' in respect of behaviour at home (85%), outside the home (64%), the friends their child was associating with (51%), staying out late (36%), arguments (78%), not listening (63%) and '*talking things over*' (54%). Although none of the parents in the current study rated their child's behaviour as a 'major' problem on the Severity of Difficulties checklist, their answers to the open-ended questions on the same baseline postal questionnaire rather belied this response.

In the majority of cases, young people were experiencing multiple difficulties. These included not only the difficulties mentioned above, but also offending, self-harming, running away and mental health problems, as shown in Table 6.2:

Table 6.2 Number of difficulties reported at referral

Number of problems	As reported by young people (*n=24*)	As reported by parents (*n=16*)
1-5	2	0
6-9	16	2
10 or more	6	14

Parents gave graphic descriptions of problem behaviour within the home, ranging from '*naughty*' or '*bad*' behaviour to temper tantrums, aggression and violence. One parent commented:

> '*The moods, rages, manipulation* (and) *violent behaviour from* (our) *daughter has led to a complete breakdown in relations. She is demanding, bad-tempered and depressed*' (mother of 14 year old Carys).

Another parent described the weeks leading up to referral to the service:

> '(She) *has been violent and abusive for eight weeks.* (She) *ran away, was found by police …came home, smashed up the house then went to a friends house for three days and refused to speak to us. Social services recommended* (the Hilltop service) *to us for a breather*' (mother of 15 year old Leanne).

Several parents reported a lack of compliance with house or family rules and a '*disrespect for family home and possessions*'. The impact of the young person's behaviour on other family members (whether parents or siblings) had also been the catalyst for referral. The mother of Douglas (13 years) reported that, '*he has two small sisters who have many injuries caused by him*', while Jim's mother explained, '*I am now not sleeping and as a result* (of his behaviour) *I needed a period of respite to catch up'*. Parents reported feeling unable to cope with multiple difficult behaviours:

> '*He was kicking doors, pinching, burglary, yelling, screaming, drinking…at the end of the day I don't see why I should end up being punched*' (mother of Jack, 14 years).

> '*He was stealing, lying, bullying his sister, drugs, drink, just anything he could get into he was getting into*' (mother of David, 13 years).

Apart from their concerns about their children's behaviour, parents were also upset about the difficulties in their relationships with them. The father of Victoria, aged 15, described his inability to reason with his daughter, '*she was very abusive to me and my wife, being very hurtful'*. Stephen's stepmother described difficulties associated with parental separation, '*he was playing one parent off against the other. He* (had) *rules in one household and being able to do whatever, whenever, in the other household*'.

The young people also reported difficulties in family relationships, often involving arguments, violence and a breakdown in communication. Douglas (aged 13) reported that, *'me and my mam were always arguing…things were getting to breakdown point as my mum couldn't cope'*. Similarly, Olivia (aged 15) explained, '*I was having*

difficulties with dad, I couldn't have a conversation, I ended up shouting which led to arguments'. She also commented on the difficulties of being left at home alone, *'I wasn't very happy that nobody was in the house for me, I had to see to myself at 15'*.

In these difficult situations, some young people clearly welcomed some respite from their family. For example, Alex (aged 15) explained that he had come to Hilltop because of *'my mam's boyfriend punching me in the face*' and Liam (aged 12) told us that, *'my mam and dad wanted a break and so did I'*.

Problems outside the home had also precipitated a referral to Hilltop. Offending, missing school and risk behaviour were highlighted. Victoria's father described how his 15 year old daughter's '*erratic behaviour*' included, '*playing truant, getting into trouble with the police and shoplifting'*. Similarly, the parent of Sarah (aged 14) described the difficulties that had led to the referral:

> '*I couldn't control her and was concerned about her welfare, running away for days, drinking, taking drugs, underage sex. I had her arrested for stealing from me…and neighbours.* (Her) *behaviour affected siblings…respite was needed*'.

Referrals were often accepted when families were at crisis point. Parents sometimes mentioned that it was an incident which had been the '*last straw*', after a long period of difficulty, that had led to referral to social services and, subsequently, to placement at Hilltop:

> '*Right, the last resort was when she was picked up at one o' clock in the morning drunk and disorderly and on drugs*' (mother of 14 year old Joanne).

> '*I just thought, it is out of control now…..and then he was becoming more and more violent and abusive, verbally abusive at home and I just didn't think I could cope and that's when I rang the number and then it started from there*' (mother of 14 year old William).

> '*…just shouting her mouth off at me and going out and causing trouble with these young people and getting herself into bother, like skiving off school and running away and that…..and then she got caught shoplifting and that was the final straw and we took her in after that and that's how she got referred to Hilltop*' (father of Victoria, 15 years).

> '*It got to the point where he was going for me and I was going for him, cos he was going for me. There was just a certain point where you just couldn't hold back and he refused to come home and I refused to have him back*' (mother of David, 13 years).

Violent behaviour

Many of the young people displayed violent behaviour both within the home and outside of it. The majority of parents interviewed at baseline (13) reported that their child was violent towards them, although only two considered this violence to be a 'major' problem. Most parents (12) also reported that their child was violent to others, but only one considered this to be a 'major' problem. Parents' accounts of the young people's violent behaviour were often quite alarming:

'*He held a knife to me throat and threatened to stab us*' (mother of Douglas, 13 years).

'*It all come to a head one day when I couldn't do anything with her. She stabbed me with a knife. Yeah, she just grabbed a knife because I wouldn't let her go out*' (mother of Olivia, 15 years).

'*It was really bad, she was smashing the house up and everything, fighting with everyone, fighting her sisters, her sisters saw everything. Had a knife to me*' (mother of Joanne, 14 years).

'*Me husband is a big, six foot two big man and Leanne is only a little girl but he's a gentleman and he would not hit back and she was biting him, she blacked his eye, she was extremely violent, she was also extremely violent towards my eldest two…….. she actually knocked me out, physically knocked me out*' (mother of 15 year old Leanne).

Running away

Running away from home, whether overnight or for several hours was also identified as a common difficulty for young people. Workers indicated that there was evidence of running away for around three-quarters (19) of the group at referral. Young people were asked to estimate how many times they had run away from home in the six months prior to referral. They indicated that, most commonly, they had had run away on three occasions during this period, although the number of times ranged from one to 12. Some young people had only gone missing for a few hours, but others had stayed away for days at a time:

'*I needed time away from mum and the problems at home, I wouldn't stay at home, I was running away and not going back for a few days, staying out overnight*' (Sarah, aged 14 years).

In addition, over a third (9) of the group had been '*thrown out*' of their home in the year prior to referral. For some young people, this had resulted in a number of accommodation moves. One young person, who had moved from his mother's house to his father's and then to a grandparent, told us bleakly:

'*I kept getting kicked out of my family's homes*' (Paul, aged 15 years).

Problems at school

Home and school problems went hand in hand. Only half (13) of the young people were receiving mainstream education and one in eight were refusing to attend school at all, as shown in Table 6.3:

Table 6.3 Educational provision at referral (n=25)

Type of education	%	Number
Mainstream education	52	13
Learning support unit within mainstream school	20	5
Pupil referral unit	16	4
Refuses to attend school	12	3

Although the majority of young people in the study had educational provision of some kind, many were reluctant to attend. The majority of them (22) had truanted over the six months prior to referral and 40% (10) reported that this was a frequent occurrence. The average number of days absent due to truancy during the past month was seven. Most of these young people had missed four days of school through truancy during the past month, but one-third of the sample (8) had truanted on ten or more days in the past month.

As the high rate of truancy indicates, many of the young people were, to a greater or lesser extent, detached from school. Their behaviour within school when they did attend often resulted in even greater detachment from the school system, as most (20) had been temporarily excluded (suspended) from school in the past year. Workers reported that, for over three-quarters of the group (19), when they did attend school their behaviour was often poor. The average number of school days lost in the past month through temporary exclusion was six for the whole group. However, over a quarter (7) had been temporarily excluded for ten or more days. Furthermore, almost a quarter (6) of young people had been permanently excluded from school during the year prior to referral.

Problems at home and at school may be mutually reinforcing. When young people are absent from school, due to truancy or exclusion, this may increase stress in the home environment. It may also increase the likelihood that young people associate with anti-social peers and become involved in crime (Graham and Bowling, 1995). Similarly, young people who have a troubled home life may become disengaged from school.

Substance misuse

One-quarter of young people reported 'major' problems with drugs and around one-third reported 'major' problems with alcohol. In total, though, nearly two-thirds (15) reported some degree of problem with drug or alcohol use. The misuse of alcohol was slightly more common (13 young people) than the use of drugs (10). One-third (8) of the young people reported problems with both drug and alcohol misuse.[6] The proportion of young people reporting drug or alcohol misuse was considerably higher than in Biehal's earlier study, in which one-fifth reported substance misuse.

Parents were less likely to report that their children had major difficulties with substance abuse. However, caution is needed in making these comparisons, as only two-thirds of parents completed the baseline questionnaires whereas all but one of the

[6] Pearson correlation: severity of drug problems correlated with scores for severity of alcohol problems (.505, p=.012).

young people did. In around one-third of cases where young people reported major problems with drug or alcohol use, no data was available from parents. However, in families where parents and young people both completed questionnaires, parents typically reported these problems to be 'mild' or 'moderate.' This suggests that either parents were unaware of the extent of their children's substance abuse problems or they were, indeed, relatively unconcerned.

When information from young people, parents and professionals was pooled, however, and information on *an*y problem with substance misuse was sought (not simply 'major' problems with it), it appeared to be even more widespread. Between them, professionals were aware of substance misuse by over half (14) of the young people. However, information from young people and parents indicated a more widespread problem. Reports showed that over three-quarters (19) of young people in the study had been involved in some form of substance misuse. Over two-thirds (17) had experienced problems with alcohol and 60% (15) had problems with drug use over the six months prior to referral.

Offending

There was evidence that the majority of young people in the group had had some involvement in offending. When information from young people and parents was pooled, this indicated that almost all of them (23) had been in trouble with the police during the previous six months. This was a higher proportion than in Biehal's earlier study, in which just over half of the sample was known to have offended in the previous six months. Slightly fewer of the young people (19) themselves reported some degree of involvement in offending. One-third (8) viewed it as a 'major' problem and a similar number (7) as a 'moderate' problem. Problem alcohol use and involvement in crime appeared to be linked, as around two-thirds (13) of those who reported their own involvement in offending also reported problems with alcohol.[7]

Some young people had entered the youth justice system as a consequence of their offences. Workers reported that over a third of young people (9) had received a reprimand or final warning in the six months prior to referral to the study and a fifth (5) had been charged with an offence. Although in-depth information on the nature of offences was not collected, workers did report that almost two-thirds (15) of the group had been involved with petty theft and four of them had problems related to fire setting.

