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The Evaluation of the Adoption Support Fund

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Contents

1	List of Figures	5
2	List of Tables	8
3	Executive Summary	9
3.1	Key Findings	10
3.2	Implications for policy and practice	16
4	Introduction	19
4.1	Details of the Fund use	19
4.2	Scope changes	20
4.3	Aims of evaluation	21
4.4	Methods	22
4.5	The structure of this report	23
5	The Implementation of the ASF	24
5.1	Introduction	25
5.2	The assessment for the ASF services	25
5.3	Changes in how funding used for post-adoption support is being channelled and impacting on core services	38
5.4	Views on the ASF scope changes and other policy developments over the past 2 years	48
5.5	Awareness of the ASF	52
5.6	Conclusions	57
6	Changes in the local markets for provision of post-adoption therapeutic services	60
6.1	Introduction	60
6.2	How the market has expanded in response to increased demand	61
6.3	Challenges to growth and meeting demand	63
6.4	Wider evidence on changes in local markets for provision of post-adoption support services.	67
6.5	Conclusions	71
7	Since the introduction of the ASF has the experience of post-adoption services improved?	73
7.1	Introduction	74

7.2	Experiences of adoption support services pre-ASF	74
7.3	Experiences of adoption support services since ASF implementation: Online and postal surveys	76
7.4	Experiences of adoption support services since the ASF implementation: In-depth parent interviews and online survey (local authority and provider responses)	84
7.5	Timeliness of access to the ASF services and the impact of the Fair Access Limit	91
7.6	Barriers to accessing Adoption Support Services since ASF implementation	97
7.7	Improvement in family experiences of adoption support services	100
7.8	Conclusion	101
8	Support needs of applicants to the Fund	103
8.1	Introduction	103
8.2	Prior Support needs	104
8.3	Child behaviour, development and wellbeing	110
8.4	Family functioning, parental efficacy and parent-child attachment	116
8.5	The Wellbeing of Adoptive parents	118
8.6	Conclusion	119
9	Has the ASF improved the lives of adopted children and families?	121
9.1	Introduction	122
9.2	Child behaviour, development and wellbeing	124
9.3	Family functioning, parental efficacy and parent-child attachment	143
9.4	Wellbeing of adoptive parents	152
9.5	Conclusion	157
10	Final Conclusions	159
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?	159
10.2	Has the assessment process improved?	161
10.3	Has the market of post-adoption support grown?	161
10.4	Adopters experience of post-adoption support services	162
10.5	Improving the lives of adoptive children and their families	163
10.6	Implications for policy and practice	164

1 List of Figures

Figure 1: Proportion of applications made by therapeutic service type applied for	20
Figure 2: Relative Frequencies of 'thinking about the assessment itself, how far do you agree or disagree with the following statements?' of baseline respondents	29
Figure 3: Relative Frequencies of 'How satisfied do you feel with' of baseline respondents	30
Figure 4: Relative Frequencies of 'If yes, what was the response to that request?' of online survey of adoptive parents	34
Figure 5: Relative Frequencies of 'How did you first hear about the Adoption Support Fund?' of baseline respondents	53
Figure 6: Relative Frequencies of 'How did you hear about the ASF' of online survey respondents	56
Figure 7: Relative Frequencies of 'How would you rate your understanding about your entitlements to adoption support services?'	57
Figure 8: Relative Frequencies for local authority staff of changes as a result of the ASF	68
Figure 9: Relative Frequencies for service providers of changes as a result of the ASF	70
Figure 10: Relative Frequencies for local authority staff and service provider agreeing to the provided statements	71
Figure 11: Relative Frequencies of the first and second adopted child receiving adoption support services of the online survey respondents	77
Figure 12: Relative Frequencies of the first and second adopted child receiving therapeutic adoption support of the online survey respondents	78
Figure 13: Relative Frequencies of rating of the relationship with the current adoption agency of online survey respondents	79
Figure 14: Relative Frequencies of rating of the quality of support of online survey respondents	80
Figure 15: Relative Frequencies of the impact of the ASF in terms of receiving services of online survey respondents	81

Figure 16: Relative Frequencies of reported satisfaction with various aspects of the support of follow-up respondents	82
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	97
Figure 18: Relative Frequencies of 'Have there been any barriers regarding your access to adoption support services?'	98
Figure 19: Relative Frequencies of 'If you have not previously received any therapeutic post-adoption support, why not?' of baseline respondents	106
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	107
Figure 21: Mean scores of SDQ subscales of baseline respondents compared to population norms	111
Figure 22: Four-band classification of children's SDQ scores at baseline	112
Figure 23: Comparison of SDQ means of baseline and follow-up data	127
Figure 24: Four-band categorisation of total difficulties score at baseline and follow-up	130
Figure 25: Total difficulties mean scores at baseline and follow-up	131
Figure 26: Comparison of BAC means of baseline and follow-up data	133
Figure 27: Comparison of aggression at baseline and follow-up	135
Figure 28: Aggression mean scores at baseline and follow-up	135
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	136
Figure 30: Relative Frequencies of impact of services received through the ASF for respondents of the online survey of adopters	137
Figure 31: Comparison of the relationship subscale of The Carer Questionnaire mean scores at baseline and follow-up	144
Figure 32: Mean scores of individual items relationship subscale of The Carer Questionnaire at baseline and follow-up.	145

Figure 33: Mean scores of the relationship subscale of The Carer Questionnaire at baseline and follow-up	146
Figure 34: Responses to self-attributed outcome questions of follow-up respondents	147
Figure 35: Relative Frequencies of impact of services received through the ASF of online survey respondents	148
Figure 36: Mean scores of the SWEMWBS score at baseline and follow-up	153
Figure 37: Mean scores of the SWEMWBS score at baseline and follow-up	153
Figure 38: Responses to 'I feel more optimistic about the future as a result of the package of support'	154

2 List of Tables

Table 1: Proportion of the baseline respondents who are likely to have a disorder	113
Table 2: Prediction of any psychiatric disorder of baseline respondents: comparison with Goodman et al. sample.	113
Table 3: Descriptive Statistics of BAC-C and BAC-A	114
Table 4: Descriptive Statistics and Reliability of relationship subscale of 'The Carer Questionnaire'	117
Table 5: Comparison of SDQ means of baseline and follow-up data	126
Table 6: Prediction of any psychiatric disorder of follow-up respondents at baseline and follow-up: comparison with Goodman et al. sample	132
Table 7: Comparison of BAC mean scores of baseline and follow-up data	133
Table 8: Comparison of sample proportions meeting the clinical threshold at baseline and follow-up	134
Table 9: Aggression mean scores at baseline and follow-up	136
Table 10: Comparison of The Carer Questionnaire mean score at baseline and follow-up	144
Table 11: Comparison of SWEMWBS means of baseline and follow-up data	152

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% through social media networks of adopters.

Also mirroring the above findings, 8 of the 20 families interviewed 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 receive 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 provided 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 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

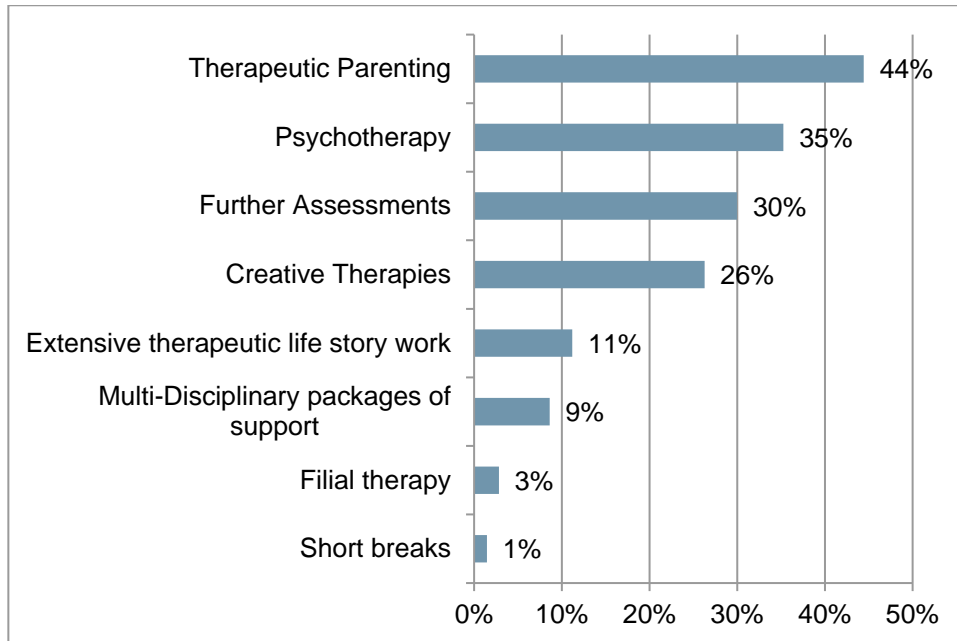
³ The standard deviation is £6,469, which shows that there is a large variation in the cost per application.

