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The Evaluation of the Adoption Support Fund

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Contents

1 List of Figures

2 List of Tables

3 Executive Summary

Following 10 local authority prototype projects, the Adoption Support Fund (ASF) was introduced across England in May 2015.[1] Between May 2015 and February 2017 10,231 families were funded to receive a range of post-adoption therapeutic services through the Fund.

From May 2015 to February 2017 the Tavistock Institute of Human Relations undertook an evaluation of the new Adoption Support Fund. The key aims were to:

- Describe the implementation of the ASF, to see if there had been any changes triggered in how funding used for post-adoption support was being channelled and how this impacted on core services;

- Describe how the assessment for post-adoption support had been influenced by the introduction of the Fund;

- Ascertain if, and how, the ASF funding stimulated expansion in a market for post-adoption support;

- Assess whether families' experiences of post-adoption support services had improved; and

- Measure improvement in the lives of families who received therapeutic services through the Fund.

The evaluation took a mixed methods approach combining 4 key methods which produced the following data:

- An online survey of adopters and prospective adopters across the UK via the Adoption UK website (awareness of the Fund and access to post-adoption support). This was a repeat of a survey undertaken by Adoption UK in 2011 as part of the 'It takes a village to raise a child' study. The online survey was used to gauge changes in adopters' perceptions of adoption support since the implementation of the Fund (n=586). In addition, the online survey was adapted to collect feedback from local authority staff (n=124) and independent providers (n=50);

[1] The prototype local authorities were: Newcastle, North Yorkshire, Manchester, Leicester City, Solihull, Gloucestershire, Cornwall, East Sussex, Hampshire and Lewisham.

- A longitudinal postal survey of adoptive parents accessing the ASF (2 waves to track distance travelled, from shortly after the ASF application to 7 months after the first wave survey). Thirty per cent of families approved for the Fund gave consent to participate in the survey. Of those, 51.5% (n=792) returned the first survey. Seven months later 481 (61%) follow-up responses were received;

- Local authority case studies and review of prototypes (case studies of 10 local authorities and one year follow-up of prototypes). These were constructed from 86 in-depth semi-structured interviews from local authority representatives (2 waves of case study visits), 33 providers and 10 telephone interviews with the local authorities that were the early prototypes for the ASF; and,

- Longitudinal in-depth interviews tracing family journeys and experiences. In total, 20 sets of parents were interviewed at wave 1 and 16 of those were interviewed again at wave 2.

3.1 Key Findings

Implementation of the ASF

The ASF has triggered some changes in the way post-adoption support funding is being channelled by local authorities and this has had a range of impacts on core services:

- Three broad trajectories of delivery emerged in response to the increased demand stimulated by the ASF depending on the original set-up of the local authority post-adoption support service prior to the Fund, these were:

    - Teams with strong in-house therapeutic provision expanding staff and training;

    - small teams dependent on external commissioning; and

    - a mixed delivery approach.

- These trajectories of service development have changed adoption support team structures through expansion, upskilling in the ASF-eligible therapies and/or by increasing their commissioning activities; and,

- While it is too early to define a single ‘good practice’ model, the larger multidisciplinary and therapeutically trained teams appear to be clearer in their understanding of how to strategically use the ASF to meet local need.

There were 3 key barriers to the fuller provision of therapeutic post-adoption support identified in the early implementation of the ASF post-adoption:

- Excessive workload increases of post-adoption support teams and insufficient capacity to meet demand;

- Role changes brought about through increased need for the administration, commissioning and auditing of services; and,

- An inability to respond to the capacity issues because of lack of confidence in the future of the ASF caused by the introduction of a Fair Access Limit, the Fund's guaranteed continuity, and the way in which regionalisation (via Regional Adoption Agencies) will impact locally.

Although it would be premature to define a 'good practice' model, the following enablers, largely drawn from the larger multidisciplinary and therapeutically trained teams, can be considered for successful implementation of the ASF regardless of the size of the team or type of service trajectory taken:

- Attention to supporting the role of social workers and finding solutions to the increased demand in administrative work;
- Regardless of the size of the adoption support team, the case studies indicate that upskilling of social workers in therapeutic knowledge is improving the efficiency and quality of assessments, liaison with clinicians and appropriate commissioning of external provision;
- Processes that ensure the quality and depth of assessments are not sacrificed by the need to respond to increased demand; and
- Investment in intelligence gathering and strategic thinking around local need and workforce planning.

Assessments

Assessments of need for post-adoption support services varied from area to area and were difficult to separate from the wider work of providing adoption support including therapeutic interventions themselves. However, assessments of need were seen to be becoming more formalised as a result of the ASF's requirements. Overall, local authorities believe the ASF has improved the assessment process and parents are satisfied with the assessments they are receiving.

Parents had a positive view of the assessment process:

- Overall, parents currently approved for the ASF funded services reported high levels of satisfaction with the different aspects of the assessment. Respondents were especially satisfied with the process (74%), the identification of needs (73%), and the consideration of their view and preferences (72%);

- The in-depth interviews of 20 sets of parents showed variable degrees of understanding about the assessment that led to the ASF funding. This was because of the way the statutory assessment for post-adoption support, the ASF triggered assessments and assessments by therapists overlap and are inevitably related to each other;

- Overall parents interviewed in-depth said that what was important in assessment was:

    - A good relationship with services;
    - Holistic assessments by skilled and knowledgeable professionals;
    - Regular reviews of support; and
    - Transparency about what and how much is available.

Views on the ASF scope changes and other policy developments over the past 2 years

Although the duration of the evaluation limits the ability to capture the full consequences of changes to the scope of the ASF some issues were emerging in the second case study visits:

- Scope changes, tightening of application scrutiny resulted in more applications being rejected and being reviewed for application a second time;

- The requirement for applications to have had an assessment no longer than 3 months prior to application created more work for post-adoption support teams;

- The extension of the Fund to SGOs had begun to create concerns within teams about the processes and capacity to manage demand;

- Regionalisation and sustainability of the Fund were future issues that teams experienced as instability that prevented strategic growth either internally or externally; and

- The impact of the Fair Access Limit was not captured in the case studies because it was introduced after the data collection period.

Awareness of the ASF

The most common way that parents who received services funded through the ASF (sample of baseline respondents) first heard about the Fund was through their social worker (58%), 12% heard about it through Adoption UK and the rest through a wide variety of sources from the media to other adopters.

Similarly the online survey of adoptive parents found that 51% of respondents who were aware of the Fund heard about it through their social worker and 46% though social media networks of adopters.

Also mirroring the above findings, 8 of the 20 families interviews in-depth found out about the Fund through approaching social services for support. The 20 families demonstrated varied understanding of the scope of the Fund.

Local authority case studies demonstrated a wide range of awareness raising activities for the ASF.

The market for post-adoption therapy services

The market for independent post-adoption support services expanded in response to the increased funding available and the limits on the capacity of local authority adoption support services. The independent sector though was not yet sufficiently developed to meet the rapid and substantial increase in demand.

Key challenges to growth of local markets to meet the demand are lack of trained therapists in the ASF approved therapies and the capacity of the independent providers to fund and provide the necessary supervision required to practice effectively. In addition local authority adoption support professionals raised quality concerns about the market and this is exacerbated by the stretched capacity of independent providers struggling to meet the sudden demand.

The experience of post-adoption support

Parents allocated the ASF funded services reported high levels of satisfaction with the various aspects of the support offered in the first survey. Respondents were in particular satisfied with the type of support, 88% indicated feeling satisfied with this. One aspect where respondents reported higher levels of dissatisfaction was the timeliness of the support. Nearly one fifth (19%) reported to be dissatisfied to some extent with how quickly the support was going to start even though still more than two-thirds (72%) reported to be satisfied with how quickly they will received support.

In the follow-up survey parents reported high levels of satisfaction with all aspects of the support they had received. In terms of the type, frequency, quantity, duration of sessions, choice and location of provider, over 80% indicated satisfaction. This figure was slightly lower (68%) for satisfaction with the timeliness of receiving support after the assessment of need had taken place.

Local authority staff and therapeutic service providers overwhelmingly agreed that quality of provision had improved since the launch of the ASF, and families viewed the ASF-funded support as appropriate and generally of high quality. However, when it came to parents' experience of statutory adoption support services, satisfaction levels seemed to stay much as they were, reflecting very mixed experiences. In particular:

- In the online survey of adoptive parents, relationships with statutory adoption support services had not changed significantly between 2011 and 2016, with 26% of families reporting poor or non-existent relationships in 2011 and in 2016; and

- Over half (58%) of families surveyed online believed that the provision of post-adoption support had improved since 2015, although most families (86%, reducing to 75% for families approved for adoption since 2010), believed the adoption support system needed improvement.

In depth parent interviews identified that a number of barriers to accessing support seemed to still be in place, including a lack of knowledge and expertise from adoption workers about families' needs and the available provision. Timeliness of support was perceived by families as a growing issue for the ASF as well, whilst poor relationships with and/or low levels of contact from post-adoption teams remained an area that families felt needed improving. Whereas families were experiencing consistent, responsive and regular targeted support from therapists, many families had experienced little, if any, proactive support from adoption support services.

Likewise, variable experiences with other core services involved in families lives and a lack of consistent multi-agency collaboration seemed to affect how well families felt supported. Three areas that were felt to improve family experiences of adoption support services were:

- Consistent, responsive, skilled and non-judgemental professionals;

- Support in communicating with and accessing other mainstream services; and

- Transparency about what support was on offer and available.

Improvement in the lives of children and families

Half of families who responded to the baseline ASF parents' postal survey (50%) using the ASF had sought post-adoption support prior to the Fund being available. Many parents indicated that looking back they needed support before they eventually sought it. The analysis suggests both that the Fund is answering a genuine need and that the right families are seeking support through it.

Responses to the longitudinal postal survey of the ASF by parents revealed that a substantial proportion of children showed the effects of early childhood neglect and abuse with commensurate predicted levels of emotional, behavioural, developmental and psychiatric problems. Parents reported a wide range of difficulties and struggles in parenting and indicated strongly that these had had a detrimental effect on their own mental health and wellbeing. In particular the findings established:

- Children using the Fund showed substantially higher levels of emotional, behavioural and development needs than both children in the general population and compared to looked after children as a whole, and showed a very high level of predicted psychiatric disorder;

- Family functioning and parent-child relationships within the families using the Fund were found to be very challenging; and

- The mental health and wellbeing of adoptive parents accessing the Fund was substantially poorer than the wider adult population.

Although improvement cannot directly be attributed to services provided by the ASF, between the baseline and follow-up surveys, children receiving support through the ASF showed small but significant changes in measures of impact, specifically:

- Improved behaviour and mental health;

- A small reduction in the predicted prevalence of psychiatric disorders among the sample of children; and,

- A small decrease in aggressive behaviour.

A very high proportion of parents (84%) believed that the ASF had helped their child. Despite positive changes on most indicators, children's needs remained extremely high and complex at the follow-up survey stage.

The functioning of families in receipt of support through the ASF improved; with the greatest improvement being seen in parents' understanding of their children's needs and increased confidence in taking care of their children.

A large majority of survey respondents believed that the support provide through the ASF had helped them as a parent (85%); helped their family as a whole (82%); and made the adoption placement more stable and less likely to break down (66%).

Individual family situations are highly complex but there was a widespread view from parents and professionals that the ASF has made possible the provision of therapies that help to meet complex needs.

Parents in families receiving support through the ASF saw modest but meaningful improvements in their wellbeing.

Parents said that with the benefit of hindsight their families would have benefited from earlier therapeutic support and particularly therapeutic parenting training.

3.2 Implications for policy and practice

The ASF has provided a new resource for local authorities to meet the needs of adoptive families. It has also raised awareness about adoption support needs and created an incentive for parents to seek help. Whilst this evaluation looked at a small number of local authorities, there were some elements of good practice that local authorities may want to consider.

The ASF has created an impetus for adoption support teams to respond faster to requests for assessments of need. Local authorities have adopted a more formalised assessment process so that it dovetails with the ASF application process. In particular, this was seen as an important step to take in response to the ASF requirement that a recent (no older than 3 months) assessment of need is conducted before an application is made. One local authority recognised that their assessments had become more narrowly focussed on the identification of therapeutic services and rectified this by creating a more systematic and integrated process that resulted in an improvement in the way a family's needs are tracked. Ensuring that in-depth and tailored working around family needs are not compromised as a result of streamlining the assessment of need process is something that other local authorities may want to consider.

Adoption support teams with more in-house capacity and multidisciplinary staff appeared more able to respond strategically to the introduction of the ASF because they already had greater capacity to plan for and meet demand and the skills in-house to build on to provide therapies. Smaller teams appeared less able to deal with the demands of the

ASF, were more reliant on external providers for services and were less confident in assessing therapeutic needs. The regionalisation of adoption, through Regional Adoption Agencies (RAAs) may create opportunities for growth and efficiencies of scale to improve commissioning and upskilling in therapeutic interventions for adoption support teams. Some local authorities were already considering this but all will want to begin thinking about how the move to RAAs can improve adoption support services.

Some local authority case studies revealed that the role of the social worker was being compromised by the workload that ASF applications were creating. This stemmed from the increase in administrative tasks such as carrying out assessments of need and completing ASF applications. Whilst workload was raised as an issue by almost all the local authorities observed, there was no agreed way to best respond. Larger local authorities, with more staff, could balance the increase better, whereas the impact appeared more significant for smaller ones. One local authority introduced some new, dedicated support for the administrative elements of the Fund that appeared to be well received by staff. Adoption support teams may benefit from considering how to respond to the administrative pressures and free up social worker time to work with families.

Evidence from parents suggested that their adoption support needs were not reviewed regularly, which meant they may reach crisis point before recognising the need to seek help or left them feeling isolated, unsupported and dependent on their own ability to ‘fight for services’. More frequent contact and reviews could improve the experience of adoptive parents and ensure their needs are still being met and that any support received is still appropriate. These processes could also be designed to capture the impact of therapeutic interventions and be used to support commissioning/service development. Adoption support teams could consider what processes they have in place for reviewing support needs and how satisfied adoptive families are with them.

Local authorities might consider how they can influence workforce development of local therapy providers. Good practice identified by some case studies included mapping and sharing information with other local authorities and including independent providers in strategic planning. Local authorities may benefit from these collaborative approaches to help influence local markets to meet upcoming support needs.

Adoption support services have experienced a raised profile as a result of the ASF, which sends a clear message of recognition of the needs of adoptive families. Similarly, parents have been able to better articulate their family’s needs. The local authority case studies and family in-depth interviews indicate the potential for influencing other statutory services. For example, a few adoption support teams either gave examples of working closer with CAMHS or the virtual school which they attributed to a raised profile and the development of expertise. Similarly, some families interviewed in-depth described how the ASF funding allocation had been a trigger for improved coordination with the child’s

school. Local authorities could consider this potential catalyst for improving the wider scaffolding of support around families as a longer-term investment that can improve stability and create better conditions for adoptive families to experience the full benefits of therapeutic provision.

4 Introduction

The Adoption Support Fund (ASF) was introduced in England in May 2015 following pilots (prototypes) in 10 local authorities. The ASF is specifically aimed at:

- Enabling adopted children and their families to access therapeutic support;
- Encouraging families to come forward for assessment;
- Identifying latent demand for therapeutic support; and
- Stimulating the market to ensure adequate therapeutic support is accessible across the country.

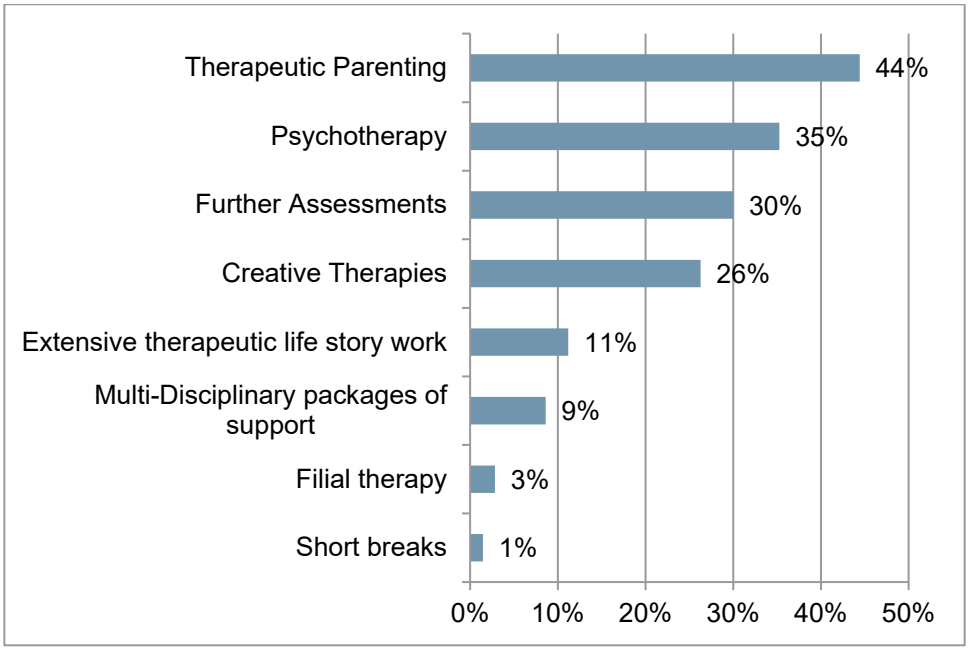
4.1 Details of the Fund use

In the 20 months since the ASF first became available there has been a larger than expected uptake from families across England.[2] From May 2015 until the end of February 2017, 10,552 approved applications to the ASF were registered, representing 10,231 individual families. A small proportion of families made more than one application, with a maximum of 4 applications per family observed during the period family. The total cost of all applications was £42,659,773 during that time period. The average cost per application was £4,043 and the highest single application was for £198,862.[3] Approved applications were made In 148 of all 152 local authorities in England.[4] The highest number of successful applications per local authority was 323 and the lowest 3.

Adoption support services applied for a wide range of different services for families through the ASF. The most common type of service was therapeutic parenting training (44%), followed by psychotherapy (35%), and further assessments (30%). Other types of services families applied for were creative therapies (26%), extensive therapeutic life story work (11%) and multi-disciplinary packages of support (9%).[5][6] Fewer families applied for filial therapy (3%), and therapeutic short breaks (1%).

[2] All figures in this section are as of the end of February 2017 and are derived from the ASF application dataset
[3] The standard deviation is £6,469, which shows that there is a large variation in the cost per application.
[4] Four local authorities therefore did not make any direct applications because other local authorities make applications on their behalf (either due to an existing arrangement or a joined up children's service).
[5] The typology of services used here appeared on the application as tick-box options and were completed by the adoption support team during the application process.
[6] Note: multiple services could be applied for in a single application. The percentages displayed here refer to the proportion of applications that included at least one service of this type.

Figure 1: Proportion of applications made by therapeutic service type applied for



Note: N=10,552; Source: Application data.

4.2 Scope changes

During the course of the evaluation the ASF has undergone a number of modifications and changes that potentially affect how it is used by families, local authorities and external therapeutic providers. In interpreting the results it must be considered that data would have been collected prior to, or during some of those changes. Throughout the report it is made explicit where this may be an issue or 'scope changes' are referred to in a general way by local authorities grappling with applications and the scope of the Fund.

The main changes that have occurred are:

- A tightening of application criteria and scrutiny of applications, specifically:
  - Funding a ratio of 1 hour clinical supervision per 25 hours of direct therapy;
  - A requirement that the requested therapeutic provision be informed by a local authority assessment of adoption support need that is no older than 3 months;
  - Retrospective funding for email and/or telephone support for families once the activity has taken place and is known;
  - Bringing rates for travel expenses in line with other public sector rates; and
  - Reduction in the funding of hourly rates for therapist travelling time.

- Extension of eligibility to the Fund in January 2016 to include children who have been placed with a family but are still pre-adoption order;
- Extension of eligibility to the Fund in April 2016 to include:
  - Adopted children up to age 21;
  - Children subject to a Special Guardianship Order; and
  - Children living in England but adopted from countries other than England (intercountry or overseas adoptions).
- Introduction in October 2016 of the Fair Access Limit – limiting the value of applications to £5,000 per adopted child, per year. Additional funds, over the £5,000 Fair Access Limit, can be sought for exceptional circumstances on a case by case basis via a matched funding approach, with local authorities and the ASF sharing the additional costs.[7]

4.3 Aims of evaluation

This report presents the results of an independent, 2 year evaluation of the ASF implemented by the Tavistock Institute of Human Relations. The evaluation aims to address the following questions:

1. Is the ASF achieving desired outcomes on improving the lives of adopted children and their families?
2. How are adopters generally experiencing post-adoption support services?
3. What is the quality of the provision of post-adoption support services through the ASF: appropriateness, timeliness, accessibility, duration, location?
4. What are the key barriers and enablers for good practice in implementing the ASF?
5. How is the assessment process working in local areas?
6. Has the ASF triggered changes in how funding used for post-adoption support is being channelled and how does this impact on core services?
7. How is the market developing - are there more families receiving more services? Are there more service providers?

[7] The Fair Access Limit was introduced in late 2016 and therefore came after most evaluation data collection had already been undertaken. It was referenced in the later local authority case study and family interviews. However, the full effect of this change will not be captured by the evaluation.

4.4 Methods

Four evaluation methods were used:

- An online survey of adopters and prospective adopters across the UK via the Adoption UK website (awareness of the Fund and access to post-adoption support). This was a repeat of a survey implemented by Adoption UK in 2011 called 'It takes a village to raise a child'[8] with a different sample which was used to gauge differences in perceptions of adoption support since the implementation of the Fund. In addition, the online survey was adapted to collect feedback from local authority staff and providers. The sample of 586 respondents from England in 2016 consisted of 548 adoptive parents, 33 prospective adopters and 6 individuals/families thinking about an adoption. A total of 124 local authorities' employees completed the survey. More than half (53%) indicated to be social workers and 23% adoption managers. A further 6% were Adoption Support Workers and 6% were Senior Social Workers. Total sample of 50 service providers completed the survey. Among those around half (54%) were private therapy provider and 30% voluntary therapy provider. Throughout this report where the results of the different aspects of the online survey are referred to this is clearly named: online survey of parents, online survey of local authority professionals, and online survey of independent therapy providers;
- A longitudinal survey of adoptive parents using the ASF (2 waves to track impact before and after therapeutic interventions). There were 792 responses (response rate of 51%) received in the first wave and 7 months later 481 follow-up responses (response rate of 61%) were received. Throughout this report where results are discussed the survey will be referred to as: the postal survey of the ASF parents;
- Local authority case studies and review of prototypes (case studies of sample of 10 local authorities and one year follow-up of prototypes). These were constructed from 86 in-depth semi structured interviews from local authority representatives (x 2 waves of case study visits), 33 providers (8 from voluntary agencies, 2 NHS and 23 independent organisations or sole traders) and 10 telephone interviews with the local authorities that were the early prototypes for the ASF. Where this data is discussed the term 'local authority case studies' will be used; and
- In-depth whole family case studies (Longitudinal in-depth interviews with 20 families tracing family journeys and experiences). It was decided not to

[8] Pennington, E. (2012) It takes a village to raise a child. Available at: https://www.adoptionuk.org/sites/default/files/documents/Ittakesavillagetoraiseachild-Report-June12.pdf

interview children after ethical consideration. Twenty sets of parents were interviewed at wave 1 and 16 at wave 2. The views of the 20 families are not intended to represent the views of all adopters using the Fund, but are a window through which to see in-depth lived experience of using services provided through the Fund. However, where key themes triangulate with other evidence this is made clear. Where this data is discussed the term 'In-depth parent interviews' is used.

4.5 The structure of this report

This report synthesises data from all strands of the evaluation to focus on 5 key areas of the process or intended impact of the ASF:

- The implementation of the ASF;
- Changes in the local markets for provision of post-adoption therapeutic services;
- Since the introduction of the ASF has the experience of post-adoption services improved;
- Support needs of applicants to the Fund; and
- Has the ASF improved the lives of adopted children and families?

5 The Implementation of the ASF

Key findings

- Assessment of need for post-adoption support services are localised and bespoke processes. These are becoming more formalised as a result of the ASF requirements.
- Overall, local authorities believe the ASF has improved the assessment process and parents are satisfied with the assessments they are receiving.
- There are 3 broad trajectories of delivery that have been influenced by the ASF:
    - Strong in-house therapeutic provision / multi-disciplinary teams made up of social workers, clinicians and / or therapeutically-trained social workers providing direct therapeutic services;
    - Limited internal, direct therapeutic provision and reliance on external commissioning, where the internal adoption team's capacity is more constrained; and,
    - Mixed delivery, with historically well-resourced in-house provision, capacity and direct delivery by a team of therapeutically-trained social workers with some commissioning of more specialist support.
- These trajectories of service development have changed the team structures through expansion, upskilling in the ASF therapies or by increasing commissioning activities.
- Although some teams (particularly those with less internal capacity or with mixed delivery) were working at full capacity, they were reluctant to expand or commit to a commissioning model because of uncertainties about the future scope of the Fund and the plans for regionalisation.
- Workload had become a serious problem in teams and there was a concern about the changing nature of their practice. The impact on staff wellbeing was an issue of concern.
- Larger, more multidisciplinary and therapeutically trained teams were better able to implement the ASF, meet the needs of families and think strategically about future opportunities to develop the service.
- Awareness of the ASF and adoption support services generally has improved among adopters but understanding of the scope of the Fund was mixed.

5.1 Introduction

This chapter describes the implementation of the ASF from assessment to the allocation of therapeutic services. The purpose of the ASF is to provide a resource to mobilise a national system of local adoption support services to deliver therapeutic support to adoptive families that have been slipping through the net of traditional service boundaries and eligibility. Primarily through data from longitudinal case studies (10 local authorities at early implementation and 6 months later) the following sections explore trajectories of implementation and begin to identify enablers and barriers to success.[9]

5.2 The assessment for the ASF services

Key findings

- Assessment of need for post-adoption support services are localised and bespoke processes. These are becoming more formalised as a result of the ASF requirements.
- Staff across the case studies felt confident about their assessment processes and their ability to identify families' needs. However, those adoption support teams with fewer or no therapeutically-trained workers did not feel as equipped to recommend appropriate interventions.
- Overall, local authorities (65%) believe the ASF has improved the assessment process.
- Overall, parents currently approved for the ASF funded services reported high levels of satisfaction with the different aspects of the assessment. Respondents were especially satisfied with the process (74%), the identification of needs (73%), and the consideration of their view and preferences (72%).
- In the in-depth interviews of 20 parents the overlap of processes for statutory assessment for post-adoption support, the ASF triggered assessments and assessments by therapists resulted in variable degrees of understanding about their assessment that led to the ASF funding.

[9] All the case study areas have been given pseudonyms and the full cases are in Appendix 5.

- Overall parents interviewed in-depth said that what was important in assessment was:
  - a good relationship with services;
  - holistic assessments by skilled and knowledgeable professionals;
  - regular reviews of support; and,
  - transparency about what and how much is available.

Local authorities have a duty to offer to assess the support needs of anyone who is affected by an adoption placement (Adoption and Children Act 2002). This applies to the child, the adopters, and birth families. For adoptive families this includes a wider range or support than the therapeutic support within the scope for the ASF. A key expected outcome of the introduction of the ASF was that assessments of need for therapy conducted by the local authority would become timelier and result in the offer of more appropriate services.[10] The local authority assessment of need for post-adoption support is not a discrete or standardised process. The approach taken varies between local authorities and varies within local authorities between cases depending on the purpose of the assessment or on the familiarity of the social worker with the family or children in question. Assessment for the ASF therefore is not a discrete process and the procedures have changed during the life of, and in response to, the Fund. This chapter describes the assessment process for therapeutic services that may be part of or draw from the broader assessment of need for post-adoption support services.

The majority of local authority case studies (7) were using forms from the British Association of Adoption and Fostering (BAAF) assessment but in most cases these local authorities described making modifications over time in order to make them more streamlined or more consistent with their own procedures. One case, for example, having trialled different forms, chose to use a single assessment form based around the Common Assessment Framework (CAF). This was felt to gather more detailed and structured information which would better suit their needs. Another local authority spoke of drawing on Early Health Assessment (EHAT) and Child in Need (CIN) assessment forms.

Most of the case study local authorities explained that the assessment process varied in-depth and duration depending on the circumstance of the family and on the differing

[10] This should be distinguished from both any assessment that a therapeutic provider undertakes at the onset of the therapy and from specialist assessments that themselves are applied for as discrete pieces of work through the ASF (if either other sort of assessment is referred to it will be identified.)

familiarity the team had with each family. In some local authorities this variation was structured into a 'tiered approach' where for example an initial meeting or telephone consultation might be followed by, if deemed necessary, a home visit, and then input from additional professionals with specific expertise or insight. In other authorities a less structured judgment was made by the team as to the necessary depth of assessment.

More complex cases would normally be referred to team members with clinical skills in those teams where clinical or therapeutic capacity existed. In most cases, local authority staff talked of consulting professionals from other services who have contact with the family in question, such as those from schools and mental health services. They also reported revisiting existing assessments and reports that might contain relevant information. This was seen as a way of avoiding the duplication of labour and of lessening the burden on the family.

Examples illustrating variation in assessments for therapeutic support via the Adoption Support Fund

In Dunbria as the majority of children were placed out of borough, social workers aimed to do the assessment in one visit (of one day). Once the assessment was completed, the social worker would also get permission to share it with other professionals (e.g. the local authority near the family) to get recommendations from others in terms of providers, who would undertake their own assessment. They would also share this with colleagues for additional input if necessary. Following this, the treatment plan and funding would be agreed.

In Westfordshire social workers undertook the assessment of families' needs. This included talking to other professionals, so that their view was represented in the single assessment; asking parents what kinds of help they thought they needed and discussing what therapies were most appropriate, making it *"all part of a discussion".* The social workers' assessment report was then shared with the local provider. A three-way consultation would then be arranged (the social worker, the therapist and the family) and the local provider would undertake their assessment, propose a treatment plan, cost it and send it back to the social worker. 2 applications were made to the Fund: the application for consultation, and then for the treatment (once the plan was agreed).

In Newingham the team undertook various types of assessments, with 3 main assessment categories. First, *straightforward assessments*, which tended to involve working and meeting with adopters and collecting relevant information. Second, *extended assessments*, which usually took about 8 weeks, and were a more structured way of addressing different areas of child functioning. Third, *complex assessments*, which might have included a piece of work from the Occupational Therapist on sensory issues, or the clinical specialist looking at child attention and functioning. Overall, assessments were tailored to the needs of the child, and the whole team in their different specialities

inputted into the process. There was no waiting list for assessments: the team started within 5 days of receiving a request and from allocation they had 20 working days to start the assessment process. The straightforward assessments were likely to be completed in about 20 days, whilst complex cases could take a number of weeks. Treatment plans were made in discussion with the parents.

Following referral from adopters or referrals from other agencies (schools or youth services); Oxton social workers then undertook the assessment of need through several meetings / visits with the families, which included meeting the child and establishing a relationship. Other professionals would also input into the assessment (schools, health, and LAC service) and there might also have been professional meetings. The assessment was then shared with the family and they would be offered a package of support via the ASF. The assessment process could take 3 to 4 months to complete.

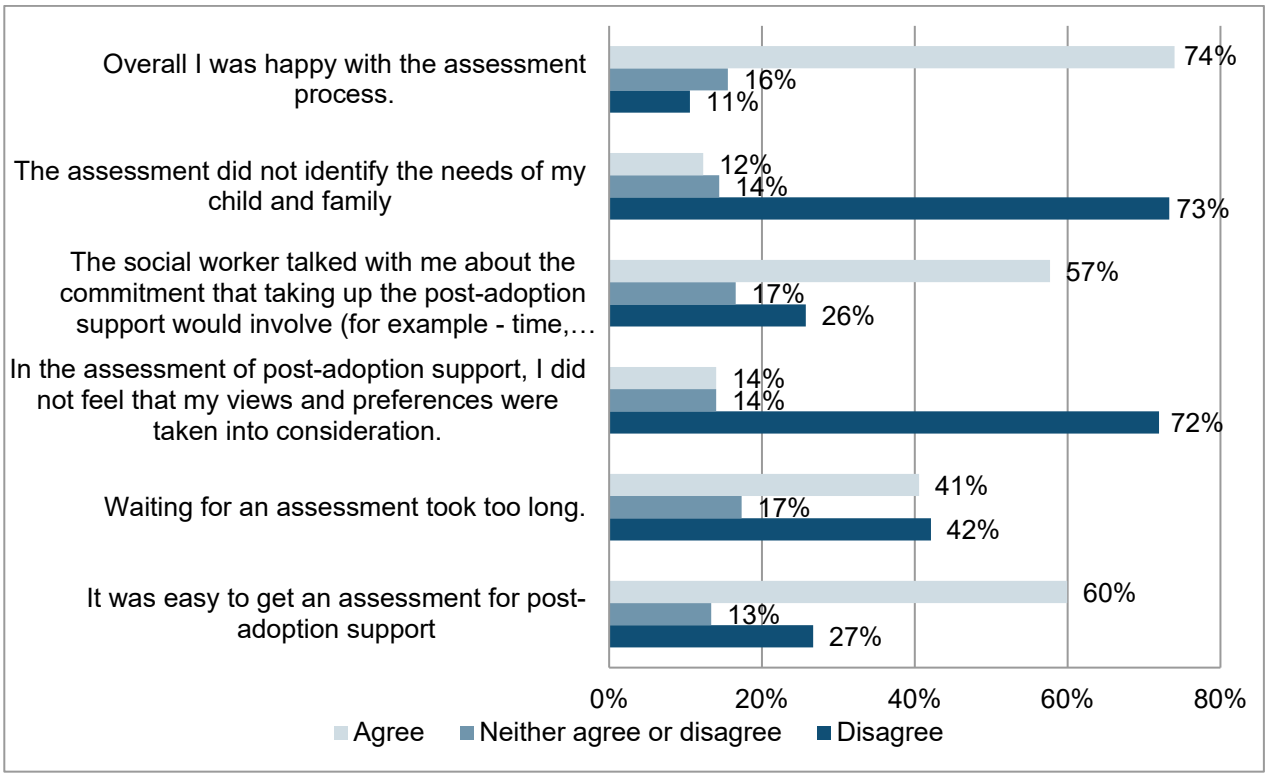
Satisfaction of parents currently accessing the ASF with the assessment of need

The postal survey of the ASF parents aimed to explore respondents' satisfaction with the assessment, more precisely in relation to ease, timeliness, interactions with social workers, the outcome of the assessment and the overall process.

Overall, parents reported high levels of satisfaction with the different aspects of the assessment. Respondents were especially satisfied with the process (74%), the identification of needs (73%), and the consideration of their view and preferences (72%). One aspect of the assessment was rated considerably lower than all other aspects - nearly half of the respondents (41%) felt that the waiting time had been too long. However, also 42% indicated that the waiting time for the assessment was not too long. A full list of responses to the questions about the assessment are displayed in Figure 2.[11]

[11] Note that the second and fourth questions are negatively phrased when interpreting this figure

Figure 2: Relative Frequencies of 'thinking about the assessment itself, how far do you agree or disagree with the following statements?' of baseline respondents



Note: N=764 to N=779 depending on item Source: Baseline survey.[12]

Following the assessment of need, 37% of respondents reported to be offered a choice of different providers to deliver therapeutic support, whereas nearly two-thirds (63%) said that they were not offered a choice.

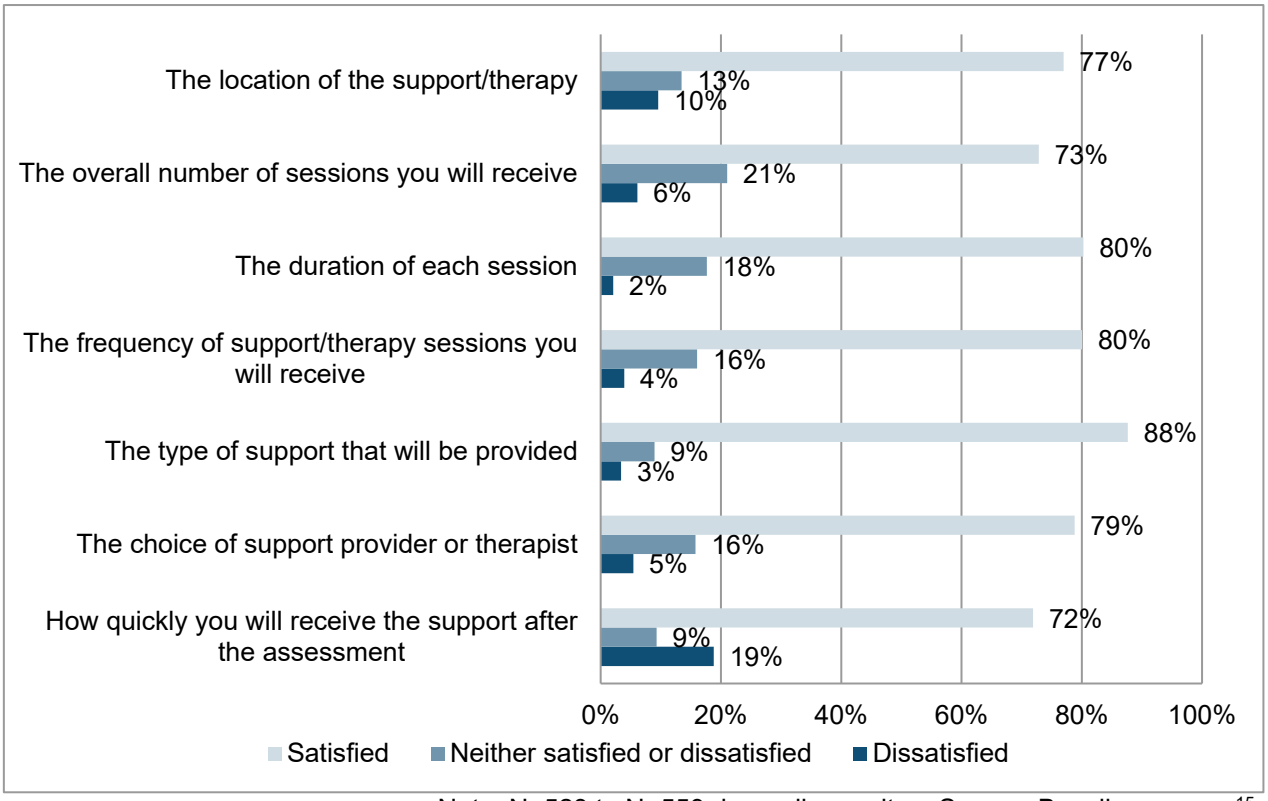
Parents satisfaction with support offered

Of all respondents 75% knew at the time of completing the survey the type of support they were due to receive through the ASF. This subgroup of respondents was asked to rate various aspects of the support they had been offered on a 7-point Likert scale.[13] Aspects of support included: timeliness, the choice of service provider, the type of support, the quantity of sessions, the duration of sessions, and location of support.[14] Again, responses were simplified and presented in Figure 3.

[12] "Strongly disagree", "Disagree", and "Somewhat disagree" are merged into "Disagree", "Strongly agree", "Agree", and "Somewhat agree" are merged into "Agree"
[13] Likert-scale is a rating scale for which respondents are asked to indicate their level of agreement or disagreement.
[14] Note: In 52% of cases this support had not started so their responses were not based on experience of the service.

On the whole, respondents reported high levels of satisfaction with the various aspects of the support offered. Respondents were in particular satisfied with the type of support, 88% indicated feeling satisfied with this. One aspect where respondents reported higher levels of dissatisfaction was the timeliness of the support. Nearly one fifth (19%) reported to be dissatisfied to some extent with how quickly the support was going to start even though still more than two-thirds (72%) reported to be satisfied with how quickly they will receive support.

Figure 3: Relative Frequencies of 'How satisfied do you feel with' of baseline respondents



Note: N=523 to N=559 depending on item Source: Baseline survey.[15]

Improvements in the assessment process since the ASF

In most cases local authority staff explained that the length of time taken over each assessment varied. However in most areas the introduction of the Fund had resulted in, or at least corresponded with, a tightening and shortening of the assessment process. Half of the case studies highlighted that the ASF had encouraged, or strengthened, a process of formalising and structuring the councils' ways of assessing.

[15] 'Strongly dissatisfied", "Dissatisfied", and "Somewhat dissatisfied" are merged into "Dissatisfied", "Strongly satisfied", "Satisfied", and "Somewhat satisfied" are merged into "Satisfied".

"Pre-ASF, we had realised we didn't have formal assessments in place. We had started looking at this, but only in a low-level way (…). For us the ASF was very timely, it spurred on a process that we were already undertaking". (Team Leader).

"…[our] assessment process had to be developed –I think the ASF has focused us in terms of thinking about how we do any assessment and how we present it" (Social Worker).

For one local authority case study, the introduction of the ASF initiated a major 'culture' change to the way the adoption support team worked around assessment of need. Before the requirement to identify specific services and make applications to the ASF the team had used an extensive assessment process, embedded in its interactions with the family. Since the introduction of the Fund this process had become briefer, more standardised and more focused on the identification of services. Workshops were implemented to strengthen the process:

"They have to be a lot quicker and more streamlined and all together turned round in a much quicker way." (Social Worker).

To compensate for the loss of depth in the assessment process the team implemented a systematic process of review. A positive consequence of the new assessment process was that social workers felt that they were now tracking the experience of the family through the adoption support process better: "*We track them better now through our (ASSA Adoption Support Service Advisor)- assessments and the ASF applications"* (social worker).

Others didn't report any changes, except modifying their forms to include information requested by the ASF in order to reduce the administrative tasks for applications:

"So much of the work is admin, so the forms we put in place reflect what the ASF asks for so that we can cut down some of the burden of this extra work". (Social Worker)

The central reason for the changes to assessment processes was the Fund's requirement that the local authority provide an up-to-date assessment of need for each child for whom (or on the basis of whom) an application was being made. As the Fund progressed the requirement was introduced that each application needed to be supported by an assessment of need undertaken within the previous 3 months.