Sexual risk

Risky sexual behaviour was a further area of difficulty evident within the sample at referral. Workers reported that over a quarter (7) of the young people were placing themselves or others at sexual risk. This was echoed by parents who commented on the problems of their children engaging in underage sex. One mother expressed concerns that her 15 year old daughter '*has been trying to get pregnant*'. Concerns about sexual risk were more frequently reported in relation to young women (5) than young men (2).

[7] Pearson correlation: severity of alcohol problems also correlated with offending (.529, p=.008).

The influence of peers

With the onset of adolescence, peers begin to exert a stronger influence on behaviour and this may be a negative influence for some young people (Rutter, Giller and Hagell, 1998). The influence of their peer group clearly contributed to the behavioural difficulties of a number of young people in the study. Some parents and some young people felt that peer groups had had a negative influence on behaviour, particularly their behaviour outside the home. For example, Victoria's father complained that she was, '*involved with the wrong crowd….going out causing trouble with these young people,*' while Joanne mentioned that the young people she associated with '*were a bad influence*.' One parent was extremely concerned about the influence that friends and adult boyfriends had had on her daughter since the age of 13:

> '*She was with a crowd of girls that on a weekend would meet up on street corners and get absolutely drunk and smoking, drinking, going out, staying out….*' (mother of 15 year old Leanne).

In some cases, young people felt ill at ease and excluded by others of their own age. They appeared to model their behaviour on others in an attempt to gain acceptance. For example, Harry was a rather unhappy 13 year old who felt that he did not '*fit in*' either at home or with other young people and who clearly found peer relationships difficult to manage. He said he had difficulties with:

> '*Fitting in with the young people around here, some people are bad and some people are good, I just don't know which ones are which*'.

In a few of these cases, it seemed that peers exerted their influence through bullying:

> '*Her friends that she was knocking about with, they were like picking on her and she was taking things from, from the home, like to buy, like jewellery …cos she didn't get much money. But I think her friends also knocked her confidence, she had no confidence or nothing like that*' (mother of 13 year old Catherine).

> '*When he moved in all the young people would go "This is our area, you're not coming here". So* (his brother) *every time he went out got his head kicked in, cos David was with him he was tarred with the same brush. Then things turned and David was starting to like hang about with them but he was never, they were never friends, just sort of, they would come for him when they felt like it…they weren't real friends*' (mother of 13 year old David).

Almost all of the young people thought to be negatively influenced by peers were using drugs. However, there was no evidence that peers were the principal cause of the young people's emotional and behavioural difficulties. In all of the cases cited above, the young people had multiple difficulties, including parenting that was both weak and inconsistent, or, in one case, emotionally abusive. In two of the above cases, past experiences of sexual abuse were thought to be linked to continuing emotional difficulties and in one other case the young person experienced neglect and severe rejection. The influence of peers was clearly just one of several risk factors. However, it is likely that these clusters of risk factors were closely interrelated, for

example bullying is known to be a common experience among young people who have experienced abuse or neglect (Prior and Paris, 2004).

Abuse and neglect

This emerging picture of difficulties experienced by young people and their families suggests that the young people in the sample were not simply troublesome but also very troubled. Indeed, whilst there was certainly evidence of behavioural problems and risk behaviour, significant levels of need in relation to abuse and neglect and mental health and emotional difficulties were also apparent. In total, half (12) of the sample were thought to have experienced abuse or neglect, either currently, in the past, or both.

Histories of abuse or neglect

A number of the young people had experienced abuse or neglect earlier in their lives. We saw earlier that, for one-fifth of the sample (5), past contact with social services had been to some extent due to concern about abuse and for two young people neglect had been one of the reasons for past contact. Evidence of any past child protection (CP) concerns was explored with social workers and community support workers. The information available suggested that around one-quarter (6) of the young people had been the subject of a CP case conference and at least four had been placed on the CP register. For one- fifth of the young people (5) concerns had been raised in the past about possible physical abuse and for three of the young people there had been concerns over possible sexual abuse, as shown in Table 6.4:

Table 6.4 Reasons for past child protection concerns (n=25)*

Type of abuse	%	Number
Neglect	8	2
Physical abuse	20	5
Sexual abuse	12	3
Emotional abuse	8	2

*Information from professionals was not available in all cases, so these figures may be an underestimate.

Current abuse and neglect

At the point of referral to the service, there were continuing concerns about abuse and neglect. When they were younger, physical abuse had been the most common form of maltreatment, but by this point in their lives, emotional abuse was more commonly mentioned and was reported to be a current problem in relation to one-fifth of the sample (5). However, half of the young people reported that their parents sometimes hit them. Information from the professionals in the study indicated that, at referral, there were one or more current CP concerns in relation to around a quarter (6) of the sample. One young person was currently the subject of a CP enquiry and another was on the CP register:

Table 6.5 Reasons for current child protection concerns (n=25)*

Type of abuse	%	Number
Neglect	0	0
Physical abuse	8	2
Sexual abuse	4	1
Emotional abuse	20	5

*Some experienced more than one kind of maltreatment so they appear in this table more than once.

Emotional abuse and rejection appeared to be a particular problem. For example, during the research period, Stephen moved back and forth between his mother's and his father's houses. He had lived with his mother and her former partner when a small child and had been neglected and physically abused at that time. His father and stepmother felt that his current behavioural problems derived from his mother's long-term rejection of him and Stephen himself was well aware of how his mother felt about him:

> '*ADHD he has got, because he creates attention, but I think it all stems from rejection from his mam....she just wouldn't let him in the house*' (father of Stephen, aged 15 years).

> '*She didn't care about me, so I'm not even bothered about her*' (Stephen, aged 15 years).

The foster carer looking after Paul at follow-up described a similar pattern of rejection and similarly ascribed his difficult behaviour to this experience within his family. He had been rejected by his mother and had then moved briefly to stay with his father. According to the carer, Paul was particularly hurt that his father '*put him in care*' and yet had accepted his partner's three children:

> '*He wanted to live with his mam and his sister, but his mam doesn't want him there…..she doesn't want anything to do with him, but she doesn't want anyone else to help him….The only thing he kept saying to me was, how long do you think it will be before I get back with me mam? He wanted so much to be with his mam and sister on Christmas morning, but his mother wasn't having it….. and there's none of them want him….That's it, you have got a very angry 16 year old. I mean, he is not a bad young person, he is just lashing out at everybody because he's so angry*' (carer of Paul, aged 15 years at placement).

The mother of David was quite open about the fact that both she and her ex-husband had rejected him and understood that this must have had a significant impact upon him. She described an incident where she had refused to let him stay at home and had sent him to his father who '*he hadn't had anything to do with for years*':

> '…..*after two and a half weeks his dad rejects him, all he knows he gets put on a train and from the train he gets picked up by social services, been rejected off me…..Social Services brought him back here and he proper went for me, there was*

just so much anger in him, but it was confusion more than anger, had to be' (mother of David, aged 13 years).

Victoria explained at referral that she hoped that her placement at Hilltop would '*help me get close to my mam and dad again*'. However, her mother complained that Victoria was allowed to phone home from Hilltop whenever she wished, whilst she would have preferred to break off all contact during the weekly periods of respite care:

'*She would phone all the time, all the time….we disconnected the phone so she couldn't….When they are up there they should have no contact with their parents whatsoever, because it's giving them a break and it's giving us a break and that's how I think it should be, you know*' (mother of Victoria, aged 15 years).

Our earlier study of community support teams similarly found that many troubled and troublesome adolescents have experienced abuse or neglect, and that emotional abuse was the most common form of maltreatment for this age group. At referral, one-third of that sample was thought to be experiencing emotional abuse (Biehal, 2005). The abuse of adolescents is not always recognised as a serious problem. This may be because adolescents may respond to it differently than younger children. Research on abused adolescents in the United States has shown that, while they are more physically durable than younger children, they tend to display the effects of abuse in other ways, through self-harm, depression, running away or offending (Rees and Stein, 1997).

Young people's emotional and behavioural difficulties

Social workers and community support workers reported that around a quarter (6) of the young people had mental health difficulties. In order to obtain an objective measure of the young people's emotional and behavioural difficulties, both they and their parents were asked to complete the Strengths and Difficulties Questionnaire (SDQ).[8] Analysis of this measure revealed that a very high proportion of the young people had scores above the threshold for mental health disorder.

In a community sample, only 10% would be expected to have abnormal scores (Goodman, 1997). In contrast, in our sample abnormal scores indicating high levels of mental health needs were far more common, as parents' ratings indicated that at least 56% of the total sample was above the clinical threshold for emotional and behavioural difficulties. However, as this data was not available from one-third of the parents, who did not complete baseline questionnaires, this may be an underestimate. [9]

[8] On the parent version of this measure, the range for low need is 0-13, some need is 14-16, while the range for high need is 17-40 (once the pro-social sub-scale is excluded). On the self-report version, the corresponding ranges are: low need 0-15, borderline 16-19 and high need 20-40.

[9] Given the low number of parent responses at baseline (n=16), calculating percentages in relation to the sample completing the questionnaires might lead to an overestimate of the percentage above the clinical threshold for emotional and behavioural difficulties among the sample as a whole. In order to avoid a possible distortion of this kind, the percentages given are calculated in relation to the sample as a whole (n=25) rather than as a proportion of the number who answered this question.

The self-report ratings of the young people themselves gave a similar picture, as shown in Table 6.6:

Table 6.6 Comparison of SDQ Total Difficulties scores with community sample

	Normal % (*n*)	**Borderline % (*n*)**	**Abnormal % (*n*)**
Community sample	80	10	10
Parent ratings (n=16)	0(0)	8 (2)	56 (14)
Young person ratings (n=24)	12(3)	32 (8)	52 (13)

*The percentages given are calculated in relation to the sample as a whole and may therefore underestimate the true proportion. See footnote 9 below.

Analysis of the sub-scales of the SDQ indicated the proportion of young people experiencing specific difficulties, including conduct disorder, hyperactivity, emotional problems and peer problems, as well as the proportion displaying pro-social behaviour, as shown in Table 6.7:

Table 6.7 SDQ sub-scale scores *

	Parent rating (n=16)			***Young person rating (n=24)***		
Sub scale	**Normal % (n)**	**Borderline % (n)**	**Abnormal % (n)**	**Normal % (n)**	**Borderline % (n)**	**Abnormal % (n)**
Conduct problems	0	0	100 (16)	13(3)	17(4)	71(17)
Hyperactivity	6(1)	19(3)	75(12)	38(9)	21(5)	42(10)
Emotional symptoms	31(5)	13(2)	56(9)	71(17)	4(1)	25(6)
Peer problems	19(3)	6(1)	75(12)	58(14)	42(10)	0
Pro-social	31(5)	19(3)	50(8)	63(15)	17(4)	21(5)

*The percentages given are calculated here in relation to the number who completed questionnaires. It is important to note that SDQ data from parents was provided in relation to only 16 young people (66% of the sample). Where percentages do not add up to 100 this is due to rounding.