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/Ittakesavillagetoraiseeachild-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 Dunbriar 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); Oxtun 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.

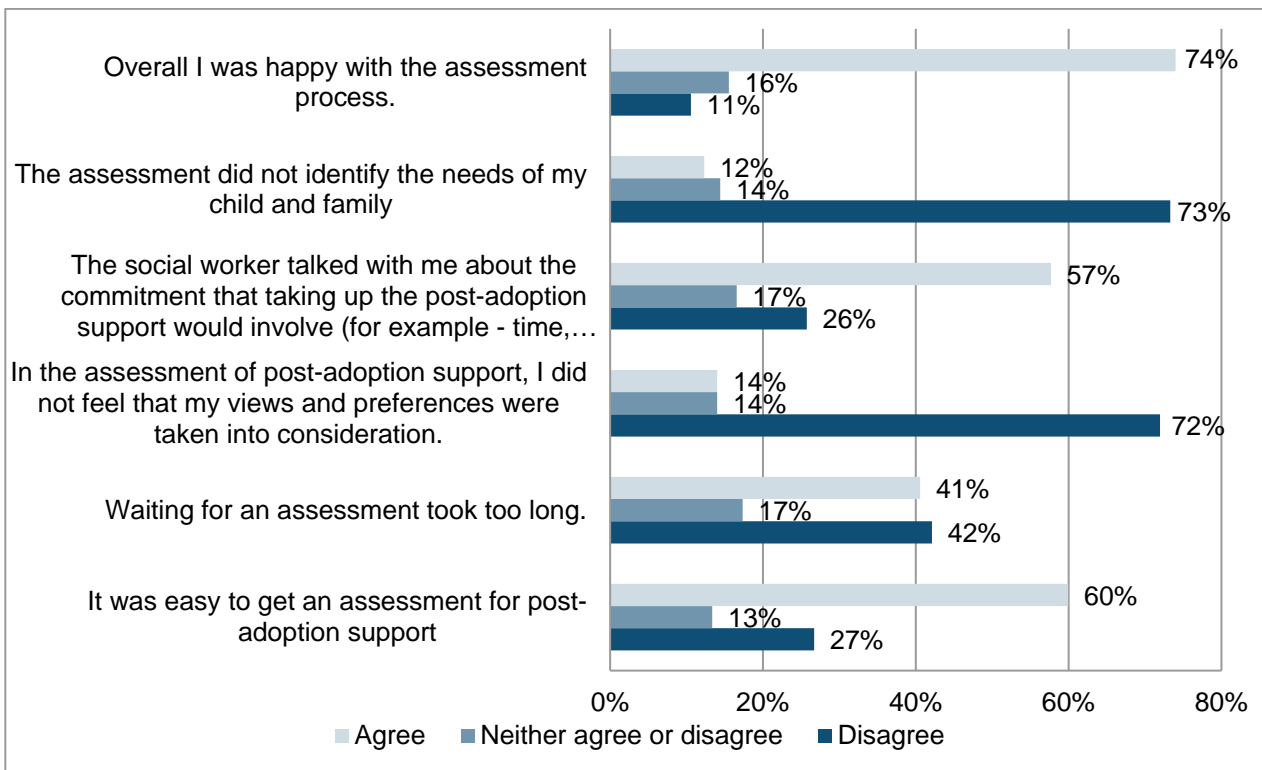
Satisfaction of parents currently accessing the ASF with the assessment of need

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.

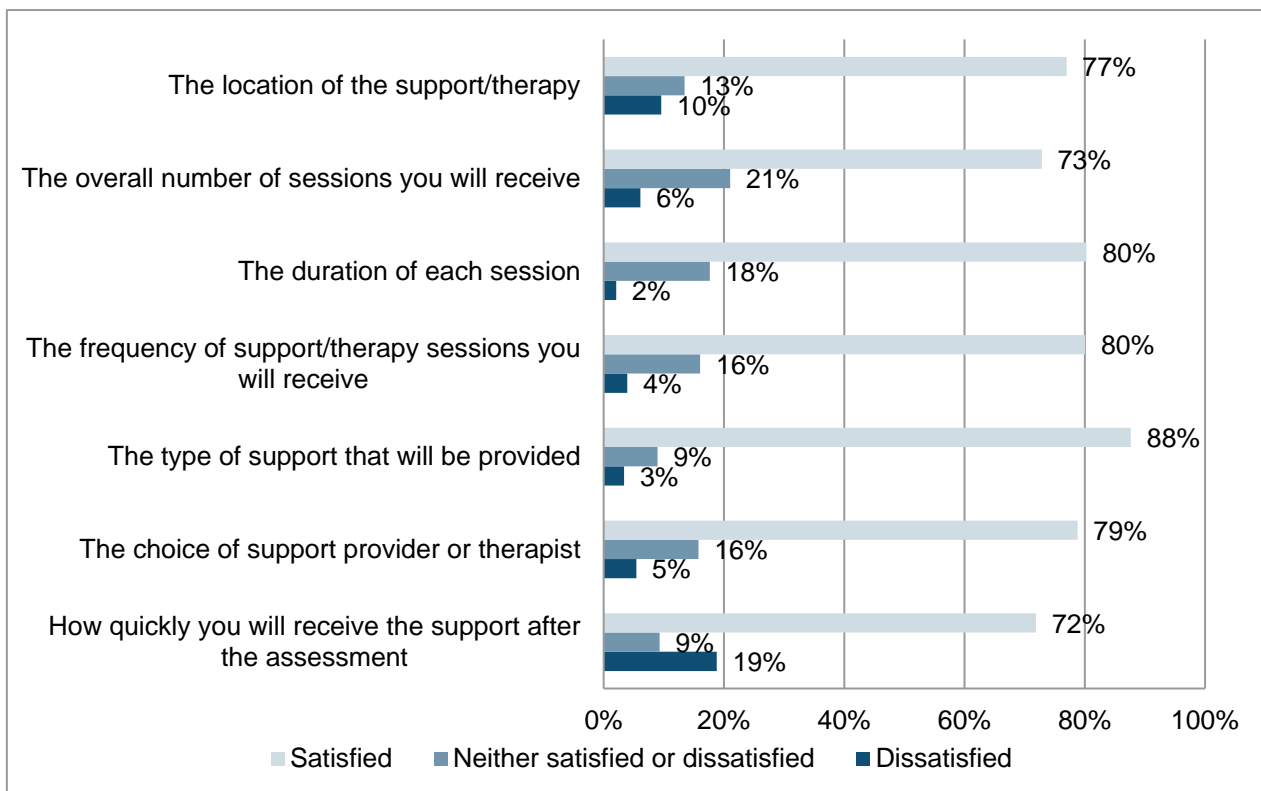
¹² "Strongly disagree", "Disagree", and "Somewhat disagree" are merged into "Disagree", "Strongly agree", "Agree", and "Somewhat agree" are merged into "Agree"

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 2011¹⁶ 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.