Prior to the Fund few post-adoption teams had separate budgets for the commissioning of external services, so the process of assessment would unfold during the team's work directly with the family. Once a valid and up-to-date assessment was made a condition of receiving funding, and at the same time the volume of families seeking support

increased, there was a greater need to have a more streamlined and standardised approach.

A number of local authorities described developing ‘update procedures’ allowing them to review the original assessment, note any changes in family circumstances, and in so doing renew the assessment’s validity. This was seen as more efficient than re-assessing the family in full in terms of both the staff time taken and the burden placed on the family themselves.

The online survey of local authority employees (n=124) revealed that 65% thought that the assessment of need processes improved as a result of the ASF. However, 18% disagreed with that statement.

The majority of local authority case studies mentioned that their assessment processes were continuing to improve. Local authority staff talked of sharing the assessment with the selected external provider as part of the commissioning process. However it was noted by a number of staff that often the therapeutic provider would wish to conduct their own assessment of the child as a way to initiate the support. There was some suspicion of this practice within a number of local authorities as these provider led assessments were often lengthy and expensive. However, local authorities, particularly those without clinical or therapeutic expertise, felt they had limited ability to challenge the need for this additional step.

In other cases local authorities were undertaking or commissioning more specialist assessments which in some circumstances proved to be interventions in and of themselves:

> *“We are doing many more specialist assessments - psychological and emotional assessment (…) it’s been really helpful. By going through this assessment process, some families end up saying that it was really helpful, that they understand the issues now and we don’t need the therapy. With someone really being able to break that down for them means the assessment alone is enough. 3 or 4 families have gone through this process” Social Worker).*

On the whole, staff across the case studies felt confident about their assessment processes and their ability to identify families’ needs. However, there were some exceptions: those adoption support teams with fewer or no therapeutically-trained workers did not feel equally equipped to refer to, or recommend, appropriate interventions. These cases found themselves relying on external providers, without social workers necessarily being able to input. For some, the challenge with specialist assessments was compounded by a lack of skills and not feeling qualified enough to make decisions or quality-assure providers. Interviewees from 2 Local authorities, for example, felt that though other professionals inputted into the assessment process (such as teachers and/or current

therapists that the families were seeing), having a psychologist or therapist as part of the post-adoption support team would be a great asset. They were hoping this might become a possibility through the regionalisation process.

This was a challenge identified by some providers as well, who emphasised the complexity in undertaking assessments and the importance of having the necessary clinical skills and understanding of adoption, which was felt to be somewhat lacking.

> *"The assessment skills are an issue. It's a therapeutic fund, so you need therapeutic skills to assess and decide" (Independent provider).*

Improvements in assessment for adoption support services since 2011

The perception that local authorities were undertaking more assessments, and of a higher quality, is further evidenced by the online survey of adoptive parents.

The data shows that there was a significant increase in the number of parents that requested assessments between the online surveys undertaken in 2011 and 2016. According to the online survey of adopters, the number of parents that requested an assessment increased from nearly a third of the respondents (31%) in 2011[16] to more than half (53%) in 2016 for the first child.[17] A similar increase was found for the second child, with the number of parents that requested an assessment increasing from 32% to 55%.[18] Despite the overall increase in families requesting assessments there was no significant change in terms of the response to the request of an assessment.[19] In 2011, 79% of the respondents reported having had an assessment carried out when they had requested one whereas, in 2016, 84% indicated having had an assessment carried out (see Figure 4). This indicates that 16% had not had an assessment carried out even though they were entitled to one in 2016.

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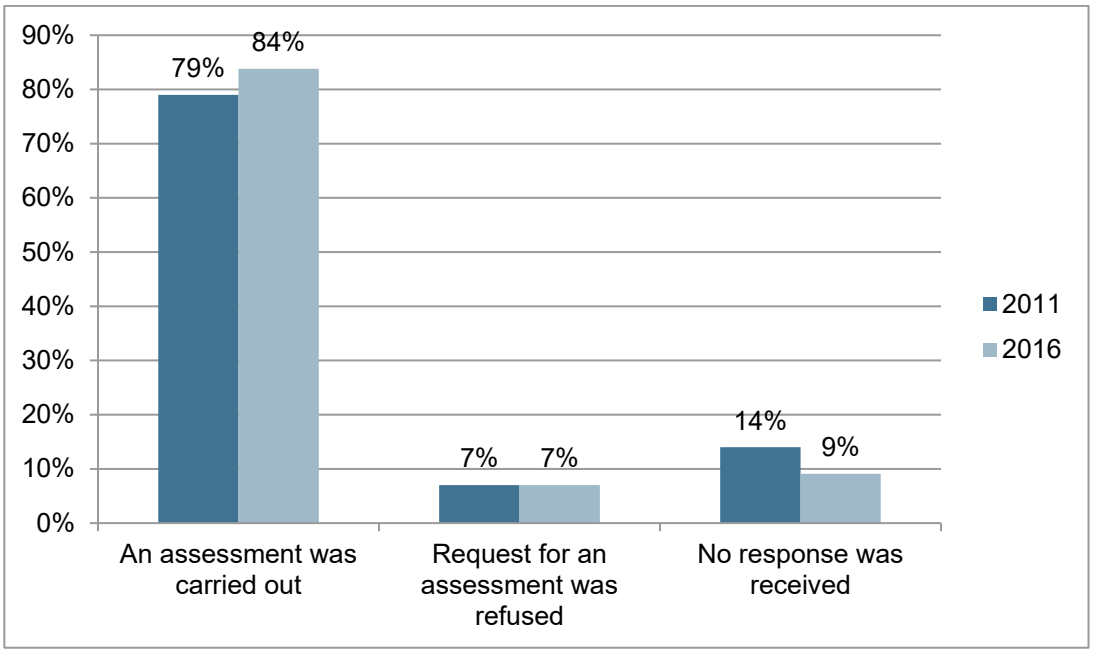
[16] Report can be found here: https://www.adoptionuk.org/sites/default/files/documents/Ittakesavillagetoraiseachild-Report-June12.pdf

[17] A significant association between 'requesting an assessment' and 'time of the survey' was found for the first child, $\chi 2(1, N=787)=33.928$, $p<.001$, Cramer's $V=.208$.The effect size indicates a small to medium effect.

[18] A significant association between 'requesting an assessment' and 'time of the survey' was found for the second child, $\chi^2(1, N=373)=18.772$, $p<.001$, Cramer's $V=.224$. The effect size indicates a small to medium effect.

[19] No significant association between 'the response to the request and 'time of the survey' was found, $\chi^2(2, N=346)=1.43$, $p=.489$, Cramer's $V=.064$. The effect size indicates a small effect.

Figure 4: Relative Frequencies of 'If yes, what was the response to that request?' of online survey of adoptive parents



Note: N=346; Source: Online survey of adopters and prospective adopters 2011 and 2016.

Taking into account all responses to the online survey of adopters, irrespective of whether or not they had requested an assessment, significantly more respondents reported having had the needs of their family assessed by their local authority in 2016 compared with 5 years earlier.[20] This number increased from nearly a third (32%) in 2011 to almost half (48%) in 2016. When parents received an assessment and support needs for their child had been subsequently detected, significantly more local authorities agreed to meet those needs in 2016 than in 2011.[21] In 2011 76% of the local authorities agreed to meet the identified needs while 89% in 2016 did so according to the surveyed sample.

In-depth parent interviews: the assessment process[22]

The 20 families conveyed mixed awareness about whether they had received an assessment for the support financed through the ASF. From the range of descriptions it seems likely that the assessment of need for wider adoption support (pre dating the

[20] A significant association between 'receiving an assessment' and 'time of the survey' was found, $\chi 2(1, N=821) = 19.457$, $p<.001$, Cramer's $V=.154$. The effect size can be considered as small.
[21] A significant association between 'the local authority agreeing to meet the identified need' and 'time of the survey' was found, $\chi 2(1, N=315)=7.034$, $p<.01$, Cramer's $V=.154$. The effect size can be considered as small.
[22] All family names and identifying details are anonymised. Each family's experience is summarised in Appendix 6.

ASF), an assessment specifically for therapy to inform the ASF application and assessments carried out by therapists were difficult to distinguish.

Of those that knew they had had an assessment for therapy, the general feeling was that application process was simple and they were grateful to their post-adoption worker for their support and speed in progressing applications.

> *"It is relatively simple, it's sort of designed to make it as easy as possible" (Mother)*

However, there were also mixed feelings from parents about the relatively light-touch approach to the ASF application. Responses seemed to differ, depending on whether parents were already in contact a lot with social/adoption workers and if they felt workers were knowledgeable about the different options available and had a good awareness of the family situation. On the whole, parents appreciated social workers leading on applications, and completing paperwork for parents, which seemed to happen in the majority of cases. It seems that where relationships with workers were already established, families reported an easy and quick process. Others felt the assessment was not thorough enough as it was too reliant on the expertise of the social worker and/or the parents about what support might be most appropriate and knowing what was possible and available.

Choosing the therapeutic support

The parents felt that trust in post-adoption workers and social workers came across as a factor that was important in assessments. The degree to which they wanted to influence the choice of therapy or felt they had the expertise to do so varied.

> *"So we don't always have all the facts to…give the right answers…" (Father)*

> *"Yeah, you have to trust in their professional judgement" (Mother)*

Nine families interviewed either had or were in the process of having an ASF funded therapeutic assessment in the first round of interviews. In 2 of those families, a long-term package of therapy was provided, beginning with a number of assessment sessions. The other 7 received funding specifically for a therapeutic assessment, which resulted in a report, recommending a therapeutic approach. Further funding was usually then applied for to undertake the expected long-term, intense therapy. The families that had these assessments found them to be both reassuring, informative and a useful aid for getting additional non-ASF support, for instance through the local school. Their experience was that these took a holistic view of the child rather than just dealing with a set of symptoms.

Where doubts about quality and depths of assessment were expressed, this was often in situations where a particular therapy had been suggested or agreed in the assessment, with no other options explored.

Support from professionals during assessment

Many families expressed the view that if services could work better together, this would save both time and cost. These parents were concerned that if assessments were not thorough enough, the therapy funded by the ASF might not be the most appropriate. A few families felt that even though they having to go through the local authority for an assessment for therapeutic support was a barrier to families. They were uncomfortable with the intrusion, and previous bad experiences of the adoption process had led to a lack of trust.

Families' experiences of assessments continued to be varied in the second interviews. Seven families had further applications for the ASF support since the first interviews, predominantly for ongoing therapy following a therapeutic assessment. For example, one family had completed once-a-week sensory processing therapy, and the second application was for twice-weekly sensory processing therapy, as had been originally recommended in the initial therapeutic assessment. The family felt they were now ready for and needed more frequent therapy, and so met with a social worker, who reviewed the situation, before submitting an application. They felt the process still worked well:

> *"…that's the good thing that you don't have to be chasing the paperwork or doing any applications yourself…I think that's a positive. Because I think we've got enough, you know, school, other meetings, nurse. Now we've got this ADHD, you know going for check-ups at the hospital and that sort of thing. It is…heightened emotional …and stressful things." (Mother)*

> *"…the delivery and everything is very well managed to be honest." (Father)*

However, in the second interviews parents also spoke of delays with applications and problems for social workers in ensuring applications were eligible. There was a feeling that there was lack of transparency and clarity in communication about the ASF, ranging from what could be funded through to what they were then actually funded for. As well as wanting to know more clearly what needs were eligible for support through the ASF, families repeated their desire to receive more information about what support was available through other services.

> *"…you should have a manual for every child that's adopted – this is what you can apply for…or you **may** be able to apply for. I think that they do it so people don't apply…I don't know…" (Mother)*

In a few cases, what families had believed to be funded through the ASF in the first interviews, they had since found out was not.

> *"…we actually don't know very clearly which bit is the funding." (Father)*

"We found out today that the telephone calls that support us, we thought was through the Fund, but it is not." (Mother)

Six families (out of the 20) could name the number of sessions of therapy that had been funded for them (either in the first or follow-up interviews) but 12 families did not know how many sessions they were getting within their funded package, although some thought that it would be lasting for as long as needed. Two families were yet to have their therapy package confirmed at the time of the second interview.

Even though the families interviewed in-depth interviews did not have a high level of awareness of what services were funded by the ASF or what could clearly be delineated as an assessment leading to an application, they all stressed the importance of the skills and knowledge of the social worker and the need for a more thorough and holistic assessment. Finally, most families did not mention any reviews of their ASF support. Whether these had taken place, but without their involvement and/or knowledge, is not clear. However, families generally spoke of the need for reviews and the desire for regular conversations with their post-adoption workers, which it seemed, for most families, in particular those who had not adopted through an agency, was not happening.

The Jennings Family – The ASF funds access to a professional able to engage with their child

Rose and Alistair experienced many frustrating attempts to get help for their 2 daughters over 10 years. Nerissa, their youngest, 12-year old daughter, displayed extreme anxiety. This became overwhelming following the transition to secondary school and led to Nerissa refusing to attend education. Although the family received numerous referrals, Nerissa struggled to engage in initial assessments and for this reason, professionals refused to offer further support. However, Rose and Alistair felt that professionals were not adaptable or consistent enough to engage their child and that they were being blamed as bad parents. No-one seemed to listen to their requests for long-term, consistent, in-depth support.

Once the ASF was launched, Rose and Alistair chased their social workers for 9 months to get an assessment of support needs and referral to intensive therapy. They were told that their child was unlikely to benefit because of their lack of engagement with professionals. Following continued pushing, a referral was made for a specialist therapeutic assessment. The family travelled over 100 miles for this and when Nerissa refused to leave the car at the intensive therapy centre, the therapist came to the car and talked to her for 2 hours. Nerissa then agreed to continue the assessment within the building. Following a further application to the ASF, the family was funded for 52 sessions per child. Therapy began before Christmas 2016, beginning with sessions for Rose and Alistair alone.

Although there had not been any changes yet for the children, Rose and Alistair were already benefiting, mainly because they no longer felt judged and blamed, but supported and understood. They were feeling more hopeful about the future, despite the emotional and logistical demands of therapy ahead. However, as they reflected,

"…If it had been a lot earlier…would have been a lot easier…"

5.3 Changes in how funding used for post-adoption support is being channelled and impacting on core services

Key findings

- There are 3 broad trajectories of delivery that have been influenced by the ASF:
    - Strong in-house therapeutic provision / multi-disciplinary teams made up of social workers, clinicians and / or therapeutically-trained social workers providing direct therapeutic services;
    - Limited internal, direct therapeutic provision and reliance on external commissioning, where the internal adoption team's capacity is more constrained; and,
    - Mixed delivery, with historically well-resourced in-house provision, capacity and direct delivery by a team of therapeutically-trained social workers with some commissioning of more specialist support.
- These trajectories of service development have changed the team structures through expansion, upskilling in the ASF therapies or by increasing commissioning activities.
- Although some teams (particularly those with less internal capacity or with mixed delivery) were working at full capacity, they were reluctant to fully commit to expansion or develop a strategic commissioning model because of uncertainties about the future scope of the Fund and the plans for regionalisation.
- Workload had become a serious problem in teams and there was a concern about the changing nature of their practice. The impact on staff wellbeing was an issue of concern.
- Larger, more multidisciplinary and therapeutically trained teams were better able to implement the ASF, meet the needs of families and think strategically about future opportunities to develop the service.

This section describes how the ASF funding is being channelled through local systems to meet the needs of families and how this is changing adoption support delivery models. The findings represent the picture of the early stages of response in the first 6 to 8 months of the ASF. Although trajectories of service development are discernible at this stage, the services described may be in flux rather than fixed. The key impacts described by adoption support services and independent providers of therapeutic providers are outlined.

Local delivery trajectories

The case studies (available in full in Appendix 5) bring to light the diversity and organic nature of emerging local adoption support models. Across the 10 case study authorities, 3 broad types of delivery models can be identified. The key difference between them is the extent to which they make use of external provision.

Strong in-house therapeutic provision / multi-disciplinary teams made up of social workers, clinicians and/or therapeutically trained social workers providing direct therapeutic services. In this model, the service is historically less reliant on external provision. The reason for this is due to a combination of contextual factors (e.g. gaps in the market/overall underdeveloped local provision) and/or internal ones (relatively larger teams and an in-house therapeutic provision that is strong enough to meet the needs of the majority of families through direct delivery). Particularly good case studies of this arrangement are Newingham and Northburn.

Limited internal, direct therapeutic provision and reliance on external commissioning, where the internal adoption team's capacity is more constrained. This is either because of necessity (e.g. the local authority places the majority of children out of area, hence relies on external providers in placement areas) or because there might be a mix of some provision elsewhere in the public e.g. Child and adolescent mental health services (CAMHS) and/or independent sectors. Examples of these types of cases can be seen in the details of Westfordshire, Oxton, Norchester, Estborough, Dunbria and Westfolk.

Mixed response with historically well-resourced in-house provision and capacity and direct delivery by a team of therapeutically-trained social workers (e.g. Dyadic Development Psychotherapy (DDP) and Theraplay) and clinicians, as well as external commissioning from a range of providers (public, statutory and independent sectors). Good examples of this are Bridmouth and Osterland.

The trajectories are best viewed as a way of reflecting the diverse picture of the ASF's implementation and of the different 'directions of travel'. This is because the implementation of the ASF varied depending on the combination of different internal and contextual factors. These include: the size of the post-adoption support team and the

ability to directly provide therapeutic interventions, the level of demand for services and the extent of internal provision (and/or external commissioning). The political will and orientation of the organisational culture towards growing an external market for the provision of children's social care may also be factor.

Impact of the ASF on local authority provision

Two rounds of local authority case study visits offered a view on the impact of the ASF's introduction on areas such as team structures, processes and ways of working. Although different trajectories were visible, across the board the ASF was raising the profile of adoption support teams locally and changing their structures and roles. A key theme that remained unchanged over the course of the 2 rounds of interviews with local authority staff related to the increased workload of post-adoption teams, which affected all case study areas, each of which responded in different ways. There was also evidence that the introduction of the ASF was improving and formalising the assessment process, building new relationships between services, councils and service providers.

Structures

One way to look at the ASF implementation is through the trajectories of service changes and/or expansion. In the early weeks of implementation the local authorities began to highlight potential plans to manage the increased workload, with the recognition that more staff would be required as the ASF implementation continued. Six months later half of the case studies already reported an expansion of their teams.

The majority of local authorities who expanded their service were those that had historically stronger internal provision and therapeutically-skilled staff. This points to a key difference between local authorities in terms of the extent to which they have been able to charge their in-house services to the ASF, reinvesting in the service mainly by funding extra posts. Particularly for those with already developed in-house therapeutic provision and relatively large multi-disciplinary teams, the ASF strengthened their core offer, enabling the expansion of the range of therapeutic models in which their own staff were trained and further upskilling staff in therapies that were required (e.g. DDP). Even within this model there was a need for external commissioning where the increased demand for services was creating capacity issues, when placing children out of borough or when specialist work was required for families with particularly complex needs.

A good example of this was the Newingham team who, since the introduction of the ASF, expanded their team (administrative and business support and new therapeutic staff) to cope with the increased demand from families. They also trained in additional therapies that hadn't been offered before, such as DDP and Theraplay, expanding their offer even further. As the local provision in the area was very under-developed, Newingham's ability to deliver in-house was perceived as being all the more valuable. Similarly, Northburn

County Council, which had recently made a planned shift to a therapy-led service, began to commission externally to meet the demand caused by the ASF but, over time, addressed internal staffing gaps and shifted the balance towards maintaining a largely in-house service.

For services that had a mixed response of well-resourced in-house provision (and capacity for direct delivery by a team of therapeutically-trained social workers) and external provision, the first reaction to the Fund was to increase the commissioning of external providers, rather than grow the service. However, over time, they expanded their team and began to also fund in-house services through the ASF.

For Osterland Council, for example, the majority of provision was in-house prior to the ASF. Since the introduction of the Fund, an increasing proportion of their time was spent undertaking assessments. The volume of commissioned external services also increased, both in quantity and range, in line with levels of referrals. In the latter part of implementation, the team expanded slightly (through the recruitment of a new member of staff to help support assessments and applications). They also commissioned externally, particularly for specialist assessments (for example, sensory integration, Story Stem and Clinical Child Assessments), as well as for expressive therapies. At the same time they began to fund the provision of in-house services through the ASF (e.g. parenting courses based on Non-Violent Resistance -NVR). This was done in an effort to provide better value for money (due to the much higher costs of externally-commissioned services) as well as to enable the growth of the service, by using the revenue to extend work that fell outside the scope of the ASF itself.

Similarly, Bridmouth County Council initially responded by commissioning to meet the demand and to cover specialist needs (e.g. to make up for the lack of in-house creative therapies) rather than change the service structure. However, in the follow-up visit, the team was in the process of expanding so as to grow internal capacity. This expansion was not entirely attributed to the ASF as these appointments were also to help fulfil a new contract with a neighbouring local authority. However, the planned response to the ASF was to increase the proportion of in-house provision through a programme of recruitment and training in therapeutic techniques. This would minimise the buying external services which would avoid the difficulties in assessing quality and the complications around supervision, accountability and contracting issues.

Adoption services that had a greater dependence on external providers (and were therefore more ‘outward facing’) and/or relatively small teams, were building on their experience with a small number of providers. In this category, social work teams were focussing almost exclusively on triage and assessments, reducing direct family work and commissioning externally for therapy. The low level of local provision was a challenge to meeting the increased demand. While there was variation in team size, local authorities falling within this trajectory had highly experienced, but relatively few (or no),

therapeutically trained staff who were able to deliver directly. Despite dependence on external providers even these teams were investing in training for their staff.

These smaller 'outward facing' teams felt that full capacity of local services had been reached. Some, for example, could not deliver particular therapies due to the lack of social worker supervision in the area, or lower clinical skills. This continued to feature as a challenge in the second case study visits. In addition, due to stretched capacity and a focus on applications and assessments, they were perhaps not investing as much time as they would have wanted, to create more funds to reinvest in the service:

> *"Last year we did [a high number of] applications, but no direct work. There is no way we could do this level of applications and do the work as well" (Team Leader).*

For all types of delivery, even those investing in growth there were still reservations about committing resources in a context of uncertainty about the Fund, as well as the drive towards regionalisation. This sometimes resulted in the recruitment of temporary or part time posts, which made it feel difficult to plan long-term and strategically. In Westfolk for example, there had been plans to recruit staff but, due to the temporary nature of many of the posts and uncertainties around regionalisation it was difficult to recruit permanently.

Workload and role changes

By far the biggest challenge confronting case studies was the impact that the ASF was having on the capacity of post-adoption teams. While in the first phase of implementation this was due to the rapid increase in referrals and assessment when the ASF was introduced, affecting case studies to varying degrees. By the latter part of implementation, the pressure on capacity became even more prominent and were identified as being the key challenge in implementation, including providers.

Staff across all areas reported continued increases in their workloads as they had more and more families already receiving support as well as new families coming forward for assessments, leading to an increased total, even if demand itself was steady.

One of the major consequences of the pressure on capacity, expressed by the vast majority of case studies (9 out of 10), is the changing nature of adoption support social work practice due to the changes to the role brought about by the introduction of the Fund. This was a theme that emerged strongly in both rounds of case study visits.

Staff interviewed across the majority of local authorities spoke of a shift to an 'administrative', 'commissioning', and/or 'auditing' role. They continued to view (though to varying degrees) their work as being predominantly concerned with undertaking

applications and assessments, and signposting to, and reviewing the effectiveness of, therapies that were being delivered by external providers.

There were undoubtedly some benefits attached to this shift. By the time of the second case study visit, 3 local authority cases described having increased their knowledge and understanding of how to scrutinise providers by developing stronger quality assurance and commissioning processes, which was seen as positive in terms of wider 'safe practice'. One local authority, for example, spoke of how the ASF had pushed the post-adoption team into a commissioning role (because the commissioning team didn't have the resource to work with them on the ASF-related tasks), enabling them to:

> "…*put in place stricter criteria, such as DBS and qualification checks, and this is a good thing"…* [reaching a point in which] *"we're much better on this now, or getting there" (Team Leader).*

Similarly, for another case:

> *"(…) we've had to take on this new commissioning function. As a result we got much tighter and put in more safeguarding because we felt that this is now our responsibility. We weren't used to having to do this". (Team Leader).*

Despite these being seen as important opportunities for development and growth, the different context for social work practice created by the ASF continued to represent a difficult trade-off. In particular, for those with smaller teams, with less therapeutic in-house capacity, and more heavily reliant on external commissioning, the situation was one in which highly-skilled and experienced staff were predominantly doing assessments, rather than delivery, in order to ensure that families received quick and timely access to the support they needed. At times this meant "*putting on the backburner"* things that staff could do themselves. As another social worker noted:

> *"Ironically, we're spending so much time on commissioning out now that we're not doing the things we can such as our attachment courses" (Team Leader).*

Social workers who had some therapeutic training expressed the concern that the pressure on capacity meant they were missing the opportunity to be upskilled in order to deliver the work themselves, which they experienced as disempowering:

> *"My only worry is I don't want to only signpost (…).We want to be more trained, skilled rather than providing and commissioning someone else to do that work" (Social Worker).*

Those local authorities falling into the mixed delivery category were finding themselves making more use of external providers than might have otherwise been the case: as one interviewee said,

"For us as workers it has changed the nature of what we do. I am having to deal with financial decisions on a daily basis and I feel more like a broker for services rather than a social worker" (Social Worker).

Staff highlighted the implications of this in terms of staff morale, with social workers, who often have therapeutic training, moving towards contracting as their key role, rather than direct delivery. As one interviewee said:

"We now do less direct work with children and families, so there is less chance to practise the work we most enjoy and get job satisfaction from (…) We have become commissioners and we have had to stop providing our parenting course as we don't have the resources to cover it" (Team Leader).

One interviewee noted the struggle to manage and maintain their identity as a post-adoption service, with the de-skilling of longer term and more experienced staff and the decreased opportunity for valuable practice experience for the newer, and more junior, staff. In another local authority case, this issue was discussed at Director-level, with plans to potentially create a dedicated post for business support, thus releasing social workers from this task.

On this theme of a transformed role of social workers, some team leaders/senior members of staff spoke about the issue that this was raising in terms of the retention of experienced and highly-valued workers. For example:

"Our biggest battle will be to keep our more experienced workers. They might go elsewhere to practise and deliver work with families, which is what they are trained to do and would like to do, and we'd be left with a disseminated service" (Senior Manager).

Those with larger, multi-disciplinary and therapeutically-trained teams were, on the whole, less affected (although still noted the issue). This is because they were more easily able to fund their services through the ASF and invest back into the team through upskilling of staff who could then deliver services directly:

"We've probably gone from more external commissioning to more internal delivery (…) we're growing the capacity to do that and looking to upskill staff to develop therapeutic skills. We've got that as an agenda on how we can provide more services". (Team Leader).

In an effort to counteract this trend, make the service 'future-proof' or to strengthen provision even further, even some of those more affected were re-investing funds generated from claiming social work hours used to provide some services, to develop in-house services through upskilling their staff in particular therapeutic interventions (Dunbria, Westfordshire, for example). However, there was also the challenge of finding

the necessary clinical supervision for their staff, due to the highly specialised nature of the some of the therapies (e.g. DDP) and the low number, or absence, of professionals locally available to provide it. This meant that:

> *"…without the professional clinical supervision, we still cannot deliver the service ourselves, our hands are still tied." (Senior Manager).*

There was a recognition overall that more staff would be required in post-adoption support. However, with the announcement of the Fund continuing and with the imminent regionalisation of adoption, some cases felt in a better position to be able to think more strategically about how to manage their services going forward and felt positive about being able to manage the trade-off. As one interviewee said:

> *"…even if we could deliver therapies ourselves, we still have a set number of social work hours so we'd have to decide whether those hours would be for the staff to deliver DDP, for example, or to do the assessments. Now that we know the Fund will continue, we can think strategically. It is do-able, we have the flexibility to do this in our service. We just need to think about how we want to move forward. We will need more staff involved in this area of work but we are going regional as well so it may all change".* (Senior Manager).

There are important choices that teams are facing to balance capacity with the role of the local authority in how it decides to meet demand.

> *"The complexities [for how we use the ASF] are in making decisions about whether we provide services in-house or use the external providers." (Senior Manager)*

Impact on relationships with other core services

In the initial weeks of implementation, most local authority case studies did not report major changes in terms of their relationships with other statutory agencies as a result of the ASF. However, where relationships or joint working arrangements were already present they were key to the successful implementation of the ASF. In the second case study visits there was further evidence of opportunities brought about by the ASF in terms of strengthening professional relationships with other services and neighbouring authorities.

There were examples of how the ASF raised the visibility and profile of the adoption service internally:

> *"There is much more interest in this service now. Prior to the ASF, the ASSA role, my role, was only a name. It's grown ten-fold now, it's promoted adoption support and we want to move this forward" (Team Leader);*

Post-adoption teams became more visible to other services, and were being contacted more for advice and help.

Three local authority cases mentioned having more conversations with looked after-children (LAC) social care units. For one case, this had the effect of enabling the team to 'pick up' issues at a much earlier stage. This was seen as being the result of the ASF's widened scope to cover pre-order:

> *"…we now get referrals from social care units where children are still looked after - placed but not adopted (…) we are having pre order meetings and if we have capacity we'll make an application to the Fund" (Social Worker).*

Two local authority cases spoke about developing stronger relationships with schools. One case, for example, had increased their work with schools, doing attachment training with teachers, and was also talking to other authorities, looking at how they could extend their reach. We found examples of this kind primarily to be occurring in those local authorities, described in the previous section, that were able to fund their internally delivered therapeutic work through the ASF due to their internal capacity. They then reinvested the income by widening their offer and undertaking further work that fell outside of the scope of the Fund itself, but was felt to be essential in supporting needs of adoptive families (schools in this case).[23]

The relationships with CAMHS services were more varied. In some areas, CAMHS was structurally integrated in teams as part of the delivery set up (Newingham, for example) or had historically strong relationships with them involving multi-disciplinary working around adoptive families (Osterland and Bridmouth). In one case, efforts were being made to improve relationships and integrate services through a Service Level Agreement. However, even when this was seen as being good, the cooperation in some cases had reduced in recent years as a result of CAMHS's diminishing resources, capacity constraints or skills gaps. As one interviewee noted:

> "*Their funds, resources for adoption are very low and they haven't really got any expertise in adoption". (Social worker)*

One of the difficulties related to the extent to which attachment issues were seen as falling within the remit of CAMHS services. Three case studies for example mentioned the absence of alignment between working models, with CAMHS not seeing attachment as a mental health issue and that somehow an opportunity was being missed in terms of the ASF's potential to increase CAMHS's resources. Other local authorities described

[23] Support, guidance or training for professional networks, schools is out of the ASF scope.

that while not yet having improved or facilitated weaker relationships, implementing the ASF could facilitate conversations with CAMHS, as they had started attending the ASF workshops (Northburn, for example).

In general, case studies found they benefited from their existing relationships with colleagues in other areas. This was particularly helpful in terms of sharing knowledge about providers or sharing learning from practice:

> *"Post-adoption support workers meet several times a year across the area to share ideas and good practice, and discuss current practice issues. This has been so beneficial; these meetings have helped with the Fund. We've developed a list of people, providers, we can access" (Social Worker).*

The Wilson Family – an example of poor multi-agency support before and since the ASF began

Suzanne adopted 16 year old Lorraine at the age of 8, alongside her younger brother, Dean, following significant neglect. Lorraine was initially quiet and appeared to settle well, but aged 11, her behaviour became physically and verbally aggressive. Short-term, non-specialist CAMHS support provided was unhelpful and Suzanne felt blamed for Lorraine's challenges. Despite some settled periods, by Summer 2015, Lorraine's behaviour was becoming more uncontrollable. An assessment of needs and application to the ASF led to family therapy beginning by December 2015.

Although life initially calmed, incredibly difficult attachment and related emotional issues were raised during therapy. Lorraine began disclosing her regular social media contact with her birth family and threatening Suzanne. Suzanne asked for Lorraine to be temporarily placed in foster care, but this was not acted on and in April 2016, following an assault by Lorraine, the police were called, Lorraine was placed in foster care and the family was referred to the Youth Offending Team (YOT).

Suzanne was supported by the family therapist, but a lack of social worker support meant that the YOT process of reconciliation stalled. No tangible help was put in place to help Lorraine return home safely and by the end of 2016, Lorraine's care order was formalised. Despite the traumatic circumstances, Lorraine, Suzanne and Dean continued to engage as a family and Suzanne hoped to continue to be part of Lorraine's support network. However, if there had been more proactive advice, support, training and therapy at an earlier stage or even once Lorraine was in foster care, this situation might have been prevented. Individual workers were very supportive, and the ASF support helped Suzanne cope, but it came too late for the family. They were living with the consequences of not having had appropriate support at an earlier time.

5.4 Views on the ASF scope changes and other policy developments over the past 2 years

Key findings

Although the duration of the evaluation limits the ability to capture the full consequences of changes to the scope of the ASF some issues were emerging in the second case study visits:

- Scope changes, tightening of application scrutiny resulted in more applications being rejected and being reviewed for application a second time;
- The requirement for applications to have had an assessment no longer than 3 months prior to application created more work for post-adoption support teams;
- The extension of the Fund to SGOs had begun to create concerns within teams about the processes and capacity to manage demand;
- Regionalisation and sustainability of the Fund were future issues that teams experienced as instability that prevented strategic growth either internally or externally; and,
- The impact of the Fair Access Limit was not captured in the case studies because it was introduced after the data collection period.

During the 2 years of the evaluation, it is not surprising that policy has developed and changes are anticipated by services that can impact on the way they are implementing the local delivery of the ASF. There were some key changes to the scope of the ASF that the evaluation has begun to pick up the early impacts of. Although these are not fully explored by the evaluation, as they were not predicted and therefore not explored directly, these insights emerged and are worth noting. The key scope and policy developments to be considered are:

- A tightening of application criteria and scrutiny of applications;
- Restrictions in scope of the Fund – interventions that originally were within the scope of the Fund (at the prototype phase) no longer are – e.g. individual therapy for parents;
- Requirement that new applications to the Fund be accompanied by an assessment of need completed within the preceding 3 months;
- Extension of eligibility to the Fund to include:
    - Adopted children up to age 21;

    - Children who have been placed with a family but are still pre-adoption order; and,
    - Children on Special Guardianship Orders (SGOs).
- Introduction of the Fair Access Limit – limiting the value of applications to £5000 per adopted child, per year. Additional funds can be sought for extenuating circumstances on a case by case basis, and matched funding can be sought through applying local authorities. The Fair Access Limit was introduced in late 2016 and therefore came after most evaluation data collection had already been undertaken. It was referenced in the later local authority case study interviews however the full effect of this change will not be captured by the evaluation; and,
- Progress towards the regionalisation of adoption support.

Criteria for applications

The changing criteria for applications resulted in many more being rejected, sometimes inconsistently. This was a key difference between the 2 rounds of interviews that impacted on the ASF delivery. So, for example, when local authorities commissioned services incrementally (e.g. 10 sessions then a review) each time these would require another application. In addition the new requirement for 3-monthly assessments resulted in the need for additional assessments. Local authority staff also reported applications 'bouncing back and forth', often several times and sometimes inconsistently (e.g. the same applications being accepted once but not a second time), which resulted in an increasing amount of workers' time being taken up by additional administrative tasks. This affected the capacity of teams, as one interviewee said:

> *"…this is a problem because we have a tight window to do applications and if we're confronted with a sudden change that we're unaware of, we could be revising it many times and this impacts on our capacity even further". (Social Worker)*

Two local authority case studies highlighted that there wasn't enough expertise in-house to complete the applications correctly, which further impacted on the time spent on the administration of the Fund. This resulted in delays, backlogs and increased waiting lists (all decreased timeliness of support), with families who needed support finding themselves waiting…

> *"…while staff are trying to figure out what's wrong with the application". (Social Worker)*

A further consideration emerging over the course of implementation was the extended scope of the Fund to cover SGOs: how to absorb this work was something that around

half of the case studies were grappling with at the time of the second case study visit. For many, SGOs and post-adoption were managed by different teams, and so there were concerns about how to support referrals and oversee assessments with scarce capacity.

Local authority views on regionalisation

The second round of case study visits also aimed to explore progress of, and views on, regionalisation as well as on the sustainability of the ASF.

In all case study areas, there were no firm plans on how regionalisation would materialise, but conversations were taking place. Interviewees highlighted both advantages and disadvantages that regionalisation would bring. In terms of the former, there was an acknowledgement that by pooling resources, provision would be extended. In addition, thoughts on advantages included: giving families a much more consistent offer; enabling a lot of networking and sharing good practice and ways of working, which many thought would be extremely valuable; providing opportunities for training, for example through opportunities to ring-fence; re-structuring teams in ways to free up staff to deliver interventions. As one interviewee said

> *"… you could really have a multi-disciplinary team who can work diversely across a broader geographic area, like a pot of skills to choose from". (Social Worker)*

In terms of anticipated disadvantages, there was a fear across most areas that regionalisation would imply the loss of 'personal touch' with families. Others wondered whether regionalisation would bring challenges of travel time and efficiency, and whether it would exacerbate differences in the quality of provision between regions.

Local authority views on sustainability

In terms of the sustainability of the ASF, the view across the case studies was that should the Fund cease, it would be detrimental to families. It would cause more breakdowns, and fewer children would be adopted, because there would not be guaranteed support and parents would be less confident in adoption, particularly in the more complex and hard to place cases. All local authority case studies revealed a widespread view that it was important to have a broad range of therapies to offer because a holistic approach means that families are less likely to need support in later years. However, without access to resources, councils would have to rely less on external commissioning, drastically reducing the ability to meet need.

Uncertainty brought about by scope issues

Changes to the scope of the ASF, the changing criteria and the issues around applicants was in all local authorities experienced as confusing and taking up considerable amounts

of time. Many said the changes as having been undertaken without consultation or warning, and felt that more clarity would be useful. As one interviewees said

> "*What used to be accepted, is being thrown back now – it seems the criteria have changed. It would be useful if we had an overview of what they want, more clarity over that to get it right first time to avoid any delays (Social Worker)*

Concern was expressed that the management of the Fund in terms of what was and wasn't in scope did not match the needs of families' complex needs, which was a view widely shared by providers. The majority felt that not funding work in schools, for example, was a limitation:

> *"To be able to attend a meeting is important but this isn't funded. And it's not that we're asking for the Fund to train someone in schools. A meeting with the school would have to come out of the pupil premium but of course some schools are better than others for this. They will fund for liaison meetings, which these are, but if you don't word it in the right way it won't get accepted. It all feels just a bit clunky" (Team Leader)*

Similarly, some felt that the reduction of funded work with families (e.g. individual therapy for parents) was an underestimation of the importance of working holistically, and not just with the child, with potential repercussions on outcomes. Providers interviewed shared this view. The majority mentioned that the Fund should be more *"whole system"* in particular through: (a) training within schools on attachment disorders and the needs of adopted children *"my plea for embedding the ASF, early intervention is good, education and training of teachers and social workers. They need to know about attachment as well if you want to have a long-term impact";* and (b) individual therapy for parents with emerging mental health needs triggered by adoption.

5.5 Awareness of the ASF

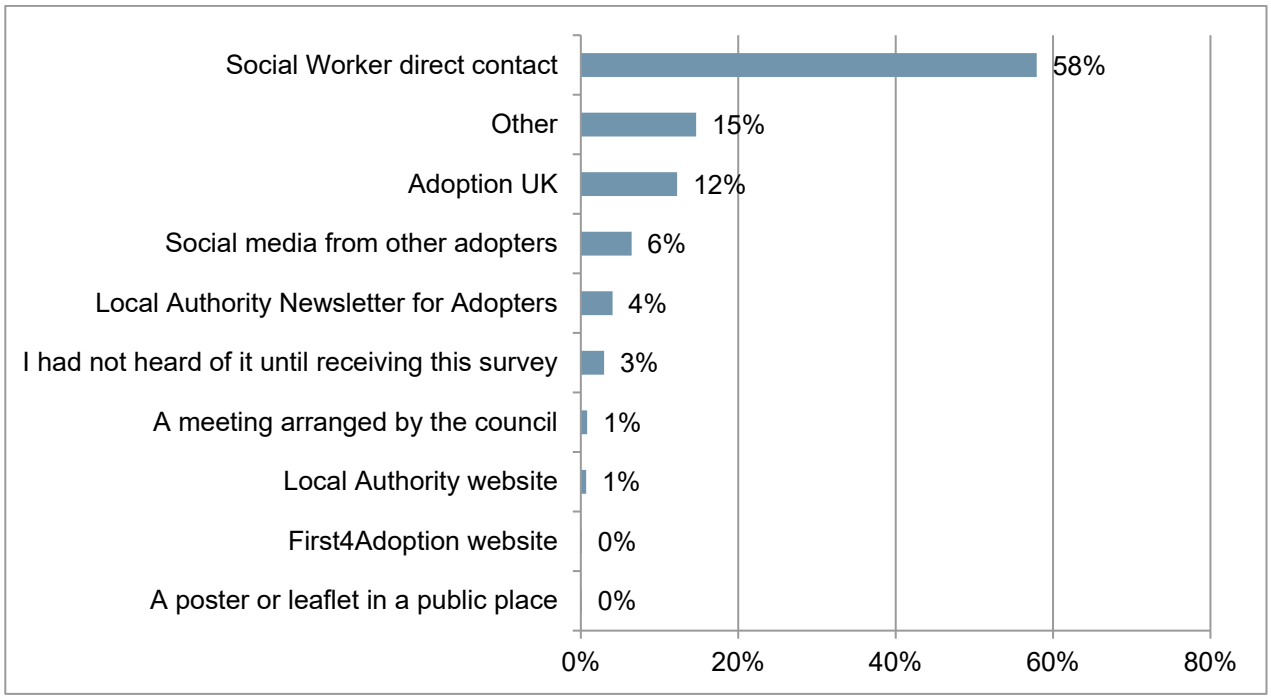
Key findings

- The most common way that parents who received services funded through the ASF (sample of baseline respondents) first heard about the Fund was through their social worker (58%), 12% heard about it through Adoption UK and the rest through a wide variety of sources from the media to other adopters.
- Similarly the online survey of adoptive parents found that 51% of respondents who were aware of the Fund heard about it through their social worker and 46% though social media networks of adopters.
- Also mirroring the above findings, 8 of the 20 families interviews in-depth found out about the Fund through approaching social services for support. The 20 families demonstrated varied understanding of the scope of the Fund.
- Local authority case studies demonstrated a wide range of awareness raising activities for the ASF.