Both parent and self-report ratings indicated scores above the clinical threshold for conduct problems for the majority of the young people in the study. Also, parent scores indicated that hyperactivity was a serious problem for at least half (12) of the total sample and self-report scores indicated hyperactivity for nearly half (10). As might be expected, there was a strong correlation between scores for hyperactivity and for conduct problems.[10] Yet, oddly, there was no significant correlation between parent and young people's scores on either of these sub-scales.

Nevertheless, parents and young people generally agreed on the severity of the young people's emotional and peer problems, as there was a fairly strong correlation

[10] Pearson correlation, parents: .625, p=.013 (n=16); young people: .533, p=.007 (n=24).

between parents' and young people's scores on both of these sub-scales.[11] There was also a moderate correlation between a measure of externalising behaviour composed of five items from the parent questionnaire (behaviour at home, behaviour at school, involvement in offending, violence to parents and violence to others) and the parents' ratings of conduct problems on the SDQ.[12] However, it was surprising to find that that there was no correlation between parent and young people's scores for Total Difficulty on the SDQ.

Mental health and emotional difficulties may of course be triggered or exacerbated by wider difficulties and life experiences. As we have seen, most young people in the study were experiencing problems, whether with substance misuse, offending, family relationships or due to their experience of abuse and neglect. In addition to this, workers also reported evidence of loss. Around half (12) of the young people had been recently separated from a parent and one had suffered a recent bereavement.

Suicide attempts and self-harm

Young people were also asked about any episodes of self-harm or suicide attempts, either currently or in the past. One quarter reported having attempted to commit suicide, half of these in the past year, and over one-third (37%) reported self-harm. This represents a very high incidence of self-harm, since the rate of self-harm among 11-15 year olds in the general population who have no mental disorder is negligible (1.2%). The rate in this study is closer to the rate for 11-15 year olds with depression (18.8%) and higher than the rate for those with conduct disorders (12.6%), anxiety disorders (9.4%) and hyperkinetic disorder (8.5%) (Meltzer, 2001). The survey from which these comparisons are drawn provides some clues to why so many of these young people may self-harm, since this is more common among adolescents in families with a high degree of family discord or where parents have mental health problems (identified on the GHQ). As we will see, both of these were common among our sample.

Family functioning

Family difficulties and relationships

All families will experience difficulties of some sort from time to time, but for many of the families in this study these difficulties had reached crisis point. Young people, parents and workers were asked about any family difficulties at the time of referral to the study. Their responses revealed a picture of troubled families in which marital conflict and domestic violence were not uncommon. Workers indicated that conflict with partners was currently a problem for one-fifth (5) of the families, while whilst 40% (10) of the parents who responded told us that they had had frequent arguments with their partner/spouse over the past three years. The young people were well aware of this conflict, as around one-third of them reported that their parents/step-parents were frequently angry with each other and one-fifth (5) reported that their parents/step-parents hit each other. Further evidence of domestic violence was provided by workers, who indicated that this was a problem in one-third of the

[11] Pearson correlation .625, p=.013 for emotional problems; .614, p=.015 for peer problems (n=16).
[12] Pearson correlation: .590, p=.016 (n=16).

families (8). In a quarter (6) of families, adult relationships had recently broken down completely and the partners had recently separated.

An objective assessment of family functioning was made using the short (12 item) general functioning scale of the Family Assessment Device (FAD) (Epstein, Baldwin and Bishop, 1983). This measure is based on systems, communication and learning theory and covers problem-solving, roles, communication, affective responsiveness, affective involvement, behaviour control and general functioning. The FAD is a well-validated measure in both its long and short versions (Byles *et al*., 1988; Ridenour *et al*., 1999; Weiss and Jacobs, 1988). On the 12 item general functioning scale, the cut-off score for unhealthy functioning is two (Miller, Epstein, Bishop *et al.*, 1985).

Baseline scores on the FAD indicated that general family functioning was poor for the majority of families. All but two of the young people and all but three of the parents gave ratings which scored their families above the clinical threshold for unhealthy functioning. The young people's perceptions of family functioning were clearly bleaker than those of their parents, as their mean and median scores were noticeably higher, as shown in Table 6.8:

Table 6.8 Baseline scores for family functioning

	Rated by young people (*n=24*)	**Rated by parents (*n=16*)**
Mean	2.62	2.26
Median	2.5	2.29

There was a fairly strong correlation between parent ratings of family functioning and young people's total scores on the SDQ.[13] Parents were more likely to rate family functioning as poor where young people had high scores for emotional and behavioural difficulties.

Both the reports of young people and professionals and the standardised measure used, the FAD, indicated that family functioning as poor in most families. Many experienced high levels of conflict and domestic violence was a problem for a substantial minority. The young people's behavioural problems were likely both to contribute to family difficulties and also to be influenced by them.
In summary, information collected from young people, parents and workers indicated a high level of wide-ranging, often multiple, difficulties for the families. Substance misuse, education disruption and mental, behavioural and emotional problems were common. Over half of young people scored above the threshold for emotional and behavioural difficulties, higher than would be expected in the general youth population. Past and current abuse and neglect were also evident as was overall family dysfunction. The majority of families scored above the threshold for unhealthy family functioning and respondents described poor communication, marital disharmony and domestic violence.

[13] Pearson correlation .585, p=.017.

7. Outcomes: changes in child and family functioning

For many young people and families receiving the comprehensive supported respite service, child and family functioning had improved by follow-up. It is important to bear in mind that, in a small study of this kind, it was not possible to assess the relative impact of placement at Hilltop in relation to the input of community support workers, social workers or other professionals. It is likely that all made some contribution to the changes that took place. Furthermore, changes within the family and at school, as well as, in some cases, separation from a negative peer group, also contributed to outcomes. Nevertheless, it seems likely from the accounts of young people and parents that, in many cases, these services made an important and positive contribution to the process of change.

A table of statistics summarising change scores outcome measures between baseline and follow-up is given at the end of this chapter.

Changes in the number of problems reported

Although three-quarters (19) of the young people completed questionnaires at both stages of the study, just over half of the parents (13) did so. As a result, data on changes in the number and severity of difficulties were available from the parents of only just over half of the young people in the study. Overall, families were likely to report a significant reduction in the number of problems at follow-up, as shown in Table 7.1:[14]

Table 7.1 Change in number of problems reported by parents

Number of problems	Parents (n=13)		Young people (n=19)	
	At referral	At follow up	At referral	At follow up
1-5	0	3	2	10
6-9	1	5	13	4
10 or more	12	5	4	4

Over half (10) of the young people reported a reduction of three or more problems, but two reported no change in the number and three reported additional problems by follow-up. Similarly, half of the parents (6) reported a reduction of three or more problems while five reported little or no change in the number, and one reported additional problems. However, young people and parents did not necessarily agree as to the extent to which the number of problems had fallen or risen. Where change scores for both parents and young people were available, in only half of these families (6) did parents and young people report changes in a similar direction and of a similar magnitude.

[14] Young people: t-test showed mean change in the umber of reported problems was 2.68, t=3.545, p=.002.
Parents: t-test showed mean change in the number of reported problems was 2.46, t=2.94, p=.012.

Change in the severity of difficulties

There appeared to be improvement in most of the problems reported at referral for at least half of the young people, as shown in Tables 7.2 and 7.3:

Table 7.2 Parents' view of changes in severity of difficulties (n=13)

Difficulties	Better % (n)	Same % (n)	Worse % (n)
Behaviour at home	46 (6)	54 (7)	-
Behaviour outside the home	77 (10)	23 (3)	-
Parents' concern about friends	62 (8)	15 (2)	23 (3)
Stays out late	77 (10)	8(1)	15 (2)
Parent/young person arguments	69 (9)	23 (3)	8 (1)
Young person 'doesn't listen'	54 (7)	39 (5)	8 (1)
Parent/young person 'can't talk things over'	62 (8)	31 (4)	8 (1)
Alcohol problems	54 (7)	39 (5)	8 (1)
Drug problems	39 (5)	46 (6)	15 (2)

Although less than half the parents interviewed felt that the young person's behaviour at home had improved it is important to note that, despite their graphic descriptions of how difficult they found the young person's behaviour, none of them had rated it on this scale as a 'major' problem at baseline so there was limited scope for improvement on this measure. Around three-quarters were less concerned about behaviour outside the home and staying out late. Furthermore, according to the parents, communication appeared to have improved in between half to two-thirds of cases (in respect of arguments and the young person's willingness to listen and to talk things over).

At follow-up, the majority of the young people considered that their behaviour at home had improved, as shown in Table 7.3:

Table 7.3 Young person's view of changes in severity of difficulties (n=19)

Difficulties	Better % (n)	Same % (n)	Worse % (n)
Behaviour at home	84 (16)	11 (2)	5 (1)
Parents' concern about friends	42 (8)	47(9)	11 (2)
Stays out late	37 (7)	32 (6)	32 (6)
Parent/young person arguments	74 (14)	21 (4)	5 (1)
Parent 'doesn't listen'	52 (10)	37 (7)	11 (2)
Parent/young person 'can't talk things over'	42 (8)	42 (8)	16 (3)
Alcohol problems	26 (5)	69 (13)	5 (1)
Drug problems	37 (7)	58 (11)	11 (2)

Like the parents, many also indicated that parent-child arguments were now less of a problem and that parent-child communication had improved overall. However, only a quarter of the young people felt that they now had less serious problems with alcohol and only just over one-third felt that their drug use was now less of a problem.

Other changes in young people's behaviour

Running away

Fewer young people had run away between referral and follow-up, than had done so in the six months prior to placement at Hilltop. Just eight were known to have run away during this period, compared to 19 during the earlier period. All of these eight were accommodated by the local authority for a while or left home to stay for a time with relatives or friends. These moves away from home will be discussed in the next chapter.

Violence

There was also a marked reduction in violent behaviour. Over half of the parents interviewed at follow-up reported a reduction in the young person's violence towards them and towards others, as shown in Table 7.4:

Table 7.4 Parents' view of changes in young person's behaviour (n=13)

	Better % (n)	Same % (n)	Worse % (n)
Violence to parent	54 (7)	23 (3)	23 (3)
Violence to others	62 (8)	15 (2)	23 (3)

The number known to be truanting from school had also reduced. In fact it had halved, falling to 11 compared to 22 in the six months prior to placement. Just eight had been temporarily excluded, compared to 20 in the earlier period, but eight had been permanently excluded by follow-up.

Substance misuse

Some young people reported that their substance misuse was now less of a problem. One quarter (5) rated their alcohol use as less of a problem than it had been when they were first placed in Hilltop and around one-third (7) rated their drug misuse as less serious than before. However, over two-thirds (13) reported no change in their alcohol use and for more than half (11) there had been no change in their drug use.

Offending

Offending behaviour continued to be a serious problem, however, as 15 young people had been given a reprimand or final warning by the police, which was higher than the number known to have been reprimanded or warned in the six months prior to referral (9). Six young people had been convicted by follow-up. In addition, seven young people had been victims of crime.