¹⁶ Report can be found here:

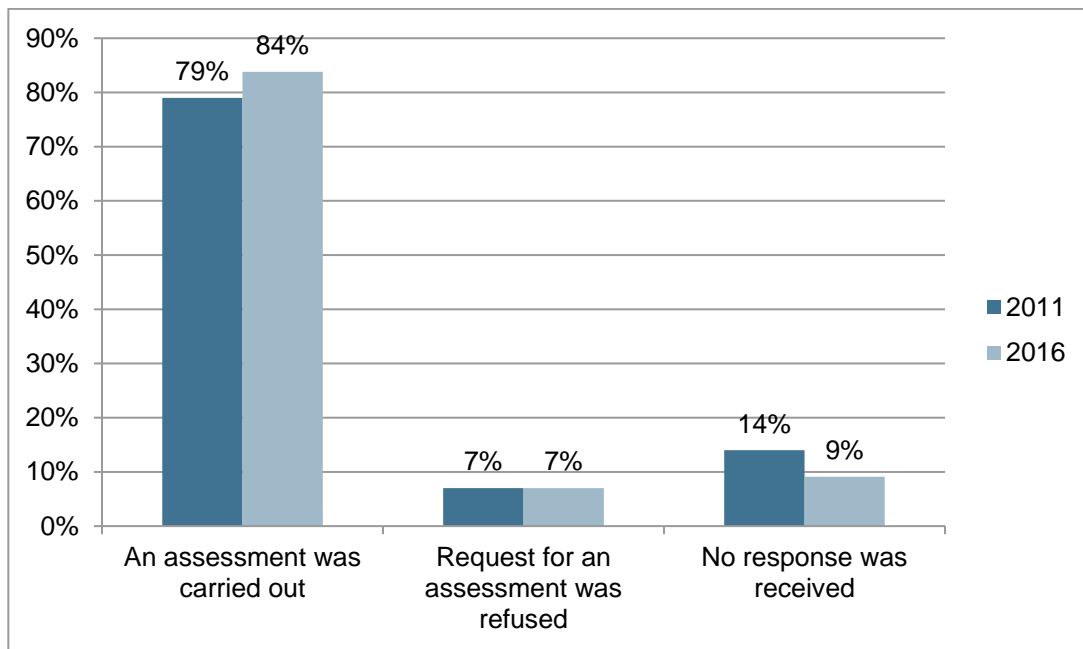
<https://www.adoptionuk.org/sites/default/files/documents/Ittakesavillagetoraiseeachild-Report-June12.pdf>

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 process²²

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, Oxtun, 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

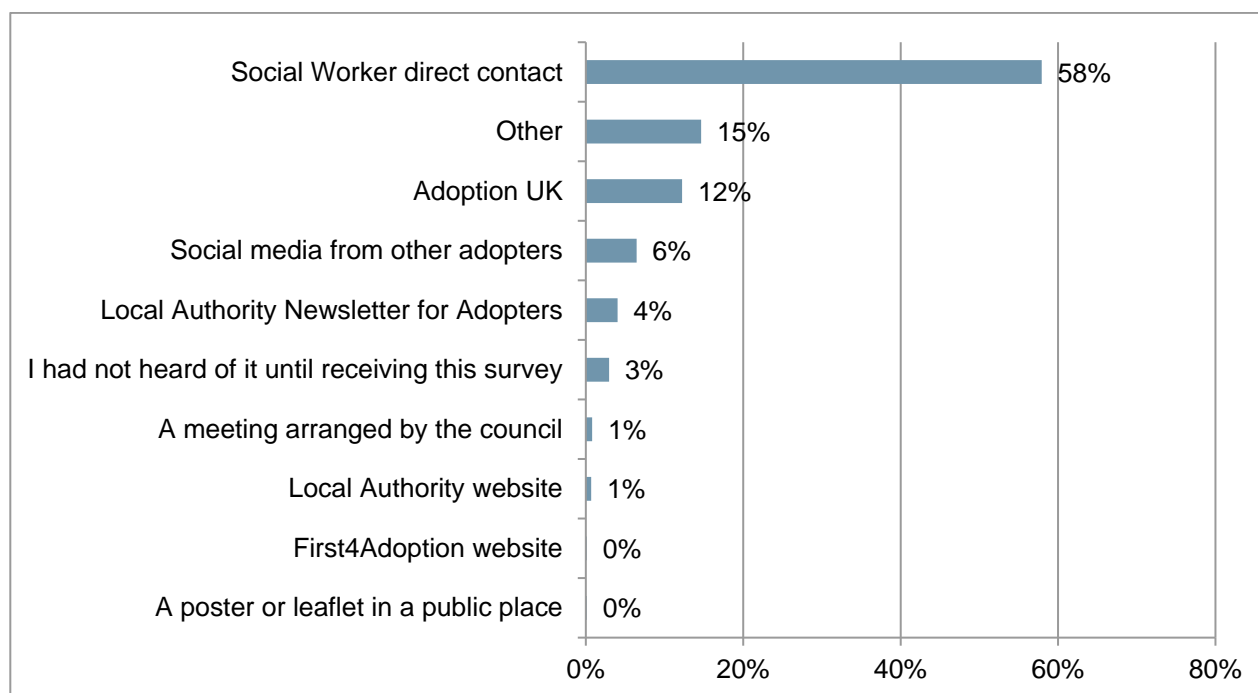
Key findings

- 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% through social media networks of adopters.
- Also mirroring the above findings, 8 of the 20 families interviewed 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

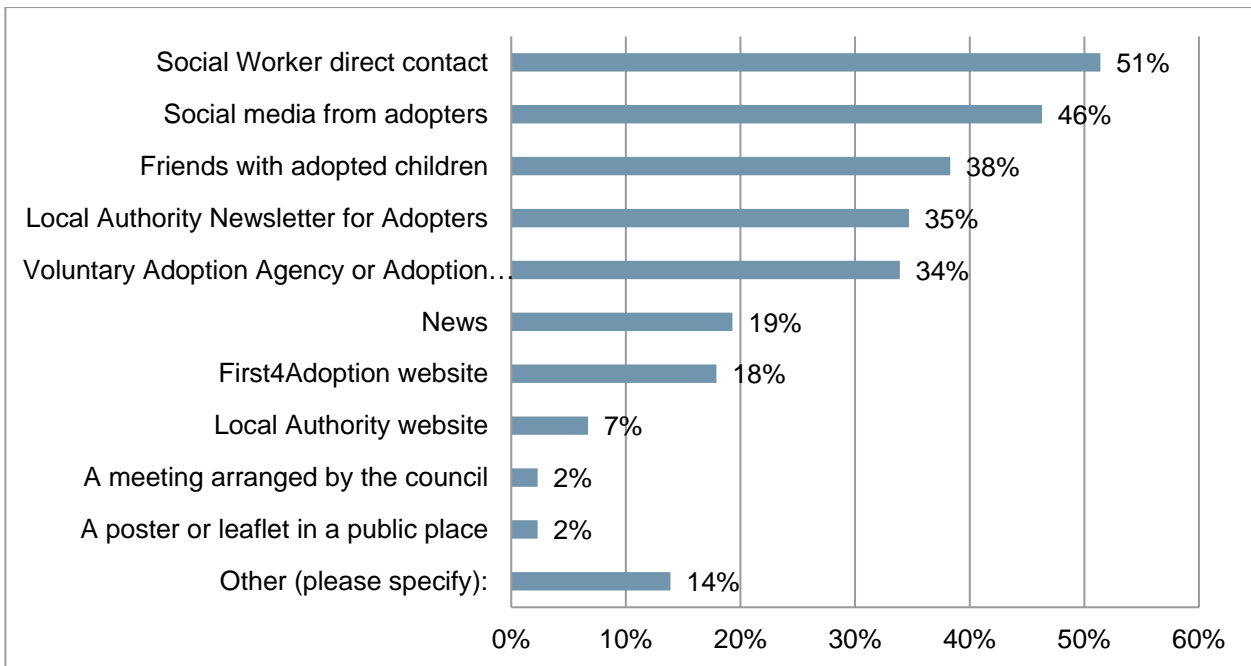
to knowing how much support families can get, only a few families specifically said they knew they could make repeat applications. Most others hoped it would be there for as long and for as much support was needed, but didn't know if there were any limits or not.

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

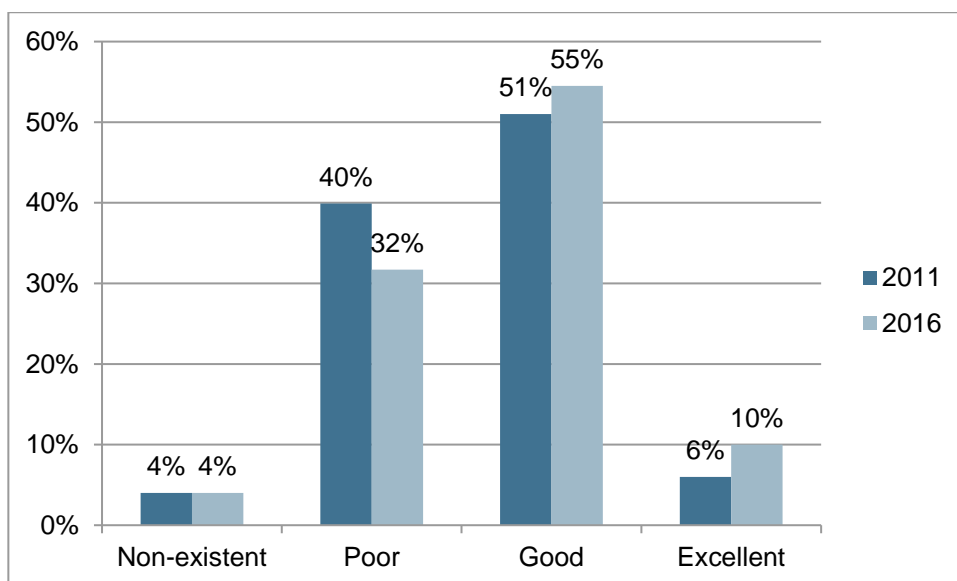
²⁵ Several selections possible as this represents a combination of the questions ‘How did you first hear about the Adoption Support Fund?’ and ‘Since hearing about the Adoption Support Fund for the first time, have you heard about it from another or multiple sources?’.