Raising awareness of the entitlement to post-adoption and therapeutic support has been a key part of the implementation strategy. This section provides a picture of the level of awareness of adoptive parents and describes how local authorities have promoted the new resource.

Information about the ASF was disseminated via a variety of channels to raise awareness of the Fund and encourage adopters to come forward for an assessment of needs. In the postal survey of the ASF parents, more than half of the respondents (58%) first heard about the ASF through direct contact with social workers, and a further 12% heard about it through Adoption UK. Figure 5 presents the full list of possible ways of hearing about the ASF with the corresponding relative frequencies. Respondents that ticked ‘other’, named ways of hearing about the ASF, including news or media, therapists and clinical psychologists, adoption agency, or other adoptive parents.

Figure 5: Relative Frequencies of 'How did you first hear about the Adoption Support Fund?' of baseline respondents



Note: N = 744; Source: Baseline survey.

Local authority awareness raising activities

Over the course of the ASF implementation, local authority staff reported undertaking various activities to raise awareness of the ASF. These included the use of formal communication mechanisms and more informal ones. In terms of the former, examples included sending letters via local authority mailing list of adopters; including information on newsletters and the local authority Facebook pages (social media) / websites. In terms of the latter, staff made use of their existing activities and programmes to inform adopters about the ASF directly. Examples included introducing families to the ASF at coffee mornings, parenting programmes and workshops, support groups, training sessions run for families and annual family days. The majority of councils described making use of these spaces to encourage families to pass on the information to people they knew and who might need support, believing that 'word of mouth' would be a very effective way of enabling council staff to reach those who may need support but might have not asked for it in the past.

In addition to the above, interviewees across case studies reported raising the awareness of the ASF through other relevant (internal and external) services and agencies such as: CAF and children's teams, CAMHS, schools, GPs and other providers which some felt had a significant impact on raising awareness. Overall, staff proactively sought to "get the message out there", which was felt to have contributed to a steady stream of people requesting support.

Parent in-depth interviews: knowledge about the ASF

Not knowing about the ASF was one of the most common barriers raised by families interviewed. 8 of the 20 families became aware of the ASF because they asked for help and the ASF was suggested by the worker in response.

> *"We hadn't heard of the Adoption Support Fund until this Theraplay course was suggested." (Mother)*

Three families found out about the ASF through word of mouth and then approached a worker for help. Two parents heard about it at an adoption-focused conference, and one of these had also seen it in a newsletter. Two parents were told about it by a therapist, one of whom had also seen it in a newsletter. The other had previously attended a coffee morning where it was talked about. Two families were contacted and informed by their local authority at a meeting for adoptive parents, specifically about the ASF. However one family said if they hadn't also been told about it by a friend, they wouldn't have registered the contact from the post-adoption team, as they were so busy with life. Two were already being supported by adoption workers who suggested the Fund. At the time, these families were not specifically asking for extra support.

Some parents also mentioned that because they were so busy, they needed to be able to rely on professionals to tell them about support available. Adoptive families feel they have enough keeping them busy, without researching new support available. Additionally, it seems that hearing about the ASF from different routes helped reinforce the message that it was there for families. It also increased the chances of being heard about by parents. For instance, if families were dealing with crises at the time, correspondence could get missed.

Six of the families interviewed seemed to know generally well what the ASF was and what it was for.

> *"We are led to believe that it's not just for the child, it's for the family, or just us two, in a sense, to have some form of therapy or support to be able to then help the child." (Mother)*

The remaining families had varying levels of knowledge about what the Fund was. Two families said they didn't know what it was at all. Awareness of what was and was not eligible for support was also mixed. Because of individual circumstances, some families knew specific criteria such as excluding children placed from outside England and pre-adoptive families (both criteria are now changed). On the whole people were aware they were eligible but not a lot more than that. Most knew where to go to get support because families had been through the process, but some felt many others wouldn't know who to go to and might feel reluctant if they didn't have a named contact. Finally, when it comes

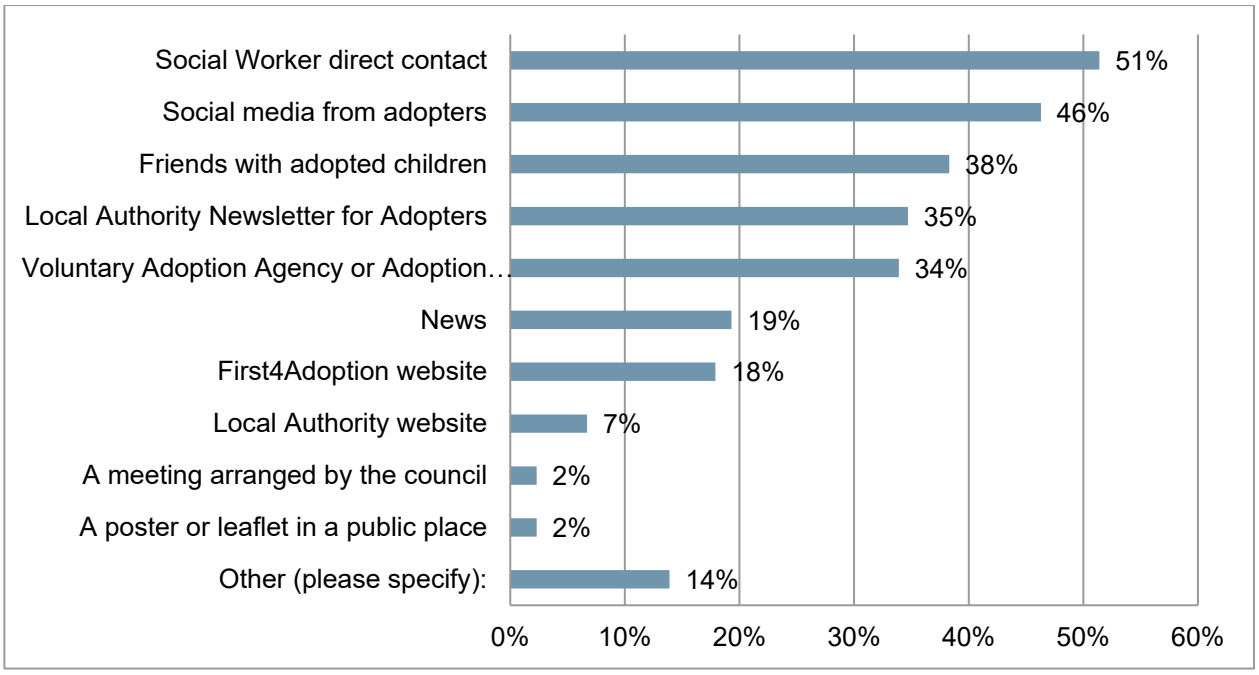
to knowing how much support families can get, only a few families specifically said they knew they could make repeat applications. Most others hoped it would be there for as long and for as much support was needed, but didn't know if there were any limits or not.

Wider awareness about the ASF

A large proportion of the respondents to the 2016 online adoptive parents' survey sample (81%) were aware of the ASF. However, it should be noted at this point that this sample is not representative of the general population of adopters. The sample was self-selected sample that had access to the Adoption UK website, Adoption UK magazines, Tavistock website or newsletter from the Department for Education. They are more likely to be active in adopter circles and therefore would be expected to be more aware of programmes such as the ASF. Around half (51%) of the online survey sample who were aware of the ASF heard about it through direct contact with their social worker and nearly half (46%) through social media from other adopters. Less important communication channels were poster/leaflets and meetings organised by local authorities (see Figure 6). More than one-third (35%) of respondents to the online survey of adopters in 2016 have heard about the ASF through a Voluntary Adoption Agency (VAA) or an Adoption Support Agency (ASA). The most common organisation mentioned was Adoption UK with around two-thirds of the entries referring to Adoption UK.[24] Other VAAs or ASAs with 2 or more mentions were Adoption Matter, Barnardo's, CCS Adoption, Family Care, Family Futures, PACT, PAC-UK, Nugent Adoption, New Family Social and After Adoption. Other responses include adoption magazines, other professionals, other websites or online forums, Department for Education and their own work.

[24] Percentages differ for the questions 'How did you first hear about the Adoption Support Fund?' (70%) and 'Since hearing about the Adoption Support Fund for the first time, have you heard about it from another or multiple sources?' (60%).

Figure 6: Relative Frequencies of 'How did you hear about the ASF' of online survey respondents



Note: N=475 Source: Online survey of adopters and prospective adopters 2016.[25]

Improvements in understanding the entitlements to support services from 2011 to 2016

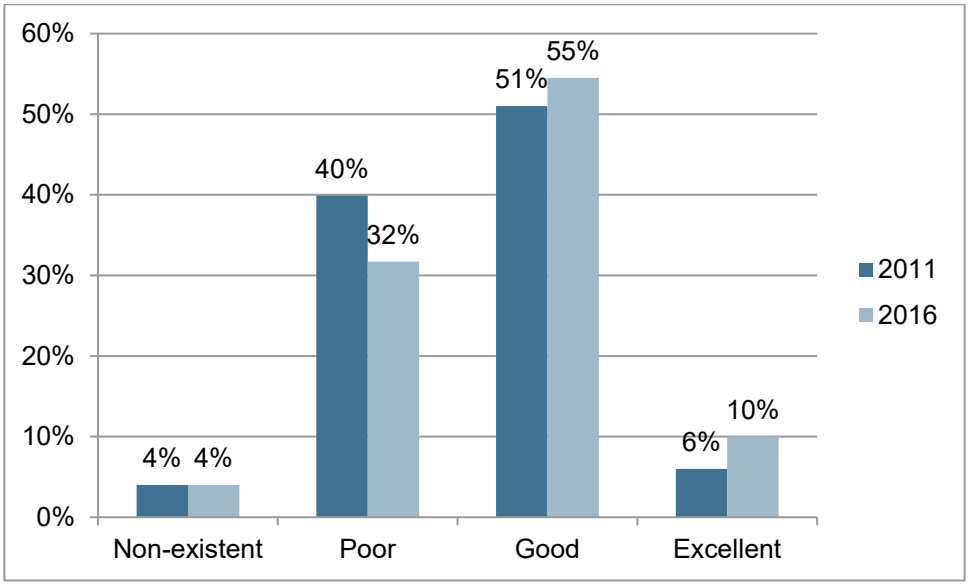
A very important first step in the adoption process is the understanding of adoption support and the entitlements to it. The survey 'It takes a village to raise a child' conducted in 2011 found that the majority of respondents (66%) did not understand the importance of adoption support during their time as a prospective adopter. This percentage significantly decreased in the following 5 years to 57% of respondents.[26] However, this still means that less than half (43%) understand the importance of adoption support.

In a similar fashion, the knowledge about entitlements to adoption support services significantly increased from 70% in 2011 to 76% in 2016.[27] Related to that is the improvement of the understanding of entitlements to adoption support services (see

[25] Several selections possible as this represents a combination of the questions 'How did you first hear about the Adoption Support Fund?' and 'Since hearing about the Adoption Support Fund for the first time, have you heard about it from another or multiple sources?'.
[26] A significant association between 'understanding the importance of adoption support' and 'time of the survey' was found, $\chi 2(1, N=853)=5.85$, $p<.05$, Cramer's $V=.083$. The effect size can be considered as small.
[27] A significant association between 'knowing about the entitlements to adoption support services' and 'time of the survey' was found, $\chi 2(1, N=853)=4.23$, $p<.05$, Cramer's $V=.07$. The effect size can be considered as small.

Figure 7). In 2011 56% of the respondents rated their level of understanding as good or excellent, while in 2016 nearly two-thirds (64%) did so (U= 71824, p<.05).

Figure 7: Relative Frequencies of 'How would you rate your understanding about your entitlements to adoption support services?'



Note: N=853; Source: Online survey of adopters and prospective adopters 2011 and 2016.

Significantly more adopters have also been informed about their right to request an assessment for adoption support.[28] This increased from around a third (35%) in 2011 to nearly half (47%) of the respondents in 2016. In contrast to that, the proportion of respondents that stated information had been giving by the adoption agency about the adoption support services they provide has not significantly changed.[29] In 2011 75% of the respondents were informed and in 2016 71% of the respondents stated that their agency has provided them with information about adoption support services.

5.6 Conclusions

Has the ASF influenced positive changes in the assessment process?

Assessment of need for post-adoption support services are localised and bespoke processes. These are becoming more formalised as a result of the ASF requirements.

[28] A significant association between 'having been informed about their right to request an assessment' and 'time of the survey' was found, χ^2(1, N=840) =10.95, p<.001, Cramer's V=.114. The effect size can be considered as small.
[29] There was no significant association between 'having been given information by the adoption agency about the adoption support services they provide' and 'time of the survey', χ^2(1, N=828) =1.63, p=.201, Cramer's V=.044. The effect size can be considered as small.

Although there were some concerns raised about the therapeutic skills of assessors and of the lack of clinical understanding of complex needs reflected in the management of the Fund, overall local authorities believe the ASF has improved the assessment process. In addition, parents are satisfied overall with the assessments they are receiving.

Has the ASF triggered changes in how funding used for post-adoption support is being channelled and how does this impact on core services?

The ASF has triggered changes in how funding for post-adoption support is being channelled and this has mainly impacted on adoption support teams and not very much on other core services. There are 3 broad 'models' of delivery that have been influenced by the ASF.

- Strong in-house therapeutic provision / multi-disciplinary teams made up of social workers, clinicians and / or therapeutically-trained social workers providing direct therapeutic services;
- Limited internal, direct therapeutic provision and reliance on external commissioning, where the internal adoption team's capacity is more constrained;
- Mixed model, with historically well-resourced in-house provision and capacity and direct delivery by a team of therapeutically-trained social workers (e.g. DDP and Theraplay) and clinicians, as well as external commissioning from a range of providers (public, statutory and independent sectors).

The boundaries between the models described above are much more fluid than the categories suggest. Rather than seeing them as strongly delineated models, they are best viewed as a way of reflecting the diverse picture of the ASF implementation and of the different 'directions of travel'. These trajectories of service development have changed the team structures through expansion, upskilling in the ASF therapies, or by increasing their commissioning activities.

At the time of data collection, by the second case study visit, the view was that even though teams were working at full capacity, some were reluctant to fully embrace expansion or develop a more strategic commissioning model because of uncertainties about the future scope of the Fund and the plans for regionalisation.

Workload had become a serious problem in teams and there was a concern about the changing nature of social work practice. The impact on staff wellbeing was an issue of concern.

Larger, more multidisciplinary and therapeutically trained teams were better able to implement the ASF, meet the needs of families and also better able to think strategically about the future opportunities to develop the service.

Local authorities proactively sought to raise awareness of adoptive families and potential adopters about the ASF. The online survey of adoptive parents indicates that awareness of the ASF is high and that awareness about entitlement to adoption support services has improved from 2011 to 2016. Awareness of the scope of the Fund was mixed and parents accessing in this the early implementation phase were likely to be in crisis.

What are the key barriers and enablers for good practice in implementing the Adoption Support Fund?

The emerging trajectories are to an extent historical, and are also in flux as local services grapple with the changing landscape for adoption support services. There were 3 key barriers identified in the early implementation:

- workload increases of post-adoption support teams;
- role changes brought about through increased administration, commissioning and auditing of services;
- inability to respond to the capacity issues because of lack of confidence in the future of the ASF and the way in which regionalisation will impact locally.

Although it would be premature to define a ‘good practice’ model, the following enablers, largely drawn from the larger multidisciplinary and therapeutically trained teams, can be considered for successful implementation of the ASF regardless of the size of the team or type of service trajectory taken:

- Attention to supporting the role of social workers and finding solutions to the increased demand in administrative work;
- Regardless of the size of the adoption support team, the case studies indicate that upskilling of social workers in therapeutic knowledge is improving the efficiency and quality of assessments, liaison with clinicians and appropriate commissioning of external provision;
- Processes that ensure the quality and depth of assessments are not sacrificed by the need to respond to increased demand; and
- Investment in intelligence gathering and strategic thinking around local need and workforce planning.

6 Changes in the local markets for provision of post-adoption therapeutic services

Key findings

- The market for independent post-adoption support services has expanded in response to the ASF, but this is limited.
- Two key ways independent providers have expanded are through recruitment of therapists and developing and refining specialist support in post-adoption services.
- Local markets varied across areas and were not considered yet to be sufficiently developed to meet the rapid and substantial increase in demand.
- Key challenges to growth of an independent market sector to meet the demand are a lack of trained therapists in the ASF approved therapies and the capacity of the independent sector to fund and provide the necessary supervision required to practice effectively.
- Local authority commissioners have concerns about how to monitor the quality of the independent market.

6.1 Introduction

One of the assumptions behind the introduction of the ASF was that a local market of independent post-adoption therapeutic provision would be stimulated and developed.

The following chapter explores data from the local authority case studies including providers, and follow-up interviews with leads from the original ASF prototype authorities on how this model of post-adoption support has developed since the introduction of the ASF. Emerging themes from the first case study visits to local authorities were developed into an online survey for local authority staff and providers. The findings described in the following chapter are based on the responses to: the online survey of 124 local authority staff (predominantly social workers) and 50 independent providers; 86 semi-structured face to face interviews with local authority adoption support teams and 33 providers (8 from voluntary agencies, 2 NHS and 23 independent organisations or sole traders); and 10 telephone interviews with prototype leads.

6.2 How the market has expanded in response to increased demand

In order to respond to the demand and increase capacity, provision of post-adoption therapeutic services has expanded in different forms. These can be broadly clustered in 2 trajectories: organisational growth through recruitment of new staff; and/or extending capacity through the development of some additional services.

Organisational growth through recruitment

In terms of the former (organisational growth through recruitment), the majority of providers interviewed working as part of organisations (i.e. rather than sole traders) described taking on new staff to deliver more of the services and interventions that they already provided. These ranged from expanding the number of therapists to deliver interventions and increasing supply and/or increasing back office capacity to support the administrative activities required by the ASF. Two independent providers, for example, mentioned creating a new post specifically to manage relationships with social workers, and recruiting an human resources post. Within this category of expansion there are also larger network organisations, who deliver therapeutic interventions through individual practitioners. Through the ASF, these organisations were able to spread their services to new geographic areas. As one provider said:

> *"[The ASF] allowed us to put out more work. I started with 6 therapists and now have about 20, now covering all the Northwest*". *(Voluntary Sector Organisation).*

How to meet demand while at the same time maintaining the quality of therapeutic work remained a theme emerging over the 2 rounds of case study work. As one provider noted, growing the business further and *"growing too much, too quickly"* was not in their ethos, as this could compromise their ability to deliver dedicated therapeutic services to families, which required *"more than just having a set of sessions"* (i.e. it involves case work).

Development of additional services

Organisations that had developed additional services as a result of the ASF described expanding their skills-base or innovating through the development of new services. Three organisations, for example, recruited independent professionals with specific skills and expertise in particular therapeutic interventions (e.g. DDP, Theraplay and art and drama therapy). One had developed new 'off-site' services, which were described as an innovation specifically enabled by the ASF.

> "*We are bringing more people who can do specialist support. For example, we have staff doing training in life story work now, we have improved our skills and we*

are skilling people up, knowing there is a demand. The quality of what we provide is better" (Voluntary Adoption Agency)

Half of providers interviewed described an investment being made in in-house training, enabling a general process of internal upskilling of staff. While for some this may have not necessarily been a direct result of the ASF (as some highlighted they would have undertaken the training anyway), it nevertheless enabled professional development and improvement. For others, the possibility to upskill was seen as a direct result of the ASF implementation, supporting the development of a new specialism in adoption support and an expansion of their offer. As 2 private providers said:

"The ASF is helping me to develop and I do research on adoption (…) It allows me to tailor things and to seek training myself". And: *"I am reading more and more about adoption and looking into this and how it differs to fostering, how they compare. So you could say I am developing a specialism in this way*". *(Independent provider)*

Two independent providers also described developing in-house training. In one case, a 'skills audit' was carried out to identify gaps and further develop the therapeutic offer, and in another between 4 and 13 members of staff had been trained in a particular therapy:

"We have taken on board the additional expense of in-house training to meet the demand. Training in sensory attachment intervention: we had 4 people trained initially and then we had a trainer come in and train all of us for a week. So we now can offer this from all our therapists, there are 13 of us now offering this". (Independent provider)

In addition to the views from local authority staff, the majority of provider interviewees reported the opportunity brought about by the ASF to strengthen relationships with local authority staff or create new ones, as a result of expanding the number of local authorities they were offering services to. Similarly, the majority of case studies were building up their knowledge of the local market. This was being done through proactive research by core staff as well as through engagement with colleagues across neighbouring authorities, workers in other boroughs and/or known agencies. Some were pooling their knowledge and developing joint lists of providers as part of their consortium arrangements. The most valued routes for access to knowledge of local provision for most case study interviewees were recommendations from local authority (or other agency) staff working internally or in other local authority areas.

Despite the expansion described above, the overall view on the extent to which local markets had developed as a result of the ASF did not change from the first round of interviews. Providers and local authority staff interviewed shared the view that while the ASF had created demand for independent sector provision, the ability to stimulate supply

at the level necessary to meet this demand was still lacking overall. The development of local provision was seen to be largely to do with the expansion of, and increase in work for, existing providers and the shifting of practice (e.g. people moving from the public sector and setting themselves up independently), rather than with the emergence of new providers.

6.3 Challenges to growth and meeting demand

The key challenges to meeting demand through further growth of local markets of independent providers were: training, supervision, lack of confidence in the sustainability of the ASF and uncertainty around the impact of foreseeable changes in the post-adoption support landscape.

The first related to the limited availability of required clinical expertise and the time required to get to an adequate level of training to practice: even though providers had recruited new staff, many highlighted that it was nevertheless difficult to find people with the right skills-set and the knowledge of adoption necessary to adequately deliver therapeutic interventions. As one provider said:

> *"There is just a dearth of practitioners with the expert and specialised knowledge of adoption that is required (…). I try to develop the service by getting more therapists but the gap remains in getting therapists that are equipped to deliver the interventions required by the ASF" (Voluntary Adoption Agency).*

Another provider echoed this view by highlighting that while they allocated some cases to other psychologists, doing so also meant taking a risk:

> *"We've allocated some work to psychologists who have done a little bit LAC [Looked after Children] work but not that much (…). We don't want to start allocating families to people who aren't good, LAC, adoption-experienced clinicians (…) and there is not many of us out there at the moment" (Independent provider).*

Overall, the implication of this challenge was, in some cases, that referrals needed to be halted:

> *"We have to recruit new staff, which is positive as it means our organisation is growing. But at the same time it's a challenge to recruit at the required level of skill and experience. So at the moment, we have a moratorium on referrals, as we are well into next year now for our capacity for intake of assessments". (Voluntary Sector Organisation)*

The issue around the gap in the required level of expertise was also seen as not being easy to overcome. This was largely to do with the current lack of supervision, which the majority of providers viewed as a critical element for market growth and development, and the time required to invest in training.

> *"Practitioners would have to be able to fund themselves to specialise in some of these therapies, which is challenging: how do we ensure therapy training for staff and supervision, which is expensive and takes several years?" (Independent provider).*

This was echoed by some local authority staff in both rounds of interviews who cited the lack of necessary supervision as inhibiting their own capacity to deliver therapeutic interventions (and therefore limiting their ability to meet some of the need).

Acting as a further hindrance to market development was the uncertainty of the continued availability of funds, which providers and local authority staff felt created a degree of 'risk aversion'. In other words, because, on the whole, the availability of funds in the future was still uncertain, this could act as a disincentive for organisations to invest in training and/or focus their services on adoption-specific interventions, further limiting the opportunities to gain the expertise required and thus increase capacity to meet the need. As one independent provider said:

> *"What happens in 2020? The end of the Fund? There is a huge risk that all the benefits will end".*

These interviews were undertaken in the early months of the ASF implementation and may be very early to expect that capacity issues could be addressed. However, despite an acknowledgement that perhaps further down the line supply would gradually increase, at the present time the view and experience on the ground was that the market was not developing quickly enough for the demand.

Quality of provision

A key theme emerging from the 2 rounds of interviews related to a continuing concern around the quality of provision. This was seen in relation to the way the market was developing, which many felt was mainly an expansion of existing providers and some in the public sector setting up private practices. There were 2 key concerns: firstly that small or sole trader private organisations cannot meet the complex needs of a whole family in crisis; and secondly that the sudden increase in demand was compromising quality.

Local authority staff pointed out that the level of expertise and capacity required when working with families in crisis is significant. This raised a question around whether the trajectory of developing an external market was the right one to be able to cope with the demands that therapeutic support requires.

"…our perception is there are probably more people setting themselves up in private practice. This is concerning because of the complexity of the cases and how small providers can meet the systemic needs of a family. There's an element of risk here" (Voluntary Adoption Agency).

"I expect more people going private is going to be risky for practitioners. And in care terms, it's the opposite of the integrated and joined up services that is needed" (Voluntary Adoption Agency).

The consequent increase in work for existing providers was creating a situation in which meeting demand and maintaining high quality work was seen as paramount. For many, this meant choosing to put a stop to referrals.

"I would say there's not a huge take off of new organisations and agencies, but an increase in work for the existing ones, and we are grappling with that, to meet the demand whilst keeping up the required quality". (Social Worker)

The concern about quality was echoed across the case study sites and was largely spoken of in terms of the extent of the expertise available, which related to the issue of the specialised nature of the therapies. As one interviewee noted:

"…the worry for me is that some of these providers are regulated but often there might be a shallowness of expertise about adoption. We know that [name of organisation] have a pool of therapists available but many are not well trained, we are getting complaints about this" (Social Worker).

For some, the concern was also augmented by the difficulty of knowing how to quality-assure providers. While many had processes in place to assess quality, they still felt there was a gap in relation to quality control:

"I have a concern about the services we commission: where is the quality control in terms of Joe Blogs setting up a (…) therapeutic play service? Where is the quality assurance within that, who digs deeper into that service? There needs to be a more robust system". (Team Leader).

Those local authority case studies that had fewer therapeutically trained staff on their teams felt particularly challenged by how to quality-assure those external services that they had not accessed through recommendations by their peers, without guidance in place on how to do so. For some, there was a question about the extent to which the ASF could be supported by more regulation of providers to reduce the risk of poor quality. Others felt that *"the system was being abused",* with providers potentially recommending inappropriate interventions or interventions of inappropriate intensity.

Six of the case study areas reported concerns about rising prices for therapeutic support or value for money when commissioning external services. From these services there was a feeling that in-house services could be provided more cost-effectively. In 4 of the case study areas, where the local market was described as limited there were concerns that providers, particularly individuals were raising prices.

From a provider view, the point was raised several times that they were not central enough to decision making in the assessment process that the application for the ASF was based on, and they felt that the lack of clinical expertise in the central management of the Fund was an obstacle to the approval of funding in the application process.

Stretched capacity

The introduction of the ASF, and the consequent increase in referrals, was stretching the capacity of current and known providers, which, despite expanding, had waiting lists or expected to be in a position to have them in the near future:

> *"The ASF is having a massive impact on capacity. We could see people 7 days a week and so many referrals, families are coming through (…) we are having to say no to people". (Independent provider).*

As was the case for local authorities, providers said that the changes to the ASF and the increase in administrative tasks experienced in the latter part of implementation created more work and less capacity. A number of providers reported increased waiting lists for assessments and delays in starting the work, overall greatly reducing timely access to support (thus impacting negatively on families). As one provider noted:

> *"Overall, it's not so much that we're seeing constant increase in demand. Rather, it is the mixture of the demand and increased admin that is creating a situation in which a lot of time is being spent on getting the application through, which reduces the ability to start the work, creating a backlog" (Independent provider)*

While local authority staff across all case study areas experienced a shortage of supply, again the extent of the challenge differed according to the cases' internal models and/or whether they found themselves in a geographically isolated area. Those with strong in-house provision (Newington, Bridmouth, Northburn) and relatively large teams, found this perhaps less problematic, as the need could be met internally and the reliance on external commissioning was lower. These areas were able to use the ASF to further upskill internal staff in the required therapies.

The difference in the level of provision was particularly evident if placing children out of area, for example, in areas where the market for therapeutic services was limited or, in some cases, absent. This was seen as particularly challenging because of the increased support needs of children placed out of area. As interviewees said,

"(…) we have a family in [name of placement area] and we completed an assessment of post-adoption support needs. Further assessments indicated that various interventions needed to take place but there was nothing in the area for one of the children. So although the therapy has been identified there is nothing in that area to fill that need" (Team Leader).

"Before [the ASF] we'd limit the amount of DDP we offered. Even now though we can't offer too much DDP due to lack of providers" (Social Worker).

"There is an issue of provision overall and the ASF has increased pressure on local providers and LA staff in other boroughs. Delivering post-adoption support in areas that you're not familiar with is a nightmare; making sure you're getting good workers, it's really hard to get recommendations from LAs. You'd have to find out from them who they have used, who they would use again. But these workers got busy very quickly and you're left way behind in a queue of knowledge. I went to an LA asking for DDP in their area, asking for someone they have used, and this person took 6 months to get back to me, that's how busy they all were" (Team Leader).

Most case study areas, regardless of their emerging model, felt that equipping internal staff to deliver services would be more cost-effective, improve social worker retention and help them to continue to have access to staff who understood the organisation and had important links with internal services (e.g. children's team), which providers do not always have.

6.4 Wider evidence on changes in local markets for provision of post-adoption support services.

The emerging findings from the first case study visits were developed into online survey questions for therapy providers and local authority post-adoption support services to further test their validity. Fifty providers and 124 local authority professionals responded to the online survey.[30] The results corroborate the key findings from the case studies.

In reference to local authorities' 'growth in local markets', we assessed this through the indicators on either internal growth (indicated by the training or recruitment of staff) or external growth (indicated by the development of new contacts with service providers).

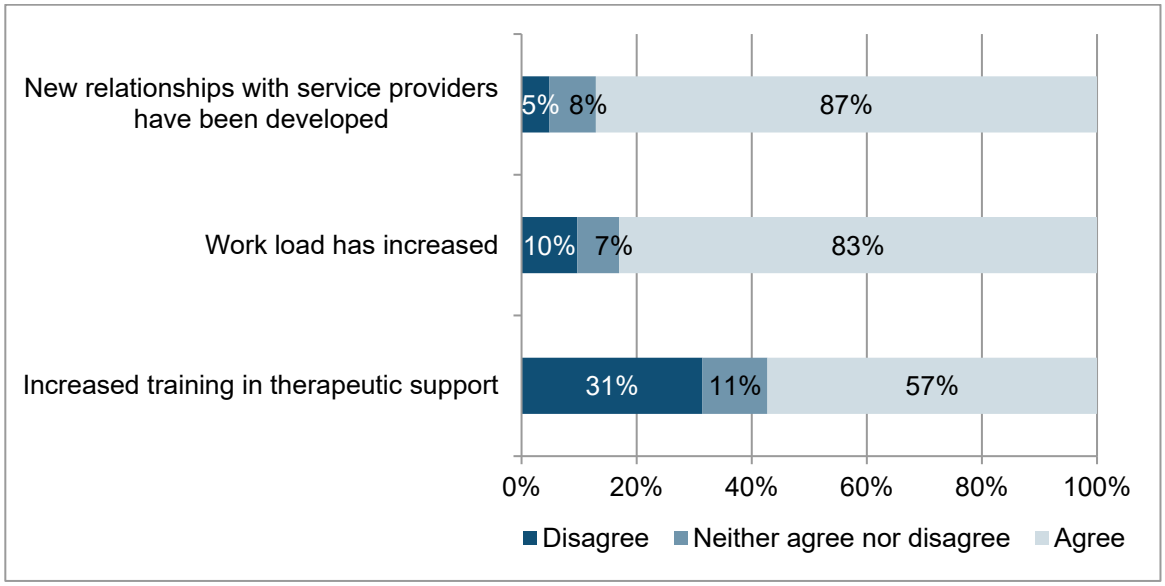
[30] It should be noted that the sample is not representative of the population of service provider and local authority staff. However, the sample of service provider represent a wide spread in terms of region, size of organisation and services offered and the sample of local authority staff in terms of region and role.

With regards to the development of new relationships with providers, 87% of the 124 local authority employees agreed that this had happened as a result of the ASF with 21% strongly agreeing (see Figure 8). Responses showed that internal upskilling was less prevalent with 57% agreeing that the local authority they were working at had undertaken training for staff in therapeutic support in response to the ASF. However, 31% disagreed that staff had been trained as a result of the ASF.[31]

The majority of surveyed local authority staff (83%) agreed that their workload had increased as a result of the ASF and more than half (53%) strongly agreed (see Figure 8). Qualitative comments to this answer identified reasons for this increased workload that were in line with findings from the case studies. In particular the additional administrative work that was required was mentioned:

> "*Time taken to carry out assessments, find providers, negotiate package, apply and re-apply to ASF, manage changing rules, waiting for organisations to carry out multiple assessments, waiting for appointment dates and following up, waiting for treatment dates etc..." (Senior Social Worker)*

Figure 8: Relative Frequencies for local authority staff of changes as a result of the ASF



Note: N=124; Source: Online survey of local authority employees.[32]

For service providers that responded to the survey, there has also been an internal growth for most of the respondents (see Figure 9). Half of the service providers (50%) agreed that they had expanded their team as a result of the ASF and around two-thirds

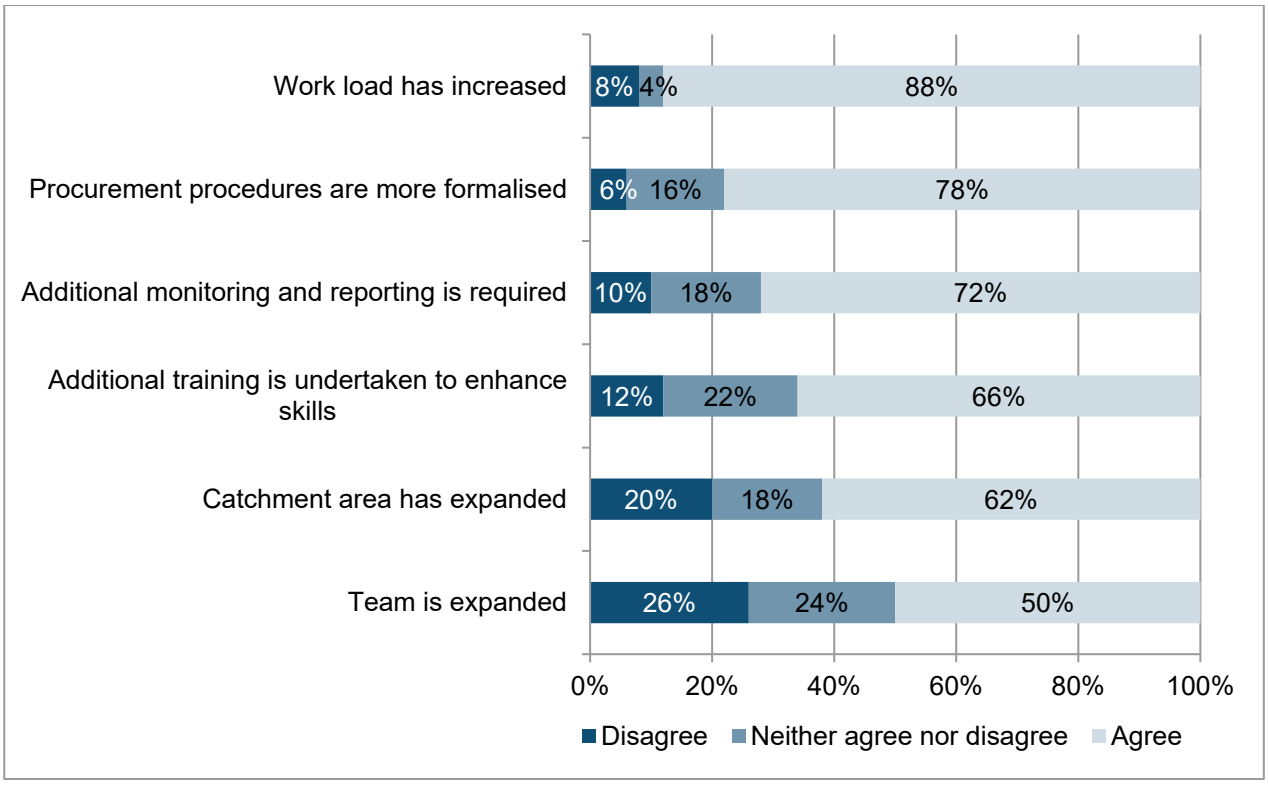
[31] 12% were neutral.
[32] 'Strongly disagree', 'Disagree', and 'Somewhat disagree' are merged into 'Disagree', 'Strongly agree', 'Agree', and 'Somewhat agree' are merged into 'Agree'

(66%) stated that they had undertaken additional training to enhance skills. Nearly two-thirds (62%) also agreed that their catchment area had expanded because of the ASF. This ties in with the fact that 94% stated that the proportion of work on adoption support had increased as a result of the ASF. Larger service providers (more than 10 members of staff) were also more likely to have expanded their team than providers with a small team (10 or less members of staff) or sole traders.[33]

The strongest response from service providers was found in terms of the increased workload (see Figure 9). The vast majority (88%) agreed that the workload within their organisation had increased because of the ASF. The qualitative comments indicated that this increase in workload occurred due to the increased demand for therapies, which resulted in a higher number of referrals and the coverage of a wider geographical area. However, responses also pointed out that additional time is necessary for administrative work such as preparing costings for local authorities and talking to local authorities about want they wanted to commission. This was supported by the finding of a large positive correlation between increased workload and additional monitoring and reporting.[34] In addition, the view was that the procurement procedures were more formalised than before the ASF according to 78% of the respondents.

[33] There was a significant association between 'size of organisation (categories: 1, 2-10, 10+)' and 'expansion of team', $\chi 2(2, N=48) = 17.38$, $p<.001$, Cramers'V =.60. The effect size can be as very large.
[34] There was a significant correlation between increased workload and additional monitoring and reporting ,$r(48)=.58$, $p<.001$. The effect size can be considered as large.

Figure 9: Relative Frequencies for service providers of changes as a result of the ASF



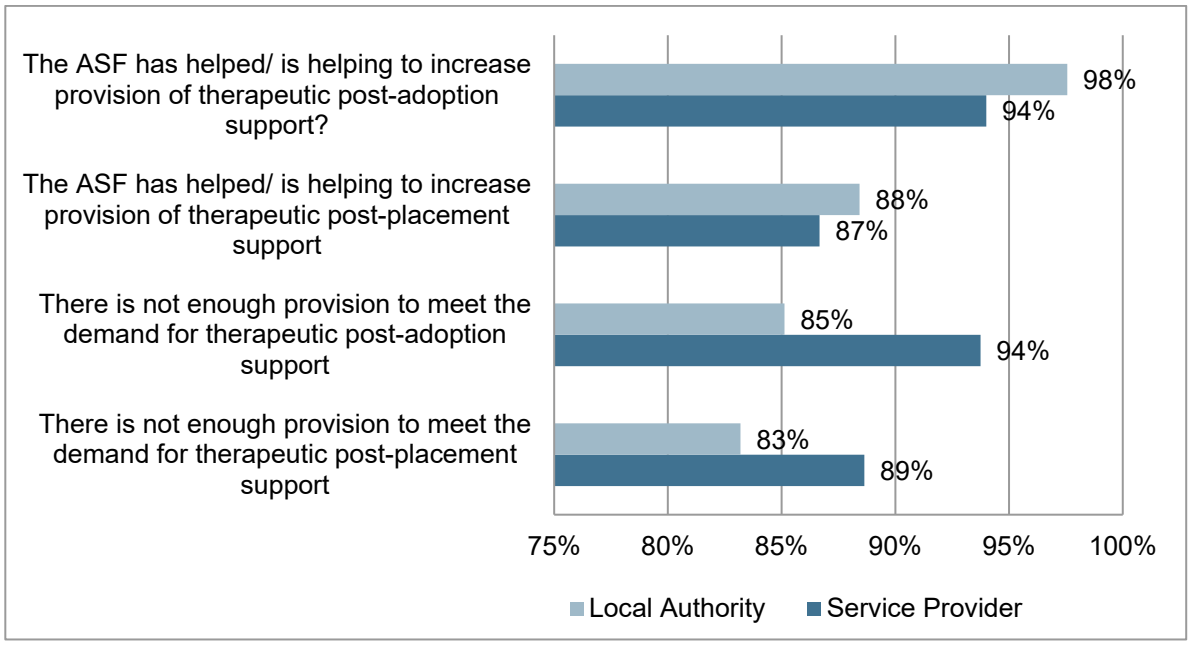
Note: N=50; Source: Online survey of service providers.[35]

The online survey of service providers also supported the finding from the case studies that the ASF stimulated growth of the market for therapeutic support, but that the market was not sufficiently developed to meet the increased demand. Figure 10 presents the view of local authority employees and service providers. The figure shows that respondents from within local authorities were slightly more positive towards the impact of the ASF on the market development. Nearly the whole sample (98%) agreed that the ASF helped to increase provision of therapeutic post-adoption support and 60% even strongly agreed. Furthermore, 94% of service providers expressed this opinion.

However, large proportions of service providers and local authority employees stated that from their experience there was not enough provision to meet the demand for therapeutic adoption support. This was found for therapeutic post-placement support as well as for therapeutic post-adoption support (see Figure 10).

[35] 'Strongly disagree', 'Disagree', and 'Somewhat disagree' are merged into 'Disagree', 'Strongly agree', 'Agree', and 'Somewhat agree' are merged into 'Agree'.

Figure 10: Relative Frequencies for local authority staff and service provider agreeing to the provided statements



Note: N=124 and N=50; Source: Online survey of local authority employees and service provider.[36]

6.5 Conclusions

The market for independent post-adoption support services has expanded. However, at this point in the implementation of the ASF this seems to have been a secondary response to meet capacity needs unmet by the expansion of local authority adoption support teams outlined in the previous chapter.