Although a few became involved with the criminal justice system due to their behaviour in the community, for example, theft, being drunk and disorderly, criminal damage or other anti-social behaviour, in a number of cases, at least some of the young people's offending took place within their families. Six were accused by their parents of stealing money from them (either in cash or through cheque or card fraud) and three had had been reprimanded, warned or convicted as a result of their actual or threatened violence towards family members. In addition, one boy was convicted for punching a teacher and another for stealing a Game boy from another young person at Hilltop.

Child protection concerns

By follow-up, professionals were concerned about abuse or neglect in relation to ten young people, whereas these concerns had only been expressed in relation to six of them when they were originally placed at Hilltop. At that time, one had been the subject of a child protection (CP) enquiry and one had been on the CP register, but by follow-up two had been placed on the CP register and there had been CP enquiries in relation to a further two. Shelley had been placed on the CP register due to emotional and physical abuse, while Ian was registered once evidence was uncovered of his father's sexual abuse of his sisters.

This increase in formal enquiries and registration as time progressed should not be taken to indicate that young people began to experience abuse and neglect once services were provided. Instead, it is far more likely that family support interventions of this kind may serve a case-finding function. A similar phenomenon was found in a large North American study of family preservation services, where there was a significantly larger increase in the percentage of cases of child abuse in the group receiving intensive services, in comparison to the control group (Schuerman, Rzepnicki and Littell, 1994). This study concluded that more intensive contact with families brought with it greater surveillance, so that more abuse was detected. Biehal's earlier study of community support teams similarly suggested that contact with social services in itself made it more likely that ongoing abuse or neglect would be identified (Biehal, 2005).

Changes in emotional and behavioural difficulties (the SDQ)

There were significant, positive changes in scores on our standardised measure of emotional and behavioural difficulties, the SDQ.[15] This showed a striking degree of improvement on young person ratings but, paradoxically, on parent ratings the proportion with scores in each band (normal, borderline, or abnormal) remained the same, as shown in Table 7.5:

Table 7.5 SDQ Total Difficulties scores at referral and at follow-up*

	number at follow up *(number at baseline)*		
Source	**Normal**	**Borderline**	**Abnormal**
Parent ratings (n=13)	0 *(0)*	1 *(1)*	12 *(12)*
Young person ratings (n=19)	13 *(3)*	2 *(5)*	4 *(11)*

*Baseline numbers in each range differ from those in Table 4.5 as some participants were lost
to follow-up.

However, although mean scores would suggest that parent's perceived little change, this is somewhat misleading. On parents' ratings, ten of the young people showed improvement by follow-up, and for four of these, the improvement was substantial. Nevertheless, despite this positive change, most young people remained above the clinical threshold for emotional and behavioural difficulties (and so did not score sufficiently highly to move from the 'abnormal' or 'borderline' category to the 'normal' category).

Analysis of the individual subscales indicates that, on parent ratings, positive change was most likely to occur in relation to conduct problems, as scores by around half of the parents (6) indicated improvement by three points or more in relation to conduct problems. Around half of the young people (9) similarly indicated that their own conduct problems had improved (although in only three families did both parent and young person indicate improvement in this respect). One-third (3) of these young

[15] Paired samples t-tests. Young people: mean change -5.48, t= 3.491, p=.003.
Parents: mean change -4.23, t=2.326, p=.038.

people had entered long-term care by this point. Ten of the young people also indicated a reduction in emotional problems by three or more points.

Changes in general family functioning (the FAD)

General family functioning, as measured by the FAD, also showed some improvement overall. For many families, positive change therefore occurred on those dimensions measured by the FAD, namely family problem-solving, communication, behaviour control, affective involvement and responsiveness and general functioning.

Scores for both young people and parents indicated that the majority of them perceived that family functioning had improved. However, while the young people's perceptions of change by follow-up were statistically significant, this was not the case for the parents.[16] As we have seen, at baseline young people's average ratings of family functioning were higher (worse) than the parents'. At follow-up there was greater positive change in the young people's average ratings of family functioning than in the parents' ratings, as shown in Table 7.6:

Table 7.6 Mean change scores for family functioning

	Rated by young people (*n=19*)	**Rated by parents (*n=13*)**
Mean	-.52	-.19
Median	-.5	-.08

However, despite the overall picture of positive change, in one case both the young person and the parent indicated that family functioning had deteriorated, as did two further young people and four other parents (from different families).

The greater degree of positive change recorded by young people, in relation both to their own emotional and behavioural difficulties and to family functioning, may be due to the fact that their higher initial scores indicated a greater sense of crisis at baseline than their parents. It is in the nature of crises that they eventually subside, to some degree at least, leading to a greater reduction in scores for family problems, a phenomenon known as regression to the mean. Although those with very high scores for difficulty at referral may have shown some natural improvement over time, this is unlikely to account for the full extent of change that occurred across the sample and it is therefore possible that the services provided did indeed have some beneficial impact.

Changes in young people's perceptions of their well-being

The change in scores on Cantril's Ladder, our measure of young people's perception of their own well-being, suggested that young people's own ratings of their quality of life had significantly improved. Young people were asked to indicate where they saw themselves currently on a ladder, ranging from 'couldn't be better' at the top to

[16] Young people: paired samples t-test mean change -6.26, t=3.070, p=.007.
Parents: scores did not have a normal distribution, so the non-parametric Wilcoxan Signed Rank test was used p=.208.

'couldn't be worse' at the bottom. Their average scores on this ten point scale rose by nearly three points between referral and follow up[17].

Changes in parents' psychological state

Mental well-being, as measured by the General Health Questionnaire (GHQ-12), showed a statistically significant improvement for the majority of parents.[18] Of the 13 who completed questionnaires both at baseline and at follow-up, ten had been above the clinical threshold for poor mental health at baseline but only three remained above this threshold by follow-up. For eight of the parents, mental well-being had improved substantially (by seven or more points on a 12 point scale).

At follow-up, parental mental health and parents' perceptions of family functioning were closely correlated, with scores for poorer mental health associated with scores for worse family functioning.[19] There was also some indication of a moderate correlation between parent ratings of the young person's emotional and behavioural difficulties (on the SDQ) and their own mental health, although this did not quite reach significance.[20]

To summarise, at follow-up, there was a marked fall in the number of reported problems. Around half of both the parents (n=13) and young people (n=19) reported three or more, fewer difficulties than at referral. In many cases, young people and parents reported improvements in the young person's behaviour and in parent-child communication, as well as a reduction in parent-child conflict. In particular, in over half of the cases of reported child violence to parents, and in nearly two-thirds of the cases where young people were violent to others, some improvement was reported at follow-up.

However, patterns of substance misuse appeared harder to change. Only a quarter reported alcohol misuse to be less of a problem by follow-up and one-third reported less of a problem with drug use. There was also no evidence of improvement in offending behaviour, as even more young people had been drawn into the criminal justice system by follow-up.

Scores for emotional and behavioural difficulties improved for many of the young people, but the majority, nevertheless, remained above the clinical threshold at follow-up. Mean scores for family functioning (on the FAD) also showed positive change. Parental mental health showed some improvement too, as over five of the eight parents with initial scores indicating mental health difficulties (on the GHQ-12) had fallen below the clinical threshold on this measure by follow-up.

Overall, then, there was positive change in many respects, particularly in relation to young people's behaviour within the home, their emotional and behavioural difficulties, and their communication and relationships with parents. Problems of substance misuse became less severe for some of the young people, but there was no

[17] Paired samples t-test: mean change 2.845, t=-3.698, p=.002.
[18] Wilcoxan Signed Rank test: p=.002.
[19] Pearson correlation .571, p=.008, n=20.
[20] Pearson correlation .427, p=.06, n=20.

sign of any decrease in involvement in offending. However, although the social services professionals working with these young people and families might do some work on these issues, tackling these difficulties was more likely to fall within the remit of youth offending teams and substance misuse teams.

Change in scores on our outcome measures between referral and follow-up are shown in Table 7.7. Changes which are statistically significant are highlighted in bold.

Table 7.7 Change scores on outcome measures

Outcome measure *(n)*	**Perspective**	**Mean score at baseline (SD)**	**Mean score at follow-up (SD)**	**Mean change**	**Sig.**
SDQ *(19))*	Young person	19.74 (4.62)	14.26 (6.81)	-5.48	**0.003**
SDQ *(13)*	Parent	25.08 (4.29)	20.85 (6.36)	-4.23	**.038**
Well-being*(18)*	Young person	4.33 (2.48)	7.178 (1.69)	2.845	**0.002**
FAD *(19)*	Young person	31.26 (7.51)	25.00 (6.08)	-3.07	**0.007**
FAD (13)	Parent	27.38 (6.15)	25.15 (5.98)	-2.23	*0..208*
GHQ-12 *(13)*	Parent	7.8 (3.86)	2.53 (4.32)	-5.27	**0.002**
Severity of difficulties*(18)*	Young person	7.84 (1.77)	5.16 (3.70)	-2.68	**0.002**
Severity of difficulties(13)	Parent	10.38 (0.65)	7.92 (2.84)	-2.46	**0.012**

8. Placement outcomes

Information was available on 24 of the young people at follow-up. Of these, 11 had become looked after by the local authority. Six of those who were accommodated were placed solely in foster or residential care, while the other five spent some time in foster or residential care and some time placed with relatives or friends.

A further four lived away from home for a time to stay informally with relatives or friends, but were not accommodated during this period (other than during their placement at Hilltop). Apart from their periods of respite at Hilltop, only nine continued to live at home throughout the follow-up period. In total, nearly half were accommodated for a while and nearly two-thirds moved away from home for some time, either to care placements or to relatives or friends, as shown in Table 8.1:

Table 8.1 Young people placed away from home (n=24)

Placement status	**Number**	**%**
Foster/residential care only	6	25
Foster/residential care plus placement with relatives	5	21
Informal stays (only) with relatives or friends	4	17
Total who lived away from home for some time	**15**	**63**
Did not move from home	**9**	**37**

However, for most young people, episodes of accommodation or informal stays with relatives and friends were fairly brief. Only four of the 11 young people accommodated (other than at Hilltop) appeared likely to remain in long-term care. The average time away was four months. Although the time spent living away from home ranged from one to 11 months, one-third of those who left home were away for less than six weeks and half of those who moved away from home returned within three months, as shown in Table 8.2:

Table 8.2 Time living away from home during follow-up period (n=12)

Time	***n***
< 6 weeks	4
6 weeks - 3 months	2
>3 months - 6 months	4
6 months -11 months	2

The young people stayed in a variety of formal placements (under Section 20 of the Children Act 1989) as well as in informal arrangements with relatives or friends, and one spent a period of time in custody, as shown in Table 8.3:

Table 8.3 Where the young people stayed: formal and informal placements (n=15)

Type of accommodation	*n*
Children's home	5
Foster care	5
Remand hostel	1
Remand foster placement	1
With relatives (formal or informal placement)	9
Custody	1
Hostel	1
Bed and Breakfast hotel	1
Caravan (with friends)	2

Five of the young people spent between two and eight weeks at Ridgeway (in most cases, six - eight weeks) and two of these were living in other local children's homes by follow-up. None of them moved to out-of-authority residential placements. Three entered long-term foster placements and another two spent a few weeks in foster care. In addition, a further three young people who initially received respite care at Hilltop subsequently moved on to respite fostering placements (not listed).