²⁶ A significant association between ‘understanding the importance of adoption support’ and ‘time of the survey’ was found, $\chi^2(1, N=853)=5.85, p<.05, \text{Cramer's } V=.083$. 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, $\chi^2(1, N=853)=4.23, p<.05, \text{Cramer's } V=.07$. 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, $\chi^2(1, N=840) = 10.95, p < .001$, 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’, $\chi^2(1, N=828) = 1.63, p = .201$, 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 Therapy) 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).

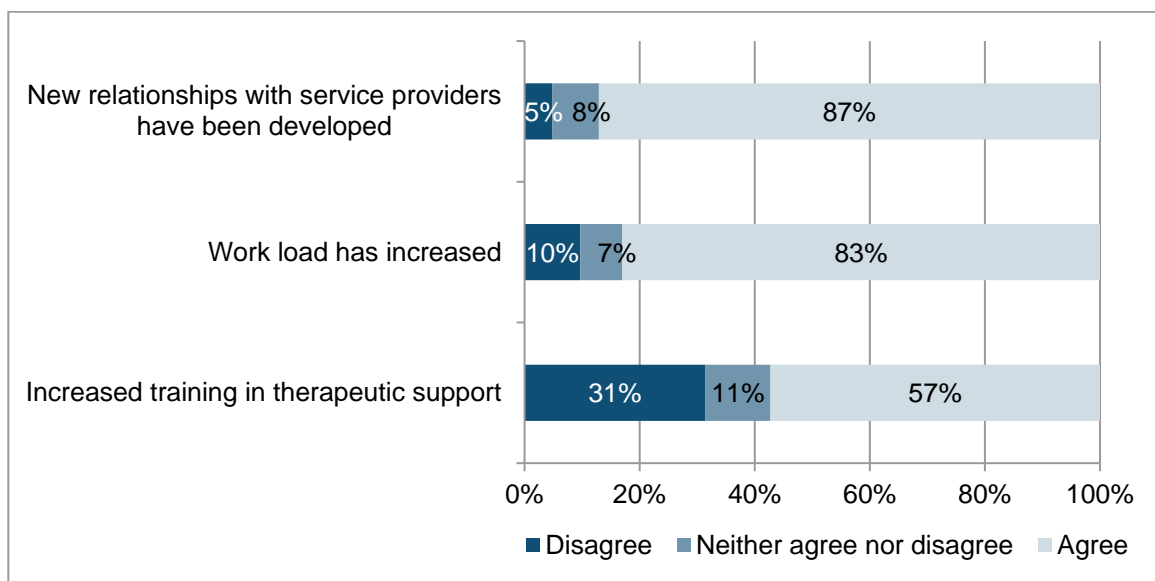
³⁰ It should be noted that the sample is not representative of the population of service provider and local authority staff. However, the sample of service provider represent a wide spread in terms of region, size of organisation and services offered and the sample of local authority staff in terms of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

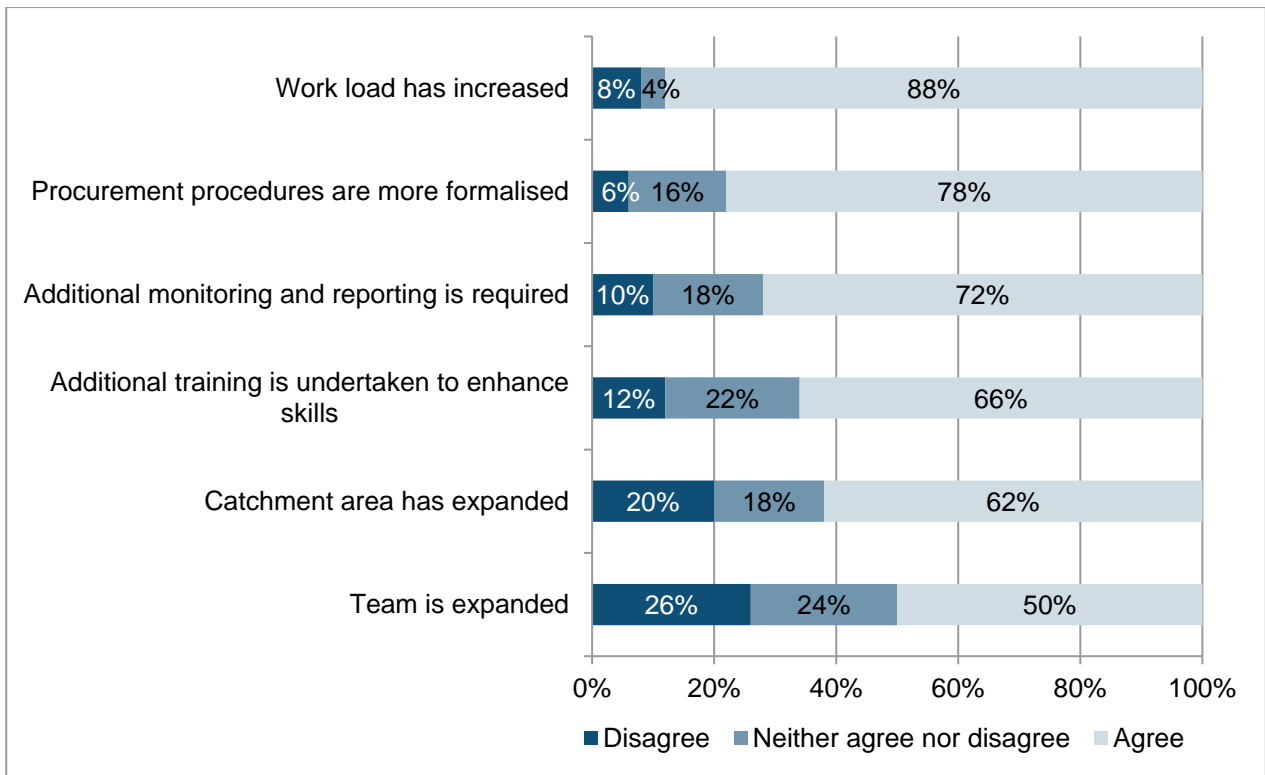
(66%) stated that they had undertaken additional training to enhance skills. Nearly two-thirds (62%) also agreed that their catchment area had expanded because of the ASF. This ties in with the fact that 94% stated that the proportion of work on adoption support had increased as a result of the ASF. 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 what 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



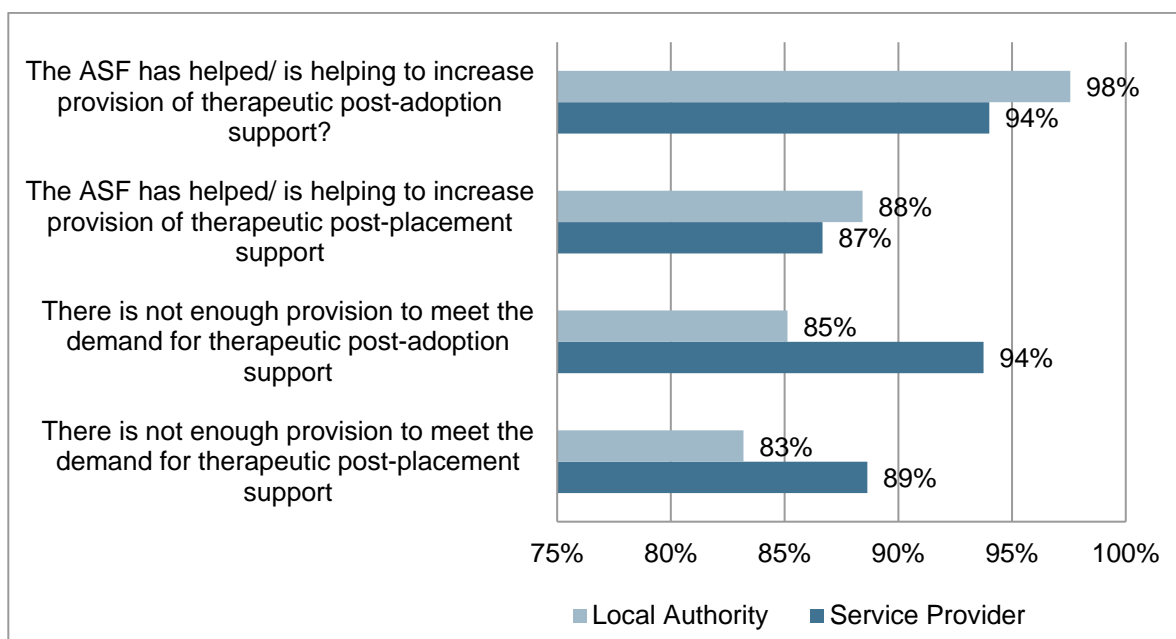
Note: N=50; Source: Online survey of service providers.³⁵

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 2011 and in 2016.