There are 2 trajectories in which providers have expanded. One is through recruitment and expanding capacity to deliver more of existing services. The second is expansion through developing and refining specialist support in post-adoption services and in some cases the development of new services.

While the ASF stimulated some growth, the view was that local provision varied across areas and that the independent sector was, on the whole, not yet sufficiently developed to meet the rapid and substantial increase in demand. The view was similar across local authority staff and providers interviewed.

Key challenges to growth of local markets to meet the demand are lack of trained therapists in the ASF approved therapies and the capacity of the independent providers to fund and provide the necessary supervision required to practice effectively. In addition local authority adoption support professionals raised quality concerns about the market

[36] 'Strongly agree', 'Agree', and 'Somewhat agree' are merged into 'Agree'.

and this is exacerbated by the stretched capacity of independent providers struggling to meet the sudden demand.

7 Since the introduction of the ASF has the experience of post-adoption services improved?

Key findings

- The majority (85%) of families that were surveyed online in 2016 (and received ASF support) stated that they had received support through the ASF that was not previously available.
- Significantly more families receiving adoption support were receiving therapeutic services in 2016 (70% for first child) than was reported in 2011 (58% for first child), indicating that the ASF has improved access to therapeutic services.
- Relationships with statutory adoption support services had not changed significantly between 2011 and 2016, at both times, 26% of families reporting poor or non-existent relationships in 2011 and in 2016.
- Families said they felt that their experiences of adoption support services could be improved if post-adoption teams offered more support and contact, such as a regular review meeting, throughout ASF provision and the post-adoption journey.
- Better coordination of multi-agency support would also help families make the most of the more in-depth and specialist provision offered through the ASF.
- Although parents accessing the Fund were initially satisfied with the timeliness of the support, as demand and waiting lists increased, families began to experience a decreasing level of timeliness.
- Families reported high levels of satisfaction with their therapeutic provider, valuing the reliable, skilled and ongoing support offered, and pleased that their families' needs were being recognised.
- There was concern expressed about the potential negative effects of the Fair Access Limit and the Fund's future sustainability on families' experiences.
- A lack of understanding and experience of adoption amongst professional staff involved was the main barrier to accessing support for surveyed families.
- Over half (58%) of families surveyed online believed that the provision of post-adoption support had improved since 2015, although most families (86%, reducing to 75% for families approved for adoption since 2010), believed the adoption support system needed improvement.

7.1 Introduction

As well as providing adoptive families with an assessment of family support needs (described in the implementation chapter), local authorities are also required to inform adoptive families about available support services (including NHS and other mainstream support). However, there is no statutory requirement to provide specific services as a result of a needs assessment. The introduction of the ASF means that there is now government funding available to help fund therapeutic services that are identified as needed during an assessment. Otherwise, apart from Pupil Premium and priority for school places, all other support available for adoptive families (such as adoption allowance, support with birth family contact, training and peer support) is dependent on assessed needs and/or the discretion of the providing authority.

This chapter examines whether accessing provision through the Adoption Support Fund improved families' experiences of adoption support services generally. It combines evidence drawn from the online survey of adopters and prospective adopters, the postal ASF parents' survey and in-depth family interviews. Local authority and provider survey responses on improvements within adoption support services are also considered here. The chapter begins by reviewing families' experiences of adoption support services prior to the ASF's implementation, followed by their experiences since then.

7.2 Experiences of adoption support services pre-ASF

Support needs of applicants to the Fund are explored later in the report, where a picture is provided of families with high level needs struggling to access appropriate services, who did not previously recognise the need for support or who believed they could cope alone. The 20 families interviewed in-depth described their help-seeking experiences with adoption support services prior to the ASF's implementation, during the first interviews. It is these experiences that we explore here.

Apart from those families who had recently adopted or been matched, many had been seeking in-depth help for many years. Of the 18 families that adopted 3 or more years ago, 14 families had been seeking support for over 3 years. For a few families, this meant at least 9 or 10 years of support seeking, with 9 of the 20 interviewed families having sought additional help within the year following adoption. Many felt they were able to ask for help from their post-adoption team when problems arose. However, whilst some felt well supported by their post-adoption workers, many others said they did not get the help they were asking for, it was inconsistent or it took a lot of chasing to receive. Therefore, many of the families interviewed felt they were left to just get on with parenting post-adoption. Equally, many of them felt that they were so busy surviving day-by-day, as long as they felt that they could cope, then they preferred to deal with things alone.

> *"…we just mucked through, you know…it wasn't very easy at all…You're just trying to survive…" (Mother)*

Others were reluctant to bring social workers back into their lives, following an intense and sometimes fraught adoption process.

> *"…And you don't want to alert people unnecessarily, because things may be taken out of your control that, erm… you don't want…You just want help with certain things…I think you worry what people may read into that or may think about that..." (Mother)*

A few families had not considered contacting post-adoption services until they felt desperate for help, and in general it seemed that it was only when situations began to turn into crises that families interviewed sought help.

> *"…as soon as you're placed with the child, you lose that social worker and then you get the post-adoption worker but for us it was almost…unless we hadn't asked what post-adoption was, they wouldn't have bothered…Nobody's ever come to us." (Father)*

Only a few had a very proactive post-adoption worker, school or a friend or family member who organised or advised them on how to seek help. For the 2 families who were yet to adopt, their adoption workers helped mobilise support packages to ensure help continued following adoption.

Types of adoption support experienced pre-ASF

Where support was received from post-adoption workers, this was sometimes in a coordination, liaison and support role to bring in better mainstream service support. Most families spoke of the availability of support groups or meetings and events put on by their post-adoption teams. A minority of families had planned, regular support, such as meetings with an independent social worker, which had been offered as part of the adoption order and was said to have been hugely valuable. There were also experiences of post-adoption teams funding or referring families to play therapy, creative therapies and/or therapeutic parenting training. Whilst one family received 4 years of Theraplay as part of their adoption order, most received limited support packages lasting approximately 6 weeks.

> *"…it was once a fortnight or…every 3 weeks…[the therapy] stopped 'cos there was no money…start again, then stop….that's not good for her…" (Mother)*

Additionally, they would have valued access to a range of different parenting strategies as they sometimes felt at a loss about what to do.

"…leading up to adoption, you go through training courses and it's all geared towards attachment and trauma… nobody ever mentioned foetal alcohol…" (Father)

Most families recognised that adoption teams were trying their best to respond to calls for help but they also expressed the view that there was a lack of transparency (about what workers could and could not do) and promises of support that never materialised. Two families felt that they were forgotten whilst their post-adoption service was being re-organised and generally there was a perception that in the past (prior to the ASF), it took longer to assess needs and decide what provision might be needed. Even when support needs were identified before the ASF, the long-term, consistent and in-depth support that parents were seeking did not seem to be available.

7.3 Experiences of adoption support services since ASF implementation: Online and postal surveys

Key findings

- The majority (85%) of families that were surveyed online in 2016 (and received ASF support) stated that they had received support through the ASF that was not previously available.
- Significantly more families receiving adoption support were receiving therapeutic services in 2016 (70% for first child) than was reported in 2011 (58% for first child), indicating that the ASF has improved access to therapeutic services.
- Relationships with statutory adoption support services had not changed significantly between 2011 and 2016, with 26% of families reporting poor or non-existent relationships in 2011and in 2016.

This section explores family experiences of adoption support services, since the ASF's implementation, captured through the following data sources:

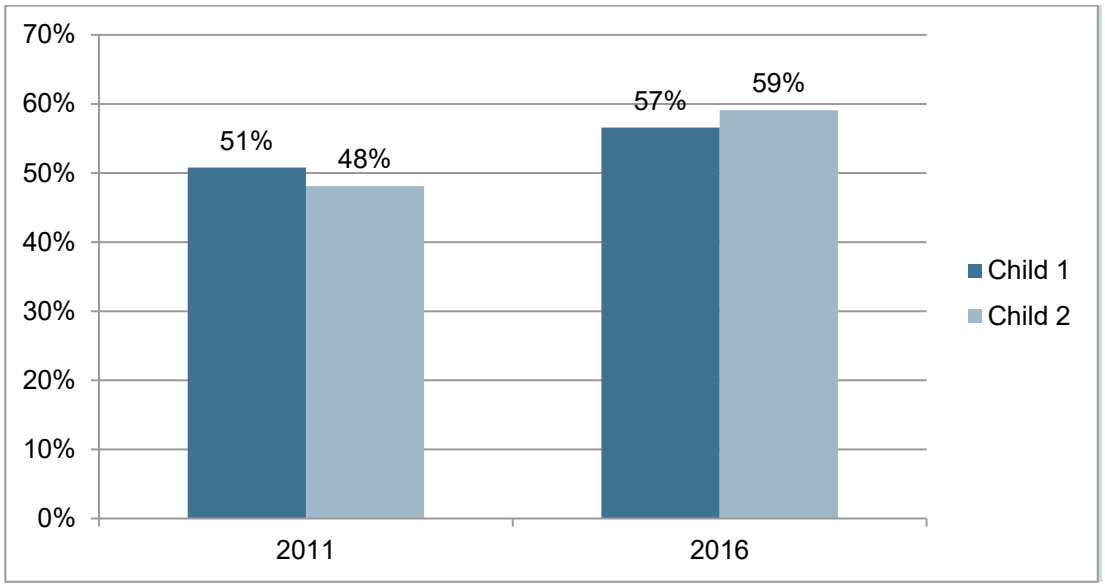
- The online survey of parents' reports of adoption support received at 2 time points, 2011 (n=283) and 2016 (n=586);
- The longitudinal parents' survey reports of satisfaction with the ASF-funded support received (n=481);
- The second round of in-depth parent interviews that describe experiences of statutory adoption support, and specific ASF-funded support (n=16); and,

- The online survey of local authority staff (n=124) and providers (n=50), giving perceptions of the quality of adoption support since ASF implementation.

Online Survey: A comparison of adopters' experiences of adoption support services between 2011 and 2016

The online survey of adopters and prospective adopters explored their experiences accessing post-adoption support in 2016, which were compared to the experiences of adopters in 2011. In terms of receiving services, more families reported to be currently receiving adoption support for their first and second adopted children.[37] However, the difference between 2011 and 2016 was not statistically significant. Nevertheless, more than half of first and second adopted children were receiving some form of adoption support in 2016 (see Figure 11).

Figure 11: Relative Frequencies of the first and second adopted child receiving adoption support services of the online survey respondents



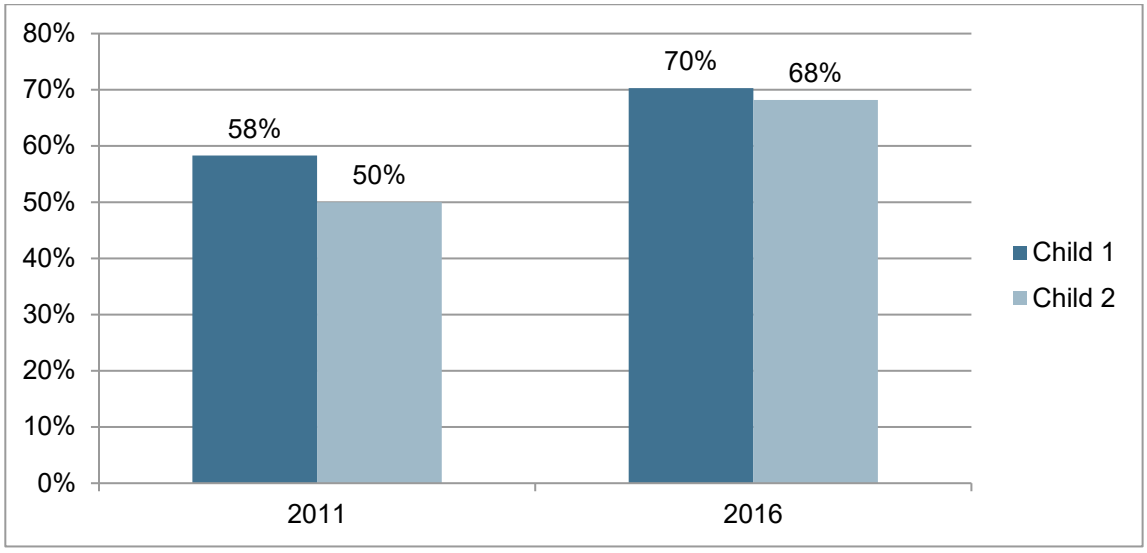
Note: N=783 and N=378; Source: Online survey of adopters and prospective adopters 2011 and 2016.

The relatively small increase in the number of families receiving some form of adoption support service might be not very surprising as the ASF is specifically designed to provide *therapeutic* adoption support. For this reason, the comparison of adopted children in 2011 and 2016 receiving therapeutic services is particularly relevant. Indeed, it was shown that there was a significant increase in the number of parents reporting to be receiving therapeutic services for their first child.[38] In 2016 more than two-thirds of the

[37] $\chi^2(1, N=783)=2.235$, $p=.126$, Cramer's V=.055 for the first child and $\chi^2(1, N=378)=3.603$, $p=.058$, Cramer's V=.098 for the second child. Both effect sizes can be considered as small.
[38] There was a significant association between 'receiving therapeutic adoption support' and 'time of the survey', $\chi2(1, N=432)=5.94$, $p<.05$, Cramer's V=.117 for the first child and $\chi2(1, N=214)=3.25$, $p=.072$,

parents who reported receiving adoption support services were receiving therapeutic support (see Figure 12).

Figure 12: Relative Frequencies of the first and second adopted child receiving therapeutic adoption support of the online survey respondents



Note: N=432 and N=214; Source: Online survey of adopters and prospective adopters.

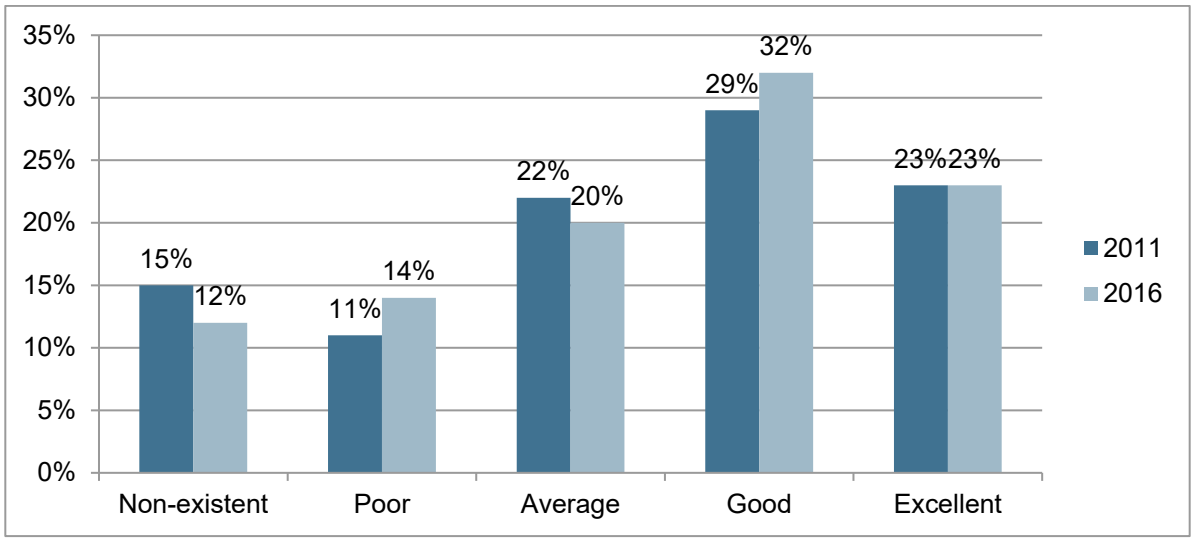
Relationships with agencies

In terms of the relationship with the adoption agency there was no improvement between 2011 and 2016 and in 2016 a substantial percentage (26%) of the respondents described their relationship as poor or even non-existent (see Figure 13).[39]

Cramer's V=.123 for the second child. Both effect sizes can be considered as small. The comparison of the second child is significant when basing the comparison on the sample of respondents having a second adopted child and not only on the ones that reported to be receiving adoption support services and having a second child ($\chi^2(1, N=412)=5.079$, $p<.05$, Cramer's V=.111). The reason for this is the larger sample size and by this means a larger power. When looking at the effect sizes for the comparison of parents reporting to be receiving therapeutic support Cramer's V is larger for the second child than the first child.

[39] There was no significant difference between 2011 and 2016 for the relationship quality, U = 76802.5, p=.755.

Figure 13: Relative Frequencies of rating of the relationship with the current adoption agency of online survey respondents

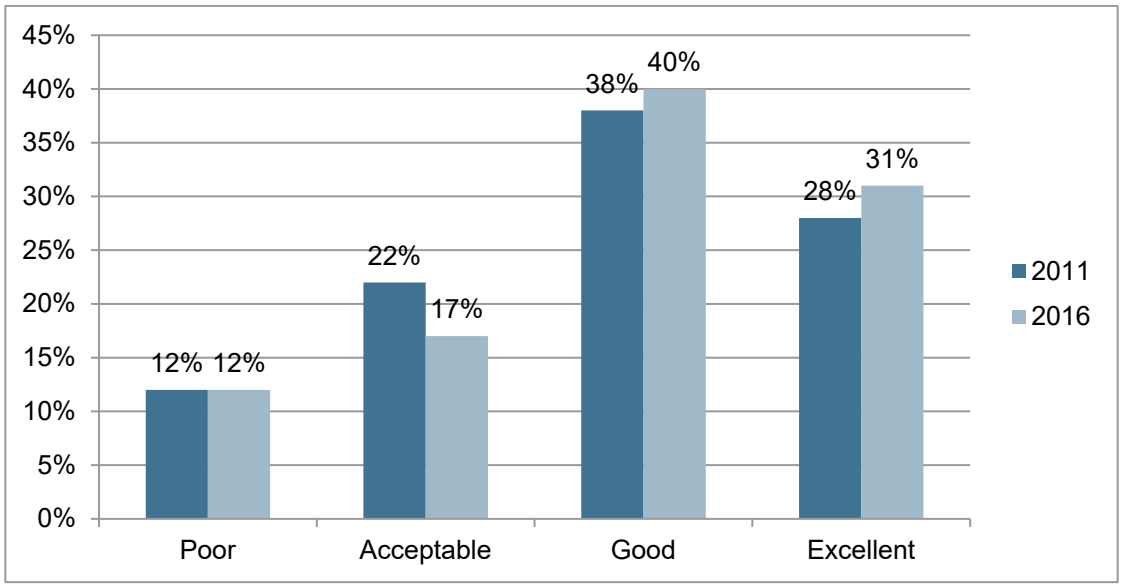


Note: N=843; Source: Online survey of adopters and prospective adopters 2011 and 2016.

Parents that received any type of adoption support for their family, whether through an assessment or otherwise, were more likely to report that it had helped them in 2011 than 2016[40], showing a decrease in perceived helpfulness from 90% to 83% of families. However, ratings of the quality of adoption support remained similar between both surveys, with a tendency for ratings to be higher in 2016 than 2011 (see Figure 14).[41] In 2011, two-thirds (66%) of parents that had received support rated the quality as at least good and in 2016 this increased to 71% of survey respondents.

[40] There was a significant association between 'services helping' and 'time of the survey' $\chi^2(1, N=578)=5.12$, $p<.05$, Cramer's V=.094. The effect size can be considered as small.
[41] The Mann-Whitney test indicated that the quality of support did not significantly differ between 2011 and 2016, U=36984, $p=.292$.

Figure 14: Relative Frequencies of rating of the quality of support of online survey respondents



Note: N=580; Source: Online survey of adopters and prospective adopters 2011 and 2016.

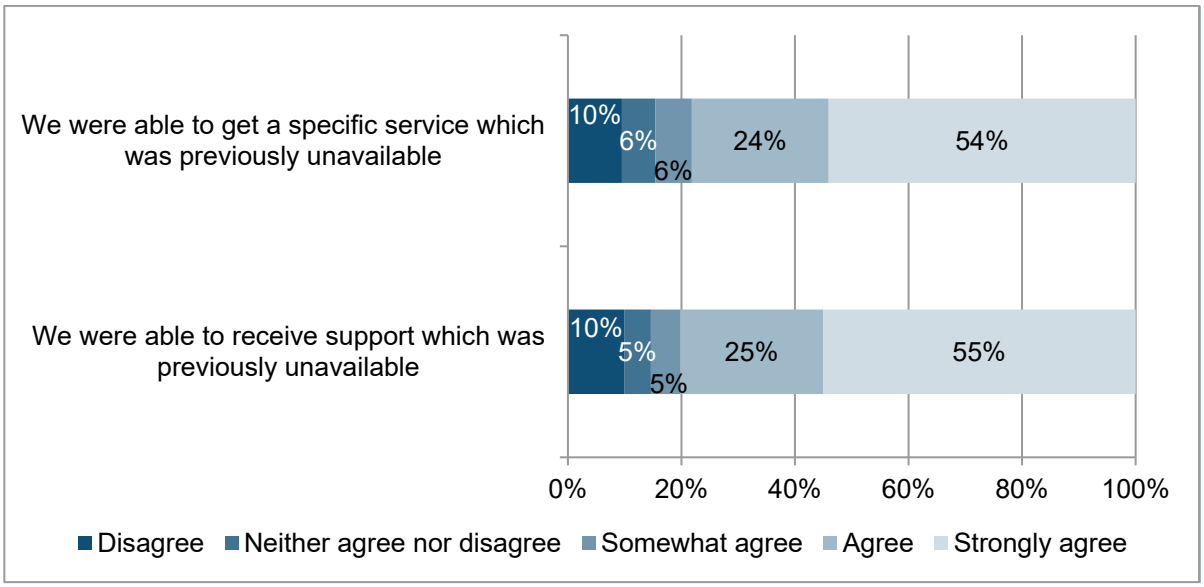
Considering these 2 responses together, it seems that whilst families' experiences of their adoption agency (this includes both local authority and independent agencies) remained mixed, the small rise in quality ratings could relate to the ASF implementation. Parents' responses in the online survey of adopters indicate that the substance of adoption support may be improving, which could be due to families now being able to access more in-depth, specialist and ongoing support through the ASF. This interpretation is supported by the in-depth parent interviews.

Increased support

Of the 203 online survey respondents for whom the local authority made an application to the ASF and which received the ASF-funded support, 85% stated that, as a result of the ASF, they were able to receive (specific) support which was previously not available (see Figure 15).

> *"Without the Adoption Support Fund we would not have received the appropriate support and placement would have broken down…" (Father)*

Figure 15: Relative Frequencies of the impact of the ASF in terms of receiving services of online survey respondents



Note: N=191 and N=187; Source: Online survey of adopters.[42]

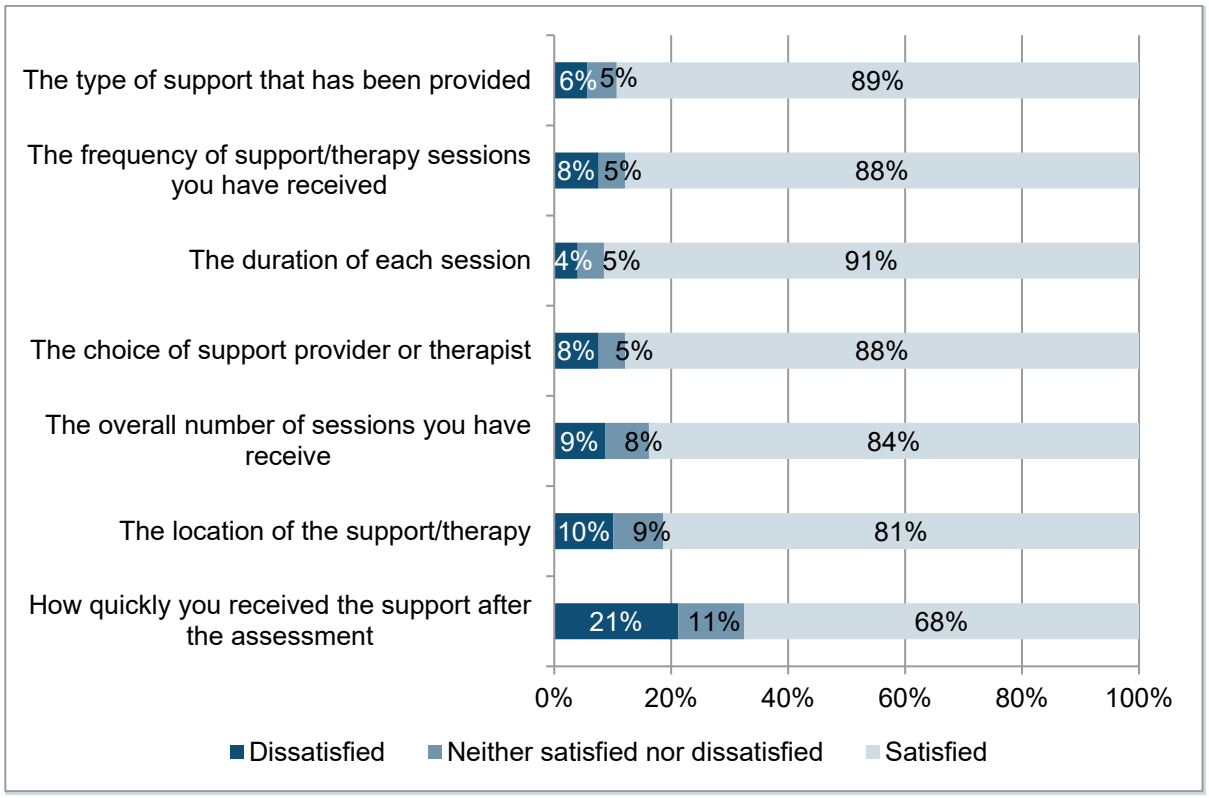
Postal survey of the ASF parents: Parents' satisfaction with the ASF funded therapeutic services

The second wave parents' longitudinal survey respondents reported high levels of satisfaction with all aspects of the support they had received. In terms of the type, frequency, quantity, duration of sessions, choice and location of provider, over 80% indicated satisfaction. This figure was slightly lower (68%) for satisfaction with the timeliness of receiving support after the assessment of need had taken place. Here, it should be noted that the cohort of survey respondents were drawn from relatively early applicants to the Fund (July 15 – June 16). They therefore represent families with particularly high levels of need (indicating a pre-ASF backlog of families awaiting help) and families whose support was allocated prior to the introduction of the Fair Access Limit.

As identified in local authority case study and family interviews, timeliness of provision became progressively more serious as existing administrative and therapeutic capacity became increasingly saturated. Therefore, while the survey respondents still reported relatively high levels of satisfaction with the timeliness of their support, it is likely that this figure (Figure 16) will be lower for more recent applicants. This is supported by the narratives of those families who had therapeutic assessments since June 2016.

[42] Strongly disagree', 'Disagree', and 'Somewhat disagree' are merged into 'Disagree'.

Figure 16: Relative Frequencies of reported satisfaction with various aspects of the support of follow-up respondents



Note: N=428 to N=434 (8 to 14 missing); Source: Follow-up survey.[43]

The Sheehy-Russo Family: The ASF ensures support continues once adoption is formalised

When placed with Caitlin and Luca in 2014, aged 4, Fleur displayed worrying behaviour, which exacerbated on starting school. Caitlin, Luca and Fleur's school were uncertain of how to approach Fleur's increasingly erratic behaviour, physical and emotional difficulties.

> *"…she effectively will kick off…and in the past this was dealt with from a behavioural point of view only…" Luca*

Caitlin and Luca self-funded parenting courses and Fleur was referred for assessments but these were narrowly focused and did not pick up the complex,

[43] 'Strongly satisfied', 'Satisfied', and 'Somewhat satisfied' are merged into 'Satisfied' and 'Strongly dissatisfied', 'Dissatisfied', and 'Somewhat dissatisfied' are merged into 'Dissatisfied'.

interconnected challenges present. The adoption was put on hold until both parents felt confident that appropriate support was in place.

In Summer 2015, Fleur's post-adoption plan was reviewed and a therapeutic assessment undertaken. Caitlin and Luca were relieved that finally a comprehensive, in-depth assessment was taking place and that someone truly understood their needs and could help meet them. The therapist recommended twice weekly sensory processing therapy but the ASF was not available for families pre-adoption at the time. The local authority began to fund weekly sensory processing therapy from September 2015 and when the ASF became available for families pre-adoption, it continued funding until Summer 2016. A second application was then submitted, this time for twice weekly therapy, which began in September 2016. The local authority also provided a short package of individual support for Caitlin and following an ADHD assessment, Fleur was prescribed medication, used only in school. With support in place, home life improving, and the family reassured by their adoption support worker that support would continue, the adoption was formalised in Summer 2016.

7.4 Experiences of adoption support services since the ASF implementation: In-depth parent interviews and online survey (local authority and provider responses)

Key findings

- Families said they felt that their experiences of adoption support services could be improved if post-adoption teams offered more support and contact, such as a regular review meeting throughout ASF provision and the post-adoption journey.
- Better coordination of multi-agency support would also help families make the most of the more in-depth and specialist provision offered through the ASF.
- Although parents accessing the Fund were initially satisfied with the timeliness of the support, as demand and waiting lists increased, families began to experience a decreasing level of timeliness.
- Families reported high levels of satisfaction with their therapeutic provider, valuing the reliable, skilled and ongoing support offered, and were pleased that their families' needs were being recognised.
- There was concern expressed about the potential negative effects of the Fair Access Limit and the Fund's future sustainability on families' experiences.

Family experiences of adoption support since the ASF implementation are divided here between the relationship with statutory agencies, timeliness of access to therapeutic support and views of the support provided.

Relationships with statutory adoption support services

Overall, parents interviewed found individual workers within adoption support services to be competent, supportive and helpful when there was contact. In the first interviews, most parents who already had contact with a social/post-adoption worker generally found accessing the ASF an easy process.

> *"… [The social worker was]…very responsive because she knows me quite well…" (Mother)*

However, those who were not already in contact with adoption support services had a more mixed experience, with some finding it difficult to get a response following their initial call for help. Despite individual workers' helpfulness, most parents felt they needed

to chase workers as there was little forthcoming contact from services. Whilst some families reflected that the process could have been quicker, all were grateful that adoptive families were getting access to specialist support. Families expressed relief that they were being listened to, that their concerns were being taken seriously and that progress towards support was being made.

> *"I sit here feeling extremely fortunate…that we are getting it" (Mother)*

By the second interviews however, in most cases, there had been very little, if any, contact from social workers since the first interviews. Many families received minimal support when they asked for it, for example to make new ASF applications, to support a specific issue or handover from placing to host authority. Otherwise there seemed to be no contact.

> *"Once the therapy's put in place, Social Services are standing back almost..." (Father)*

One family, who had formally adopted since their first interview, reflected on the difference between pre- and post-adoption support.

> *"…you realise that actually, it's a bit painful to have a social worker coming every 6 weeks [pre-adoption], but at least you had someone to talk to and someone to plan things. Well obviously now, at this point in time, we've got nobody." (Father)*

Two families who did have contact with their adoption support services since the first interviews, described a battle to get referrals to externally provided, ASF-supported therapies. One of these families had formally complained, with the help of their MP and GP.

> *"What's particularly frustrating is the fact that this is a fund that appears to be countrywide, but how it is applied appears to be local" (Mother)*

However, another 2 families continued to receive good support, one family having 6 weekly meetings with an independent social worker, previously funded by their local authority, now funded through the ASF. The majority of families expressed the wish for this kind of contact with adoption support services throughout their adoptive journey.

> *"…I just think a yearly review would be amazing and I am sure if you ask any adopted parent, most people would say that…just to touch base and know that there are people out there or new services, new therapies…" (Mother)*

Alongside this, some families wanted more help in identifying appropriate therapies, as discussed in the assessment chapter. They perceived the therapeutic knowledge of social workers to be limited.

> *"…we don't even know…we can't say…that's why you want an expert to come in and say 'Oh I know this.'" (Father)*

In terms of the wider support provided through adoption support services, a few families mentioned the value of being able to access support groups for adoptive families. Some already attended such groups, 2 were planning to do so and others had set up their own. However, since the first interview, one family's local adoption support group had been moved from evening to day-times because of reduced staffing, meaning it was no longer accessible for the parents to attend. Another family had been funded by their local authority to receive telephone mentoring from an experienced adoptive parent, alongside the ASF support.

> *"We're very, very lucky to have that because she's got the experience, she's got the knowledge, she knows who to talk to…[she] make[s] us aware of things that may be coming up in the future." (Mother)*

At the time of the second interview this support had stopped and the parents were waiting to be re-assessed for this, in the hope it would continue. These examples give a picture of other forms of support reducing or becoming less available once ASF support is in place.

By the second interviews, it seemed that most families undergoing therapy felt more supported by their therapy provider than by their adoption support workers. Additionally, frequent adoption support staff changes made it difficult to build and sustain relationships with workers. It seemed that, at the time of second interviews, the continued emphasis was on families asking, pushing and chasing for help. They were still finding it difficult to obtain information on what help was available and from where.

> *"…there are other services as well…that the social worker said [our son] would get access to…But it…has taken years literally to get to this and only because I kept coming back and back…and pressing her and pressing her." (Father)*

Although some multi-agency or individual agency meetings had taken place, overall the ASF did not seem to have resulted in families experiencing more holistic, better coordinated and more consistent support from local authority adoption or other mainstream services. Despite this, all were pleased that there was something on offer and their needs were finally being recognised.

The experience of post-adoption support in relation to wider core services

Many of the 20 families interviewed at the start of their ASF service allocation had poor experiences of seeking help through other services and of multi-agency collaboration. The core services of most relevance to addressing their problems, as identified by families, were CAMHS and schools. In the first interviews, many families described great difficulties in accessing CAMHS and challenges with engaging educational support. Eight families had changed schools to redress this problem.

Of the 12 families who had not changed schools, 6 of these described how helpful the schools were in identifying children's needs, supporting families to get assessments such as ADHD assessments and Statements of special educational needs (now replaced by Education, Health and Care Plans) and/or arranging play therapy and/or other emotional and psychological support. The other 6 families spoke about problems with understanding or support from schools, with one family describing how they came close to changing their children's school. Some of these families received help from their post-adoption worker or CAMHS to increase school staff knowledge and awareness of adopted children's needs, such as attachment issues, and agreed more flexible behaviour management techniques with teachers.

> *"With the right support, as we always believed, they begin to fly" (Father)*

As well as giving therapeutic support, some therapists also got involved in supporting parents' liaison with schools, triggering a focus around the child's mental health needs.

> *"… [The] school has been brilliant, doing all these assessments, getting the SENCO involved… it seems to be coming together" (Mother)*

Some families felt they were getting a lot of help from their school, other services, their post-adoption team and their therapy provider. For instance, one family was pleased with how the ASF respite breaks were complementing art therapy provided through mental health services in the school, and the ongoing support from their post-adoption worker. Others hoped that once ASF support was in place, other services would become better engaged with the family. A number of parents commented that it would be good to have better communication with different services, so that they could complement ASF support. For instance, a few parents expressed the wish to have a voice in how other funds for adopted children, such as Pupil Premium, were used to support their child.

> *"…there are funds that go to the school for looked after children that we have no control over, that we do not see… we don't want to see the money but we would like a say…" (Mother)*

When the families were interviewed 6 months later, support from schools continued to be inconsistent. In a few cases, the quality of support, whether good or poor, continued. Some received improved support and others experienced deterioration or varying levels of support. This was mainly due to teacher changes or lack of communication. However, once the ASF funded services were allocated, some schools did begin to mirror the recognition of need.

> "*…the relationship in school probably would have been much harder to negotiate" (Father).*

> "*Yes, absolutely… I mean I think …anything that sort of is channelled through Social Services, schools are more open to allowing them in…" (Mother)*

Eight families who had a therapeutic or occupational therapy assessment through the ASF were able to use these in communicating with schools and in supporting applications for an Education, Health and Care Plan (ECHP). Four children had had an EHCP implemented since the ASF to help support their emotional and social needs, whilst another 4 families were trying to get an EHCP in place.

The Bolton Family – The ASF benefits are strengthened when part of a holistic support package

By the time Petra and David Bolton accessed the ASF, support for their youngest, 12-year old son Luke, life had reached a crisis point and they feared for their safety. A commitment to providing therapy in Luke's post-adoption plan was no longer available and support offered was generally unhelpful and ill-informed. By the time the ASF was launched, Luke was being violent daily towards his parents. An ASF application was submitted in September 2015 and Dyadic Developmental Psychotherapy (DDP) began in November 2015.

A year later, life was improving and Luke was becoming better able to self-regulate.

> *"…he has calmed down, you know, he is a lot calmer" (Petra)*

Their therapist helped communicate with Luke's school, which led to staff training and new educational support strategies being implemented. After a good summer holiday, the new school year started well. However, teacher changes and school funding pressures led to withdrawal of additional support. The school reverted to its usual disciplinary approaches and Luke's behaviour deteriorated. Petra and David met with the school and a social worker but they had to be persistent, before being told about a school that might meet Luke's needs better.

> *"…Why do we have to wait for an emergency before anybody does anything?" (David)*

Whilst the family had benefited considerably from therapeutic support, this did not meet all of their needs. The whole range of services involved with Luke needed to work together to provide coordinated, holistic support.

Despite some evidence that the ASF is having a knock on effect of orientating core services, particularly education, to the needs of adopted children, most of the families interviewed 6 months later continued to experience disjointed services. It was sometimes commented that this was because of the stretched resources of all services involved. Opportunities to share understanding, knowledge and more closely collaborate across services, with the ASF support as a stimulus for this, are perhaps being missed.

> "*…there's no joined up approach from all these agencies. There's so many of them all not interacting well. All giving mixed messages… All badly funded…." (Father)*

All 20 families interviewed had experience of disparate and disjointed services, sometimes successfully brought together, but often not. A few families tried to coordinate

a range of support from different sources including schools and post-adoption teams and it seems that, when there was some level of coordination, it was useful and has continued so far. Other families experienced one bit of support at a time and were left feeling that they were not getting the whole range of support that was needed. Even when families felt they were near to crisis, the support did not seem adequate. At the time of the second interviews 4 families were still waiting for ongoing support to start. Three of these had been waiting for over a year, were very much in need of support and had experienced no other support while they waited. In these cases, the ASF was perhaps contributing to their experience of unresponsive and disjointed provision.

> *"It felt very…quite complicated, bureaucratic, and you know we've not got what we thought we might get…" (Mother)*

For the other families, although better coordinated support might be preferred and more effective, they were pleased there was, at last, something in place, and some families felt it had helped avoid potential crises.

The Connolly Family: An experience of bringing multi-agency support together through the ASF

Samantha and Joe Connolly adopted 7 year old twin sisters, Robyn and Tamara, aged 3 and a half. Having experienced challenges from the beginning, both girls had additional support when starting school, but funding for this stopped after a year. Samantha then approached their adoption agency for help in Summer 2015. Having adopted from out of area, the family were directed to their placing authority to access the ASF support.

In early 2016, following a brief assessment of support needs from the placing authority, the family were referred back to the adoption agency to identify appropriate therapies. However, Samantha and Joe felt that the assessment was not thorough or holistic enough. Samantha asked for a multi-agency meeting with the placing and host authorities, the school and adoption agency, to ensure the right, holistic provision was being set up. This took place in May 2016.

It was agreed that a package of therapeutic life story work with therapeutic parenting support would be delivered by the adoption agency, funded by the ASF. Beginning in Autumn 2016, sessions involved the whole family, alongside individual play therapy for Robyn and Tamara, arranged at school and funded by Pupil Premium. In Winter 2016, 3 years post-adoption, another multi-agency meeting formalised the handover between the placing and host authorities. Samantha and Joe were pleased with the input from the different organisations involved. They felt well supported by their school, adoption agency and local authority and the therapy was

going well. The new school year transition was smooth and life at home was becoming calmer.

> *"…it was all initiated really …from that … application for the support, the Adoption Support Fund… there was even a handover meeting. That wouldn't have happened otherwise…nobody would have instigated that. [The ASF]…has had a knock on effect." (Samantha)*

However, both parents thought services could be more proactive, as Samantha had organised the multi-agency meeting in the first place.

7.5 Timeliness of access to the ASF services and the impact of the Fair Access Limit

During the period of the evaluation, numbers of applicants to the ASF increased, a Fair Access Limit was introduced in response to this, (just before second interviews took place), and the Fund's scope changed. Whilst most families interviewed had been assessed at an early stage of the ASF and so were unaffected by these developments, a few were directly affected and others raised concerns about the effects of long waiting lists and a funding limit on families. The changing picture of timeliness of access and the impact of the Fair Access Limit is outlined below.

For the families interviewed, the timeliness of access to the ASF services varied greatly. In earlier stages of the ASF, the process between social worker assessment and funding being confirmed seems to have been quick, in a few cases only taking a couple of weeks.

> *"It's been brilliant… I'm just glad it's there and it didn't take long at all" (Mother)*

By the first interviews, 9 families had already started therapeutic support, 5 of these waiting less than 3 months between asking for help and support starting. Another 3 waited between 4 and 6 months before therapy started. However, one family waited about 8 months before therapy with the parents began. In one case, by the time of the first interview, the family had been chasing their post-adoption team for a year to get ongoing therapy through the ASF. However, they had been told that parenting training (that they had already attended) had been funded through the ASF, even though they were not aware of having had an assessment. By the second interview, following another 6 months of chasing and a formal complaint, they had received a funded therapeutic assessment and were waiting for therapy to begin. They were now faced with a long waiting list and had been told that they had reached their Fair Access Limit. The parents did not know when therapy would start. This was the longest wait between first request and ongoing therapy starting reported in interviews.

Of those who had already accessed ASF-funded support by the time of the first interviews, one family, which had received a therapeutic respite break, had by the second interview, also received an in-depth therapeutic assessment. However, they were also prevented from starting therapy because of the introduction of the Fair Access Limit.

> *"…he has gone over his limit and I don't know when he is going to be allocated anything else. Great! You know? What do I do in the meantime?" (Mother)*

Most families were relieved to have been awarded funding prior to the introduction of the Fair Access Limit. However, for the 2 families mentioned above, having their applications assessed just after the new limit was brought in, lengthened their wait for the recommended therapy and created uncertainty.