Among the young people who stayed with relatives, under formal or informal arrangements, at least five were known to have stayed with a grandparent at some point. This is not surprising, as grandparents are known to be the most common providers of kinship care. Other relatives who offered a temporary home were uncles and aunts and a 17 year old sister.

Instability

It will be apparent from the number of placement/accommodation types in Table 8.3 that many of the young people moved several times during the follow-up period. Indeed, they moved far more often than this table would suggest. Around half (7) of those who lived away from home moved three or more times during the follow-up period. These young people experienced a great deal of instability as they moved between parents (sometimes from one parent to another), relatives and, in some cases, care placements, '*from home to home*' as one young person put it, or, '*in and out with a suitcase*' as a parent described it.

In several cases, young people described being '*kicked out*' or '*thrown out*' by various relatives as a result of their behaviour, or running away because they were unhappy. Both young people and parents described the multiple moves that resulted as different family members offered a place to stay and then these highly volatile situations broke down:

'*Because I was……drunk and disorderly me mum kicked off and then kicked me out…And then me grandma said that she would let me live there to see if she could sort me out. And then I lived there…..me grandma kicked me out so they put us in foster care*' (Joanne, aged 14 years).

'*…..he was violent at home. I said that I wanted him out. He stayed at his grandpa's house for a couple of months and a couple of months at my stepsister's. He has stayed with my brother-in-law as well because of his bad behaviour*' (mother of 14 year old Jack).

'*Because me ma kicked us out and I moved in with me Nana and then I ran away from me Nana's and then I moved back in with me dad, and then I went back to me Nana, went back to me ma*' (Paul, aged 15 years).

Another young person described his experience of multiple moves between care placements and other types of accommodation, and the impact it had on him:

'*I was there* (Ridgeway) *seven weeks and then I got moved to foster parents which was seven weeks again and then I got moved to me main foster carer…..* (then to a remand hostel)*……and then I got moved from there to here* (another children's home)*……..... when I was getting moved around a lot I was unhappy because I was making friends and then I was moving*' (Chris, aged 15 years).

His mother remarked that Chris had moved so many times that she had lost count, but mentioned that he had also stayed in a caravan, a bed and breakfast hotel and with friends during the follow-up period.

Short-term accommodation

For seven of the young people, the support offered by the community support team and respite care provided by Hilltop did not prevent the need for a short period of accommodation when family relationships broke down. In at least two cases, the young people were perceived by parents to have calmed down after a few weeks away from home.

For example, Joanne had been referred to Hilltop because of her mother's complaints about her aggression, defiance, violence, drug abuse, and running away. Her mother thought that the origins of Joanne's emotional and behavioural problems lay in the sexual abuse she had been subjected to by her stepfather when she was younger, but Joanne's social worker felt that her behavioural problems were largely due to her mother's weak and inconsistent parenting. At the end of her tether, Joanne's mother had, '*left her at social services and told them to keep her*', but had initially been offered respite care at Hilltop rather than a full-time placement. However, respite care failed to resolve the difficulties and Joanne subsequently spent a few weeks being assessed in a specialist foster placement. Both Joanne and her mother felt that separation from her peers had been helpful and the change of environment had also appeared to help. Her mother spoke glowingly of the foster carer's skilled help:

'*She's absolutely brilliant…she's, like, calmed her right down*' (mother of 14 year old Joanne).

Olivia, whose relationship with her father was very poor, settled down at home again after six weeks in Ridgeway, followed by a further period of respite care at Hilltop. The period of accommodation had helped her to separate from a negative peer group. The improvement in her behaviour also appeared to be related to her mother's return to the family home.

Short-term placement was therefore used as a positive resource to support families, when respite care alone could not resolve young people's difficulties. Respite care at Hilltop was sometimes provided as part of a package of follow-up support.

Long-term care

At follow-up, four of the young people were in what seemed likely to be long-term care. Three boys were looked after in what were anticipated to be long-term placements. A fourth boy had been looked after for six months by follow-up, although his social worker hoped he would eventually return home. As in Biehal's earlier study, in most cases long-term care was eventually offered when parents finally refused to care for their children any more.

In the case of David (aged 13), long-term neglect and rejection by both his mother and his father, who lived apart, led him to run away repeatedly from home and for him to ask to go into foster care. His persistent running away and his determination to live apart from his parents ultimately gave social services no option but to accommodate him. Paul, too, had been shuttled between his parents and had been rejected by both. For Chris (aged 15) and Paul (aged 15), long-term care became the last resort option after they had made numerous moves between relatives, all of which had broken down. Ian (aged 13), came from a family with multiple problems, including the sexual abuse of his sisters, and had behavioural problems at home as well as serious emotional problems. Paul and David had both been looked after earlier in their lives. Previous studies have found that past experience of care is the strongest predictor of admission (see Biehal, 2005, p.156).

Three of these young people had had six to eight week placements in Ridgeway in an attempt to stabilise the situation and help them work towards a return home, but their parents remained unwilling to have them back, despite the efforts of social workers to persuade them to change their minds. All were aware that their families were unwilling to care for them. For example Chris, whose multiple moves were described above, was clear that the decision for him to be looked after had been made by '*me mum and dad, cos they didn't want us*'. Like Chris, Paul commented that he had been '*kicked out*' by his family and understood that he was in foster care because his family refused to have him, '*you come here when nobody else will keep you*'.

In three cases there had been allegations or evidence of abuse over some time and, in most cases, histories of rejection. Chris, Paul and David all alleged that they were physically abused by their fathers:

> '*I don't see me dad anymore, like. He's an alcoholic and he brayed us*' (Paul, aged 15 years).

David, who was 13 years old, had also experienced severe emotional abuse for many years. Ian was on the Child Protection register because evidence had recently

emerged that his father had sexually abused his sisters. It was unclear whether he too had been sexually abused, but he was clearly extremely angry with his father. In addition, his mother was consistently negative towards him.

Three of the young people entering long-term care had parents with drug or alcohol problems and all four had mothers who suffered from depression. Three came from families which had experienced marital conflict and separation and at least one had experienced domestic violence within his family. In all cases, therefore, environmental risk factors within the home had clearly contributed to their behaviour problems, and it was these behaviour problems, which ultimately led to their families' refusal to care for these young people.

In addition, three had individual risk factors for behavioural difficulties: David had a diagnosis of ADHD and a statement of special educational needs and both Paul and Ian had learning disabilities (and a high score for hyperactivity on the Strengths and Difficulties questionnaire). These individual risk factors undoubtedly made parenting more difficult and may have contributed to, or reinforced, parental rejection.

Paul and David were clearly deeply unhappy at home and ran away repeatedly. Paul also had serious emotional problems and these appeared to have had their origins in his experience of severe rejection. Paul had twice attempted suicide and Ian, who sounded extremely depressed when first interviewed, had self-harmed and attempted suicide prior to referral. Both Paul and Ian also displayed behaviour problems at home. Unlike the other two, though, they were not known to be abusing drugs or alcohol. Not surprisingly, their emotional and behavioural difficulties meant that they also had problems at school. Truancy was a common problem for this group. Paul was bullied at school and Ian and Chris were excluded.

However, long-term placement should not necessarily be viewed as a 'negative' outcome as indeed in some circumstances this may offer the best way of meeting a young person's needs. At follow-up, all four appeared to be happier and more settled. Thirteen year-old David and his mother were both much happier with the situation at follow-up. Here is his case study:

David lived with his mother. He had a diagnosis of hyperactivity and a statement of special educational needs. His social worker commented that there had been a long history of parenting problems, including neglect and a failure to set clear boundaries. His father had alcohol problems and his mother had drug problems, was depressed, and was considered by professionals to be neglectful and emotionally abusive. A residential worker commented that she was '*not interested in caring for him*'. Indeed she herself commented in interview on how rejecting both she and his father had been towards him, for example on one occasion when his father threw him out and his mother refused to have him back. David also complained that he was hit at home and made it clear that he was unhappy both at home and at school. His mother reported that his behaviour problems had begun when he was two years old and these were now compounded by drug problems (use of cannabis). Professionals reported that there had been a long history of parenting problems and a past admission to care.

While in respite care David's behaviour improved, but he made it clear that he did not want to live at home, running away repeatedly and asking to live with foster carers, '*I kept on running away and I was getting out of hand so I contacted social services to get into foster care. I wasn't bothered about foster care, I wanted to move*'.

By follow-up he was in foster care and the plan was for him to remain there long-term. Both David and his mother were happy with this outcome and felt that matters had improved considerably, although he said that he had no wish to speak to his mother ever again. Living in a new, more caring and structured environment, David's behaviour improved considerably. He settled in a new school where he was much happier and no longer truanted. As he explained, '*I used to feel depressed and horrible all the time….but I am happy now…..Life has got better because I am a lot happier. I am looked after better…..It's good here – we have a good laugh and go out*'.

Chris, too, was clearly much happier in a stable foster placement at follow-up, where he anticipated staying until he moved to independence at the age of 16 or 17, '*now I'm in a secure place and know that I'm not going to get moved*'. His mother commented that his behaviour had improved once he entered care. Chris and David both indicated that placement away from home had helped to improve relationships with their parents:

> '*I think basically it's like a break from me mum and dad and it's given my mum and dad a break and then we've just started to build our relationship back up again, so*' (Chris, aged 15).

> '*Moving out of my mum's, things have been going a lot better. A million times better. When me and my mum are together we get along so much better*' (David, aged 13).

While he was living at home, the support offered by the Community Support Team and Hilltop had appeared to make little impact on Ian's difficulties, but after six months in foster care Ian was more settled, was attending a new school and, according to his social worker, had higher self-esteem. His social worker thought that the fact that his father's sexual abuse of his sisters had now been acknowledged had also

helped to release the pressures in the family, leading to improvement in the relationship between Ian and his mother.

The small group who moved to long-term care, or for whom such a move was planned, was for those with serious, often long-term problems who had experienced abuse (in one case, indirectly) and, in most cases, rejection. All of them were deeply unhappy at home, although only one made it clear that he no longer wished to live with his family. Respite care at Hilltop, short-term care placements and stays with relatives had all failed to resolve child and family problems. So for these young people this was clearly a positive outcome. A different, and stable, environment appeared to have led to an improvement in their well-being, behaviour and relationships with parents.

To sum up, nearly two-thirds of the young people lived away from home for some time between referral and follow-up. Many of them experienced a great deal of instability, both before and after their period of respite care at Hilltop, moving between various relatives and, in some cases, in and out of the care system.

Most episodes of accommodation by the local authority were fairly brief and in some cases it was clear that the provision of short-term accommodation was an important family support service which helped young people and parents to change their behaviour and relationships and calmed the situation down. Follow-up respite care sometimes allowed for a supported return to the family.