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

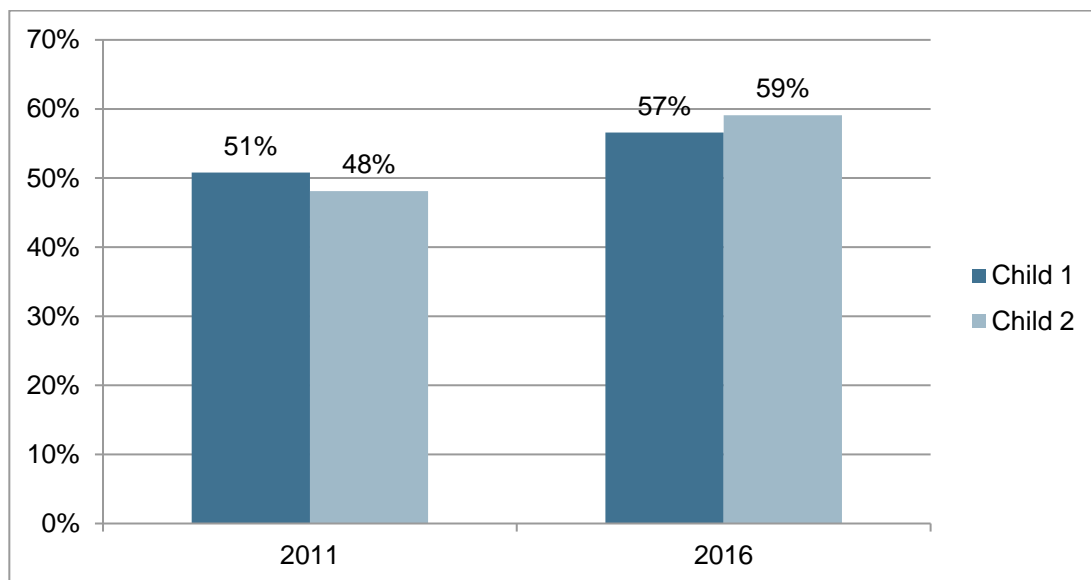
- The online survey of parents’ reports of adoption support received at 2 time points, 2011 (n=283) and 2016 (n=586);
- The longitudinal parents’ survey reports of satisfaction with the ASF-funded support received (n=481);
- The second round of in-depth parent interviews that describe experiences of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

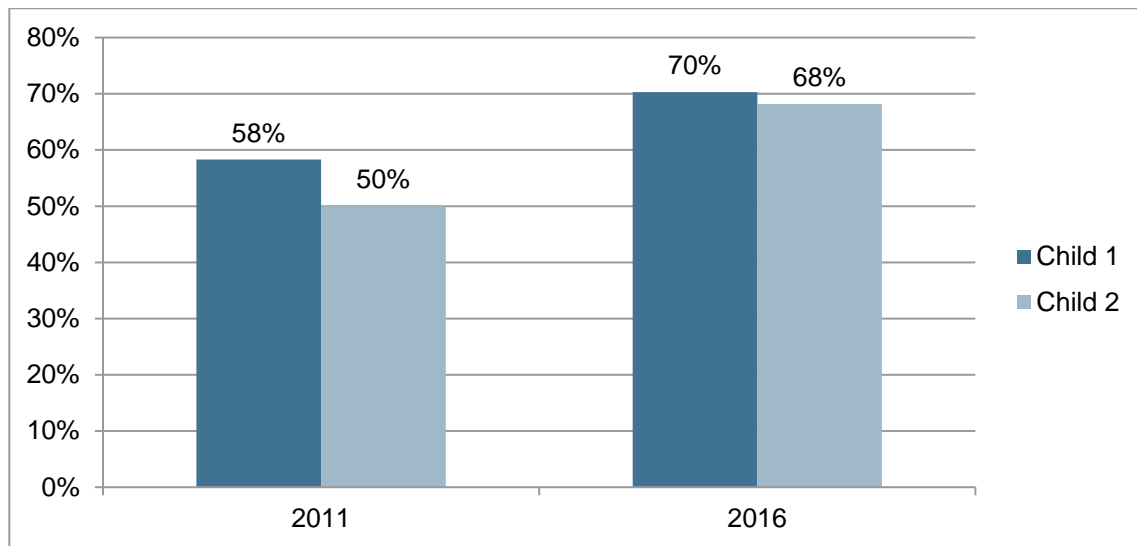
The relatively small increase in the number of families receiving some form of adoption support service might be not very surprising as the ASF is specifically designed to provide *therapeutic* adoption support. For this reason, the comparison of adopted children in 2011 and 2016 receiving therapeutic 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', $\chi^2(1, N=432)=5.94, p<.05$, Cramer's $V=.117$ for the first child and $\chi^2(1, N=214)=3.25, p=.072$,

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.