> *"…where is this help now? You have given it and now you have taken it away…" (Mother)*

Another family had creative therapy stopped because their funded package exceeded the Fair Access Limit, though they were not concerned by this. Other families were yet to be awarded funding from more recent applications (including those for a second child). One of these families commented that their therapy provider was taking the Fair Access Limit into account when designing therapy programmes, to minimise the effects. Whilst acknowledging funding limitations, 3 families recommended lifting the limit, describing the potential costs of not providing therapy in the long-term future. In contrast, 2 families mentioned that the Fair Access Limit was inevitable and necessary. Others did not mention the Fair Access Limit, presumably unaware of its implementation.

Overall, of the 20 families interviewed, it seems that the later families were assessed, the longer they waited for therapy to start, affecting families' perceptions of adoption support services. Nine of the 10 families assessed before December 2015 began support within 3 months. Of the 10 families assessed since January 2016, only 2 families began therapy within 3 months. Five families had a wait of 10 or more months. Much of this, families believed, was due to increased demand leading to longer waiting lists and the Fund's changing criteria. Additionally, it seems that more of the families that had a later assessment of adoption support needs were funded separately for their therapeutic assessments and therapy package, to help ensure the most appropriate therapy was identified and funded. However, it inevitably lengthened the time taken before therapy began because of the additional application process involved. Therefore, whilst this seems a sensible and pragmatic approach to thoroughly assessing therapeutic need, for one family, this involved additional meetings and paperwork that was experienced as unhelpful.

> *"…it was very clear that even though we agreed with the recommendations we couldn't then just move on to allocation…more information had to be*

provided…so that [the social worker] could then put a referral in…to the [therapy provider]… then from that referral she could then apply to the Fund for the amount of money required…" (Mother).

As explained in this report's introduction, changing the ASF criteria and greater scrutiny of applications to the Fund led to increased delays for some families.

"Every time it gets sent back…it has got to go back to the therapist to be able to be reworded, to come back [to us], to then go back [to the adoption support needs assessor], it just seems ridiculous…" (Mother)

Whilst this increased some anxiety, it seems that the ASF support was ultimately approved in these cases. Bearing in mind the years of help-seeking experienced before the ASF was implemented, the months of waiting for most interviewed families was relatively short and a big improvement on previous experiences. However, a couple of families mentioned that even the shorter waits could feel too long, particularly if they were facing a crisis point at the time of the support request. One family's adoption had temporarily broken down by the first interview, having sought help 7 years previously. They were still waiting for support to start at the second interview, 8 months later, and had not received other statutory support in the meantime. It was only because they had help from their wider family that the adoption was slowly being repaired. This experience had been very disheartening for this family, and they questioned whether greater prioritisation according to need could be achieved, whilst acknowledging the need for the Fund to support preventative work.

The Frazer Family – Fair Access Limit delays access to ongoing therapy

Alysoun is a foster carer, first fostering Charlie and Thomas from birth to the ages of 3 and 2 respectively. Following continued birth family contact, the brothers were placed with another family member on an SGO, but after 3 years this broke down following neglect and abuse. Charlie and Thomas were soon placed back with and adopted by Alysoun. Following increasingly uncontrollable and dangerous behaviour at home and school from Charlie, now aged 12, Alysoun's social worker supported a reluctant Alysoun to access a short therapeutic respite break, funded by the ASF. Further funding was then applied for and approved for another short break and a therapeutic assessment. Alysoun also attended attachment training as a foster carer. Already, the family were benefitting.

"It's the best thing" (Alysoun)

Charlie seemed calmer, and outbursts became less violent and more manageable. Alysoun was learning to respond differently and became more open to receiving help. The therapeutic assessment recommended further assessments and ongoing therapy but the Fair Access Limit was introduced and support provided so far had already

exceeded the limit. By January 2017, Alysoun didn't know when therapy would begin and no other help had been suggested or offered in the meantime.

> *"…it was all helpful, but …I mean these things…they are helpful at the time… and then they go …and you have got nothing… and then slowly and gradually…it feels…that we are going to…fall back into where we were…nobody is coming to talk to me…."*

Support from the ASF had already helped improve family life considerably. A year before, the adoption nearly broke down and this was avoided. But now, Alysoun and Charlie were feeling let down. Charlie was struggling and outbursts were increasing. If they continued without help, Alysoun worried that they could reach another crisis.

The Ewens Family – A mixed experience of the ASF

Shauna and Nick adopted 16 year-old Monica and 8 year-old Amelia when they were 10 and 5 years old, respectively, both from another UK country. After an incredibly traumatic time with Monica and no support, Monica was moved into foster care and the care order formalised in early 2016. Amelia experienced significant neglect with her birth family and after Monica moved out in 2015, her behaviour became more worrying. This included excessive risk-taking and dysregulated responses to physical harm.

Following persistent chasing, the placing authority funded a few short-term, inconsistent, therapy packages for Amelia. At the same time, Shauna worked with the host local authority in England to prepare an ASF application for when Amelia would be eligible, 3 years post-adoption. By April 2016, the family received in-depth therapeutic and sensory processing assessments. The therapeutic assessment report arrived later in the summer and a further ASF application was submitted for ongoing, intensive therapy. Due to changing criteria, the application was returned and re-submitted a number of times before being approved a week before the Fair Access Limit was introduced. After much chasing, the sensory processing report arrived in November 2016, and the family was due to begin intensive therapy in January 2017, nearly a year since the first ASF application.

> *"I think that they need to get on with it… you are having to push all the time, we have got enough to be worrying about…without having to do that."*

After years of help-seeking and initial relief that the ASF existed, Shauna and Nick were now frustrated and doubtful about the Fund's sustainability and ability to support their needs. Other therapeutic support was refused in the meantime and by January, the family had been without any support for 9 months. They knew Amelia

was struggling and felt that the short, inconsistent bursts of therapy were damaging to Amelia's attachments. They hoped the therapy would be worthwhile.

Views on the therapeutic services delivered

Overall, the families that had begun therapy and/or had a therapeutic assessment were happy with the services offered and then provided.

> *"We've had access to the Fund now and we've come through. It's calmed down a lot." (Mother)*

> *"…I think our needs were understood and the…first stage of the service, the [therapeutic] assessment was just…incredible….really good…thought provoking, enlightening, reassuring…" (Mother)*

At the time of the first interviews, the 20 families interviewed were at different stages of receiving the ASF-funded support, from chasing an initial assessment of support needs, through to having had 9 months of therapy (not all funded through the ASF). Of the 16 families interviewed again, up to 8 months later:

- One family's therapy package had formally finished;
- Two families had completed short-term therapeutic support and were now waiting for longer-term, ongoing therapy to begin;
- Two families were yet to start ongoing therapy; and,
- Eleven families had therapy packages that were underway.

All of those interviewed were generally pleased with the therapeutic provision, despite the challenges involved in accessing therapy. Many families received additional help outside of sessions, could contact therapists in between sessions and received support in explaining their needs to schools and/or received regular reports.

> *"…she responds to emails as well, which is great…the phone call when things are in crisis. She was on call with the school just yesterday morning or the morning before…very responsive and engaging…she has been very supportive in that respect…" (Mother)*

Generally, regular, planned sessions, mostly with the same highly skilled and non-judgemental person delivering therapy, were seen to be important factors in families' assessment of their therapeutic relationships. Many parents talked of feeling understood for the first time, even though the experience of therapy could be very challenging and raise traumatic issues. They also felt on the whole that the type of support being provided

was appropriate, although some wondered what else might be useful or how their support needs might change over the years.

In the first interviews, while there were very few fears expressed about the therapy itself, one fear mentioned was if the therapy did not work, parents would not know where to go next. Another fear was that it may have started too late to be of help. During the second interviews, some parents of teenagers still had the same fears and 2 parents questioned the benefits of therapy they were waiting for.

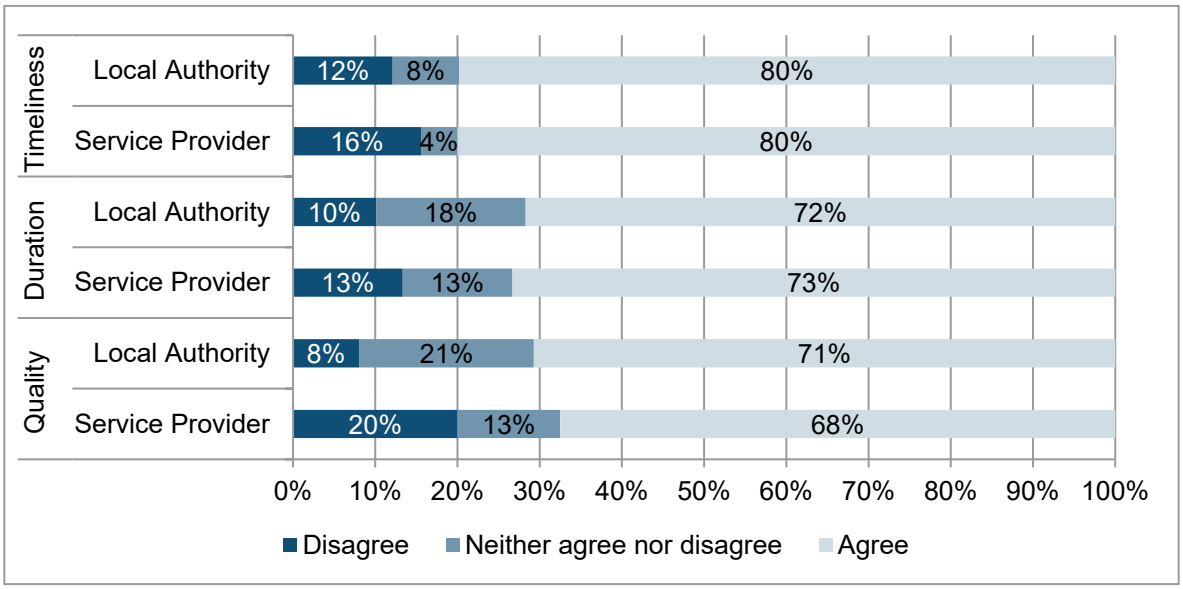
In both first and second interviews, most families expressed fears about the Fund's sustainability. Parents expressed fears that the Fund might close, that it wouldn't be available if families needed it again in the future, or that therapy offered would be cut short. All of these fears led to worries about the outcomes for their children if these fears materialised. However, a few families expressed no fears at all and felt only positive about the support.

Local authority and provider online survey: Views on the impact of the ASF on post-adoption support

The online survey explored the views of local authority employees and service providers on the impact of the ASF on the provision of post-adoption support in their area. Views across service providers and local authority employees were consistent with each other (see Figure 17) and mostly consistent with families that responded to the longitudinal survey (see Figure 16).[44] Overall, they agreed that support provision had improved, was of a more appropriate duration and of better quality as a result of the ASF implementation. Both local authority and provider responses about timeliness were more positive (80% of respondents rating it as improved) than families (68% of respondents satisfied with timeliness), indicating that timeliness has indeed improved considerably since ASF implementation, though it may not be quick enough in some family circumstances.

[44] This is based on the 101 responses from local authorities that do commission external providers to deliver adoption support (from the total number of 152 surveyed local authority staff).

Figure 17: Relative Frequencies of improved provision of post-adoption support as a result of the ASF: Comparison of local authority staff and service provider



Note: N=101 and N=50; Online survey of local authority employees and service provider.[45]

7.6 Barriers to accessing Adoption Support Services since ASF implementation

Key findings

Two key barriers to accessing Adoption Support Services were:

- A lack of understanding and experience of adoption amongst professionals There was a lack of awareness of when support was needed; and,
- Poor self-awareness of when support was required to prevent crisis.

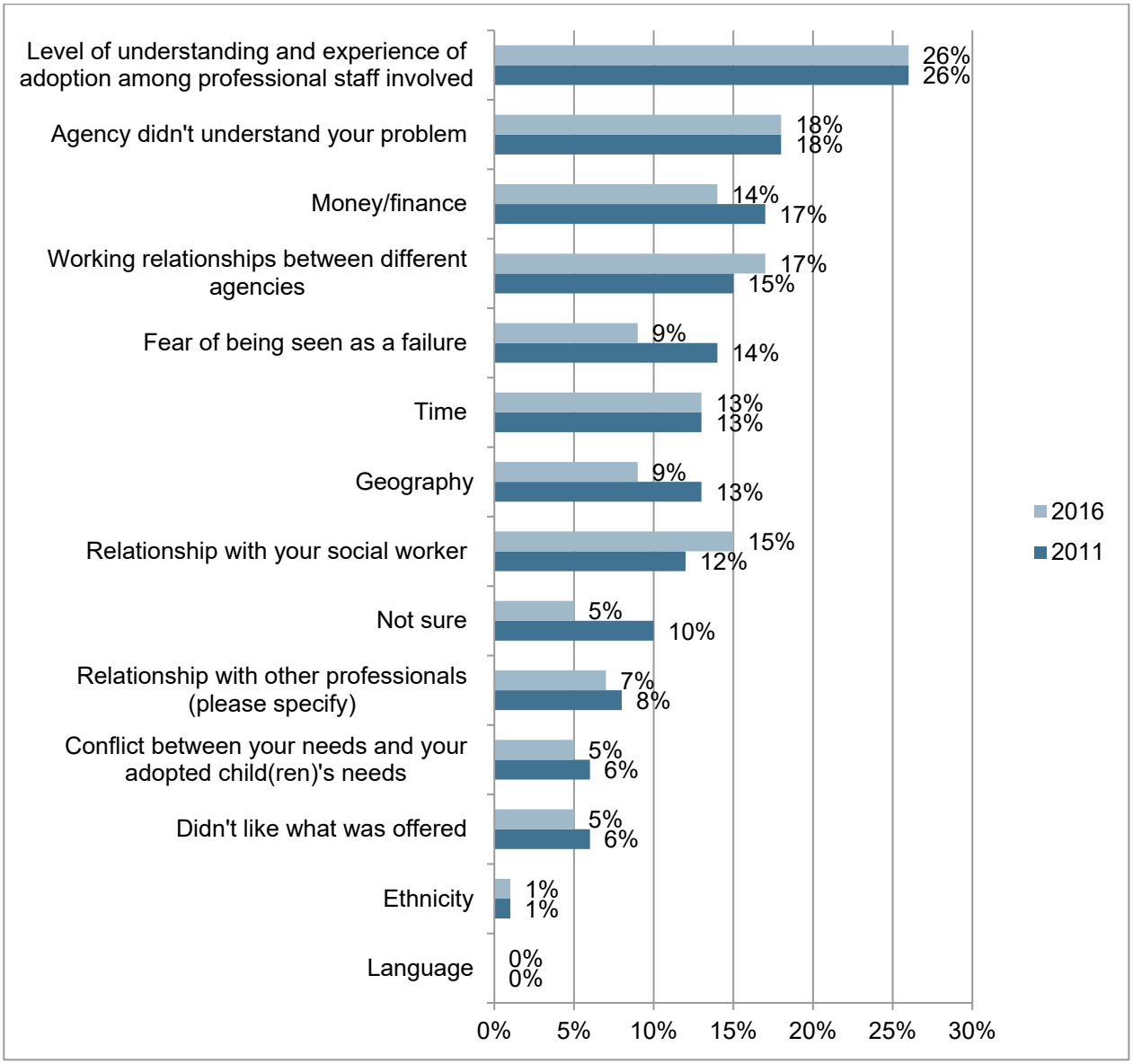
Online Survey – A general view of barriers to adoption support services

Parents responding to the online survey in 2011 and 2016 identified a number of significant barriers to accessing adoption support services. On average, respondents reported slightly fewer barriers in 2016.[46] The principal barriers were still the level of understanding and experience of adoption among professional staff involved and the

[45] 'Strongly disagree', 'Disagree', and 'Somewhat disagree' are merged into 'Disagree'. 'Strongly agree', 'Agree', and 'Somewhat agree' are merged into 'Agree'.
[46] There was a slight decrease in the average number of reported barriers from 2011(M= 1.48, SD=1.93) to 2016 (M=1.37, SD=1.37).

agencies' understanding of families' needs (see Figure 18). Interestingly, 5% fewer parents reported a fear of being seen as a failure in 2016 compared to 2011. This perhaps indicates that the existence of the ASF is improving perceived acceptability of asking for help amongst families.

Figure 18: Relative Frequencies of 'Have there been any barriers regarding your access to adoption support services?'



Note: N=853; Source: Online survey of adopters and prospective adopters 2011 and 2016; several selections possible.

In-depth parent interviews: Barriers to accessing the ASF support

Parents interviewed suggested a number of barriers to accessing the ASF support. Some of these were from their own experience, from the experiences of adoptive families they

knew or were aspects of accessing support they imagined could be difficult for some parents. Firstly, some parents mentioned that there were families who had not accessed the Fund that needed help but did not know they did. A number of families spoke of previous times when they thought they could cope but in hindsight, it would have been better to seek help. Additionally, some knew they needed help, but did not know there was anything available.

> *"…I know of another lady who is having a terrible time at the moment with her son…and I told her about the Adoption Support Fund, cos she needs some type of help for her son…she didn't know anything about it, no one's told her and I would honestly say these things aren't advertised at all." (Mother)*

Some parents said they felt that you should be in crisis to access the Fund. Others said they felt that their situation wasn't perceived as bad enough by social workers for them to be entitled to access the ASF support.

> *"…I just get the impression that they think that you are doing so well you probably don't need… that's the feeling that I get…"You are coping really well, so we might give you a little crumb but we don't really need to give you much more"… (Mother)*

There were others who felt their requests added pressure to already busy social workers. Additionally, 2 mentioned that they thought some parents felt they had failed at parenting if they needed to ask for help.

Apart from those who were already chasing support and were then told about the ASF, many others said that the act of having to ask for or chase support was a barrier in itself. One parent commented that you felt like you were begging and that this may deter some from seeking support. Four families reluctantly brought social workers back into their lives, following poor adoption experiences, nor did they want to bring more professionals into their children's lives, disrupting the family.

> *"…input from people, strangers, you know, more strangers coming in, to do more stuff, I think that would be one area that I would say would …sort of put us off…" (Father)*

A further barrier to access was if the professionals supporting families did not have the knowledge to help identify needs. One family described how they spent the initial years of their adoptive placement trying to work out what connected all of the impairments and behaviours of their children and had not previously heard of Foetal Alcohol Syndrome. Social workers did not suggest this and since it was diagnosed for both children, the family were finding that they were informing workers about the condition and what that meant in relation to support needs. Overall, parents understood that resources were stretched but that they needed the right, informed support at the right time. A number of

families raised the issue of a lack of trained professionals able to meet adopted family's needs, whether working in mainstream or specialist services.

7.7 Improvement in family experiences of adoption support services

Key findings

- Over half (58%) of families surveyed online believed that the provision of post-adoption support had improved since 2015, although most families (86%, reducing to 75% for families approved for adoption since 2010), believed the adoption support system needed improvement.

Online Survey: Improvements in family experiences of adoption support services

Significantly fewer respondents in 2016 stated that the current adoption support system needed improving compared to 2011, reducing from 92% of respondents to 86%.[47] However, this indicates that the majority of respondents still thought it did need improvements. Interestingly, there was a significant positive correlation between the year parents were approved as adopters and their view on improvements to the adoption support system.[48] Looking at this more closely, 75% of respondents who were approved after 2010 stated that the adoption support system needed improving while 91% of respondents who were approved before 2011 stated that.[49] This further suggests that the adoption system did improve.

In line with that, in 2016, more than half of the adopters or prospective adopters (58%) agreed that the provision of post-adoption support had improved since 2015, although 20% disagreed.[50] On the positive end, comments to this question pointed out that there were more opportunities for, and more individually tailored, support than there used to be

[47] The percentage of online survey respondents that stated the adoption system needs improving did differ by year of the survey, $\chi^2(1, N=852)=6.98$, $p<.01$, Cramer's V=.091. The effect size can be considered as small.
[48] The correlation between the year parents were approved as adopters and their view on improvements to the adoption support system was significantly correlated, $r(822)=.124$, $p<.001$. The effect size can be considered as small according to conventions.
[49] The percentage of online survey respondents that stated the adoption system needs improving did differ by year of being approved as an adopter (categories: 2010 or earlier, 2011 or later), $\chi^2(1, N=540)=22.73$, $p<.001$, Cramer's V=.185. The effect size can be considered as small.
[50] The correlation between 'year of approval as adopter' and 'view on improvement of the provision of post-adoption support' was not significant, $r(402)=.03$, $p=.549$.

due to the ASF. One respondent even described it as a lifeline for adopters. However, adopters also expressed their anxiety about the Fair Access Limit.

> *"It is only with the advent of the ASF that we have been able to get specialist support appropriate to the level of identified need. Even with the cap on the ASF, this is now at risk. Only with an ASF that returns to funding according to the level of individual need can my family access the appropriate support and overcome the risk of disruption." (Father)*

> *"It's scary to think it might go and we will be left alone without support again." (Mother)*

7.8 Conclusion

Overall, families' experiences of adoption support services can be seen to have improved since the ASF was implemented based on triangulating data drawn from a range of sources: the online survey of adopters, local authorities and providers, the longitudinal survey of the ASF recipients and interviews with 20 families who applied for ASF support. The data also suggests that perceptions of the quality of adoption support services improved, although not significantly. Local authority staff and therapeutic service providers overwhelmingly agreed that the quality of provision had improved since the launch of the ASF, and families viewed ASF-funded support as appropriate and generally of high quality. However, when it came to people's experience of statutory adoption support services, satisfaction levels seemed to stay much as they were, reflecting very mixed experiences.

A number of barriers to accessing support seemed to still be in place, including a lack of knowledge and expertise from adoption workers about families' needs and the available provision. Timeliness of support was perceived as a growing issue for the ASF as well, whilst poor relationships with and/or low levels of contact from post-adoption teams remained an area that families felt needed improving. Whereas families were experiencing consistent, responsive and regular targeted support from therapists, many families had experienced little, if any, proactive support from adoption support services.

Likewise, variable experiences with other core services involved in families lives and a lack of consistent multi-agency collaboration seemed to affect how well families felt supported. Three areas that were felt to improve family experiences of adoption support services were:

- Consistent, responsive, skilled and non-judgemental professionals;
- Support in communicating with and accessing other, mainstream services; and
- Transparency about what support was on offer and available.

If post-adoption and other services were able to better liaise and coordinate, this could provide families with a wider scaffold of support around and related to the ASF provision.

The Davidson family: A good experience of ongoing support

Sandra and Ed Davidson's adopted son, 9 year old Richard displayed a range of disturbing behaviours from the time of his placement (aged 3 and a half). These included violence and aggression, compulsive lying, stealing, an inability to allow other people control and sexualised behaviour. The placing authority provided independent social worker visits every 6 weeks to support the family, which has been critical to supporting Sandra and Ed in their roles. However, this didn't prevent life from getting more difficult. In summer 2015, the parents were due to meet their social worker to discuss possible life story work with Richard but instead they found themselves talking about the adoption potentially breaking down.

> *"…when she came, we said 'we can't talk about that now, we're basically at our wits end'…" (Sandra)*

As a result, the local host authority was contacted and the 2 authorities worked with Sandra and Ed to apply for the ASF funding. Five months later Sandra and Ed began Dyadic Developmental Psychotherapy (which Richard joined later) and they all, together with their birth child Andrew, also took part in drum therapy.

Nine months later, life at home was feeling a lot calmer. Whilst there were still daily frustrations and difficult behaviour from Richard, Sandra and Ed felt better able to cope, and Richard seemed to be more aware of his behaviour and effects on others. Although it wasn't yet leading to big changes, violent episodes had reduced and it felt that positive progress was being made.

> *"I think we are definitely better equipped…" (Ed)*

Whilst the drum therapy has now stopped because of the Fair Access Limit, Sandra and Ed were not worried about this. Whilst the sessions were enjoyable, they found the DDP more valuable as an intervention and hoped that this would continue, as they realised that there was a lot still to work through with Richard. Meanwhile, the independent social worker has continued regular visits, which Sandra and Ed were delighted with. Sandra and Ed experienced excellent support from social workers at both local authorities, and felt they had been actively involved in discussions and decision-making about support, despite workers being increasingly burdened with administration and bureaucracy.

> *"Without that funding we would not be sitting here as a family today and [Richard] would be back in care. I absolutely guarantee it." (Ed)*

8 Support needs of applicants to the Fund

Key findings

- Half of families responding to the ASF baseline postal survey of parents (50%) using the ASF had sought post-adoption support prior to the Fund being available.
- Many parents indicated that looking back they needed support before they eventually sought it.
- Families accessing the ASF showed very high levels of need.
- Children using the Fund showed substantially higher levels of emotional, behavioural and development needs than both children in the general population and compared to looked after children as a whole, and showed a very high level of predicted psychiatric disorder.
- Family functioning and parent child relationships within the families using the Fund were found to be very challenging.
- The mental health and wellbeing of adoptive parents accessing the Fund was substantially poorer than the wider adult population.
- The analysis suggests both that the Fund is answering a genuine need and that the right families are seeking support through it.

8.1 Introduction

In this chapter we explore the circumstances and needs of the families who have used the ASF both in terms of their needs prior to the creation of the Fund and in terms of their needs at the point of accessing the Fund. The questions of families' needs at the point of accessing the Fund are explored in relation to the 3 main outcome domains of: child behaviour, development and wellbeing; family functioning, parental efficacy and parent-child attachment; and parental wellbeing. This chapter draws predominantly on the findings from the baseline longitudinal survey and the first round of family interviews.

Information was sought through the baseline survey and family interviews about the history of the family support needs and about previous attempts to access post-adoption support. Data was also collected at the baseline survey and then again at follow-up 7 months later. In the next chapter this data is compared at each time point in order to demonstrate change over time for families in receipt of therapeutic support through the

ASF. Here the baseline data is used to provide valuable information about the profile of adopters and their children in terms of their need for (therapeutic) support at the start of the process. This helps form a clearer understanding of who has accessed the Fund and the types and level of need they have presented and in so doing may help form a clearer picture of the need for the Fund itself.

Along with being able to present initial scores on the relevant psychometric scales, where population norms or comparable datasets existed we have sought to make comparisons between these and our sample families. For both the Strengths and Difficulties Questionnaire (SDQ) and Short Warwick and Edinburgh Mental Well-being Scale (SWEMWBS) population norms exist, so that scores of the survey sample can be compared to the general population.[51] Moreover, for The SDQ and the Brief Assessment Checklist (BAC-C for children and BAC-A for adolescents) there exist clinical thresholds that allow for the classification of respondents according to their scores, again allowing a clearer understanding of the profile of the ASF applicants at the point of accessing the Fund. For the SDQ we were also able to undertake a comparison between our sample and a sample of looked after children (LAC) from a recent UK study reported by Goodman 2004.[52] To help illustrate what these survey findings mean at the level of the family we include evidence from the family interviews where parents have described the challenges they and their children have faced.

The overall picture gained of families accessing the ASF is one of a group with extremely high and long standing needs. The vast majority of adopted children within these families showed very high levels of emotional, behavioural and developmental issues, with family relationships being strained and challenging and parental mental health substantially poorer for this group than for members of the adult population as a whole.

8.2 Prior Support needs

Prior attempts to access support

As part of developing an understanding of the profile of families applying to the ASF, a series of questions in the baseline survey aimed to collect information about families' therapeutic adoption support needs before their assessment of need to receive services funded through the ASF. Respondents were asked about their attempts to access support through either statutory or independent services before the Fund was

[51] More information about the psychometric scales can be found in the section 'Child behaviour, development and wellbeing' and 'The Wellbeing of Adoptive parents' below.
[52] Goodman, R., Ford, T., Corbin, T., & Meltzer, H. (2004). Using the Strengths and Difficulties Questionnaire (SDQ) multi-informant algorithm to screen looked-after children for psychiatric disorders. European Child & Adolescent Psychiatry, 13, ii25-ii31.

established. Details about respondents' attempts to receive therapeutic support either privately or through their local authority are summarised below:

- Exactly half of the baseline survey sample (50%) stated that they had approached their local authority for an assessment of need for post-adoption support prior to their most recent assessment;

- Of these respondents one third (33%) reported that they had approached their local authority once, whereas nearly half (45%) stated that they had approached them between 2 and 4 times. However, 22% also said that they had approached their local authority for an assessment of need more than 4 times;

- Around two thirds (63%) of those families who had approached their local authority for an assessment at least once before the most recent assessment for the application to the ASF stated having received one;

- Of these families that received an assessment 64% also received therapeutic adoption support, whereas 36% did not receive any type of therapeutic adoption support following their assessment; and,

- The families who did receive some type of adoption support reported high levels of satisfaction with the service they received. Nearly two thirds (62%) agreed that the support received met their families' needs and 26% did not agree.

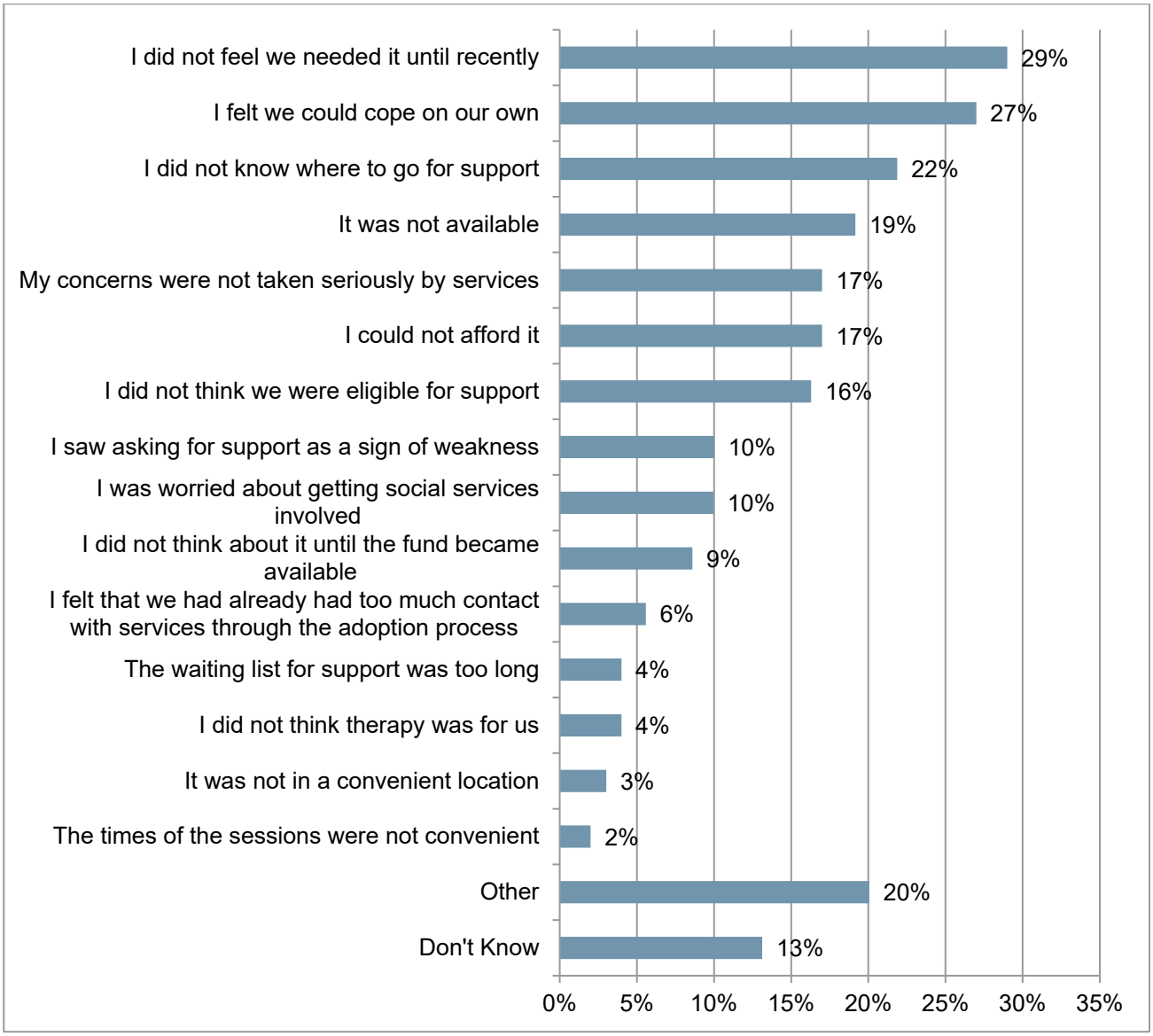
The survey further asked if respondents had previously paid for post-adoption support themselves. Of all respondents 15% had paid for support before. Taking the information about receiving support via their local authority and privately paying for therapeutic adoption support together revealed that, in total, 30% of the total survey sample received some kind of post-adoption support prior to the establishment of the Fund, meaning that the majority (70%) had not. Of those who received therapeutic support nearly half (48%) received it through their local authority, 38% paid for support themselves, and 14% paid for therapeutic adoption support as well as having received support via their local authority.

Respondents gave various reasons for not having accessed support previously.[53] A high number of respondents said that they had not accessed support prior to the ASF as they had not felt they needed it (29%), that they could cope on their own (27%), or that they did not think of looking for support until the Fund was established (9%). Other reasons referred to included: obstacles to accessing support like not knowing where to access

[53] All respondents who reported having previously paid for post-adoption support were excluded from the analysis of this question.

support (22%), respondents' perceptions of and relationships with the local authority such as feeling that concerns were not taken seriously by services (17%), or an attached stigma to accessing support like feeling that asking for support is a sign of weakness (10%). Figure 19 displays the full list of reasons for not accessing therapeutic support previously. Those survey respondents who ticked the 'other' option gave various answers, which included: the process took too long, not meeting the criteria, not having met the child long enough, not knowing that there was support available, not having been offered support, or not knowing what type of support was needed.

Figure 19: Relative Frequencies of 'If you have not previously received any therapeutic post-adoption support, why not?' of baseline respondents

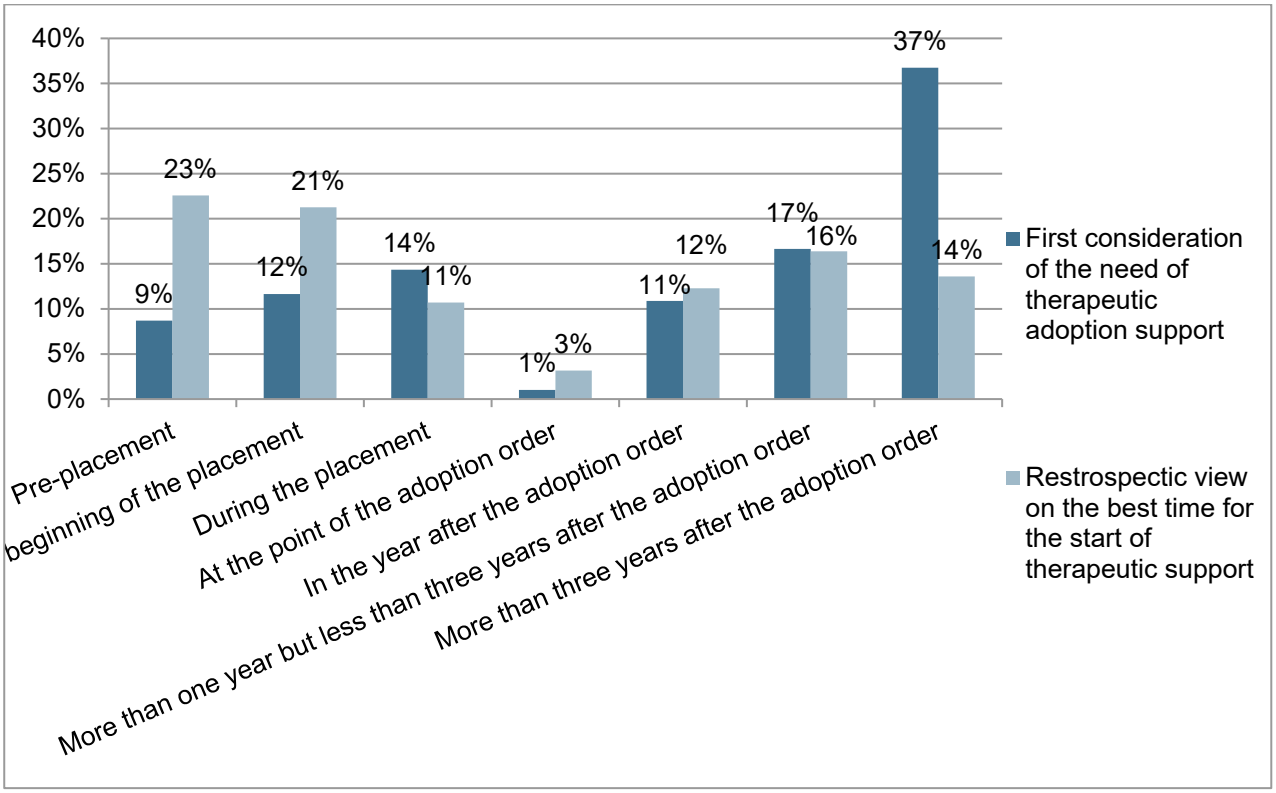


Note: N = 663; Source: Baseline survey; several selections possible.

Timing of support

Survey respondents were also asked when, in the adoption process, they first considered that their child needed therapeutic support and also to indicate from the current perspective when it would have been best for the support to start. Figure 20 compares the responses from both questions.

Figure 20: Comparison of the First Consideration of the Need of Therapeutic Adoption Support and the Retrospective View on the Best Time for the Start of Therapeutic Support of baseline survey respondents



Note: N = 781 and N = 757; Source: Baseline survey.

Comparing these 2 questions reveals that many respondents changed their opinion about when they first thought they needed support and looking back when would have been the best time to get support. Around one third (36%) of respondents said that they first thought they needed support at or before the adoption order, looking back this percentage increased to 58%.

In-depth parent interviews: the experience of ‘high levels of need’

The 20 families interviewed described their family lives since adoption and up until gaining an assessment of adoption support needs. In line with the survey findings this produced a picture of families with high support needs, who in many cases reflected that help was needed much earlier, whether or not they were aware of it at the time.

"I mean, when you go for adoption you're slightly naïve because you kind of think "well, all the children need is love and that'll conquer everything" but … you're placed with the children, got the love for them but suddenly you realise that's just not enough." (Mother)

Some parents, looking back, felt that their lack of knowledge about their children's backgrounds and how to support children with trauma and/or sensory deprivation exacerbated some issues. A number of parents wished that they and social workers had understood their child's needs better on adoption.

"We couldn't really build the picture, there's a lot…unknown still about her… it's a bit of a detective story." (Mother)

"The social worker she had didn't really know her… changes of social worker, changes of foster care, nobody actually knew the girl, it's just lack of knowledge and understanding." (Father)

Some parents reported finding things out about their children's pasts and/or witnessing distressing or worrying behaviour that they felt ill-prepared for prior to adoption. As their children settled, they started to exhibit signs of their distress and anxiety which were previously repressed, resulting in behaviour that was not present prior to adoption. This may have then led to more disclosures of information from the children that no one previously knew. In some cases there were physical medical conditions that emerged later. Particularly in relation to medical conditions there was a sense of ambiguity about the extent to which information was played down by adoption teams and pre-adopting parents, both hopeful in the positive future of adoption.

Many parents felt at the time of adopting, that they had realistic expectations of challenges, and felt ready when incidents occurred and that they could manage. As a result most families did not ask for help straight away even if they had noticed difficulties from the beginning. For others the situation was extremely challenging from the start and help was sought at an early stage. For 6 of the families, it was at least a couple of years before it became apparent that additional help was needed.

"I thought I could make it work… but it didn't work." (Mother)

The Parker Family – An example of challenges faced post-adoption

Isabelle was placed with Marie and Clive Parker in 2012 when she was a year old. Eleven months later Isabelle's new-born birth sister, Chloe, was soon placed with the family on a Fostering to Adopt placement. With adoptions formalised in 2014 and at the time of their assessment of adoption support needs in 2015, Isabelle was 5 and Chloe 3. This vignette tells the story before the ASF help began.

Before adoption, Marie and Clive believed that, regardless of the problems their children might have, the loving, stable environment they offered would have positive effects. They were ready and prepared during pre-adoption training for attachment issues and were open with workers about not adopting children with brain damage. Although the adoption report had said the birth mother might have drunk, the extent of her addictions only became clearer after 2 years of experiencing a range of issues and trying to work out what was happening. They and many professionals were not aware of Foetal Alcohol Syndrome (FAS).

From Isabelle's arrival, Marie and Clive noticed a number of problems, initially with Isabelle's eyesight, and these increased after Chloe's arrival. Both girls displayed extreme eating behaviours, easily became ill, had frequent chest infections resulting in hospitalisations and Sepsis. Alongside this, their behaviour was aggressive, obsessive and sometimes feral. Concerns were raised with professionals.

> *"We both just went from one hospital appointment to another, to another, trying to find… what was the problem… the[….] challenges and…the[...] issues." (Clive)*

Rather than the ordinary family life they had hoped for, Marie and Clive were surviving day to day. Marie changed her plan to return to work part-time, staying at home to care for the girls and finally, the family met a paediatrician who knew of and diagnosed FAS for both girls. Through further investigation and accessing numerous trainings, Marie and Clive understood more about Isabelle and Chloe's vulnerabilities. Building new therapeutic parenting techniques helped Marie and Clive's marriage but did not change the daily chaos Marie faced at home.

Having had very mixed support from their post-adoption team and asking for help ever since the girls were first placed with them, Marie and Clive were often told that they were doing a great job. When the ASF was launched, they were invited to a meeting about it, Marie attended, was encouraged to apply and therapeutic support was provided.

Family support needs at the point of accessing the Fund

Much of the evidence above suggests that that the families accessing the Fund had substantial support needs prior to the ASF becoming available and which the ASF has the potential to meet. This view was confirmed by a further examination of the responses to the baseline survey and the first round of family interviews.

8.3 Child behaviour, development and wellbeing

In the longitudinal survey child behaviour, development and wellbeing were measured by 2 different validated scales: the SDQ and the BAC-C/A.