For one-sixth of the young people (4) the evidence at follow-up indicated that they were likely to remain looked after long-term. All had multiple and serious difficulties and most of their parents had serious difficulties of their own which contributed to their often emotionally abusive behaviour towards their children. The Hilltop service had offered these young people and their families the opportunity to repair relationships, but in most cases the parents flatly refused to have their children home. Parental rejection and young people's emotional and behavioural problems made the effective renegotiation of relationships difficult to achieve. In any case, for the most part, this group of young people appeared to be happier and more settled in their care placements than they had been at home.

Although the sample in this study was very small and it is therefore not possible to generalise more widely from these findings, the evidence suggests that longer-term family breakdown was more likely where the parenting young people received was rejecting and less likely where parents were simply ineffective at setting boundaries and inconsistent in their parenting strategies. For the former group, it may be the case that a stable placement away from home may be the best way of enhancing child well-being. The community support team and the Hilltop respite care service may be more successful in helping the latter group.

9. Comparison with outcomes in the support teams study

Comparing the two samples

The young people who took part in the current study and in the earlier study of family support services (Biehal, 2005) were similar in many respects. In both studies, similar proportions had physical or mental health problems, a disability or a diagnosis of hyperactivity, although the proportion with learning difficulties was higher in this study (24%) than in the earlier one (15%). Also, the proportions with experience of past and current emotional, physical and sexual abuse were not dissimilar and similar proportions in both samples had run away from home in the previous year. Many of the young people in both samples lived in families characterised by marital conflict and, in a substantial minority of cases, domestic violence. Also, around three-quarters of the parents in both samples scored above the threshold on a standardised measure of mental health difficulties, the GHQ-12.

However, there were also a number of notable differences between this sample and the young people in the earlier study. Parents in the current study rated child behaviour and parent-child communication as relatively less problematic on the Severity of Difficulties scale than those in the earlier study. Yet, as noted earlier, their responses to open-ended questions on the baseline questionnaires rather belied this, as these were characterised by graphic accounts of their children's extremely difficult behaviour and evidence of the stress parents were experiencing as a result of this. Also, although a substantial minority of young people in both studies were reported by parents to have been troublesome to them from an early age, the proportion whose difficulties emerged before they were five years old was higher in this study, at 26%, than in the earlier one (17%). As noted earlier, where serious behavioural difficulties first emerge in the pre-school years there is an increased risk that they will persist into adulthood although, of course, this is by no means inevitable.

In both studies many young people scored above the clinical threshold for emotional and behavioural problems on the SDQ, but the scores of the Hilltop group were significantly higher than those of both groups of young people in the earlier study.[21] On young people's self-report, a higher proportion (52%) had scores above the clinical threshold in the current study (52%) than in the earlier one (42%). In both samples, the sub-scale scores for conduct problems and hyperactivity were particularly high. However, three-quarters of parents who completed the SDQ in the current study also indicated that peer relationships were a serious problem, whereas less than a third did so in the earlier study.

Given these emotional and behavioural difficulties, it is perhaps not surprising that many young people in both samples displayed behavioural problems at school and those rates of truancy and school exclusion were high. Yet again, difficulties appeared more widespread in the current sample, as only half were attending

[21] One-way Anova, p=.026, (n=19): mean scores were 23.16 (Hilltop group), 19.08 (support teams group) and 18.45 (mainstream social work group). Tukey test showed that young people's mean SDQ score at baseline was significantly higher for the Hilltop group compared to both the support teams group (p=.036) and the mainstream social work group (p=.027).

mainstream school at referral, compared to 80% in the earlier study, and accordingly, more young people in the current sample were attending Pupil Referral Units instead. Also, substantially higher proportions had truanted and had been temporarily or permanently excluded in the past six months than in the earlier study.

Young people in the current study were also far more likely to report major problems in relation to substance misuse and offending. In the earlier study, only 3% of young people reported 'major' problems with drug use, compared to one quarter of the young people in this study. Similarly, only 4% of young people in the earlier study reported major problems with alcohol use compared to one-third of the young people in this study. In total, around two-thirds of the young people placed at Hilltop reported 'major' problems with drug or alcohol use (or both).

Offending behaviour also appeared to be more widespread among the Hilltop sample than the earlier sample. All but one of the young people interviewed shortly after placement (23) reported some involvement in offending during the previous six months. Around one-third of them (8) reported that this was a 'major' problem and a further third considered their offending behaviour to be a 'moderate' problem. In contrast, in the earlier study only one in eight young people (12%) regarded their offending behaviour as a 'major' problem.

Overall, the young people and parents in both studies experienced similar, and severe, difficulties in a number of areas. In some respects, a higher proportion of the young people in the current study experienced certain difficulties than in the previous one. They were more likely to have learning difficulties, for example. They were also more likely to have problems of substance misuse, be involved in offending, to be detached from school and to have problems with their peers. In other words, they were more likely to have difficulties associated with what they did *outside* the home than those young people in the earlier study, and in particular to have difficulties that may often be peer-related, such as substance misuse and offending.

The young people who received Hilltop's respite care service therefore appeared to have more severe difficulties, in a number of key areas of their lives, than a similar sample of young people who received either a community support team service or a mainstream social work service but no respite care. This suggests that the enhanced family support service provided by Hilltop was appropriately targeted at a group with a particularly high level of need. Also, since many of them had difficulties associated with what happened outside their homes, as well as within them, spending some time away from their local area may have been particularly helpful to some.

Changes in child and family functioning

We compared the average changes in scores on our standardised outcome measures between referral and follow-up for:

- those placed in Hilltop;
- those in the earlier study who received a community support team service but *no* respite care;
- those in the earlier study, who received a service from a mainstream social worker but *no* community support team intervention and *no* respite care.

In almost all instances, we found no significant statistical difference in the degree of change on these measures for the young people in the three different groups. The only significant difference in the degree of change experienced by the groups was in the young people's rating of family functioning (on the FAD), which showed significantly greater improvement for the Hilltop group than for the Support Team group.[22] Analysis of changes on the parent-version of the FAD, on the SDQ, the GHQ and Cantril's Ladder showed no significant difference between the three groups, as shown in Table 9.1.[23]

Table 9.1 Changes on outcome measures between referral and follow-up

Outcome measure	Perspective	Hilltop Group Mean (SD)	Support Team group Mean (SD)	Mainstream Group Mean (SD)	Sig.
SDQ	Young person	-5.47 (6.83)	-2.95 (6.15)	-4.17 (5.10)	.238
SDQ	Parent	-3.92 (6.76)	-3.30 (5.44)	-1.83 (4.72)	.281
FAD	**Young person**	**-6.26 (8.89)**	**-1.67 (6.23)**	**-4.71 (8.3)**	**.022**
FAD (12)	Parent	-2.67 (5.55)	-1.93 (5.81)	-2.0 (6.53)	.924
Cantril's Ladder	Young person	2.84 (3.26)	14.60 (23.76)	9.88 (28.72)	.142
GHQ-12	Parent	-5.54	-3.05 (4.73)	-3.50 (3.96)	.177

Patterns of placement

In both studies many of the young people experienced a great deal of instability between referral and follow-up, moving between a variety of relatives and friends and, in a number of cases, in and out of care placements. Differences in the length of follow-up for the two studies makes comparison of placement rates particularly difficult, since the young people in the current study had approximately three more months in which to enter placement than those in the earlier study. This must be borne in mind when we note that in the earlier study one quarter of the young people were accommodated during the six month follow-up period, whereas in this study almost half of the sample (11) were accommodated during a longer follow-up period of nine months. Nevertheless, this is a marked difference. Furthermore, those in the current study were approximately twice as likely to enter what was anticipated to be

[22] One–way Anova on FAD change score (young person's version), p=.022. Tukey test showed scores for Hilltop young people improved significantly more than for the support teams sample (p=.037), but there was no significant difference in relation to the mainstream sample (p=.76).

[23] One-way Anova tests to compare the change scores on the FAD (parent version), Cantril's Ladder, the GHQ and on both parent and child versions of the SDQ showed that the differences between these scores were all non-significant.

long-term care, as around one in five did so by follow-up, compared to less than one in ten in the earlier study.

It is well known that placement rates vary between local authorities as they are determined not only by the needs of individual young people but by local policies and resources, which influence local thresholds for placement (Biehal, 2005; Dickens, Howell, Thoburn *et al.*, 2005). We therefore compared the pattern of placement for the Hilltop sample with the pattern for the 28 young people who were referred to the community support team in the same local authority two or three years earlier, and who participated in the earlier study. Although this comparison is likely to be more meaningful, caution is needed in interpreting this data as numbers are very small. Nevertheless, it appears that a higher proportion of those using the Hilltop service subsequently entered foster or residential care (46%, 11 young people), compared to those who received just the community support team service in the earlier study (32%, 9 young people). The Hilltop young people also appeared more likely to enter (what was anticipated to be) long-term care, as one in five of the sample (5) had done so by follow-up, compared to approximately one in ten (3) of the earlier community support team sample. The underlying reasons for long-term placement were similar in both studies, in many cases, long histories of abuse, and, for most young people, parental rejection.

It seems unlikely that the difference in these placement rates would be due to substantial changes in local policy and resources over the two to three year period between the time the earlier study was conducted and the time that this one was undertaken. It therefore seems probable that the higher placement rates for the Hilltop group may be related to the fact that this group included a higher proportion of young people with severe difficulties, as noted above.

10. Did respite care help?

At follow-up, young people and parents were invited to comment on whether they felt matters had improved, stayed the same or deteriorated since the placement at Hilltop began. In total, 17 of the 19 young people interviewed at follow-up felt that overall, life was better than it had been nine months earlier, but only two-thirds (13) of the 20 parents interviewed took a similar view of the young person's situation.

In around two-thirds (12) of the 19 families interviewed at follow-up, both young people and parents felt that matters had improved. Young people were more likely to be positive about change as a further five young people felt their situation had improved, when their parents did not.

Young people and parents' views of professional help

The majority of young people and parents felt that residential staff at Hilltop, community support workers and social workers had been helpful, to some extent at least, as shown in Tables 10.1 and 10.2:

Table 10.1 Young people's views of professional help

How far professionals helped	**Residential staff** *(n=19)*	**CST workers** *(n=18)*	**Social workers** *(n=19)*
Helped improve situation considerably	12	10	7
Helped a little	6	5	8
Was no help at all	1	3	4

Table 10.2 Parents' views of professional help

How far professionals helped	**Residential staff** *(n=14)*	**CST workers** *(n=18)*	**Social workers** *(n=20)*
Helped improve situation considerably	7	8	6
Helped a little	4	8	8
Was no help at all	3	2	6

Young people were somewhat more likely to report that residential workers and CST workers had helped 'considerably' than that social workers had done so. It is difficult to know how these perceptions were formed. They may be directly related to the comparative skills and efforts of the workers. However, such perceptions may also be influenced by whether the workers undertook direct work with them and the degree to which each worker had succeeded in forming a positive relationship with them. In

their role as case managers, social workers may have helped indirectly, by referring the family to the community support team, to Hilltop and sometimes by mobilising other services.