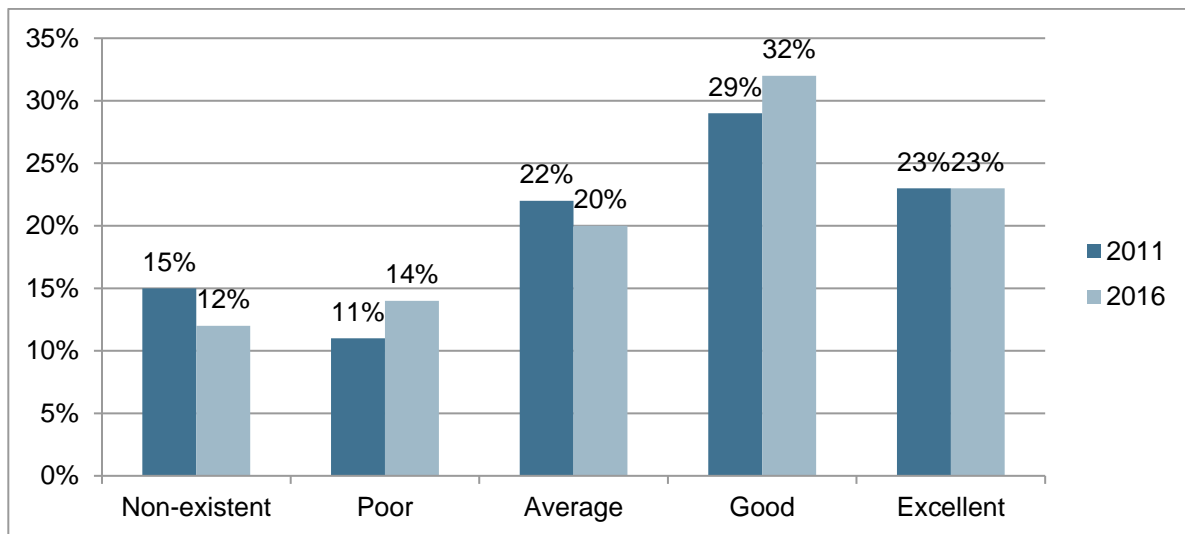
Relationships with agencies

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



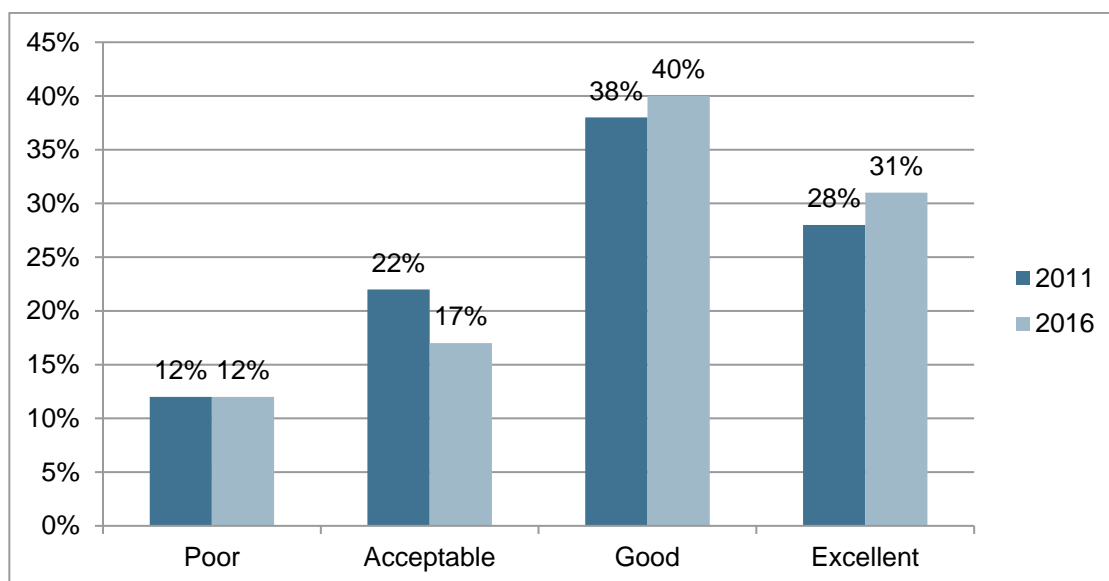
Note: N=843; Source: Online survey of adopters and prospective adopters 2011 and 2016.

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 2016⁴⁰, 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.

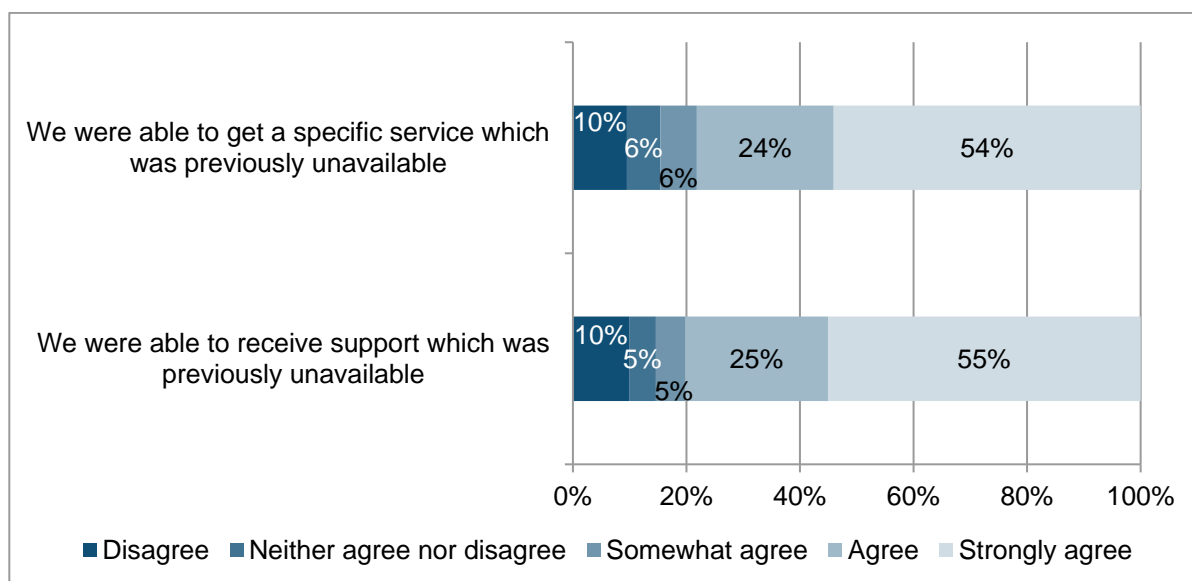
Considering these 2 responses together, it seems that whilst families’ experiences of their adoption agency (this includes both local authority and independent agencies) remained mixed, the small rise in quality ratings could relate to the ASF implementation. Parents’ responses in the online survey of 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

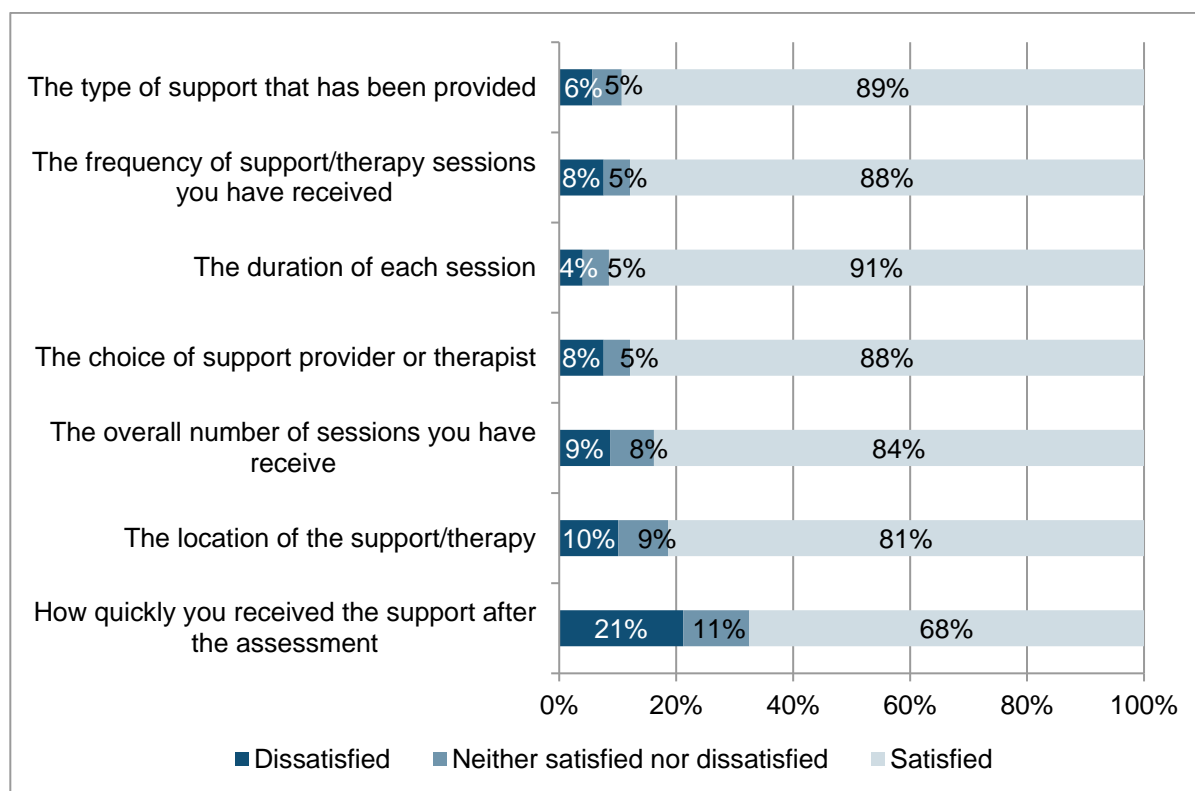
Postal survey of the ASF parents: Parents' satisfaction with the ASF funded therapeutic services

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...” 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 (EHCP). 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.

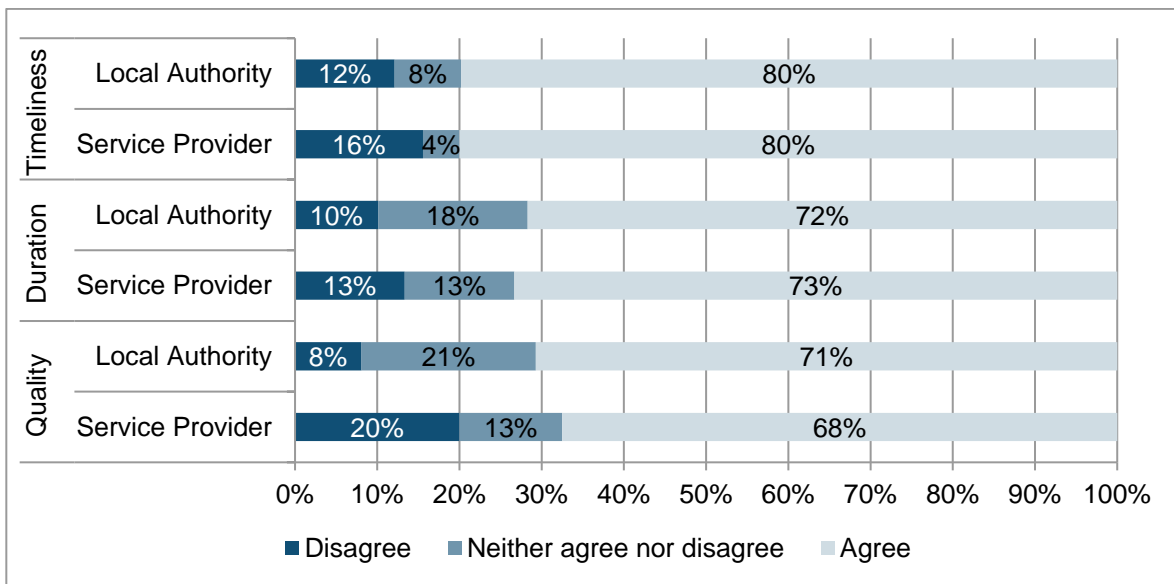
In both first and second interviews, most families expressed fears about the Fund's sustainability. Parents expressed fears that the Fund might close, that it wouldn't be available if families needed it again in the future, or that therapy offered would be cut short. All of these fears led to worries 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