Strengths and Difficulties Questionnaire (SDQ)

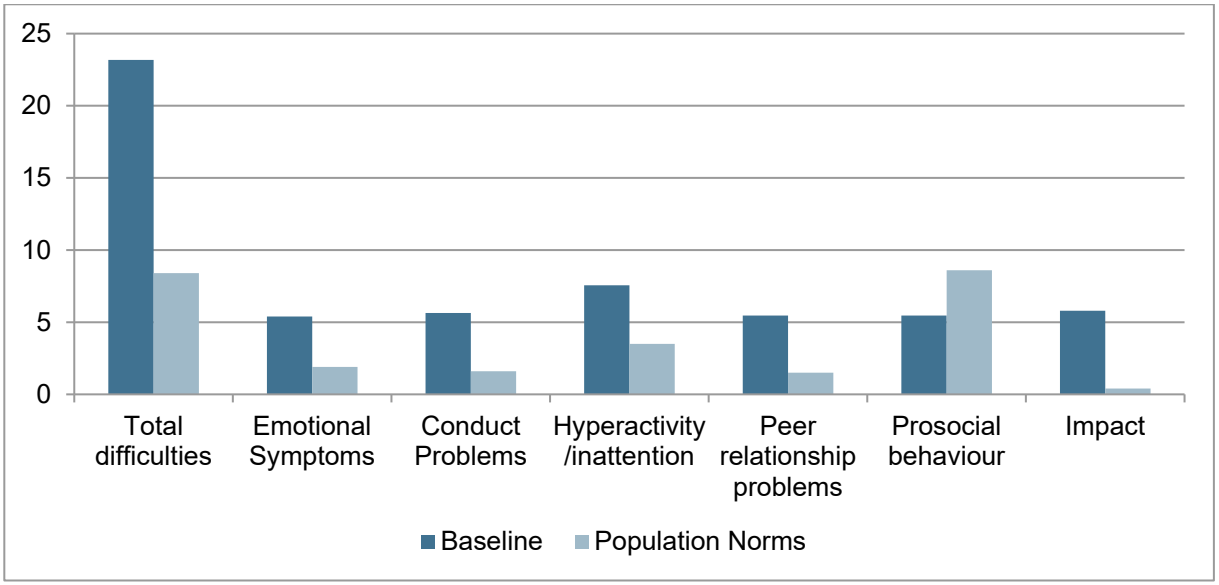
The SDQ is a screening questionnaire for behavioural difficulties and strengths, which is available in a parent-report version for children and adolescents between 4 and 17 years. The first part consists of 25 items, which are divided into 5 sub-scales each containing 5 items. The subscales assess: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and pro-social behaviours. Items are to be rated on a scale from 0 to 2, so that sum-scores per sub-scale range from 0 to 10. A total difficulties score is calculated based on 4 sub-scales excluding the pro-social sub-scale. The total score ranges between 0 and 40, where higher scores indicate greater difficulties for the child. The total difficulties scores as well as the subscales can be categorised into 'close to average', 'raised (/slightly lowered)', 'high (/low)', and 'very high (/very low)' according to specific cut-off points in relation to population means. In addition, the SDQ impact supplement was used which comprises 5 questions about the impact of the child's difficulties on different domains of their life, chronicity of difficulties, distress, and the overall burden that these difficulties place on others.[54]

Comparing the sample means to the population norms showed that the children in our sample experienced substantially higher levels of difficulties than the average for children in Britain.[55] Analysis of the scores revealed that each of the subscales scores as well as the total difficulties score of the sample significantly differed from population norms.[56] Figure 21 shows the comparison of the survey scores and population norms for the total score, each of the subscales and the impact supplement.[57] This means that the children

[54] Youthinmind, 2012.
[55] SDQ norms are for Britain rather than for England only and were created with a sample aged 5 to 15.
[56]All effect sizes can be considered as very large (Rosenthal, 1996). Again, the assumption of a normally distributed outcome was not given in each of the one-sample t-tests. As the sample is large and the corresponding non-parametric test also yielded significant mean differences at a 5% level of significance, the results of the t-tests are reported.
[57] Children that did not match the age criteria were excluded from this analysis.

represented in the survey show substantially higher levels of problems in each of the 5 dimensions of the scale.

Figure 21: Mean scores of SDQ subscales of baseline respondents compared to population norms

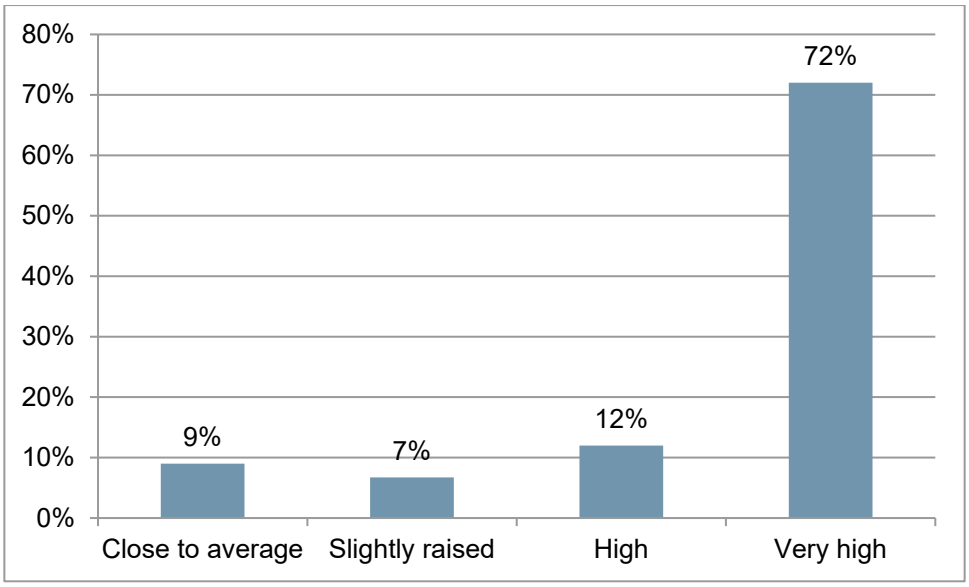


Note: N=767; Source: Baseline survey.

To further illustrate the profile of the children represented in the survey sample we applied the 4 band classification provided by the scale developer which allows for the ranking of total SDQ scores into 4 categories in relation to distance from population means. Undertaking this classifying further strengthens the view that the children in the survey face very high levels of emotional, conduct, hyperactivity and peer relationship difficulties.

Of the 767 children represented in the baseline survey only 9% were classified as ‘close to average’ and 7% as ‘slightly raised’. The majority (72%) scored as ‘very high’ and 12% as ‘high’. In line with the results on the main scale of the SDQ, the impact supplement also showed significantly higher scores for the survey sample than population norms (see Figure 22).

Figure 22: Four-band classification of children's SDQ scores at baseline



Note: N=767; Source: Baseline survey.

That the children in the sample diverge from the general population was expected, as it is well documented that adopted children, fostered and looked after children experience high levels of need.[58][59] By way of putting the level of need of this group of children in context we also sought to compare our results with those from studies conducted with similar groups of young people. While the research team found no norms on the SDQ for adopted, fostered or looked after children as are presented above for the general population, studies were found that allow for the comparison with this study's sample of children. Most relevant in this regard was Goodman, Ford, Corbin, and Meltzer's 2004 study on the use of the SDQ to screen looked-after children for psychiatric disorders. This study draws on the results of an Office for National Statistics (ONS) survey of the mental health of 5–17 year old looked after children. Based on a sample of over 1,000 children and adolescents the study attempted to calculate the reliability of the SDQ in predicating the presence of psychiatric disorders in young people.[60]

This study is doubly useful for our analysis as it not only provides an algorithm by which to calculate the probable presence of different rates of psychiatric disorders within our sample based on SDQ results, it also provides a more suitable comparison group for our

[58] Selwyn, J., Wijedasa, D., & Meakings, S. (2014). Beyond the Adoption Order: challenges, interventions and adoption disruption.
[59] Meltzer, H., Gatward, R., Corbin, T., Goodman, R., & Ford, T. (2003). The mental health of young people looked after by local authorities in England. London: The Stationery Office.
[60] Some caution should be taken in interpreting this comparison as the Goldman study draws on the wider LAC population whereas our sample solely includes adopted children who have been deemed in need of therapeutic support.

sample in terms of the level of need. Table 1 shows the predicted levels of psychiatric disorder within the sample, as broken down by type of disorder as well as a total score for the likelihood of any disorder.

Table 1: Proportion of the baseline respondents who are likely to have a disorder[61]

	Unlikely	Possible	Probable
Prediction of an emotional disorder	38.7%	11.2%	50.1%
Prediction of a conduct disorder	20.8%	14.6%	64.6%
Prediction of a hyperactivity disorder	21.7%	11.2%	67.1%
Prediction of any psychiatric disorder	5.6%	6.3%	88.2%

Note: N=768; Source: Baseline survey.

Again, to place the profile of children in our sample in context, comparing the SDQ scores with those in the Goodman et al. (2004) study the children in this study still present markedly higher levels of predicted psychiatric disorder than the comparable sample.

Table 2: Prediction of any psychiatric disorder of baseline respondents: comparison with Goodman et al. sample.

Prediction of any psychiatric disorder	Unlikely	Possible	Probable
Baseline respondents	5.6%	6.3%	88.2%
Sample of looked-after children (Goodman et al., 2004)	27.7%	26.7%	45.6%

Note: N=768; Source: Baseline survey.

[61] For a discussion of how these figures were obtained please see Appendix 1.

The Brief Assessment Checklist-Child and the Brief Assessment Checklist-Adolescent (BAC-C/BAC-A)

The BAC-C and the BAC-A are both 20 item caregiver-report psychiatric rating scales that were designed for use with looked after, fostered and adopted children and are used to identify clinically-meaningful mental health difficulties faced by children and adolescents. BAC-C is targeted at children between 4 and 11 years and BAC-A is designed for adolescents aged 12 to 17. Each of the 20 items is to be answered on a scale from 0 to 2. The total score is calculated by adding all individual scores so that the total score will range from 0 to 40. Higher scores indicate a higher level of mental health difficulties. No population norms have been published for BAC-C and BAC-A. However, as BAC is designed as a clinical screening tool similar to SDQ, a threshold criteria is provided for clinical referral. It is stated that if the total score is 5 or higher children or adolescents should be referred for further assessment to a child and adolescent mental health service or other suitable professional in case they are not already in contact with such services (Tarren-Sweeney, 2012).[62]

As the mean scores of BAC-C and BAC-A cannot be compared to population norms solely descriptive statistics are present in Table 3 below.

Table 3: Descriptive Statistics of BAC-C and BAC-A

Scale	N	Mean	SD	Median	Mode
BAC-C	494	21.20	7.65	21	18
BAC-A	258	22.93	6.29	23	18

Note: N=752; Source: Baseline survey.

Referring to the screening criteria, 99% of children and 99% of adolescents in the sample scored 5 or higher. In keeping with the findings on the SDQ, this shows that the sample represents those who have already undergone an assessment of need and have been deemed in need of support.

Aggression

In addition to the validated scales, 2 further questions sought to identify specific behavioural problems in relation to aggressive behaviour of the child towards friends or family.[63] On a 7-point Likert scale respondents are asked to agree or disagree to statements about the aggressive behaviour of their child. The majority of the respondents

[62] Tarren-Sweeney (2012)
[63] This is known to be a likely factor in the behaviour of children which is not well captured by either of the psychometric scales (Selwyn, et al.2014, Meltzer et al. 2003).

(69%) reported aggressive behaviour towards members of their family, 26% disagreed to that (M=4.84, *SD*=2.09). In contrast, only around a third (35%) indicated aggressive behaviour of their child towards friends or classmates and 56% disagreed (M=3.24, *SD*=2.01).

In-depth parent interviews: Child behaviour, development and wellbeing

To add to the above survey results, complementary questions were asked of the 20 families who participated in the first round of in-depth interviews. They were invited to begin their interview by reflecting on the family context and needs. The responses bring home the lived experience of the key issues raised in the statistics and give us an idea of what these issues could mean for children and families.

Every child described in the interviews had their own unique set of behaviours in response to a range of contexts. Common triggers were changing situations such as new environments or events or stressful activities, or specific triggers related to previous traumatic experiences. Many exhibited high levels of anxiety, low self-worth and struggled to regulate their own emotions and behaviour.

Most parents recounted experiences of their child's aggression and violence towards others, with many families speaking of aggression being targeted particularly towards the adoptive mother. A couple of young people would demonstrate anger by damaging or breaking objects. Levels of violence varied from being relatively mild to physically abusive. At least one child self-harmed. Whilst some young people only behaved like this at home, a number behaved like this elsewhere too. On some occasions, the police had to be involved.

> *"Every day felt pretty chaotic." (Mother)*

Whereas some children found it easy to make friends and many of the children were said to be popular and caring, others struggled to build relationships, were very withdrawn or were quickly falling out and fighting with friends. Controlling behaviour was frequently evident, with children unable to abide by parents' boundary setting and responding extremely when not getting their own way. Parents described children not being able to cope when someone else was taking a lead, whether through play or in life generally. A number also struggled to engage with adults, including social care professionals. Most parents linked these difficulties with attachment disorders or problems and previous experiences.

Many parents also spoke of their children's lack of awareness of danger, engaging in risky behaviour or putting themselves in vulnerable situations without awareness of consequences. Often their children may act impulsively and without thought.

> *"They were just driven by this feeling, this emotion really." (Mother)*

Half of the parents described their children getting over-excited and unable to contain themselves before or during activities. As they got older, the difference between the adopted child and their peers became starker. Indeed, a number of families said that as time went on, it became easier to see how traumatised their children were through the range of behaviours they would notice that were clearly way below the expected developmental age of their child. Many families commented on the emotional immaturity of their child and in some cases also the physical immaturity.

Following dietary and sensory deprivation, a number of children had exhibited difficulties with eating and with other functions such as balance and coordination. Other challenges included children struggling to sleep and to do things like play on their own. Constant attention and supervision from parents was often necessary. A few children had issues around toileting and a couple had demonstrated inappropriate sexualised behaviour. These were linked to anxiety, psychological and emotional effects of previous experiences as well as some medical issues. Diagnosed conditions included ADHD, Autism Spectrum Disorder and attachment disorders.

8.4 Family functioning, parental efficacy and parent-child attachment

Carer Questionnaire

The relationship subscale of the Carer Questionnaire was used to measure family functioning, parental efficacy and parent-child attachment. The Carer Questionnaire is a non-validated scale which was developed by clinical psychologists working with looked after, fostered and adopted children.[64] Following minor adjustments to make it applicable for the purpose of this study, the scale consists of 11 items on a 10-point Likert scale.[65] The score for the relationship subscale was calculated by adding all individual item scores, while the score of 3 negatively phrased items had to be reversed. The sum score can range from 10 to 100 and higher scores indicate higher levels of family functioning. No population norms exist; therefore only descriptive statistics can be reported (see Table 4).

[64] For a discussion of the rationale of using an invalidated scale and for preliminary analysis of the scale's statistical properties please see Appendix 1.
[65] One item was removed and all other relevant items were rephrased as "your child" rather than "the child" to reflect that respondents to the survey are all adoptive parents as opposed to other types of carer.

Table 4: Descriptive Statistics and Reliability of relationship subscale of 'The Carer Questionnaire'

N	Mean	SD	Median	Mode	N of Items	Cronbach's Alpha
783	62.16	15.82	63	67	10	0.87[66]

Note: N=783; Source: Baseline survey.

In-depth parent interviews: Family functioning, parental efficacy and parent-child attachment

Whilst many parents felt they had bonded well with their children following adoption, the challenges described above could often result in the family struggling to cope on a daily basis. Battles between parents and children were described by many as frequent.

> *"…we had no food in the house, because we weren't really able to go out shopping… "(Father)*

The relationship between mother and child was often the more difficult relationship within families, whether or not the mother was the main carer. Sibling relationships were mixed, many seen as usual love/hate sibling relationships, but a few presented specific challenges such as the child with the most damaging behaviour taking attention from the quieter sibling. One birth child had learnt to keep their distance from their erratic adoptive sibling.

Parents reported mixed experiences of trying to apply therapeutic parenting approaches, with many having undertaken different courses and/or training prior to the Fund being available. There were different levels of confidence in parenting skills and the tools being used. In a couple of cases, parents felt that they were unable to use therapeutic parenting without additional support. A number of parents reported that professionals identified their parenting as the 'problem' in resolving their children's issues, without taking into account the range of complex issues experienced by the family.

[66] Methodological note: Due to the non-validated status of the carer questionnaire we undertook additional analysis to better understand its psychometric properties. Following this, one item was excluded from the scale for this report. For a full discussion of this process and its implications please see the methodological appendix (Appendix 1).

8.5 The Wellbeing of Adoptive parents

Short Warwick and Edinburgh Mental Well-being Scale (SWEMWBS)

The Short Warwick and Edinburgh Mental Well-being Scale (SWEMWBS) was applied to measure parental wellbeing. SWEMWBS consists of 7 items each to be rated on a 5 point Likert-scale. Scoring involves summing up the scores of each item to a sum score ranging from 7 to 35, and then transforming the raw score to a metric score. Only for cases with no missing values were sum scores computed. In general, lower scores represent lower levels of mental well-being. In contrast to the full WEMWBS, the shorter scale relates more to functioning rather than feeling.[67]

The analysis revealed that metric scores of baseline respondents were significantly lower than available population norms provided by the scale developer (Warwick Medical School, 2001). Parents that responded to the baseline survey showed an average score of 20.75 (*SD*=3.55) compared with a population mean of 23.6, representing a mean difference of -2.85, t (766) = -22.21, $p < 0.001$. This difference yielded an effect size of -0.80, which is considered as large.[68] This finding shows that adoptive parents applying to the Fund have on average a lower level of mental well-being than the general population.

In-depth parent interviews: parent's wellbeing

Parents mentioned the strain that the challenges they faced post-adoption put on their individual mental health and relationships with each other. Many parents mentioned that they barely had time alone or as a couple to get some space. Nor did they get enough sleep when their children needed them in the middle of the night. One parent said it was difficult to look after their own physical wellbeing as a parent as they didn't have the time to exercise or eat healthily. One set of parents had divorced since adoption.

A number of mothers felt at the end of their adoption leave that they couldn't go back to work because of the extent of their children's needs. In 2 families, the father took up the main caring role. This division in parenting roles has brought some challenges for the parents themselves, as they lose their identity as working professionals and their world becomes centred on traumatised children. Furthermore, for the working parent, feelings of guilt for not being around more to help were expressed.

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[67] (Warwick medical school, 2013).
[68] The assumption of a normally distributed outcome was not given by the means of the Kolmogorov-Smirnov test. However, the t-test is shown to be robust when the sample is large, i.e. >30, and the corresponding non-parametric test also yielded a significant mean difference at a 5% level of significance (Weinberg, & Abramowitz, 2002). For these reasons the results of the parametric test are reported.

Some parents spoke of the extra cost of funding extra-curricular activities for their children, private tutoring and/or resources such as sensory toys and therapeutic books. In some cases, they were frequently replacing lost or damaged items in the house. Being an adopter was found, by some, to bring additional costs at a time when household income was shrinking.

Those families that hadn't already had birth, adopted or foster children also had the challenge of becoming new parents, developing their own parenting style and feeling guilty when they used traditional parenting techniques.

> *"…if you're disciplining them, for whatever reason, and ..." (Father)*
>
> *"... and then you feel bad..." (Mother)*
>
> *":…you know, this poor…girl…" (Father)*
>
> *":.. already feels bad and I'm telling her off!..." (Mother)*

Additionally, having less access to informal support, with whom parents can talk about how things really are, left parents feeling isolated and drained.

> *"Parental wellbeing is not considered. You put up with a lot because you think other families are worse off." (Mother)*
>
> *"…it's just horrible, how it makes you feel. I ended up on Beta Blockers in the early days, cos of heart, heart palpitations." (Mother)*

8.6 Conclusion

The picture that emerges from the survey and interview data is of families accessing the ASF who have both long standing and profound support needs. Many parents indicated that they had not fully understood the level of challenges they would face on adoption and that looking back they may have needed support earlier that they sought it. Nevertheless around half of all survey respondents reported having sought post-adoption support prior to the Fund being available, in many cases more than once.

Since the introduction of the ASF, 10,231 families have made a successful application to the ASF.[69] The profile of these families is one of very high levels of need. A substantial proportion of children show the effects of early childhood neglect and abuse with commensurate predicted levels of emotional, behavioural, developmental and psychiatric

[69] As of 7th March 2017.

problems. Parents reported a wide range of difficulties and struggles in parenting and indicated strongly that these had had a detrimental effect on their own mental health and wellbeing. These findings are both in keeping with what is known about the population of adopted children and families in the UK in general and very much support the rationale for increasing the level of support offered to adoptive families underlying the ASF.

The very high level of need may also reflect the fact that much of the evidence presented was derived from those families accessing support when the Fund first went live, as recruitment for the longitudinal survey and the family interviews was drawn from the first 12 months after the Fund started. Therefore there is a possibility that these families display even higher needs than will subsequent applicants as they were the most motivated to seek help urgently or in many cases were families already in contact with local authorities due to existing needs when the Fund became available.

9 Has the ASF improved the lives of adopted children and families?

Key findings

- Between the baseline and follow-up surveys, children receiving support through the ASF showed:
    - improved behaviour and mental health;
    - a small reduction in the predicted prevalence of psychiatric disorders among the sample of children; and,
    - a small decrease in aggressive behaviour.
- A very high proportion of parents (84%) believed that the ASF had helped their child.
- Despite positive changes on most indicators, children's needs remained extremely high and complex at the follow-up survey stage.
- The functioning of families in receipt of support through the ASF improved, with the greatest improvement being seen in parents':
    - understanding of their children's needs; and,
    - increased confidence in taking care of their children.
- A large majority of survey respondents believed that the support provide through the ASF had:
    - helped them as a parent (85%);
    - helped their family as a whole (82%); and,
    - made the adoption placement more stable and less likely to break down (66%).
- Individual family situations are highly complex but there was a widespread view from parents and professionals that the ASF has made possible the provision of therapies that help to meet complex needs.
- Parents in families receiving support through the ASF saw modest but meaningful improvements in their wellbeing.
- Parents said that with the benefit of hindsight their families would have benefited from earlier therapeutic support and particularly therapeutic parenting training.

9.1 Introduction

This chapter outlines the evidence from the evaluation concerning the question of whether accessing services through the Adoption Support Fund improved the lives of adopted children and families. It combines evidence from each of the sources of evaluation data, particularly drawing on the longitudinal survey and longitudinal family interviews.

Of particular importance here is the longitudinal survey which aimed to measure change across the following domains:

(1) Child behaviour, development and wellbeing;

(2) Family functioning, parental efficacy and parent-child attachment; and,

(3) The wellbeing of adoptive parents.

The survey sought to measure these factors with a combination of validated psychometric scales and complementary non-validated questions. Each set of questions appear identically in both baseline and follow-up questionnaires, thus permitting a distance travelled approach to be taken where significant changes between baseline and follow-up responses are identified and reported. Of the 792 respondents that completed the baseline survey 481 also completed the follow-up survey representing a response rate of 61%.[70]

The family interviews, due to the longitudinal approach taken, permit us a window into the lived experience of families receiving a service and has allowed them to make explicit the ways in which they feel the Fund may have helped them. In addition, the views of local authority staff are included on the impact that the ASF funded services have had for families.

In this study, the object of evaluation is the ASF as a whole rather than the effectiveness of any particular therapeutic intervention accessed through the Fund. When we discuss outcomes and their relationship to the Fund, these relate both to the therapeutic support received and the process surrounding that support, including interactions with local authority staff and assessments procedures. It is not possible to disaggregate the sources of benefits.

[70] A full analysis of the profiles of baseline only respondents and baseline and follow-up respondents is shown in Appendix 1: Methodology: Comparison for profiles. While small variations in the demographic profile of the 2 samples were found these do not to represent a large source bias in the sample.

Another layer of complexity to consider is that the families involved in this evaluation received different types of therapies and at different dosages. Evidence of effectiveness of many of the interventions funded under the ASF remains under-developed and patchy.[71]

Attribution

In addressing the research questions this section summarises the changes observed over time between baseline and follow-up waves of the longitudinal survey across each of the psychometric measures. In all cases where a longitudinal finding is reported in this chapter it is based on the sample respondents who completed both waves of the survey. This represents a distance travelled approach, allowing the research team to identify statistically significant changes over the course of the survey. Alone, this data cannot be used to attribute change to the Fund as a control or comparison group was not possible within the parameters of the evaluation and other factors, not captured by the survey, may account for these changes. Therefore claims on impact of the Fund cannot be made solely on the basis of the longitudinal survey evidence. This limitation was central to the inclusion within the wider evaluation of multiple data sources that aid with the attribution of any changes identified through the survey. Moreover, the following approaches were taken to address the issue of attribution as far as possible.

- Sub-group analysis of those families who have completed their therapeutic interventions against those who have not: by comparing those families who had completed their courses of support with those who had not (or who had not started) we were be able to infer the impact of the support;
- Additional survey questions that ask respondents to explicitly attribute change in their families' circumstances to receipt of the Fund. In addition to the longitudinal application of scales such as the SDQ, additional questions were included in the follow-up survey that asks respondents to directly ascribe impact to the support they have received. The results of these questions are in the below section; and,
- Triangulation with other data sources: information about the perceived impacts of the Fund were sought through each strand of the evaluation, most importantly through the family interviews but also through the local authority and provider interviews as well.

This evaluation finds modest but meaningful improvements for beneficiary children and families across the 3 outcomes domains. Outcomes detected for children were the least

[71] A recent Department for Education review by the Tavistock Institute classified 15 of the most popular therapeutic interventions for adopted children in 4 categories to denote the current state of evidence. Notably some of the most used interventions such as DDP and Theraplay remain largely unevidenced with regards to their effectiveness with adopted children. https://www.gov.uk/government/publications/post-adoption-support-interventions-independent-evidence-review

substantial in statistical terms across the 3 domains, a fact that was borne out by interview evidence, which suggests that improvements in children's behaviour and mental health were modest where they were observed at all. This finding is in keeping with what is already well known about adopted children with developmental, emotional and psychological problems as a result of early childhood neglect or trauma. These problems are known to be resistant to intervention and unlikely to show improvement over relatively short periods of time, such as the approximately 7 months between the 2 waves of the survey and family interviews. Both parental wellbeing and family functioning were shown to have improved. Again this improvement was modest. The corroboration of the family and local authority interviews adds weight to the conclusion that small but meaningful improvements have been achieved in the situations of those families accessing the Fund.

9.2 Child behaviour, development and wellbeing

Key findings: Child behaviour, development and wellbeing

- Between the baseline and follow-up surveys, children receiving support through the ASF showed:
  - improved behaviour and mental health;
  - a small reduction in the predicted prevalence of psychiatric disorders among the sample of children; and,
  - a small decrease in aggressive behaviour.
- 84% of respondents felt the support through the ASF had helped their child.
- Despite positive changes on most indicators, children's needs remained high and complex at the follow-up survey point.

This section describes the results of the longitudinal survey in relation to the **outcome of improved child behaviour, development and well-being**. Data from the family interviews and the local authority case studies provide both context and corroboration of key findings.

This outcome was measured with a combination of the SDQ and BAC validated psychometric scales and supplemented by individual questions specific to the survey. In order to identify whether the children represented in the survey had improved over time in their behaviour, development and wellbeing, baseline scores of SDQ and its subscales as well as the BAC were compared with the corresponding follow-up scores by the means of significance tests. In addition to descriptive statistics and results of the significance tests, effect sizes are reported. While significance tests are used to judge if

an observed effect in the sample is due to sample error or can be generalised to the population, effect sizes provide information about the magnitude of an effect (e.g. change between 2 measurement points or difference between 2 groups). Effect sizes are calculated in a way that allows for comparison across different outcome measures. To interpret effect sizes, usually the context and the intensity of the intervention should be considered as well as effect sizes of similar studies. In some cases, even very small effect sizes could make a substantial difference. When no comparable data is available conventions exist that allow for an interpretation of the effect sizes. For the example of the effect size Cohen's d effect sizes of around d=0.3 are regarded as small, around d=0.5 as medium, and effect sizes around d=0.8 as large. The following sections summarise the results of these analyses.[72]

Strengths and Difficulties Questionnaire

The SDQ is a screening behavioural questionnaire for children between the ages of 4 and 17, consisting of 25 items, divided into 5 sub-scales. The total score ranges between 0 and 40, where higher scores indicate greater difficulties. The first step in the analysis was to compare the SDQ scores reported by families before or early in receiving a therapy via the ASF and 7 months later.

Table 5 and Figure 23 show the comparison of the mean scores for each subscale of the SDQ and the total score at baseline and follow-up. Each subscale represents a different dimension of the child's mental health, behaviour, or relationships with others.

[72] The statistical explorations referred to in the chapter are shown in detail in Appendix 1.

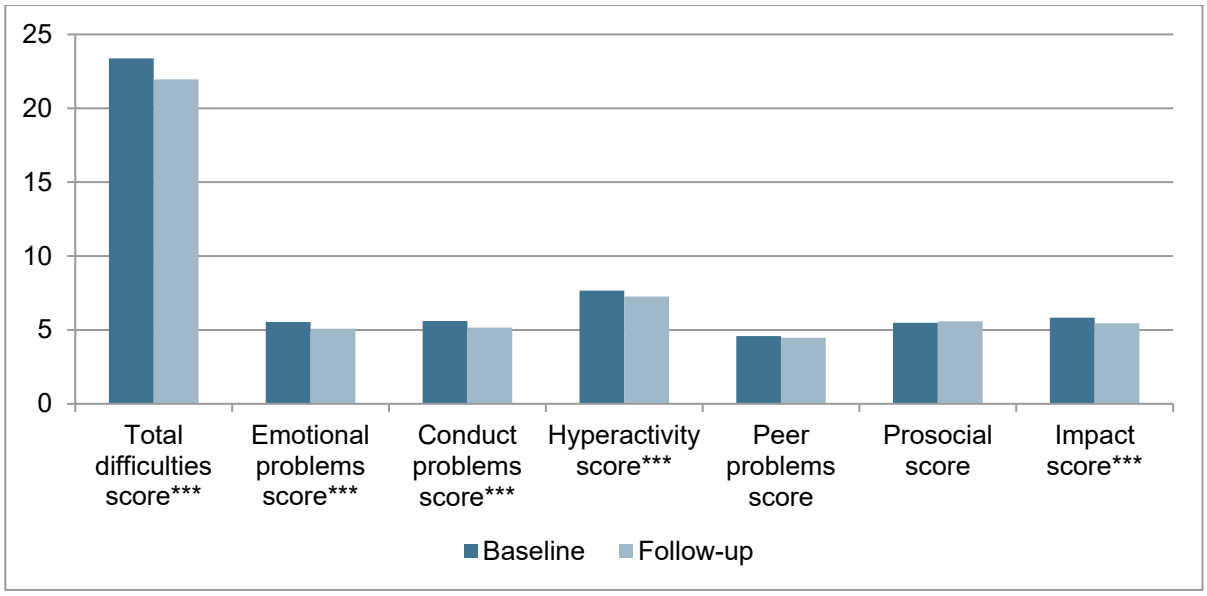
Table 5: Comparison of SDQ means of baseline and follow-up data

Scale		Baseline Mean (*SD*)	Follow-up Mean (*SD*)	Mean Diff (CI)	*df*	*P*	*Effect size d*[73]
SDQ	Emotional Symptoms	5.54 (2.63)	5.09 (2.51)	.45 (.24; .66)	429	<.001	.18
	Conduct Problems	5.60 (2.34)	5.16 (2.43)	.44 (.25; .62)	430	<.001	.18
	Hyperactivity /inattention	7.66 (2.33)	7.26 (2.36)	.40 (.21; .59)	430	<.001	.17
	Peer relationship problems	4.58 (2.42)	4.47 (2.46)	.11 (-.06; .28)	430	.212	.05
	Prosocial behaviour	5.49 (2.18)	5.58 (2.19)	-.10 (-.27; .07)	429	.255	.04
	Total score	23.37 (6.42)	21.96 (7.03)	1.41 (.88;1.95)	429	<.001	.21
	Impact	5.83 (2.64)	5.45 (2.78)	.38 (.17; .59)	428	<.001	.14

Note: *SD* = Standard Deviation, CI = Confidence Interval, *df* = Degrees of Freedom, *p* = Probability of the observed or a more extreme difference under the assumption that the null hypothesis is true, i.e., there is no difference in the mean between the baseline and the follow-up data, *d* = Standardized Mean Difference – Cohen's d; Source: Baseline and follow-up survey.

[73] Effect sizes can be regarded as very small to small according to conventions.

Figure 23: Comparison of SDQ means of baseline and follow-up data



Note: N=429-N=431; Source: Baseline and follow-up survey; * indicates significance at $p<0.05$ level; ** $p<0.01$; *** $p<0.001$.

The analysis shows that a statistically significant decrease was observed on the SDQ as a whole, indicating that on average the children represented in the sample showed improved mental health and behaviour between the 2 waves of the survey. Among the constituent subscales of the SDQ the Emotional, Behavioural, and Hyperactivity/Inattention subscale also showed significant decreases suggesting that it was particularly these aspects of the children's lives that improved. Significant change was not recorded on either the Peer problem or Pro-social behaviour subscales of the SDQ. The impact score also showed significant improvements indicating that the overall impact of the children's problems on their lives had been reduced.[74] In each case, while the results were statistically significant the effects sizes were small or very small indicating that the while improvements were observed these were modest.

The Baker Family: changes in child's behaviour and wellbeing since the ASF support

Janine and Samuel adopted 9 year-old Terry, aged 21 months old, following a stable foster placement and birth family contact since birth. Both relationships stopped on adoption. Whilst initially seeming settled, once Terry began school, anxieties and anger started to appear. Terry was compliant at school but at home became violent and uncontrollable. New events and changes to routines were

[74] This is derived from the SDQ 'impact supplement', an additional set of questions that aim to capture the impact of a child's problems on differ areas of their life (see Appendix 4)

over-stimulating and increasingly difficult. Support provided by Terry's school varied each year and an assessment of need by the post-adoption team concluded that Terry's needs were not high enough for ongoing support. A CAMHS referral was refused, although short-term support was provided sporadically. By Christmas 2014, the family were near to breaking point. In April 2015, Janine approached the local authority for help and was told about the ASF.

As well as being referred for the ASF-funded Filial Therapy and Dyadic Developmental Psychotherapy, the post-adoption team supported Janine and Samuel in discussions with the school. As a result, the school accessed training, adapted their approaches and Terry became more settled. The post-adoption worker did some life story work with Terry before Janine and Terry began Filial Therapy in January 2016. By May 2016, both parents had begun DDP. Already, life and Terry's behaviour was becoming calmer.

> *"…he is actually finally believing that he is going to be here..."(Samuel)*

Janine and Samuel felt better able to cope with challenges ahead and were hopeful that Terry would develop better self-regulation, leading to smoother future transitions, better relationships and more positive life outcomes. After 7 months of therapy, Janine and Samuel could see Terry's development.

> *" …He is talking to us more about stuff…" (Janine)*

Terry was behaving less violently, with fewer angry outbursts. It seemed that speaking more about his feelings was reducing the need to act them out. Changes to routines, and times such as Christmas though, still caused more challenging behaviour.

> *"He still …gets angry and screams at us and shouts at us, sometimes throws small things…They have improved, yeah…." (Janine)*

A recent teacher change meant that Terry was struggling more at school without appropriate support, with a knock-on effect at home. Despite this and having post-adoption worker support withdrawn, Janine and Samuel felt that the ASF-support had helped. They learnt additional therapeutic parenting skills and believed that their improved responses to Terry seemed to positively affect Terry's behaviour.

> *"…Yeah, I think it is getting better, but I think we might be getting better at doing it as well. So…the more we do it, I think the better it will get." (Samuel)*

Janine and Samuel expected the process to take a long time but reflected that the support provided had already made a big difference to their lives.

> *"…I don't know that he would still be here if we hadn't had that…we were struggling." (Janine)*

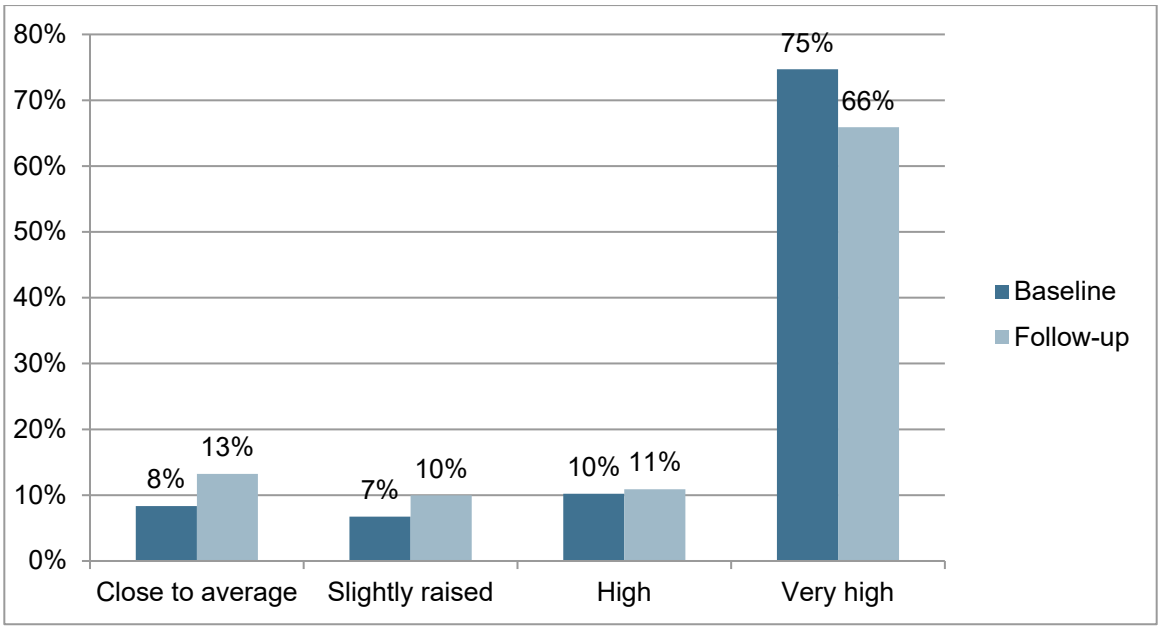
Additional evidence of direction of travel in SDQ scores

To help readers understand what the results of the above SDQ analysis mean, in addition to exploring the mean change on the total difficulties score of the SDQ, the SDQ responses were analysed in terms of the 4 part classifications provided by the scale developer. This classifies each child's total SDQ score into one of either "close to average", "slightly raised", "high" or "very high".[75] This classification places each score in relation to norms derived from children in the general population. This analysis showed that at the level of the individual child the majority of children represented in this sample, slightly over two-thirds (67.7%), remained in the same category between baseline and follow-up, 9.7% children moved into a more severe category (for example, from "slightly raised" to "high") while 22.5% of children improved by at least one band. This shows that the change observed was modest and did not apply to all the children in the sample, with most not showing measurable improvement when viewed through the 4-band classification. This analysis also highlights that a small proportion of the children actually showed a deterioration between the 2 waves of the survey.

Figure 24 shows more fully the results the SDQ data viewed through the 4-band classification.[76]

[75] The four-band categorisation is also discussed in the previous chapter Needs of children and families accessing the ASF (Scoring the Strengths & Difficulties Questionnaire for age 4-17, 2014).
[76] Percentages in Figure 24 differ from those reported in the previous chapter as for the comparison of baseline and follow-up data only respondents that completed both surveys are included in this analysis. This is true for all other comparisons of baseline and follow-up data described in this chapter.

Figure 24: Four-band categorisation of total difficulties score at baseline and follow-up



Note: N=431; Source: Baseline and follow-up survey.

This figure clearly shows a reduction over the course of the survey of children falling into the highest category of severity, with increases in each of the other 3 categories, the largest of which is the increase in children falling into the "close to average" category. Again this supports the view that overall children's mental health and behaviour improved over the course of the receiving support through the Fund.

How far can we say changes to the SDQ scores are attributable to the ASF?

As already discussed, the design of the longitudinal survey does not permit the direct attribution of observed changes to the ASF. The developers of the SDQ provide an 'added value' calculation to address the issue that the children with high need typically presenting to services are likely to improve overtime irrespective of intervention.[77] This means that one would expect a certain degree of improvement on the SDQ scores without any support having been provided.

Once this further analytic step is applied to the dataset the initially significant changes reported in the above section do not sustain and in fact the calculation returns a negative mean.[78] This would suggest that children accessing support through the Fund fared worse

[77] For a discussion of the factors behind this assumption please refer to the SDQ developers website: http://www.sdqinfo.com/c5.html

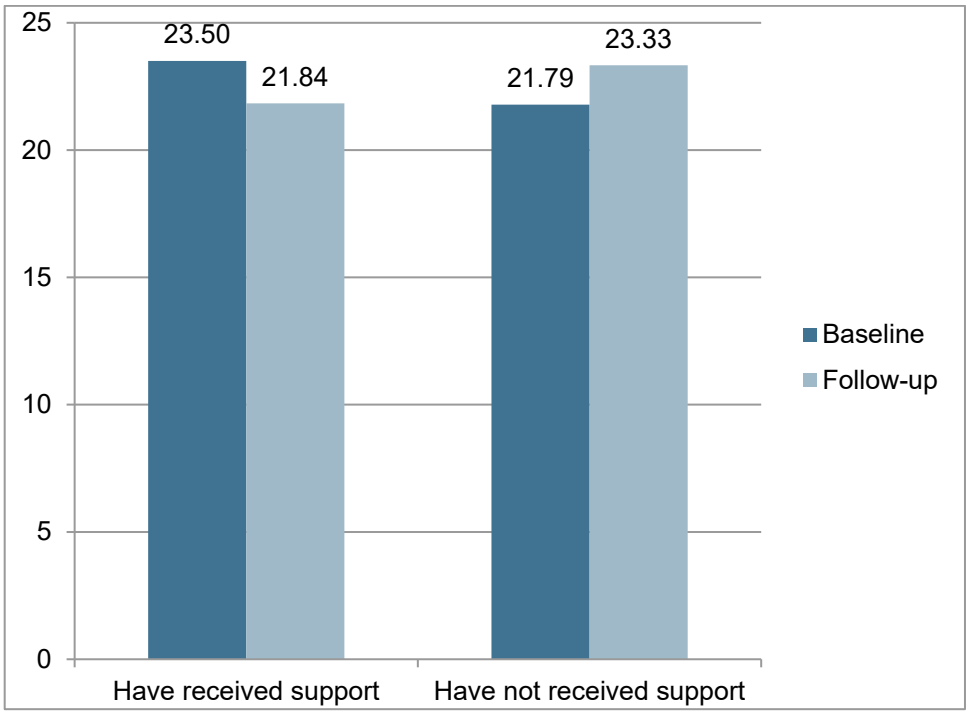
[78] Greater detail on this analysis and the context of the decision to reject its finding in this instance is elaborated in Appendix 1: Statistics in detail.

than would be expected had they received no support at all. However, for this profile of children the range of problems are known to be so severe that the usually observed improvement without intervention may not apply in this instance.[79] Moreover this finding is contradicted by both qualitative data from families and professional and by self-attributed survey responses by families.