Among the young people who reported that their situation had improved, either considerably or a little, the majority considered that Hilltop staff had helped to bring about this change. Two-thirds were also positive about help from community support workers and social workers, although to a lesser degree, as shown in Table 10.3. Much of the direct work with parents was undertaken by community support workers, which may help to explain why they were mostly likely to be rated as helpful by parents.

Table 10.3 Appraisals of social services staff by families satisfied with outcomes

Helped considerably/ helped a little	**Parents *n*** *(n=20)*	**Young people *n*** *(n=19)*
Residential staff helped	7	16
CST worker helped	11	13
Social worker helped	9	13

Cases that were more successful

Most young people enjoyed their nights at Hilltop and one social worker even thought that the young person she had referred was sometimes, '*deliberately kicking off, I think so that she could get extra nights at Hilltop*'. They enjoyed the activities offered and the opportunity to talk to staff who were both supportive and interested in them. Hilltop staff felt that young people's willingness to attend Hilltop was an important ingredient in successful cases, as this could often make them easier to engage:

> '*They want to be here, I suppose …..we're fortunate here that a lot of young people we work with want to be here because they want to remain in the family home. Whereas in a lot of our other children's homes there are young people who can't go home or don't want to be at home, which increases their behavioural difficulties shall we say*' (residential worker).

The development of caring and supportive relationships between staff and young people was not only important in itself in making young people feel understood and valued, but also played an important part in bringing about change. Contact with caring staff was particularly important for young people with experience of neglect or rejection, like Stephen:

> '*They don't give you a hard time at all. They talk to you, if they need to talk to you. They are always there for you…..They are like my two best friends, yeah…When I was there I just sat and chilled out*' (Stephen, aged 15 years).

> '*They were lovely, they were easy to get along with and they would help us anyway I, like, needed*' (Leanne, aged 15 years).

'*At Hilltop I would go out with them and talk about how things were going at home. It helped a lot*' (David, aged 13 years).

'*It was good, it was great. I wasn't in trouble at all. So it was really good there*' (Chris, aged 15 years).

Some young people and parents explained how the provision of respite care had helped to break the cycle of parent–child conflict:

'*It was very badly needed and it did help break the chain, because we were just constantly arguing and the arguments would not stop, they were just continuing the next time we met or there would be something else that triggered it, so it broke the chain*' (mother of 14 year old William).

'*Fine, fine. Still having ups and downs with him but hopefully it's getting better…..It seems to have broken the cycle*' (mother of 13 year old Douglas).

Douglas and his social worker both agreed that matters had improved:

'(Placement at Hilltop) *was positive in this case. He did appear to gain a lot of self-esteem and seemed to ride above what was happening at home. His resilience perhaps was better developed*' (social worker).

'*I'm a lot happier in myself….Before I didn't talk to anyone in the house. Now I talk to everyone*' (Douglas, aged 13 years).

Families under stress also welcomed the opportunity to have a break from each other and in some cases workers felt that this relief of pressure was essential to prevent family breakdown. Periods of respite not only relieved pressure but gave young people and parent's time to reflect and to respond to the interventions by the professionals involved. Several parents commented on the value of having a weekly break from their child, as did some of the young people:

'*I cracked up! I suffer from depression and I get really stressed when I am here[at home] because there are so many people here, so they just said I can have respite three days a week away from home and away from all of this, and it has helped*' (Sarah, aged 14 years).

'*It gives us time to think….. I wouldn't be shouting and stuff, bad-tempered, when I was here. They would be able to have a break and think themselves*' (Olivia, aged 15 years).

For positive change to take place, residential and CST staff needed to engage parents successfully, as well as young people. Residential staff in our focus groups indicated that, for the intervention to be successful, both young people and parents needed to be motivated to work towards change:

'*I think it works best when the family engage and everybody wants to change and everybody wants the same goal really in the family and that's half the battle and*

you just put the strategies in place for them to achieve the goals really, but when it's difficult it's for instance when a young person wants to stay at home and they just want a better environment and the parents don't want the same thing, it's when everything clashes really that's hard work because you have to work with the parents and the young person'.

'(Success) *depends how compliant the parents are on the whole. You've got to have them on board, you know, because some parents will just not work with us*'.

Work by Hilltop, the community support team and social workers to improve young people's behaviour and offer parents new strategies for dealing with their children clearly helped many of the young people to behave differently. It also helped to bring about positive changes in patterns of communication and helped some parents and their children to renegotiate relationships. When asked at follow-up what had changed in the past few months, young people and parents commented:

'*My behaviour…not getting into trouble so much. Then I was constantly in trouble*' (Stephen, aged 15 years).

'*I'm not losing my temper all the time and get on with my dad now, just totally different*' (Olivia, aged 15 years).

'*I get on with my mum and dad more now and instead of shouting at them. I usually just ask them stuff*' (Victoria, aged 15 years).

'*He doesn't disappear and not come home….he hasn't smashed things*' (mother of Alex, aged 15 years).

'*I'm behaving myself, not getting into fights….I don't shout as much*' (Patrick, aged 14 years.

Some young people commented on what they had learned while staying at Hilltop:

'*It's learnt me loads of stuff, how to walk away from the argument*' (William, aged 14 years).
'*Helped me control my temper and stuff*' (Liam, aged 12 years).

'*It gives us time to think*' (Olivia, aged 15 years).

Teaching young people different strategies for managing their behaviour, and also giving them the opportunity to practise different ways of responding in a different environment where positive behaviour received consistent reinforcement, was clearly helpful to the young people. The residential staff behaved in a clear and consistent manner, making it clear what was expected and what behaviour was unacceptable. One social worker commented that this positive, consistent 'parenting' style worked well with many young people:

'*…they have very clear boundaries and that really works with most of the young people cos often they haven't had that*'.

At the same time, the community support team and/or social workers offered parents different strategies for responding to their children, which they could practise on the days the young people were at home. Parents could also discuss the previous week's problems with Hilltop staff when bringing their child to Hilltop and some spoke of how much they valued this support and advice. One parent described the support offered when she delivered her child to Hilltop:

> '*….and he used to say 'Come on in' and I'd say 'Oh we've had a terrible week' and I'd be all in tears and* (he'd say) *'Oh don't worry about it, you'll be alright' and very supportive, very supportive*' (mother of 15 year old Leanne).

As discussed in chapter four, Hilltop staff tried to reinforce parents' attempts at providing more consistent parenting and setting clearer boundaries when the young people were at home. For example, if parents reported bad behaviour, the young people were not allowed to take part in special trips or activities. In this way, Hilltop offered positive reinforcement for improved behaviour at home. In the nightly one to one sessions with the young people, key workers would also discuss issues that had arisen while they were at home and help young people to consider alternative ways of dealing with their difficulties. They also discussed these issues with parents, helping family members to negotiate different ways of reacting to one another:

> '(We) *just used to talk about how the week's gone when I've been living with my parents and that and if there was any problems we'll like talk through how to solve them…See if I've had a massive row with me parents they used to like try to help us work it through with me parents and how, like, to approach it, how to solve it….Yeah, cos they told me mam and dad how to react and that when I kicked off*' (Leanne, aged 15 years).

The combination of respite care and intervention by the community support team and social workers had helped many of the young people and parents find new ways to deal with their difficulties, enhancing the consistency of their parenting and giving them greater confidence:

> '*It is difficult. There are times when she's fisting your wall or shouting at you. You want to have a go at her but you can't. So we've learnt to calm the situation a bit better. Obviously she is growing up a little bit and she has learned to walk away herself…..She can have these rages, we call them blind rages where she just doesn't stop. We ignore her and she'll go out for a walk….and then she'll come back calmer*' (mother of 15 year old Leanne).

> '*When they do have incidents now where she kicks off, they sort of revert back to what myself or community support went through with them about behaviour and what kind of things to do*' (social worker of 15 year old Victoria).

Less successful cases

On the whole, the combined respite care/community support intervention seemed somewhat more likely to be successful in families where parenting was perhaps rather weak and inconsistent, but parents nevertheless felt some continuing commitment to their children, despite the difficulties they were experiencing with them. The behavioural strategies offered to young people and parents, such as anger

management, time out and more consistent boundary setting tended to be generally less successful in families where parenting was emotionally abusive, characterised by low warmth and high criticism. As we have seen earlier, for those who seemed likely to remain accommodated in the long-term, parental rejection had been a long-standing difficulty. Where parents, and in some cases young people, could not be fully engaged, interventions appeared to be less successful.

Residential staff felt that some parents lacked motivation or commitment and insisted that their child be taken into full-time care or to leave the family home. Staff felt that in some cases, parents wanted to use respite care as a '*babysitting*' service, until the young person was old enough to leave home, rather than to engage in work to renegotiate family relationships:

> '*We do sometimes get to the stage where parents want to withdraw from the child, they will reject the child. It's particularly when they're getting them up to 16, they've had enough and all they want really is, they don't want the respite to keep the family together, they want respite until whoever it is, is old enough to, to leave home, which puts us in a bit of a quandary, because in that sense we're not, we're not really helping to keep the family together*'.

For example, in the case of Liam, neither parent nor young person saw any improvement. Both he and his parents proved difficult to engage and there appeared to be little change:

Liam was a 12 years old who was clearly very unhappy at home, was truanting from school and involved in crime. Workers reported that he had a poor relationship with his mother, who suffered from depression and had alcohol problems. His father was uninvolved and his brother bullied him. At interview Liam presented as a very quiet, sad young person and mentioned that he felt he did not fit in either at home or at school. Hilltop staff said that they had been unable to engage him at all and that he was unwilling to talk about his family. His residential worker commented that his parents:

'(His parents) *used Hilltop as a way of getting rid of him for a couple of days…they wouldn't buy into anything that we offered, really*'.

Despite this perceived lack of success, Liam himself felt that Hilltop staff had taught him how to control his temper better and how to fit in better with other young people. He also felt that his social worker had helped him to talk about his feelings and that both she and the residential staff had helped him a lot. However, his residential worker was concerned that his future looked bleak:

'*I think he is going to either end up in full-time care or in the criminal justice system…..he's obviously not happy at home so he's going out, doing some silly things outside the home. We got a call the other day that the police were looking for him*'.

Similarly, despite the fact that Sarah clearly wanted the service to help her resolve her difficulties, it was difficult for staff to engage her and to help her resolve her complex and long-standing difficulties:

Sarah, aged 14, had been sexually abused by relatives at an early age and, more recently, by her mother's partner. At referral, her mother complained that she could not control her and was concerned about her welfare as she was stealing from home, drinking, taking drugs, running away for days at a time and was sexually active despite her young age. Residential staff felt that she was exhibiting impulsive and dangerous behaviour. She was given respite care in an attempt to prevent family breakdown and she clearly hoped that it would help, as she said that she wanted '*to be part of my family again, without the arguments and fighting*'.