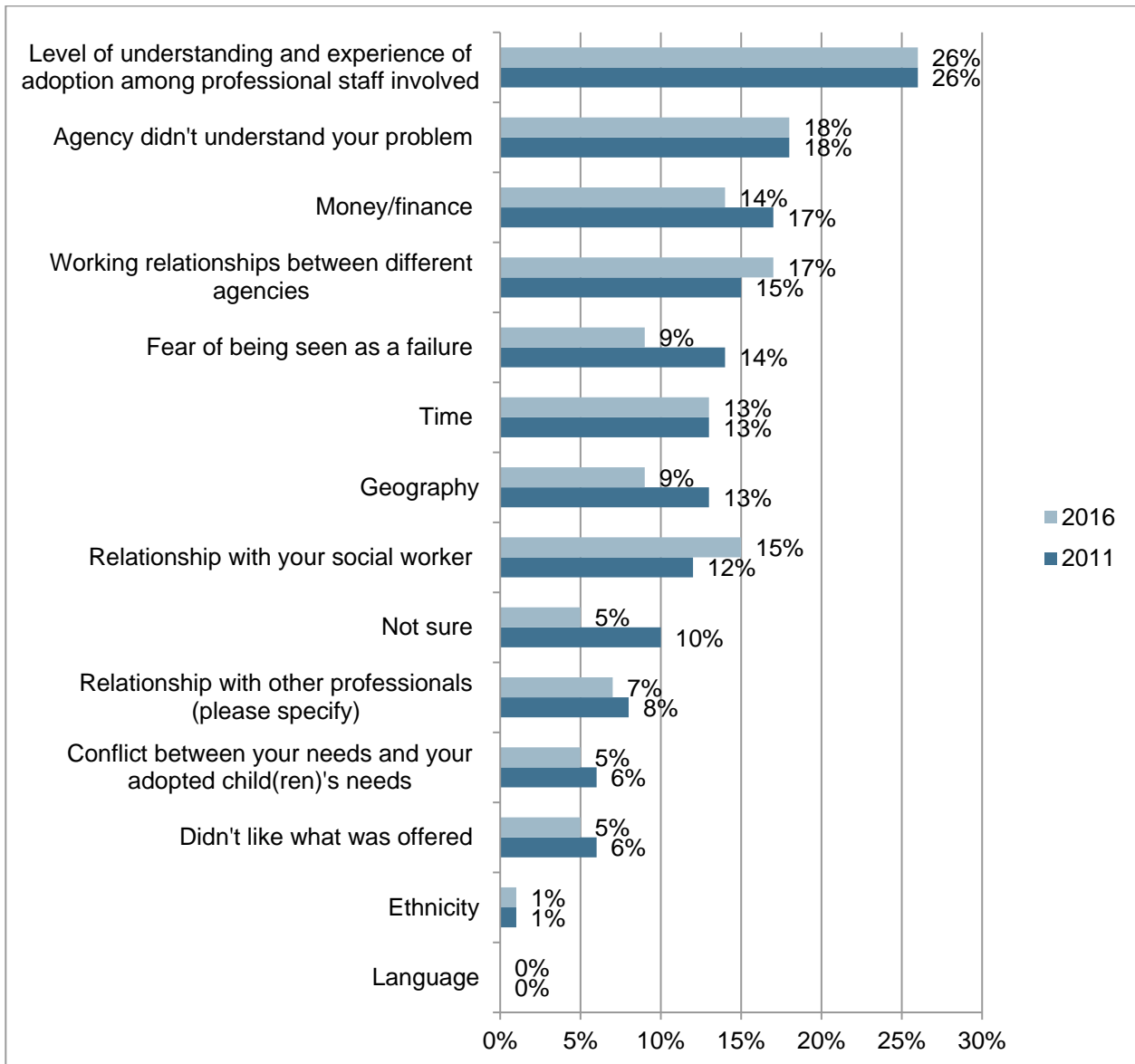
Parents responding to the online survey in 2011 and 2016 identified a number of significant barriers to accessing adoption support services. On average, respondents reported slightly fewer barriers in 2016.⁴⁶ The principal barriers were still the level of understanding and experience of adoption among 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.

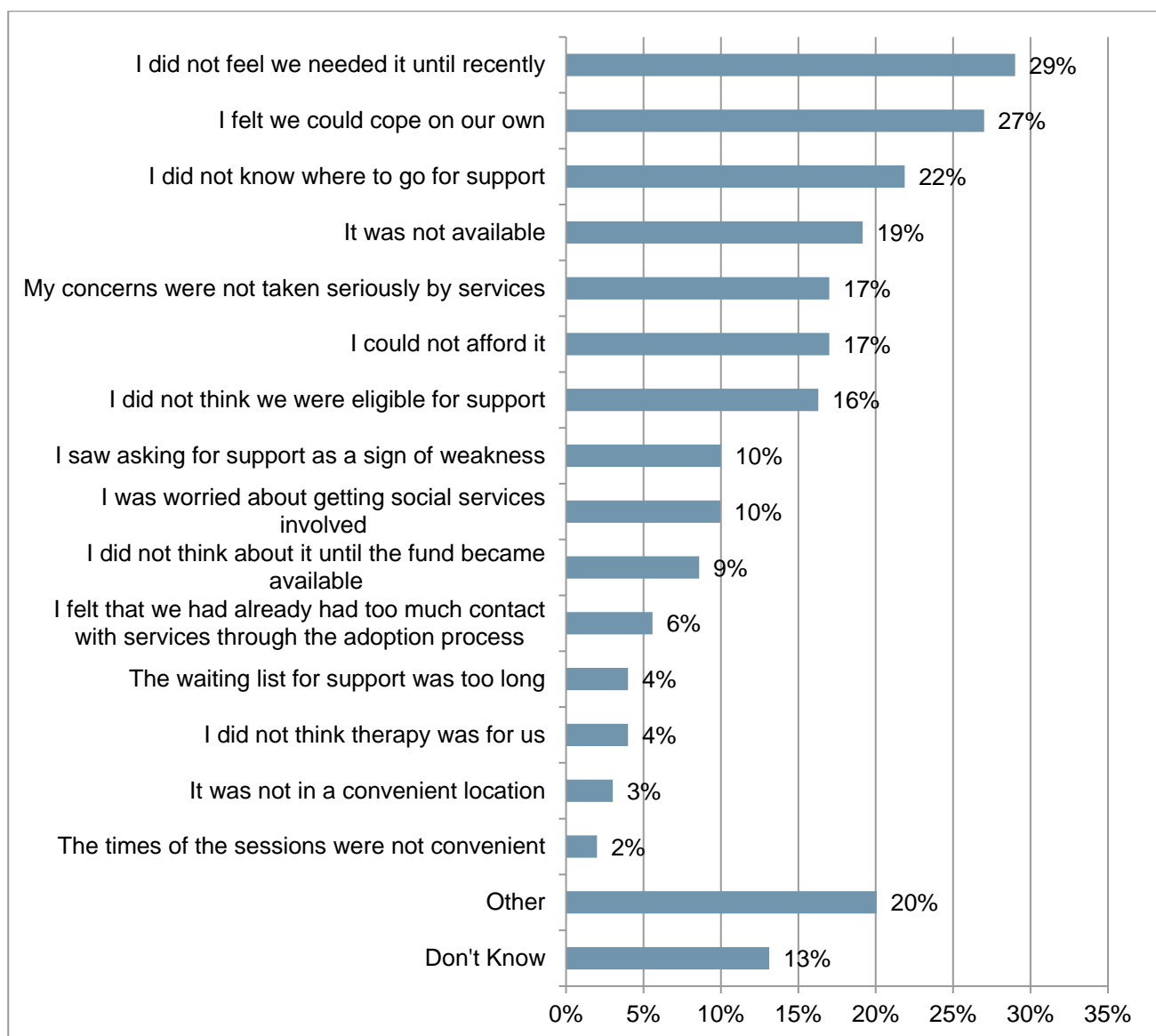
The survey further asked if respondents had previously paid for post-adoption support themselves. Of all respondents 15% had paid for support before. Taking the information about receiving support via their local authority and privately paying for therapeutic adoption support together revealed that, 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