In further investigating this question, we were able to look at the results of the psychometric scales of children from families where no one had received any support in between the 2 waves of the survey.

Figure 25 shows the difference between the 2 groups in terms of their total SDQ scores at baseline and follow-up. It clearly shows that the non-intervention group's scores increase while the intervention groups' decrease.

Figure 25: Total difficulties mean scores at baseline and follow-up



Note: N=419; Source: Baseline and follow-up survey.

To make sure that the non-intervention group is a reasonable comparison we analysed the characteristics of this group and compared them with the group of families receiving support. While this de facto non-intervention group is small (n=30) this further analysis

[79] Sonuga-Barke, E. J., Kennedy, M., Kumsta, R., Knights, N., Golm, D., Rutter, M., & Kreppner, J. (2017). Child-to-adult neurodevelopmental and mental health trajectories after early life deprivation: the young adult follow-up of the longitudinal English and Romanian Adoptees study. *The Lancet*.

showed that it did not differ from the full sample in significant ways, other than the fact that these families had not received services. This finding allows us to be more confident that this group provides a useful comparison to the main sample and suggests that the assumptions behind the added value calculation are not valid in this instance.

Change in predicted presence of psychiatric disorders over time using the SDQ

The SDQ has been used as a clinical screening tool for children and young people to evaluate whether a particular young person presents sufficiently severe issues to be considered indicative of diagnosis with a mental health problem. In addition to the other analyses of the SDQ, it is useful to illustrate the changes observed within the sample of children and young people in terms of how this might be interpreted clinically. The SDQ results were analysed using the algorithm that allows the prediction of the presence of psychiatric disorders within the sample. In seeking to quantify the change observed over the course of receiving support through the ASF, we compared the results derived through this process at baseline and follow-up. These changes are compared with the data from a study that represents 1,028 looked-after children between 5 and 17 years from an English survey conducted by the Office for National Statistics.[80] The results of this calculation are shown in Table 6.

Table 6: Prediction of any psychiatric disorder of follow-up respondents at baseline and follow-up: comparison with Goodman et al. sample

	Unlikely	Possible	Probable
Baseline	5.5%	6.5%	88.0%
Follow-up	10.4%	11.3%	78.3%
Sample of looked-after children (Goodman et al., 2004)	27.7%	26.7%	45.6%

Note: N=433; Source: Baseline and follow-up survey.

As with the previous SDQ analysis the table illustrates a small but significant improvement of the children's scores and a small reduction in the predicted prevalence of psychiatric disorders within the group but still shows that the prevalence of predicted disorders is substantially higher than in the sample of looked after children.

[80] Goodman, R., Ford, T., Corbin, T., & Meltzer, H. (2004). Using the Strengths and Difficulties Questionnaire (SDQ) multi-informant algorithm to screen looked-after children for psychiatric disorders. European Child & Adolescent Psychiatry, 13, ii25-ii31.

Brief Assessment Checklist (BAC-C and BAC-A)

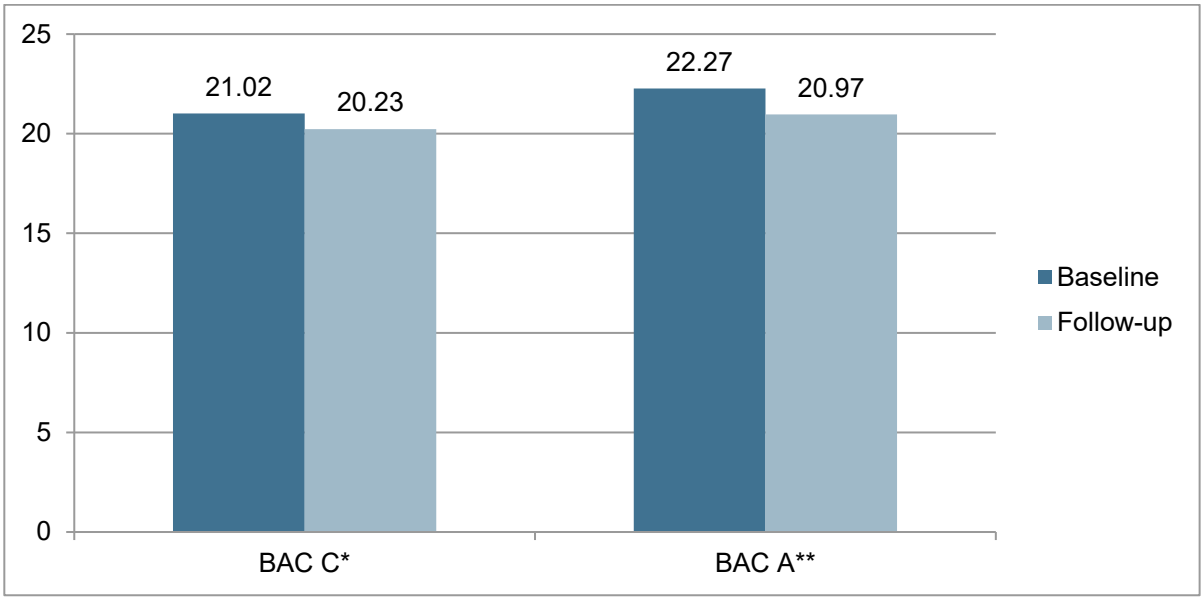
The BAC was deployed in the survey to complement the SDQ so as to give a more robust picture of children's behaviour, development and mental health. In keeping with the results of the SDQ analysis, a statistically significant reduction in mean score was observed on both child and adolescent versions of the BAC over the course of the survey. As was found with the SDQ analysis, the corresponding effect size was very small but significant (0.1 and 0.19 respectively for the BAC-C and BAC-A), indicating that the observed change was modest. Table 7 and Figure 26 show the comparison of the mean scores for the BAC-C and BAC-A at baseline and follow-up.

Table 7: Comparison of BAC mean scores of baseline and follow-up data

Scale	Baseline Mean (*SD*)	Follow-up Mean (*SD*)	Mean Diff (CI)	*df*	*P*	*Effect size d*[81]
BAC-C	21.02 (7.56)	20.23 (8.03)	.79 (.14; 1.44)	260	<0.05	.10
BAC-A	22.27 (6.18)	20.97 (7.16)	1.30 (.41; 2.19)	136	<0.01	.19

Note: N=261 and N=137; Source: Baseline and follow-up survey; *SD* = Standard Deviation, CI = Confidence Interval, *df* = Degrees of Freedom, *d* = Standardized Mean Difference – Cohen's d.

Figure 26: Comparison of BAC means of baseline and follow-up data



Note: N=261 and N=137; Source: Baseline and follow-up survey; * indicates significance at $p<0.05$ level; ** $p<0.01$; *** $p<0.001$.

[81] Both effect sizes can be considered as small according to conventions.

The BAC is used as a clinical screening tool, with scores over a threshold indicating the presence of clinically meaningful symptoms that should trigger treatment or further assessment. A very high proportion of children represented in the survey met this threshold on each scale at the baseline (98.9% for the BAC-C and 99.27% for the BAC-A). To help illustrate the magnitude of change observed over time this same calculation was undertaken with the follow-up data. A small reduction was observed in the proportion of children meeting the clinical threshold. However, this still left the vast majority of children above the threshold (96.9% for the BAC-C and 98.54% for the BAC-A).

This data shows that while improvements have occurred, children who accessed the Fund remain an exceptionally high need group even after receiving therapeutic support, prompting the view that this group will need ongoing support and intervention rather than single interventions. Table 8 shows a comparison between baseline and follow-up waves of the survey in terms of the proportion of children within the sample meeting the clinical threshold.

Table 8: Comparison of sample proportions meeting the clinical threshold at baseline and follow-up

	Baseline	Follow-up
BAC-C	98.9%	96.9%
BAC-A	99.2%	98.5%

Note: N=261 and N=137; Source: Baseline and follow-up survey.

Aggressive conduct

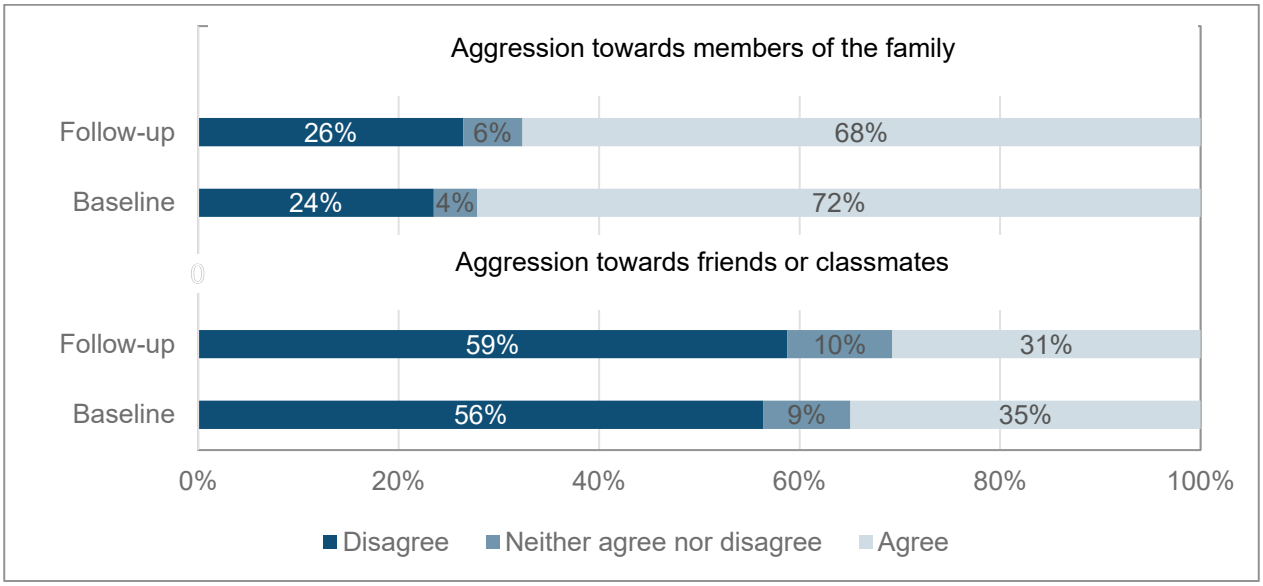
To supplement the validated scales outlined above, 2 additional questions on aggressive conduct were included in the longitudinal survey of adopted families at both baseline and follow-up. These 2 questions covered the aggressive behaviour of their child towards (i) friends or classmates, and (ii) members of the family. The questions were included as aggressive conduct is known to be an issue for adopted children and is not covered by either of the standardised scales.[82] On a 7-point Likert scale respondents are asked to agree or disagree to statements about the aggressive behaviour of their child.

On both questions the analysis showed a statistically significant decrease between the 2 waves of the survey in reported aggression. At follow-up, the majority of the respondents (68%) agreed that their child showed aggressive behaviour towards members of their family, down from 72% in the baseline. Whereas 26% of respondents disagreed with this statement, up from 24% in the baseline (M=4.84, *SD*=2.09). In contrast, only around a

[82]Brodzinsky, D. M., Radice, C., Huffman, L., & Merkler, K. (1987). Prevalence of clinically significant symptomatology in a nonclinical sample of adopted and nonadopted children. *Journal of Clinical Child Psychology*, *16*(4), 350-356.

third (31%) indicated aggressive behaviour of their child towards friends or classmates down from 35% at baseline and 59% disagreed, up from 56% (M=3.24, *SD*=2.01). Table 9 compares these results with those from the baseline, showing that small but significant improvements were reported in both cases.

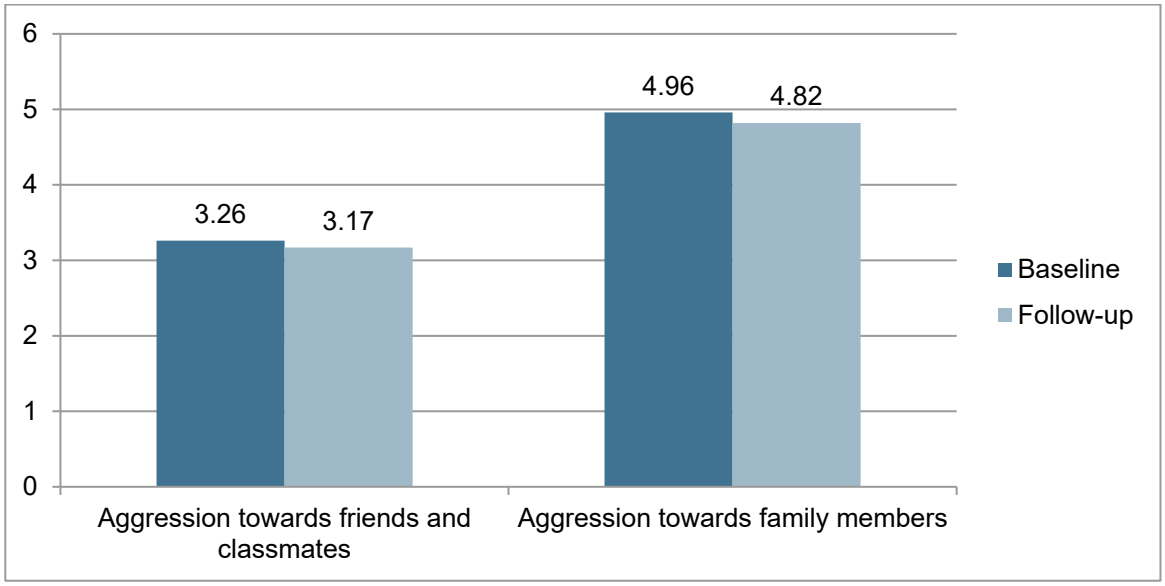
Figure 27: Comparison of aggression at baseline and follow-up



Note: N=435 and N=438; Source: Baseline and follow-up survey.

Figure 28 and Table 9 further illustrate this change by showing the difference between mean scores on the 2 questions at the 2 time points. However, and as with the 2 validated scales, the effect size recorded for these changes is very small (<0.1) despite being statistically significant.

Figure 28: Aggression mean scores at baseline and follow-up



Note: N=435 and N=438; Source: Baseline and follow-up survey; * indicates significance at $p<0.05$ level; ** $p<0.01$; *** $p<0.001$.

Table 9: Aggression mean scores at baseline and follow-up

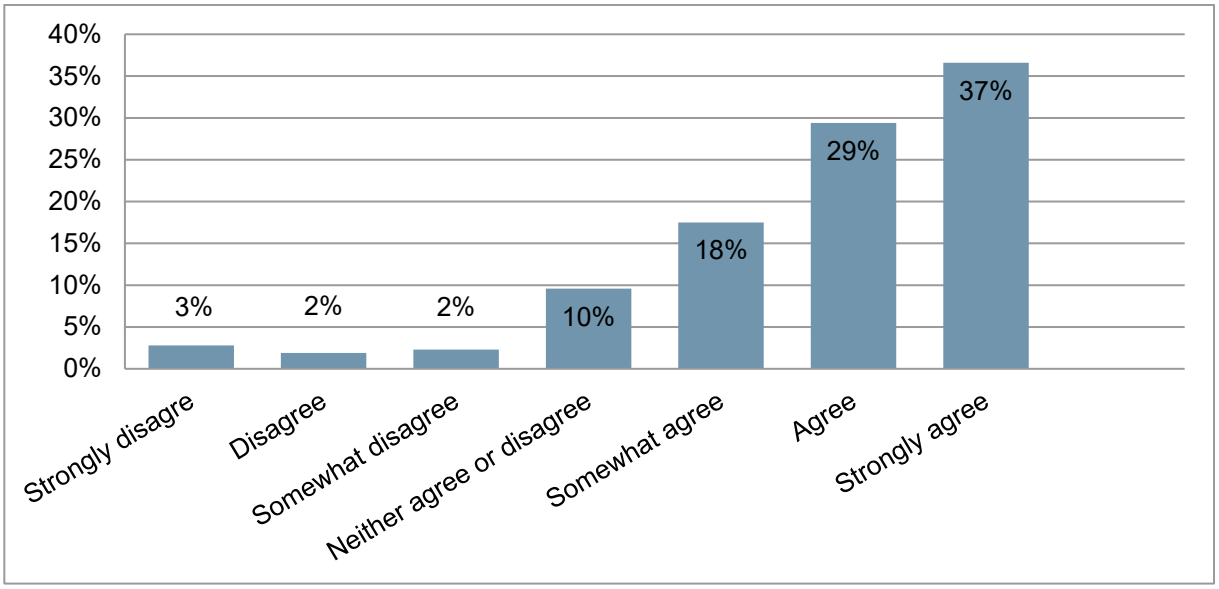
Question	Baseline Mean (*SD*)	Follow-up Mean (*SD*)	Mean Diff (CI)	*df*	*p*	*Effect size d*[83]
Aggression towards friends	3.26 (1.94)	3.17 (1.84)	-.09 (-.24; .07)	434	.27	.05
Aggression towards family	4.96 (1.95)	4.82 (1.97)	-.14 (-.30; .02)	437	.08	.07

Note: N=435 and N=438; Source: Baseline and follow-up survey; *SD* = Standard Deviation, CI = Confidence Interval, *df* = Degrees of Freedom, *d* = Standardized Mean Difference – Cohen's d.

Respondent attributed outcomes and online survey results

In addition to the validated scales and aggressive conduct questions, respondents of the longitudinal survey were asked to reflect on the impact that accessing the Fund had had on their child and report the extent to which they agreed with the statement "Receiving support through the ASF has helped my child for whom we applied to the Fund". Figure 28 shows the breakdown of survey responses.

Figure 29: Relative Frequencies of the 'Receiving support through the ASF has helped my child for whom we applied to the Fund' of follow-up respondents



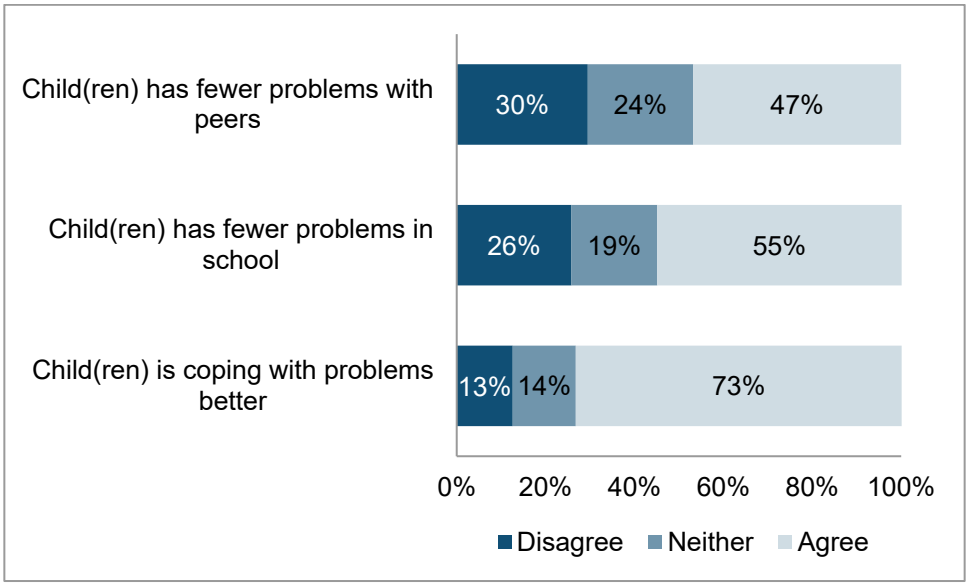
Note: N=429; Source: Follow-up survey.

[83] Both effect sizes can be considered as very small.

Somewhat in contrast with the limited change recorded through the longitudinal questions, responses to this question showed that when asked to directly attribute impact to the therapeutic support received through the Fund, the substantial majority of respondents indicated that they believed the support had benefitted their child. Almost 5 out of 6 (84%) respondents felt to some extent that the ASF had helped their child, with only 7% indicating that they disagreed with the statement.

In addition to these findings the online survey of adopters identified a subset (203) of respondents that had received support through the ASF.[84] 73% of respondents to the online survey agreed that accessing the ASF funded therapy helped their child cope with problems better, however only about half found the support had a positive impact on their child's behaviour in school and with peers (see Figure 30).

Figure 30: Relative Frequencies of impact of services received through the ASF for respondents of the online survey of adopters



Note: N=183 to N=171 depending on item; Source: Online survey of adopters 2016.[85]

Comments to this question pointed out that many families have just started to receive support or only had had the assessment so far, so it is too early to judge the impact of support. Some respondents to this question also indicated that they expected any improvements associated with support to take a long time before they would become apparent.

[84] See Appendix 1 - Methodology
[85] Strongly disagree', 'Disagree', and 'Somewhat disagree' are merged into 'Disagree', 'Strongly agree', 'Agree', and 'Somewhat agree' are merged into 'Agree'.

"It's a long term process that will be a roller coaster ride until she has learnt to deal with her past trauma";

"My daughter is having more problems but training has definitely helped us cope and possibly even prevented breakdown in the family unit" and

"My son is having therapy that in the short time it is causing him more issues as he is working through what his issues are".

In-depth parent interviews: changes in child behaviour, development, and mental health[86]

The picture that emerges from the longitudinal survey in relation to outcomes for children is one of modest but meaningful improvements. In this section we explore findings from the family interviews to better understand what the changes found in the survey look like at the level of the individual family.

During the first family interviews, parents spoke about a range of hopes for their children as a result of receiving support. These included hopes that their children would become better able to understand themselves; self-regulate and manage their emotions; express themselves and communicate; build relationships and trust with others. There were also hopes of increased confidence, resilience, self-esteem and self-worth.

At the second interview many families articulated a range of improvements in their child's behaviour. Apart from one family whose adoption had broken down, and those who had not yet started therapy by the second interviews (3), all other families were able to identify some improvements in their children's behaviour and in some cases, mental health. Some of these improvements were put down to getting older and naturally becoming more mature. However, it was cautiously felt by all of these families that positive changes had been, in some cases only partially, as a result of receiving therapeutic support.

> *"It's important I suppose to acknowledge that without the application to the Fund a lot of all these other things wouldn't have happened. So if nothing else, in my head, anecdotally, I can link those 2 things together, you know?" (Mother)*

In all cases, the child's behaviour could still be challenging, but even small improvements were felt to make a big difference. In this sense the parent's descriptions of changes in

[86] In this chapter the results of the family interviews are divided thematically between the 3 outcomes domains for the purposes of clarity. However it should be noted that, in reality, children's behaviour and mental health and parents' sense of efficacy and wellbeing are all interrelated.

their children reflect the findings of the survey. Parents spoke of their children becoming calmer, with fewer and/or less explosive violent outbursts, demonstrating greater self-regulation while still showing challenging behaviour.

> *"…she won't have the outburst for as long. So where she might have a meltdown, before she would stay in that for longer…she's able to regulate herself and pick herself up out of that a lot quicker." (Mother)*

> *"I think she has less of a need to kind of go spinning and to find that excitement" (Father)*

> *"He was angry…shaking with anger. Now he would have kicked out or lashed out but he didn't, so he is learning to pull it back. Then I just sat down and started to talk calmly …to him, he was still screaming in my face and he came down, he got himself back down again, so that is an improvement...He went somewhere and smashed something and he would have hit someone, so that is a vast improvement." (Mother)*

> *"It's better than it has been… [Violent behaviour is] …not daily but it's certainly weekly isn't it?...You wouldn't go a whole week without something happening." (Father)*

Other changes included greater self-awareness and self-reflection demonstrated by the child making more positive choices.

> *"…if she does do something wrong…when you tell her off and say don't do that, she responds more appropriately. Whereas, in the past, if you told her off for doing something she'd then go and do something far worse. [Usually to her brother]." (Mother)*

> *"…you know even her friends in school have changed quite a bit. You know she's moved away from people who have been a bit more difficult or a bit more problematic, to other kids. She's done that deliberately in her head." (Father)*

> *"You sit there thinking hmm . . . what's coming next then in the day? But…she's making those choices to go back. So we're not making her do this…" (Mother)*

One family commented that the target of their child's challenging behaviour had changed, becoming more directed towards things rather than the parents, which felt easier to manage. Finally, whilst many children continued to struggle with friendships and sharing control within play or other contexts, a few seemed to be making new and more sustained friendships, and were beginning to allow others to take some control, for instance the therapist and the parents within therapy sessions. One child, who had received 5 years of self-funded therapy at a younger age, and received the ASF-

supported therapy during their GCSEs and transition to a further education college, was now doing well.

Parents of one child who had accessed weekly, and then twice-weekly, sensory processing therapy for over a year (previously funded through the local authority and now the ASF) could describe marked improvements in their child's sensory regulation. Other parents whose children had more recently started sensory processing therapy were implementing exercises, and felt it was working well, but it was too early to identify specific improvements in this area.

Three families spoke of how there were periods when their children's behaviour and/or emotions deteriorated during the course of therapy, either related to the content of therapy sessions or a change of therapist. This again mirrors the survey results which found that a small proportion of children appeared to get worse over the course of the survey:

> *"…it had improved over the summer and through the therapy and everything. But then when the change of therapist came, it came back. I don't think it was as bad as previously. But it came back and it's kind of …been there again, you know". (Mother)*

One family was going through a similar period at the time of the second interview.

> *"…it is turbulent and it is worse than it was… I did indeed challenge [therapist] to say why is it that we are where we are? And it got worse before, and she obviously gave me the comfort that actually this is something we need to go through, which I don't think is unusual … for therapy to go through this, we will come out the other side." (Mother)*

Unfortunately, one family's adoption which had broken down by the time of the first interview, after approximately 3 months of family therapy, could not be repaired and the teenage daughter was placed on a permanent care order. The parent in this case felt that the help had come too late for their 16 year old child, who was still engaging in risky and self-destructive behaviour.

For those families who were yet to start therapy, the picture was also mixed. One family, which was about to start therapy at the time of the second interview, could see that as their child got nearer to puberty, there were increasing signs of more difficult behaviour, otherwise they hadn't experienced any changes. Another family had received 2 short therapeutic breaks and a therapeutic assessment, but was waiting for ongoing therapy to begin. In this case, following the breaks and assessment, the parent felt the child's behaviour had calmed a lot and wellbeing seemed to improve. However, the longer they waited, the more the parent could see that things were starting to get worse again and she expressed concern about her son's mental health.

Another family, who didn't know when or if their therapy was due to start, had noticed improvements over the 8 months since the first interview. This was partly due to a planned period of separation from the adoptive family, and regular, positive contact, supported by the wider family. This child was attending school again and had just started staying in the family home at weekends, in an attempt to gradually make this a permanent return. Having so far come through a crisis point in the family, without professional support, this parent was unsure whether any therapy would help. They felt that it was still probably essential for the longer-term future of their son, although were concerned that it might be too late and too much of a challenge for him to engage with.

All families felt that therapeutic support needed to continue and was likely to be needed again in the future at certain points, to enable their children's wellbeing, developmental and behavioural needs to be fully met. Although there had been positive developments for most families that received the ASF support, these were relatively minimal and parents were under no illusion that their children's problems were going to be resolved within such a short space of time. There continued to be many developmental challenges for many of the children.

> *"I mean if she's 2 or 3 years behind developmentally. She's kind of always going to be 2 years/3 years behind developmentally. She might catch up a little bit but that's just a function of what's happened to her. So we've seen her grow up but she's probably still 2 or 3 years behind" (Mother)*

A number of the same challenges identified in Wave 1 interviews were also described during Wave 2 interviews. Examples included incidents involving aggression, deceptive and controlling behaviour, difficult bedtimes and school anxieties. Families were realistic that their children might continue to struggle as they develop into adulthood, but with appropriate support, poor life outcomes could hopefully be avoided.

> *"So you know…if they don't get help, they will struggle all their lives. So you know this problem isn't going away". (Father)*

One family that had self-funded long-term therapy at a younger age, was confident that if they hadn't been able to access support the prospects for their son would be a lot worse.

> *"...if [Adopted Child 2] hadn't have had that support you'd be paying for him in the mental health services…probation…prison services or the Police…Wouldn't it be better to prevent it and create a society, you know, of decent human beings where we care about each other?" (Mother)*

Families expected that particular milestones and transitions in future years could continue to be difficult for their children, when further support would be needed.

"…you know whatever happens now, hopefully we'll see some improvement. But then actually, in 2 years' time…she'll be coming to the end of primary school and…that's always a key time for children…they…kind of need additional support at that point." (Father)

The Matthews Family – The ASF helps with important transition

Siobhan and Graham adopted 18 year-old Peter, aged one and 15 year-old Martin, aged 3. Whereas Peter settled well, Martin struggled from the beginning. He became increasingly violent and aggressive, and Siobhan and Graham were struggling. Following a long search for support, they found a local therapist specialised in working with adoptive families. Five years of self-funded family therapy began when Martin was 8. Sessions took place up to 3 times a week, with extra emergency sessions. It was an exhausting and emotional process, with small improvements and many difficult times. However, Martin gradually settled and life became a lot calmer.

When Martin reached 15 and his GCSE's year, his anxiety began to increase, behaviour deteriorated at school and home life was affected. Siobhan called their therapist in November 2015 and was informed about the ASF. By February 2016, an application for the ASF was submitted by the post-adoption team. In the meantime, the family self-funded weekly personal therapy for Martin until funding was confirmed in April 2016. After a break over the summer, therapy resumed and supported Martin as he started his chosen college, having got enough grades.

The college provided educational support, Martin settled and was achieving well. However, Martin had found a birth family member on social media and so after a Christmas break, was due to return to therapy, this time with Siobhan. The therapist was going to help Martin explore what he might do and how the family and therapist could support him. The ASF funding had so far helped Martin achieve in exams and settle at college, he had made some good friends and was comfortable. Siobhan and Graham explained however that Martin was still vulnerable, lacking confidence.

"…he's not emotionally where perhaps you would expect a 16 year old boy to be. But he's moving forward." (Graham)

Whilst realistic that more help might be needed in the future, Siobhan and Graham felt that Martin was in a much better position. This was partly as a result of recent the ASF-funded therapy but also because the previous years of therapy provided a strong foundation, meaning that recent challenges did not become a crisis.

"I would say we were very satisfied with it originally, which is why we were very keen to go back to the same provider…He knew her, she knew him…and they got to work straightaway." (Siobhan)

9.3 Family functioning, parental efficacy and parent-child attachment

Key findings: Family functioning, parental efficacy and parent-child attachment

- The family functioning of families in receipt of support through the ASF improved.
- The greatest improvement were seen in terms of parents' understanding of their child's needs, and an increased confidence in taking care of them. This suggests that the ASF support had helped them as parents and their family as a whole.
- A large majority of survey respondents believed that the support provide through the ASF had:
    - helped them as a parent (85%);
    - helped their family as a whole (82%); and,
    - made the adoption placement more stable and less likely to break down (66%).
- Individual family situations are highly complex but there was a widespread view from parents and professionals that the ASF has made possible the provision of therapies that help to meet complex needs.

For the measurement of family functioning, parental efficacy and parent-child attachment the relationship subscale of the Carer Questionnaire was used. This is a non-validated scale that was developed by clinical psychologists working with looked after, fostered and adopted children.[87]

To understand change over time in family functioning, the mean scores of the scale at baseline and follow-up were compared and a significance tests was performed. The effect size of the change (Cohen's d) was also calculated. For this scale higher scores represent better family functioning and parent-child attachment. The analysis of the scale

[87] To ensure its applicability for this study, minor adaptations were made to the scale. As part of the analysis of Wave 1, an item and scale analysis of the Carer Questionnaire was conducted. As a result of this, one item was excluded from the scale.[87] The scale now comprises 11 items, ranked on a 1-10 Likert scale. For the comparison of the baseline and follow-up scores this 'excluded item' is analysed separately.

shows a statistically significant improvement in reported family functioning with a small effect size (0.32). This suggests small but meaningful improvements were observed over the course of receiving support through the ASF.

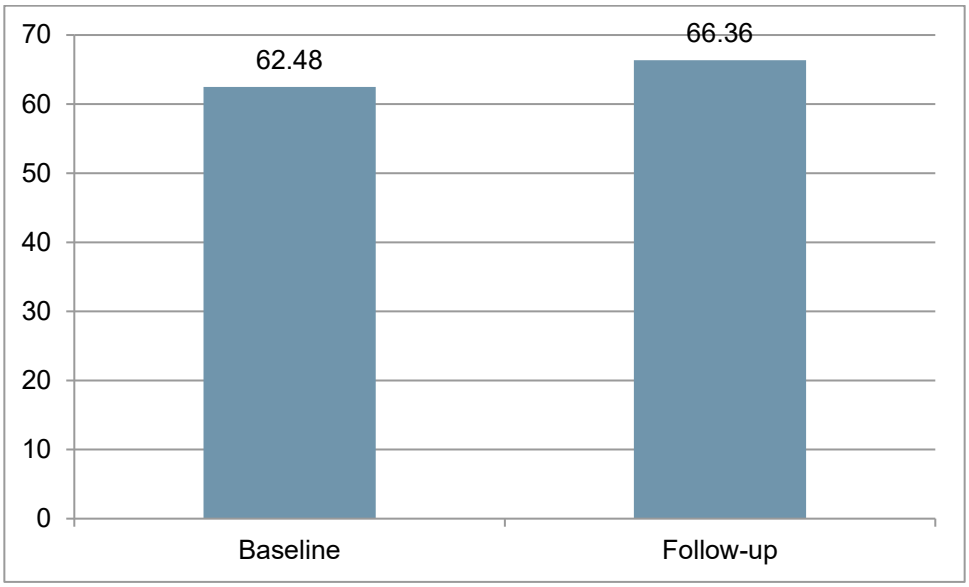
Table 10 and Figure 31 show the results of the analysis:

Table 10: Comparison of The Carer Questionnaire mean score at baseline and follow-up

Scale	Baseline Mean (*SD*)	Follow-up Mean (*SD*)	Mean Diff (CI)	*df*	*p*	*Effect size d*[88]
Carer	62.48 (14.94)	66.36 (15.73)	3.88 (2.72; 5.04)	431	<.001	0.32

Note: N=432; Source: Baseline and follow-up survey; *SD* = Standard Deviation, CI = Confidence Interval, *df* = Degrees of Freedom, *d* = Standardized Mean Difference – Cohen's d.

Figure 31: Comparison of the relationship subscale of The Carer Questionnaire mean scores at baseline and follow-up



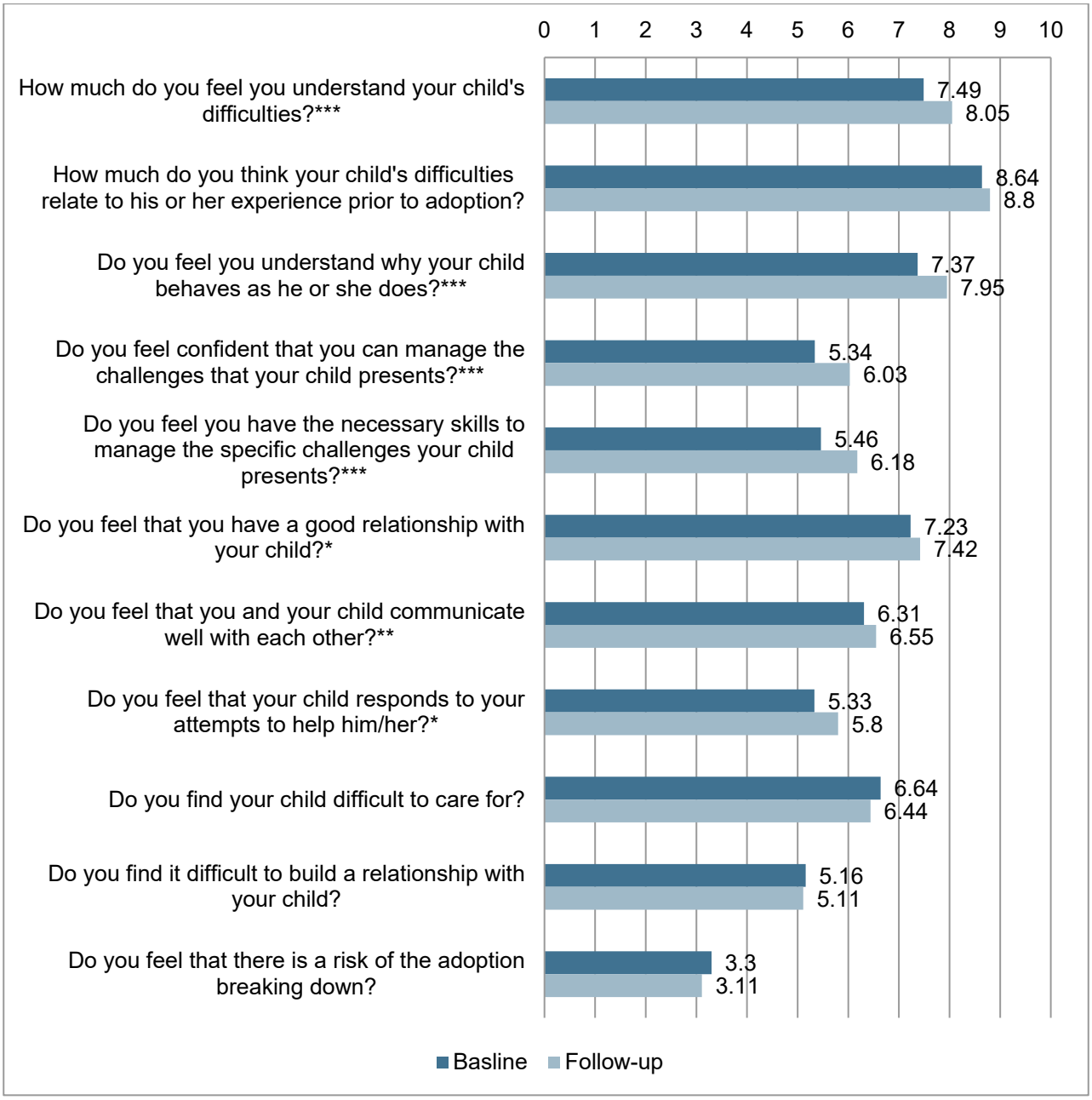
Note: N=432; Source: Baseline and follow-up survey.

As the Carer's Questionnaire is not a validated scale some caution must be taken when interpreting its total score.[89] Therefore change over time on each individual item was

[88] Cohen's d equates to a small effect.
[89] See methodological discussion in Appendix 1: Statistics in detail.

explored.[90] Figure 32 shows the mean baseline and follow scores on each item of the scale.

Figure 32: Mean scores of individual items relationship subscale of The Carer Questionnaire at baseline and follow-up.



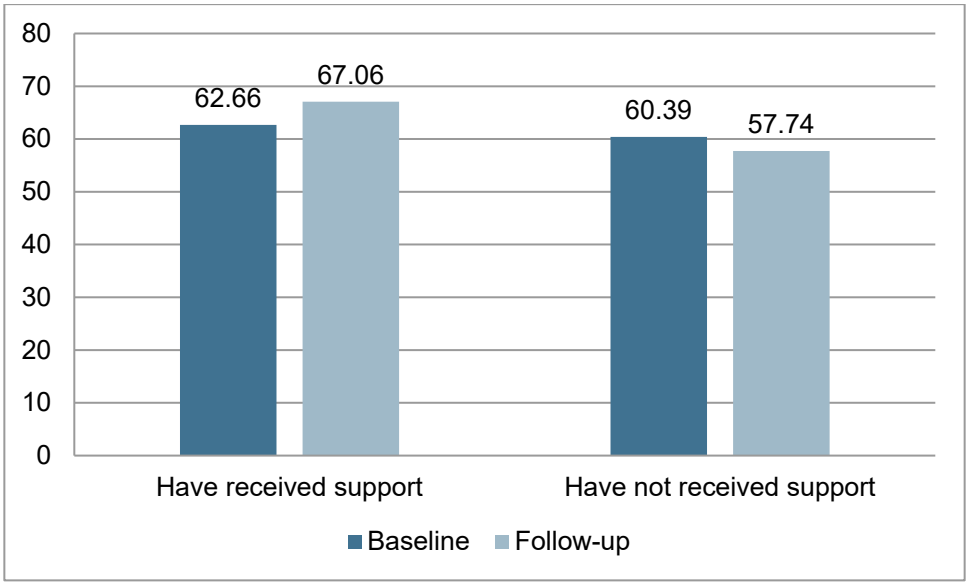
Note: N=435 to N=441 depending on item; Source: Baseline and follow-up survey; * indicates significance at $p<0.05$ level; ** $p<0.01$; *** $p<0.001$.

[90] Note that the questions: "do you find your child difficult to care for your child", "do you find it difficult to build a relationship with you child" and "do you feel that there is a risk of the adoption breaking down?" are negatively phrased therefore lower scores represent higher family functioning.