However, despite the efforts of social services staff she experienced a great deal of instability during the follow-up period. After her period of respite care she had been placed in a children's home for two months, in foster care and subsequently had a disastrous stay with a drug-using relative, punctuated by brief, unsuccessful returns to her family. Her situation remained unhappy at follow-up and plans were put in place for her to be looked after long-term. Professionals had all found her very difficult to engage and Sarah herself said that she was reluctant to talk to professionals and found it difficult to open up to people. Nevertheless, she felt that her social worker really understood her and was '*brilliant*'.

In these less successful cases, parents who behaved in a rejecting manner sometimes valued the break from their child, but complained that the intervention did not change the young person sufficiently. Their view was that the young person was the source of all problems and they were therefore difficult for workers to engage. Victoria's

father, for example, complained that his daughter had not changed sufficiently but was reluctant to consider that some change was needed on his part too:

> '*It helped us get a break…but it didn't help us to change Victoria….To be honest, it didn't help with her tantrums and her moods, did it?*' (father of Victoria, aged 15 years).

The impact of the environment

It was clear in a number of cases that a change of environment contributed to change in the young person. It was undoubtedly the case that the family environment often contributed to or reinforced young people's problems. Parental attitudes and behaviour towards the young people, the effectiveness of the parenting strategies used and the parents' own problems (for example, mental health, domestic violence or substance misuse) were all likely to have had an impact on the young people's emotional and behavioural problems. Where problems could not be resolved within that home environment, respite care could offer the opportunity both for a fuller assessment of young people's behaviour and for focused work on social and behavioural difficulties:

> '*Although we are only respite, we may live with young people for two or three days, so there's, that time to see, you know, where things are going wrong, what can be looked at*' (residential worker).

> '*They are taken out of their environment so that when they come in here it's almost a sense of normality, you know, it's very different from their environment and we can work on that then and the new skills that they bring in here or, you know, taken from here back into their environment, it's happening. Community Support goes into their environment, whereas we take them out of that environment*' (residential worker).

> '*Just the time out and having that break away,* (is) *good for them and good for the parents because it has made them realise what they have actually when they have gone home and Hilltop can really do all sorts with the children at Hilltop and it's helping them get into routines and sometimes young people don't help out at home and Hilltop will include them, asking them to help around Hilltop and different activities as well*' (CST worker).

We have also seen that in some cases, negative peer groups similarly appeared to reinforce young people's behavioural difficulties. Changing the young person's environment, even on a part-time respite basis, could therefore in itself play a part in producing positive change.

The corollary of this is that, for positive change to persist once the young person is no longer at Hilltop, there may need to be changes in the environment they return to. For respite care to be effective, therefore, interventions with the young people *and* parents (by all the professionals concerned) *both* need to have some effect. Where there was little change in parenting style when young people returned home, it was harder to make progress. As Liam's residential worker observed:

'*We just weren't getting anywhere…..There was no change at home….He was fine here and no change at home*'.

If there was little or no change in the home environment, there was a limit to what the service could achieve for the young person. One social worker felt that, nevertheless, even in these circumstances, respite care could help a young person cope better with a very difficult home environment:

'*I think the short-term respite does build the child's resilience. We can't change the situation, you know, we can change the person*'.

We have seen earlier, that it was mostly when parents were consistently rejecting that young people entered long-term care. Building self-esteem was often an ingredient in the work done by Hilltop, but in these circumstances the positive effects of this work could be hard to transfer to the home environment:

'*He was very well behaved* (at Hilltop)*….and the staff gave some excellent positive feedback that he wasn't getting at home…He was a young person that needed this self-esteem building cos at home he's just not appreciated*' (social worker of 13 year old Douglas).

Sometimes, placement at Hilltop also helped to bring about changes in the nature of young people's engagement with anti-social peer groups:

'*That was part of the deal that she went to Hilltop anyway, that she wasn't allowed no contact with the estate*' (mother of Victoria, 15 years).

When asked what had helped her change her behaviour, Victoria felt that this was due to, '*just being mixed in with new people*'. Similarly, Catherine, who had been involved in offending and drug and alcohol misuse, felt that her family's move to a new area had really helped her as she no longer saw old friends and had started a new school. Fifteen year old Leanne also felt that separating herself from peers who had bullied her helped her change her behaviour. Douglas, too, '*couldn't find his pals to go drinking and smoking*' when he was at Hilltop.

These changes in the influence of a negative peer group were not always easy to sustain, however. Stephen's stepmother commented that the positive impact of the Hilltop environment dissipated once he left:

'*As soon as he comes away from that he goes down the slippery slope again because he is alright when he is there and he has got someone to talk to and he knows he is on the right track, but as soon as he comes away he is easily led*'.

The school environment was also important. When young people were more settled in school, this could contribute to calming the situation at home:

'*Since he's stopped going* (to Hilltop) *and since he's back in proper mainstream school, he's started settling right down*' (mother of Patrick, aged 14 years).

'*While she was at Hilltop her schoolwork picked up and everything*' (mother of Leanne, aged 15 years).

11. Conclusion

The young people referred to Hilltop were at risk of family breakdown and had multiple and severe difficulties which were often long-standing. Social services interventions earlier in their lives had not resolved these and they were likely to need continuing support, from time to time, during adolescence. The abuse of adolescents is not widely recognised. However, this was a problem for a quarter of the sample and was clearly linked to their current behavioural difficulties. Emotional abuse was the most common and requires a service response as, although its effects may be less visible than in the case of physical or sexual abuse, it is evident in the emotional and behavioural difficulties exhibited by these young people. Living with domestic violence had also had a major impact on many of these young people. Multi-agency preventive services are needed to support these older children and adolescents in their families in order to avoid unnecessary placement in care or entry into the criminal justice system.

Respite care provision helped to relieve family stress and support families in re-negotiating relationships and patterns of communication. The young people experienced consistent care, with clear set boundaries, and were encouraged to reintegrate into school, deal with their drug and alcohol problems and engage in positive leisure activities. The break from home and individual support from residential workers gave the young people the opportunity to develop alternative behavioural strategies away from the environment in which their problems had originated, but also to practice these strategies in the home environment every week.

The integrated respite care/community support team/social worker service offered valuable support. Behavioural outcomes and family functioning improved for many who received the service. Parents were helped by community support workers and social workers to develop more consistent and effective parenting strategies and these were reinforced by Hilltop staff. Young people were helped to manage their anger and deal with difficulties in new ways. Where this worked, a virtuous circle of mutually reinforcing positive parenting and improved child behaviour developed. Without a control group, it is not possible to comment on how far this was due to spontaneous improvement or other factors, but the qualitative data suggests that this comprehensive service did contribute to the positive outcomes for many young people.

The principal barrier to the success of the Hilltop service was a failure to engage some young people and/or parents, and this was also the case in the earlier study (Biehal, 2006). Those most difficult to engage appeared to be the young people with long-term and/or internalising problems and parents whose parenting style was predominantly cold and rejecting. The service tended to be more effective in families where parenting was weak and inconsistent, but parents, nevertheless, showed some commitment to their child.

The group offered respite care in Hilltop, included a higher proportion with severe difficulties than the group of similar young people receiving a service either from community support teams or mainstream social workers in our earlier study (Biehal, 2005). In the light of this, it should not be surprising that a higher proportion of these young people were subsequently accommodated in foster or residential placements compared to the group in the earlier study. For most of the young people accommodated, placements were fairly short-term and constituted an important element of family support, and may have helped to prevent irretrievable family breakdown (although the follow-up period of this study means that we cannot provide evidence as to whether this was the case). As others have also argued, prevention, placement and rehabilitation should be conceptualised as a continuum, encouraging a recognition that these may be complementary rather than competing options (Whittaker and Maluccio, 2002).

Some young people, mainly from extremely rejecting families, were placed in what was anticipated to be long-term care. In these circumstances, placement should be seen as a positive outcome, not a failure, as it may be the best way of meeting these young people's needs. In these situations of chronic emotional abuse, it is unlikely that young people's needs can be met by the occasional provision of intensive family support services, such as those studied. If long-term placement is to be avoided, less intensive long-term support services may be needed. However, at least some of this group are likely to benefit more by removal to a more caring home environment. Indeed, we might question whether this small group should not have been offered secure, long-term placements earlier in their lives.

In conclusion, it is clear from this study that the use of respite placements to prevent family breakdown represents an important development in policy and practice in relation to family support. As a key element of an integrated family support service targeted at adolescents in great difficulty on the edge of care, who have severe and often long-standing problems, respite care may make an important contribution to preventing long-term family breakdown.

Appendix A
Ethical Issues and Confidentiality

There are a number of ethical issues that arise with regard to the involvement of young people, families and practitioners in research. Care has been taken during all aspects of our research (design, data collection, analysis and reporting) to conduct the study according to sound ethical standards.

Training provided to researchers ensured that good practice was carried through at all stages of data collection. Researchers adhered to the ethical protocols of the Research Unit and where necessary, the local authority in which they were researching. Researchers involved in fieldwork had experience of interviewing young people and families and had current Criminal Record Bureau checks.

Informed consent

In our study, all participants were 'volunteers' and all were fully informed as to the study's aims, objectives and importance. The research relationship between participants and the study was also made clear. The study provided such information through a variety of means, including written correspondence in the form of introductory contact letters and information leaflets and by way of verbal communication during introductions to face-to face and telephone interviews.

Confidentiality

A number of strategies were put in place to ensure confidentiality. In line with standard research practice, any identifying characteristics were removed from documentation that might be seen by agencies and individuals outside of the research team. Participants in the research were allocated codes and pseudonyms to ensure confidentiality in data presentation. These practices have been adhered to in all reporting stages.

Confidentiality was assured throughout the course of data collection. In addition, the management of disclosure, whereby participants may reveal information that might suggest risk; either to themselves or others was discussed in detail.

Data storage

Data was subject to rigorous security. Contact details and keys to allocated codes were kept secure and in separate locations and were accessible by members of the research team only.

Databases were password protected and stored on secure locations. Separate databases were used for storing contact details and case information.

Appendix B

Statistical Analysis and Reporting

Our main approach to data analysis was qualitative. However, some quantitative analysis, involving the use of statistical tests, was employed.

Reporting statistics

The tests were carried out using the statistical package for social sciences (SPSS). For ease of reading we have attempted to minimise the reporting of statistical tests throughout the report. In most cases we have simply given a p-value in a test was statistically significant.

Test results

A test result of p=0.05 or less was considered statistically significant for our data. By way of brief explanation, a p-value gives the probability that a test result can be relied upon to be true of the wider population and did not happen by chance. A p-value of p=0.05 simply means that the probability of the result happening by chance is 5 in 100.

Test results and p-values have been reported as a way of supporting our findings, however, for those readers who prefer to do so, it is possible to ignore reference to the statistics without losing an of the key information of meaning of the text.

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