As Figure 32 shows responses to each item improved over time, in keeping with the result for the analysis of the scale as a whole, suggesting that family functioning improved over the course of receiving support though the Fund. It is noticeable from this further analytic step that greater improvements were registered on items that relate to the parents' understanding of the child and in the confidence they have in their ability to care for their child. Of the 11 items on the scale, 4 did not return statistically significant changes. Most notably, the questions relating to the risk of adoption break down and the 2 relating to difficulty in caring for and building a relationship with their child were among those that were not statistically significant.

To identify the role played by the ASF in these changes, a comparison between the main sample of families receiving services and the smaller group of families that had not, was undertaken. Figure 33 shows the results of this analysis. As in the case of the SDQ this analysis suggests that families in the non-intervention group showed a decline in the quality of relationship, parental efficacy and parent child attachment whereas those receiving support showed an improvement.

Figure 33: Mean scores of the relationship subscale of The Carer Questionnaire at baseline and follow-up



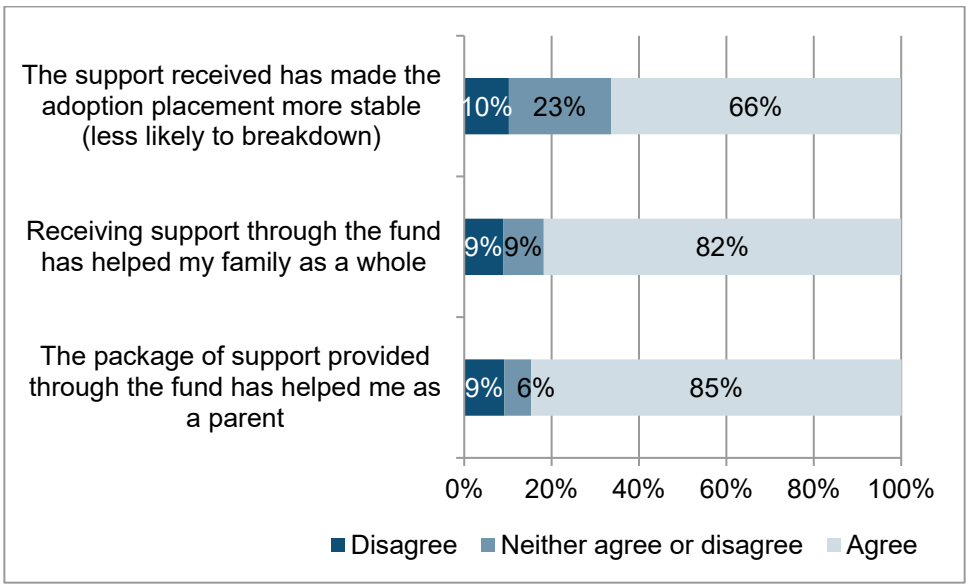
Note: N=428; Source: Baseline and follow-up survey.

Self-attributed outcomes and online survey results

To further help with the issue of attribution, respondents answered 3 questions in the follow-up questionnaire relating to their overall views of the using the Fund. These comprise questions about whether the support has helped thr respondent as a parent, helped the family as a whole and made the adoption placement more stable. Figure 34

below shows the extent to which respondents agreed or disagreed with the following statements to these questions.

Figure 34: Responses to self-attributed outcome questions of follow-up respondents

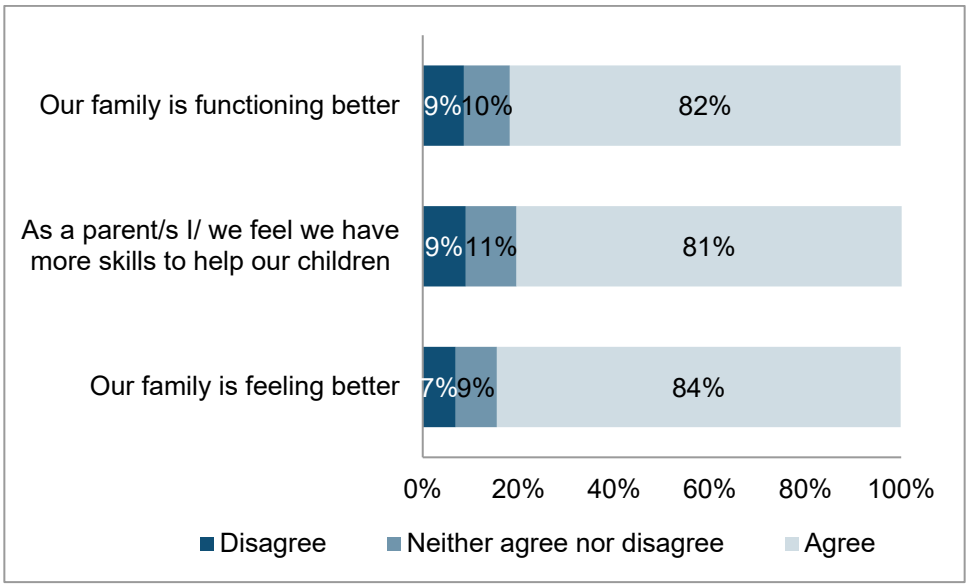


Note: N=428 to N=430 depending on item; Source: Baseline and follow-up survey.

Figure 34 shows a large majority of survey respondents believed that the support provide through the ASF had helped them as a parent (85%) and had helped their family as a whole (82%). A smaller proportion, but still a majority, agreed that the support received has made the adoption placement more stable and less likely to break down (66%).

Online survey respondents to the 2016 survey who received services were especially positive about the value it added to the family functioning and wellbeing (see Figure 35). The majority of respondents (82% and 84%) agreed that the services received helped their family functioning and wellbeing. Also, 81% of respondents agreed that as a result of the services received through the ASF they feel they have more skills to help their children.

Figure 35: Relative Frequencies of impact of services received through the ASF of online survey respondents



Note. N=189 to N=173 depending on item; Source: Online survey of adopters 2016.[91]

In-depth parent interviews: Views on family functioning and parental efficacy.[92]

Findings from the family interviews largely support those of the survey, discussed above. Hopes expressed by parents in the first interviews included parents building new tools and strategies for supporting their children and better understanding of their children's emotions and triggers. A final hope was that the benefit of the therapy would outweigh the disruption of bringing another professional into family life.

By the second interview, all of the 13 families who had received some support by this point, had experienced improvements in family life, regardless of whether support was in early or more advanced stages. The most frequent comment made by parents was that life had become calmer.

> *"I think the home is calmer." (Mother) "Yes, it's definitely calmer." (Father)*

> *"I am not saying it is perfect, because it is far from being perfect… I don't think it will ever be perfect, but it's a hell of a lot better than…it was 5 years ago. We have had some rough, really rough times, but since he went to that school and he got all*

[91] 'Strongly disagree', 'Disagree', and 'Somewhat disagree' are merged into 'Disagree', 'Strongly agree', 'Agree', and 'Somewhat agree' are merged into 'Agree'.
[92] Specific Parent-child attachment issues were not a significant theme of the in-depth family interviews.

this help from them, and got all this adoption support, it has been a hell of a lot better…" (Mother)

Five families felt that the adoption would otherwise have broken down, even though new events or stressful times of the years still caused disruption. Life stabilised more quickly afterwards and didn't have such a negative effect on family relationships, perhaps because of parents' increased efficacy.

"I think I am seeking to rise less to it and walking away from situations. But equally trying to be a lot more empathetic towards them in order to try and move our relationship forward…" (Mother)

"It's interesting, we'll regularly have things like I'm not going to bed… but I think we are dealing with it in a much calmer way…which means that we have a happier home and it's easier..."(Father)

Many parents spoke of how they dealt with situations differently, which was having a positive result on their children's behaviour and therefore the whole family's functioning.

"…what you can do is you can change your behaviour to help their behaviour is probably the only way I can explain that." (Mother)

"…if she is kicking off at you, you walk up to her and give her a cuddle and she, she will…it is almost like 'what are you doing that for?!' Then they think 'well, actually that is making me better'…Whereas before you would be 'if that is the way you are, I am not having anything to do with this." (Father)

Although a couple of families reported improved sibling relationships since the first interviews, most others found that these could still be volatile. Overall though, parents spoke of being able to cope with these and other challenges better since the ASF support began. 12 of the 16 families interviewed in the second round said that their parenting, particularly therapeutic parenting, skills had increased and improved since the ASF support. Additionally, improved knowledge about their children's early trauma, attachment difficulties and/or medical conditions seemed to contribute to helping parents cope more easily with the challenging behaviour of their children. Many parents explained that their different, and often more relaxed responses to their children were having a positive effect on their children's behaviour, the outcomes of situations and the overall family environment.

"We've been able to use certain techniques and strategies…In order to…distract them…tonight it's a simple case of just literally lifting her up, swinging her, which is stuff we've learned through therapy as a distraction. And then she's a different child again." (Father)

"It's made sense to us, their behaviours…You can't deal with the behaviour until you've looked at the underlying problems." (Mother)

"…just talking through scenarios with [the therapist] and she is like 'try this, you know' and it works. When seemingly you can't make a break through into that situation and get someone to calm down, there is a path and that was really interesting to know." (Mother)

"…to also step back and stop trying to fix things and just be. Go with the child. Don't try and force an issue or put in a boundary that's not going to be bearable." (Father)

Even those families who felt they had undertaken a lot of training in the past and had good knowledge about attachment and therapeutic parenting, found the support beneficial to their understanding and skills:

"We thought we understood it all, but it actually makes it much clearer." (Mother)

Some families recognised that if had they received parenting training at an earlier time, it could have prevented later problems occurring and/or improved their capacity to deal with problems. As well as learning new things, parents also had existing knowledge and parenting approaches reinforced through the ASF support.

"Because I think before, it was just, you were told 'oh you're doing fine'. Really?? You know you didn't really know and you didn't certainly feel like you were doing okay and you didn't feel like you were seeing any progress or you didn't feel like you were doing a good job. But I think by having somebody there, a professional there they can kind of say, well I notice that you do that, and that really helps and such and such. So it gives you specific areas, feedback to you, you know what you're doing and how it's helping and how it may help in the future, and you can see that. It just gives you a bit of reassurance really." (Mother)

Reinforcing existing knowledge and skills unsurprisingly seemed to have a knock-on positive effect on parents' wellbeing. This seemed to help parents persevere with a more therapeutic style of parenting.

"So it's reassuring for me…it means that I can therapeutically parent the kids better than I would without that support." (Mother)

"We can tell people we're doing it, we're not making things up, we're following professional advice…"(Mother)

"It is still utterly exhausting, but I am for the most part I would say 90% in control of the situation now, compared to where I was." (Mother)

Others commented that having accessed courses with other adoptive parents, helped reduce their feelings of isolation.

"… we're alright actually. This is happening to hundreds of families, thousands of families across the country. And we're not alone and it's not unusual…[the training has]…*changed our lives… "(Father)*

In general, parents agreed that receiving the ASF support made a big difference to their family.

"I think it is an absolute brilliant service, it has been a god send in this house. I don't know where we would be or what he would be doing now if we hadn't have had that funding. He probably wouldn't be here." (Father)

The Wright-Hipkiss Family: a story of both improved parental efficacy and wellbeing

Mel and Adam adopted their son, Jay, over 16 years ago and daughter, Laura, 13 years ago. They had been asking for help for more than 7 years. Instead of feeling supported, Mel and Adam felt blamed as parents for the very challenging and complex issues faced by their children. School created extreme anxieties for Jay and Laura and any support offered felt punitive. By Christmas 2015, Mel and Adam were feeling broken. Having heard about the ASF, they approached their post-adoption team in summer 2015 but faced further barriers.

The post-adoption team referred Mel and Adam to Therapeutic Crisis Intervention training and a STOP parenting course in February 2016, which unbeknownst to the family was ASF-funded. By January 2017, after nearly 2 years of fighting for therapy, the family were referred for a therapeutic assessment. Mel and Adam did not know when therapy would begin because of long waiting lists and having reached their fair Access limit. Despite this, nearly a year since the parenting courses, life at home had improved. The family finally felt understood, supported, and had new strategies.

"…if a young person comes in and throws a bag across the floor and won't speak to you, that's a sign that they need you… Just be together until they're ready to talk…" (Mel)

The training empowered and energised Mel and Adam. They felt more confident and relaxed in their therapeutic parenting, despite conflicting professional advice and as a result, life at home felt a lot calmer. Although exasperated with their post-

adoption and education services, Mel and Adam felt more optimistic now that help was on offer.

"I feel more hopeful… Less scared for the future." (Mel)

9.4 Wellbeing of adoptive parents

Key findings: Wellbeing of adoptive parents

- Parents in families receiving support through the ASF saw modest but meaningful improvements in their wellbeing.
- Parents said that with the benefit of hindsight their families would have benefited from earlier therapeutic support and particularly therapeutic parenting training.

The final domain explored was the effect the ASF had on the wellbeing of adoptive parents. In the longitudinal survey the Short Warwick and Edinburgh Mental Well-being Scale (SWEMWBS) was applied to measure these outcomes. The SWEMWBS is a 7 item scale with a score range between 7 and 35 where lower scores represent lower levels of mental well-being. To determine the change in the wellbeing of the parents, a significance test was conducted, comparing the baseline and the follow-up mean scores on the SWEMWBS scale.

Statistically significant improvements were observed between baseline and follow-up on the SWEMWBS. This showed that on average respondents' wellbeing had improved over the course of their family receiving support through the ASF. While the improvements were found to be significant the size of the improvement was shown to be relatively small. The full results of this analysis are presented in Table 11 and Figure 36.

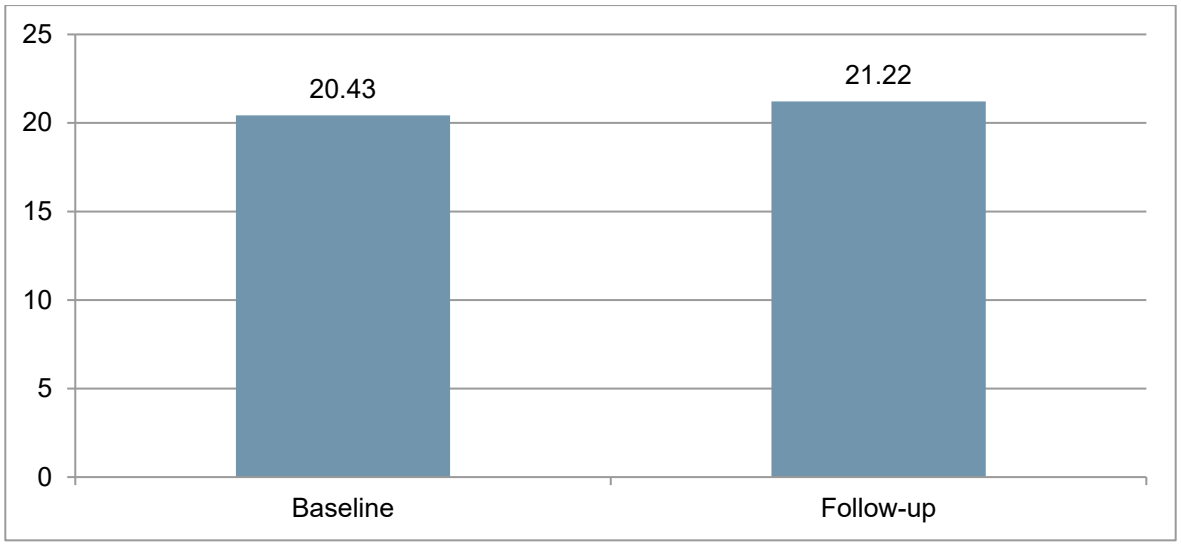
Table 11: Comparison of SWEMWBS means of baseline and follow-up data

Scale	Baseline Mean (*SD*)	Follow-up Mean (*SD*)	Mean Diff (CI)	*df*	*p*	*Effect size d*[93]
SWEMWBS	20.43 (3.30)	21.22 (3.25)	.79 (1.07; .51)	421	<.001	0.27

Note: N=422; Source: Baseline and follow-up survey; *SD* = Standard Deviation, CI = Confidence Interval, *df* = Degrees of Freedom, *d* = Standardized Mean Difference – Cohen's d.

[93] The effect size of 0.27 can be considered as small according to Cohen (Cohen, J. (1992). A power primer. *Psychological bulletin*, *112*(1), 155.).

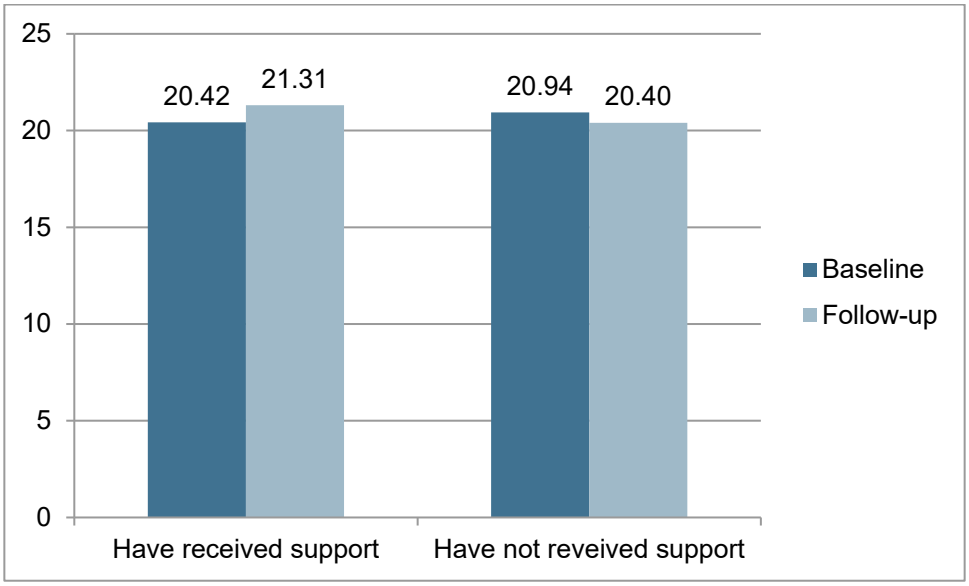
Figure 36: Mean scores of the SWEMWBS score at baseline and follow-up



Note: N=422; Source: Baseline and follow-up survey.

As for the results of the SDQ and the Carer's Questionnaire, the results of the SWEMWBS were subjected to the comparison between intervention and non-intervention groups. The result of this comparison is shown in Figure 37. In keeping with the pattern observed in the case of child and family outcomes, the wellbeing of adoptive parents, as measured through the SWEMWBS, appears to have declined in the group of parents that had not received any support and improved in the group who had.

Figure 37: Mean scores of the SWEMWBS score at baseline and follow-up



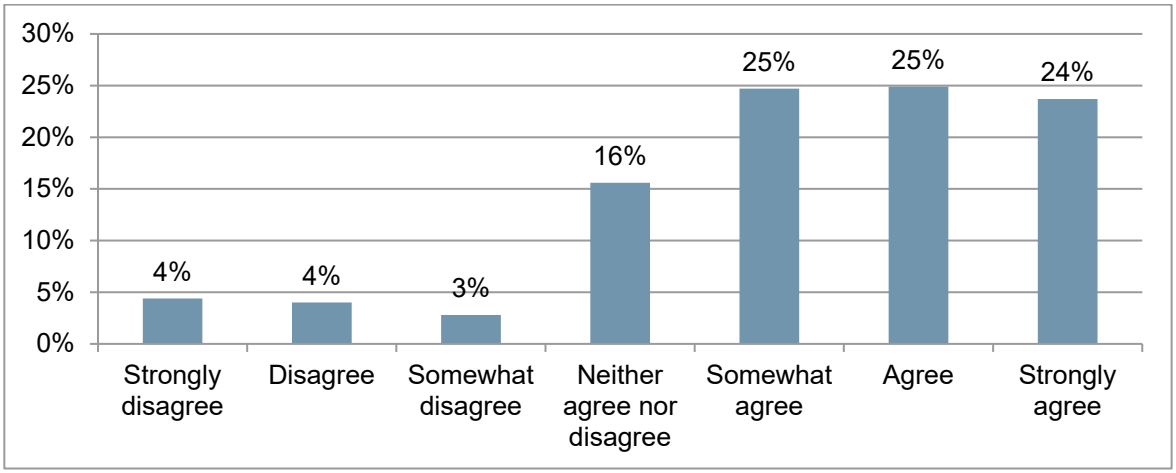
Note: N=419; Source: Baseline and follow-up survey.

Self-attributed outcomes

One additional question was added to the follow-up questionnaire of the longitudinal survey relating to parental wellbeing which asked respondents the extent to which they

agreed with the following statement "I feel more optimistic about the future as a result of the package of support". Figure 38 shows the results of this question. Almost three-quarters (73%) of parents indicated that to some extent they agreed with this statement with a little over one-tenth (11%) disagreeing to some extent with the statement.

Figure 38: Responses to 'I feel more optimistic about the future as a result of the package of support'



Note: N=434; Source: Follow-up survey.

In-depth parent interviews: views on parental wellbeing as an outcome of the ASF

During the first interviews, although some parents mentioned the effects of the adoptive experience on their individual and relational wellbeing, no parents expressed explicit hopes that through the ASF support, their own wellbeing would improve. However, similarly to the findings of the longitudinal survey, during the second interviews, this was an area of improvement that came through.

> *"I think for me it's goes in cycles or … So at the moment I think we feel, I feel calmer, I'm getting more empowered. Less depressed! In a relatively good place. I mean that doesn't mean that there aren't daily frustrations. But, on the whole, having been through a really difficult patch…" (Mother)*

> *"…this time last year I was on my knees. I was finding it really tricky. But you know we're a year on and you can see the positives."* (Mother)

It seems that for some parents, feeling listened to, understood, not judged, and that their family's needs were being taken seriously, helped them feel they were doing a better job as parents than previously. This then increased their confidence and lessened their anxiety. For others, it was seeing their children's behaviour improve that helped lead to a change in their feelings.

"…and you think… 'well, you know, we're not doing too badly if she managed to do that really nicely.' So it makes you feel better as a parent as well I suppose." (Father)

One family commented that as a result of parenting courses, they had been enabled to pay some attention to their own wellbeing:

"…and self-care…looking after yourself as individuals and as a couple and just getting some more fun back into life and laughing. That's just been fabulous, hasn't it?" (Mother)

For another couple, because their child had become a bit more independent, they were getting more time for themselves in the evenings. Two others mentioned how their relationship had improved as a result of support.

"It's life changing for us isn't it?...I would have said to you our relationship would have been at breaking point between us two, let alone the whole family… we were picking holes in our own relationship…."(Mother)

However, life still remained demanding, and in some cases, isolating for parents.

"Exhausted. Completely exhausted… at the moment living day by day…" (Mother)

"It is a shame it doesn't support more, support the parents more… "(Mother)

"….you spend all your energy planning and organising everything else, you're not planning and organising yourself." (Mother)

Many felt the need for a break or more support for their parenting roles. Three families commented that they would really benefit from help in practical areas such as navigating services, providing home support, or specialist childcare. Parents' therapeutic and practical support needs could perhaps be considered as part of support needs assessments.

One parent, who had self-funded personal therapy for a number of years, reflected on the damaging effect of adoption on their mental health. However, they also made the point that they believed adoption had made them better, more empathic human beings as a result. In some cases, parents appeared embarrassed that they were receiving or might need support for themselves individually, whilst others were more confident in articulating the importance of supporting parents' mental health. One parent, whose ASF-funded therapy was used to continue supporting them following their eldest child's adoption breakdown, found it crucial in helping them grieve their loss.

"…without the adoption support funding and the therapeutic work carried out…I couldn't be where I am now, definitely, without a doubt." (Mother)

Those parents who had previously funded their own personal or parental therapy had found it useful. Another parent had not considered personal therapy but on reflection thought it might have been useful. One spoke of being unable to self-fund eye movement desensitisation and reprocessing therapy (EMDR) recommended for them in the assessment of adoption support needs. They were not eligible for this through the NHS and were struggling to access it elsewhere. Another parent received a small package of individual support. They thought this was provided by the local authority and hoped it could continue.

> *"…I think we'll probably find we'll get to 6 [sessions] and it's like, oh we're just getting there. It's like oh right, thanks… I think they can extend depending on where we are at 6… I don't know." (Mother)*

Therefore, despite many parents feeling better as a result of getting help, it came across clearly that they also needed continued and consistent support alongside the ASF funded support for their children.

Professional views on family outcomes

In the second wave of local authority case study visits there was a common articulation that the ASF was continuing to bring benefits to families and children. Those local authority areas more reliant on external commissioning and less on in-house therapeutic expertise mentioned the opportunity that the ASF had made possible in terms of providing: more in-depth, extended, bespoke, and a wider range of, therapies for families. Staff felt that this meant that they are better able to meet complex needs, which they would not have been able to otherwise do, helping families get the expert support to cope and to avoid breakdowns.

Local authority staff highlighted additional benefits that had either become more apparent over the course of implementation or that were a result of the more recent changes to the ASF. In terms of the former, the majority of case studies highlighted that the ASF had helped recognise and normalise the challenges of adoption, reducing the stigma attached to asking for support. Local authority staff felt that this, coupled with the increased awareness of the ASF and the support available, was a major benefit for 2 main reasons: the first because it helped recognise the complex issues of adopted children and the second because it empowered adopters to come forward, thus potentially avoiding asking for support at crisis points.

Four local authority areas specifically mentioned that the ASF, and access to important therapeutic interventions, had prevented a number of breakdowns and was the difference between continuing with the adoption or not. For example:

"I have a family, an awful lot of money of packages of support has gone into that. And the child is only now becoming to realise she is worthy of being adopted and only now beginning to recognise that she has been sad for all of these years. Getting to this point is 40k worth of work but it is so valuable. And her adoptive mum is a single parent and the parent has been through extreme levels of behaviour from the child. And now she's getting there, she's pulling through. The package of care is amazing. Just before the Fund started the mum who was really struggling. The ASF and this package of care has been the difference between the breakdown and the going ahead with it." (Social worker)

9.5 Conclusion

The results of our analysis show that families accessing the Adoption Support Fund improved in each of the 3 outcomes domains of: child behaviour, development and wellbeing; family functioning, parental efficacy and parent-child attachment; and the wellbeing of adoptive parents.

The substantial majority of adoptive parents reported that receiving therapeutic support through the Fund had benefited their children. The longitudinal survey showed improvements in relation to children's emotional, conduct and attention issues. This was supported in interviews, where parents described their children as calmer, better at regulating their own emotions, and having less frequent aggressive outbursts as a result of receiving therapeutic support. While the outcomes for children were modest, insights provided by comparison with a small group of families not receiving any services suggests that for the families accessing support through the Fund, the likely trajectory of many children may have been to deteriorate over time. In this context, even small improvements can be understood as significant and meaningful for families.

Parents also reported improvements in their relationships with their children and in family functioning overall, with the substantial majority of parents indicating that support through the Fund had benefited their family as a whole. Particular improvements were seen in relation to greater parental efficacy with the adoptive parents reporting better understanding of their children's needs and having greater confidence in their ability to meet these.

Parents reported feeling more optimistic about the future, calmer and less stressed. A number also reported feeling less isolated and better listened to, both by professionals and other adoptive families. Some parents also suggested that improvements in family functioning had benefited their relationship with each other. The question of parental wellbeing can be understood both as an outcome in itself and also as indicative of improvements in the family as a whole.

While the outcomes of the ASF have been broken into 3 domains for the purposes of analysis, in the lived experiences of families, the 3 domains are intimately linked. On a conceptual level, child, parent and family functioning overlap with one another with each domain containing elements of the other, and, because of the nature of family life, these domains are interdependent. A parent feeling calmer and more capable is better able to manage difficult events with greater efficacy and in so doing, improve their relationship with and support their child's mental health. A child having fewer tantrums of less intensity will lead to a reduction of anxiety and stress in their parents. Family relationships are dynamic and are likely to be subject to either virtuous or vicious cycles of family functioning. What the evaluation shows is that, in many cases, a more virtuous cycle has been aided by support from the ASF. This conclusion is borne out by evidence from the survey and family and local authority interviews that suggest that, as a result of the ASF, adoptions have become more secure, and in some cases, that breakdown has been prevented.

While there are strong reasons to believe that the support provided has been helpful and led to improvements across each of the 3 outcomes domains, the scale of challenges faced by these families should not be underestimated nor should the impact of the Fund be overestimated. It must be remembered that for a small but significant proportion of families, circumstances, relationships and mental health got worse over the course of receiving support through the Fund. In some cases this may have been as a direct consequence of engaging with the therapeutic support. However, in most cases, this is likely to be due to other life events cancelling out any benefit that might have been observed. For the majority of families that did report improvements, these were small in size in each of the 3 domains. What came across clearly from all families interviewed was that improvements were small, inconsistent and life was still challenging. Parents expected challenges to continue for a long time, but hoped that their children would experience more positive life outcomes as a result of the services provided. As one mother commented:

> *"…people always want to know about progress…and it's not linear and it's not… you can't say, 'well, wow today we've made…' I mean even [Psychologist], she was fantastic. And she was saying… 'we get moments and that's all we get'."*

10 Final Conclusions

The key objectives of the Adoption Support Fund were to:

- Improve the lives of adopted children and their families;
- Improve the experience of post-adoption support services in particular: appropriateness, timeliness, accessibility, duration, location; and
- Expand a market for post-adoption support to improve assessment processes.

The evaluation aims to address the following questions:

1. Is the ASF achieving desired outcomes on improving the lives of adopted children and their families?
2. How are adopters generally experiencing post-adoption support services?
3. What is the quality of the provision of post-adoption support services through the ASF: appropriateness, timeliness, accessibility, duration, location?
4. What are the key barriers and enablers for good practice in implementing the ASF?
5. How is the assessment process working in local areas?
6. Has the ASF triggered changes in how funding used for post-adoption support is being channelled, and how does this impact on core services?
7. How is the market is developing - are there more families receiving more services? Are there more service providers?
8. Has the ASF triggered changes in how funding used for post-adoption support is being channelled and how does this impact on core services?

These questions are addressed in the following summary sections.

10.1 Has the ASF triggered changes in how funding used for post-adoption support is being channelled, and how does this impact on core services?

The ASF has triggered growth and upskilling of adoption support teams and a greater awareness of the range of possible therapeutic interventions. Local authorities report a new ability to offer far more therapeutic interventions to more adopters and see the continuation of the Fund as a mechanism to prevent crisis and adoption break down.

Local markets show signs of growth and local authorities are beginning to develop relationships with providers and work more strategically.

The ASF has triggered some changes in the way post-adoption support funding is being channelled and this has had a range of impacts on core services.

The case studies (available in full in Appendix 5) bring to light the diversity and organic nature of emerging trajectories of local adoption support service development. Across the 10 case study authorities, 3 broad types of delivery models can be identified. The key difference between them is the extent to which they make use of external provision:

- **Strong in-house therapeutic provision/multi-disciplinary teams** made up of social workers, clinicians and/or therapeutically trained social workers providing direct therapeutic services. In this model, the service is historically less reliant on external provision. The reason for this is due to a combination of contextual factors (e.g. gaps in the market/overall underdeveloped local provision) and/or internal ones (relatively larger teams and in-house therapeutic provision that is strong enough to meet the needs of the majority of families through direct delivery). Particularly good case studies of this arrangement are Newingham and Northburn.
- **Limited internal, direct therapeutic provision and reliance on external commissioning**, where the internal adoption team's capacity is more constrained. This is either because of necessity (e.g. the local authority places the majority of children out of area, hence relies on external providers in placement areas) or because there might be a mix of some provision elsewhere in the public e.g. child and adolescent mental health services (CAMHS) and/or independent sectors. Examples of these types of cases can be seen in the details of Westfordshire, Oxton, Norchester, Estborough, Dunbria and Westfolk.
- **Mixed response** with historically well-resourced in-house provision and capacity and direct delivery by a team of therapeutically-trained social workers (e.g. DDP and Theraplay) and clinicians, as well as external commissioning from a range of providers (public, statutory and independent sectors). Good examples of this are Bridmouth and Osterland.

There are 3 key barriers identified in the early implementation:

- workload increases of post-adoption support teams;
- role changes brought about through increased administration, commissioning and auditing of services; and
- inability to respond to the capacity issues because of lack of confidence in the future of the ASF and the way in which regionalisation will impact locally.

Although it would be premature to define a 'good practice' model, the following enablers, largely drawn from the larger multidisciplinary and therapeutically trained teams, can be

considered for successful implementation of the ASF regardless of the size of the team or type of service trajectory taken:

- Attention to supporting the role of social workers and finding solutions to the increased demand in administrative work;
- Regardless of the size of the adoption support team, the case studies indicate that upskilling of social workers in therapeutic knowledge is improving the efficiency and quality of assessments, liaison with clinicians and appropriate commissioning of external provision;
- Processes that ensure the quality and depth of assessments are not sacrificed by the need to respond to increased demand; and
- Investment in intelligence gathering and strategic thinking around local need and workforce planning.

10.2 Has the assessment process improved?

Assessments of need for post-adoption support services are localised and bespoke processes that are difficult to separate from the wider work of providing adoption support, which includes the ASF funded therapeutic interventions. However, assessments are now becoming more formalised as a result of ASF requirements. There were some concerns raised about the therapeutic skills of assessors, and this was particularly in the case of smaller adoption support teams with less in-house capacity and more dependence on external providers. Local authority staff said that a lack of clinical understanding of complex needs in the management of the Fund forced them to focus on the scope of the Fund and the administrative process.

Having said that, current parents receiving ASF support were overall satisfied with the assessments they received. Local authority staff generally agreed the ASF had improved the assessment process, and that with funding dependent on clear assessments and reviews, they were becoming more efficient and specialised in getting assessments in.

10.3 Has the market of post-adoption support grown?

The market for independent post-adoption support services has expanded mainly as a result of providing extra capacity for adoption support teams rather than as part of a local strategic plan to move to a commissioning model for specialist adoption support therapy.

There are 2 trajectories in which providers have expanded. One is through recruitment and expanding capacity to deliver more of existing services. The second is expansion through developing and refining specialist support in post-adoption services and in some

cases the development of new services. The view was that local provision varied across areas and that the independent sector was, on the whole, not yet sufficiently developed to meet the rapid and substantial increase in demand. The view was similar across the local authority staff and providers interviewed.

Key challenges to growth of local markets to meet the demand are lack of trained therapists in the ASF approved therapies and the capacity of the independent providers to fund and provide the necessary supervision required to practice effectively. In addition local authority adoption support professionals raised quality concerns about the market and this is exacerbated by the stretched capacity of independent providers struggling to meet the sudden demand.

10.4 Adopters experience of post-adoption support services

Overall, families' experiences of adoption support services can be seen to have improved. This is based on triangulating data drawn from a range of sources: the online survey of adopters, local authorities and providers, the postal survey of ASF parents and the in-depth interviews with 20 families who applied for ASF support. The data also suggests that perceptions of the quality of adoption support services improved, although not significantly. Local authority staff and therapeutic service providers overwhelmingly agreed that quality of provision had improved since the launch of the ASF, and that families viewed the ASF-funded support as appropriate and generally of high quality. However, when it came to people's experience of statutory adoption support services, satisfaction levels seemed to stay much as they were, reflecting very mixed experiences.

A number of barriers to accessing support seemed to still be in place, including a lack of knowledge and expertise from adoption workers about families' needs and the available provision. Timeliness of support was perceived as a growing issue for the ASF as well, whilst poor relationships with and/or low levels of contact from post-adoption teams remained an area that families felt needed improving. Whereas families were experiencing consistent, responsive and regular targeted support from therapists, many families had experienced little, if any, proactive support from adoption support services. One possible reason for the lack of satisfaction with statutory adoption support services relates to historically difficult relationships with social workers and previous poor experiences during the adoption process.

Likewise, variable experiences with other core services involved in families lives and a lack of consistent multi-agency collaboration seemed to affect how well families felt supported. If post-adoption and other services were able to better liaise and coordinate, this could provide families with a wider scaffold of support around and related to the ASF provision.

10.5 Improving the lives of adoptive children and their families

The most important outcome for the ASF is whether it has had an impact at all on the lives of children and families. Between May 2015 and February 2017, 10,231 families were approved to access therapeutic support. The profile of these families is one of very high levels of need. A substantial proportion of children show the effects of early childhood neglect and abuse with commensurate predicted levels of emotional, behavioural, developmental and psychiatric problems. Parents reported a wide range of difficulties and struggles in parenting and indicated strongly that these had had a detrimental effect on their own mental health and wellbeing. The picture that emerges from the survey and interview data is of families accessing the ASF who have both long standing and profound support needs.

Potential improvement from accessing a service through the ASF was measured through a self-completion questionnaire for parents that combined relevant validated measures with bespoke questions. The analysis tells us that families accessing the Adoption Support Fund improved in each of the 3 outcome domains of: child behaviour, development and wellbeing; family functioning, parental efficacy and parent-child attachment; and the wellbeing of adoptive parents.

The substantial majority of adoptive parents reported that receiving therapeutic support through the Fund had benefited their children. The longitudinal survey showed improvements in relation to children's emotional, conduct and attention issues. This was supported in interviews, where parents described their children as calmer, better at regulating their own emotions and having less frequent aggressive outbursts as a result of receiving therapeutic support. While the outcomes for children were modest, insights provided by comparison with a small group of families not receiving any services suggests that for the families accessing support through the Fund, the likely trajectory of many children may have been to deteriorate over time. Understood in this context, even small improvements can be understood as significant and meaningful for families.

Parents also reported improvements in their relationships with their children and in family functioning overall, with the substantial majority of parents indicating that support through the Fund had benefited their family as a whole. Particular improvements were seen in relation to greater parental efficacy, with the adoptive parents reporting better understanding of their children's needs and having greater confidence in their ability to meet these.

Parents reported feeling more optimistic about the future, calmer and less stressed. A number also reported feeling less isolated and better listened to both by professional and other adoptive families. Some parents also suggested that improvements in family functioning had benefited their couple relationship with each other. The question of

parental wellbeing can be understood both as an outcome in itself and also as indicative of improvements in the family as a whole.

While the outcomes of the ASF have been broken into 3 domains for the purposes of analysis, in the lived experience of families, the 3 domains are intimately linked. On a conceptual level, child, parent and family functioning overlap with one another, with each domain containing elements of the other, and also because of the nature of family life these domains are interdependent. A parent feeling calmer and more capable is better able to manage difficult events with greater efficacy and in so doing, improve their relationship with and support their child's mental health. A child having fewer tantrums of less intensity will lead to a reduction of anxiety and stress in their parents. Family relationships are dynamic and are likely to be subject to either virtuous or vicious cycles of family functioning. What the evaluation shows is that in many cases a more virtuous cycle has been aided by support from the ASF.

It is important not to underestimate the scale of challenges faced by these families, nor should the impact of the Fund be overestimated. What came across clearly from all families interviews was that improvements were small, inconsistent and life was still challenging. Parents expected challenges to continue for a long time, but hoped that their children would experience more positive life outcomes as a result of the services provided.

10.6 Implications for policy and practice

The ASF has provided a new resource for local authorities to meet the needs of adoptive families. It has also raised awareness about adoption support needs and created an incentive for parents to seek help. Whilst this evaluation looked at a small number of local authorities, there were some elements of good practice that local authorities may want to consider.

The ASF has created an impetus for adoption support teams to respond faster to requests for assessments. Local authorities have adopted a more formalised assessment process so that it dovetails with the ASF application process. In particular, this was seen as an important step to take in response to the ASF requirement that a recent (no older than 3 months) assessment of need is conducted before an application is made. One local authority recognised that their assessments had become more narrowly focussed on the identification of therapeutic services and rectified this by creating a more systematic and integrated process that resulted in an improvement in the way a family's needs are tracked. Ensuring that in-depth and tailored working around family needs are not compromised as a result of streamlining the assessment of need process is something that other local authorities may want to consider.

Adoption support teams with more in-house capacity and multidisciplinary staff appeared more able to respond strategically to the introduction of the ASF because they already had greater capacity to plan for and meet demand and the skills in-house to build on to provide therapies. Smaller teams appeared less able to deal with the demands of the ASF and were more reliant on external providers for services and were less confident in assessing therapeutic needs. The regionalisation of adoption, through Regional Adoption Agencies (RAAs) may create opportunities for growth and efficiencies of scale to improve commissioning and upskilling in therapeutic interventions for adoption support teams. Some local authorities were already considering this but all will want to begin thinking about how the move to RAAs can improve adoption support services.

Some local authority case studies revealed that the role of the social worker was being compromised by the workload that ASF applications were creating. This stemmed from the increase in administrative tasks such as carrying out assessments of need and completing the ASF applications. Whilst workload was raised as an issue by almost all the local authorities observed, there was no agreed way to best respond. Larger local authorities, with more staff, could balance the increase better, whereas the impact appeared more significant for smaller ones. One local authority introduced some new, dedicated support for the administrative elements of the Fund that appeared to be well received by staff. Adoption support teams may benefit from considering how to respond to the administrative pressures and free up social worker time to work with families.

Evidence from parents suggested that their adoption support needs were not reviewed regularly, which meant they may reach crisis point before recognising the need to seek help themselves or left them dependent on their own ability to ‘fight for services’ and feeling isolated and unsupported. More frequent contact and reviews could improve the experience of adoptive parents and ensure their needs are still being met, and that any support received is still appropriate. These processes could also be designed to capture the impact of therapeutic interventions and be used to support commissioning/service development. Adoption support teams could consider what processes they have in place for reviewing support needs and how satisfied adoptive families are with them.

Local authorities might consider how they can influence workforce development of local therapy providers. Good practice identified by some case studies included mapping and sharing information with other local authorities and including independent providers in strategic planning. Local authorities may benefit from these collaborative approaches to help influence local markets to meet upcoming support needs.

Adoption support services have experienced a raised profile as a result of the ASF, which sends a clear message of recognition of the needs of adoptive families. Similarly, parents have been able to better articulate their family’s needs. The local authority case studies and family in-depth interviews indicate the potential for influencing other statutory services. For example, a few adoption support teams either gave examples of working

closer with CAMHS or the virtual school which they attributed to a raised profile and the development of expertise. Similarly, some families interviewed in-depth described how the ASF funding allocation had been a trigger for improved coordination with the child's school. Local authorities could consider this potential catalyst for improving the wider scaffolding of support around families as a longer-term investment that can improve stability and create better conditions for adoptive families to experience the full benefits of therapeutic provision.

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