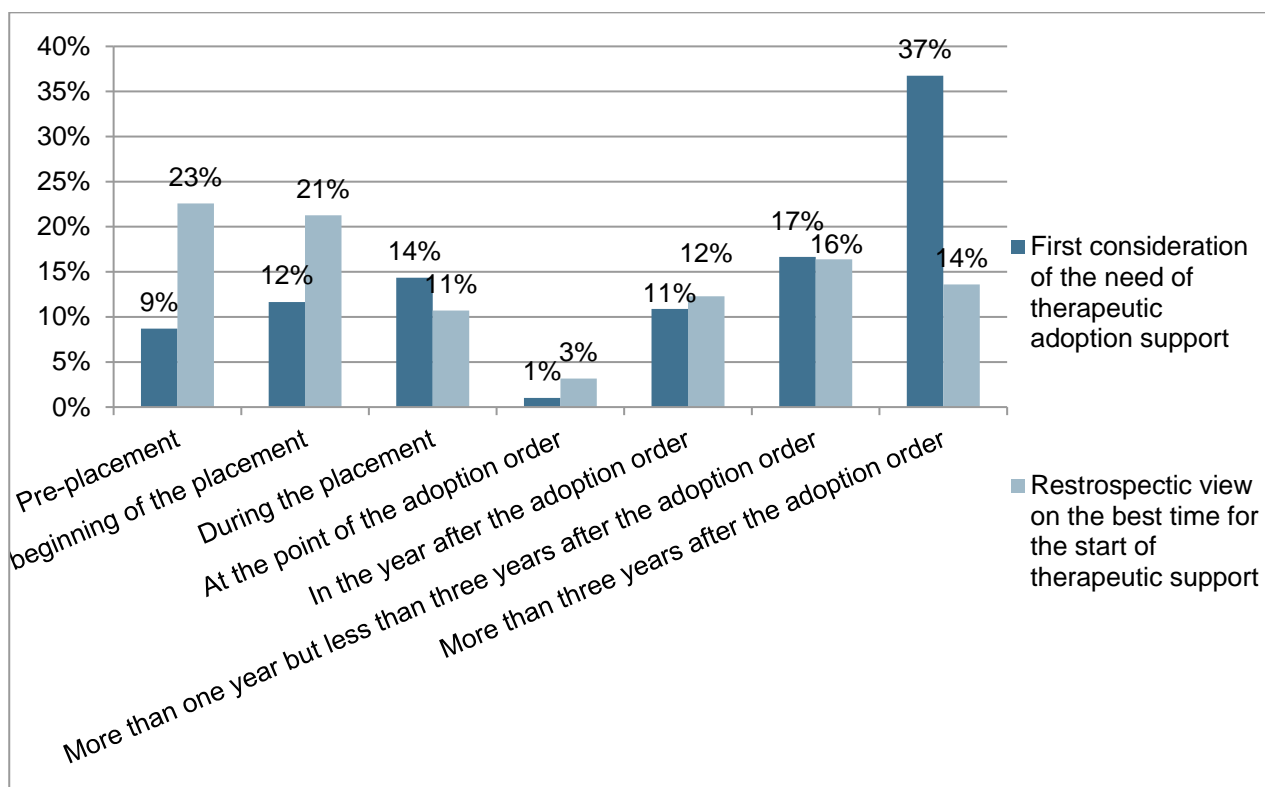


Note: N = 663; Source: Baseline survey; several selections possible.

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.

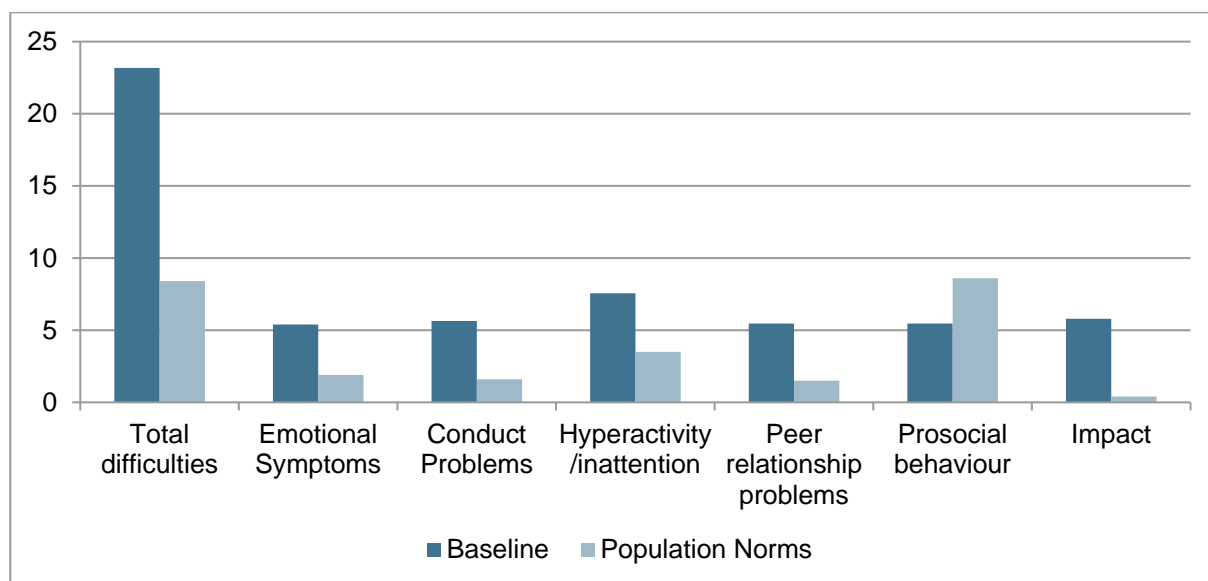
⁵⁵ SDQ norms are for Britain rather than for England only and were created with a sample aged 5 to 15.

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

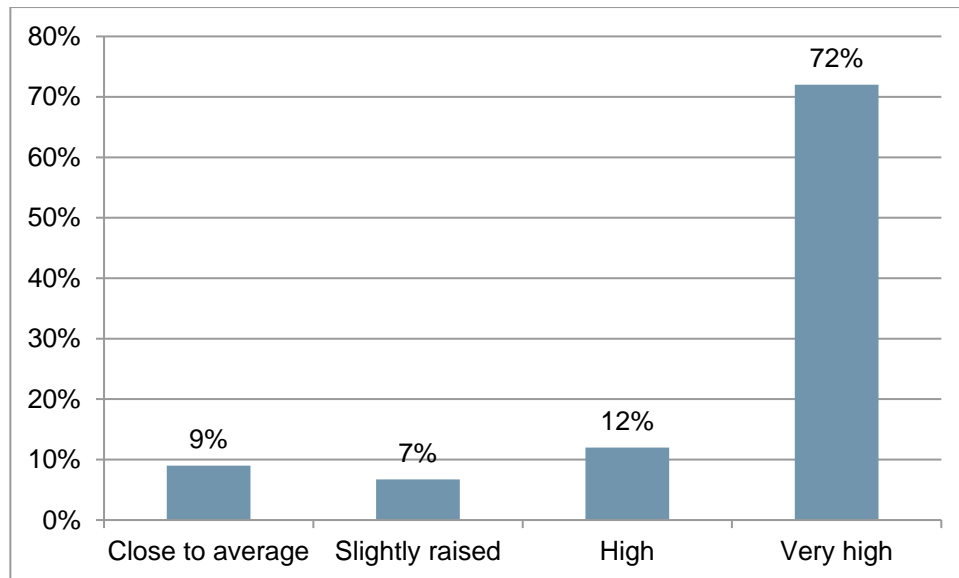


Note: N=767; Source: Baseline survey.

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.⁵⁸⁵⁹ 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 disorder⁶¹

	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.

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 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.

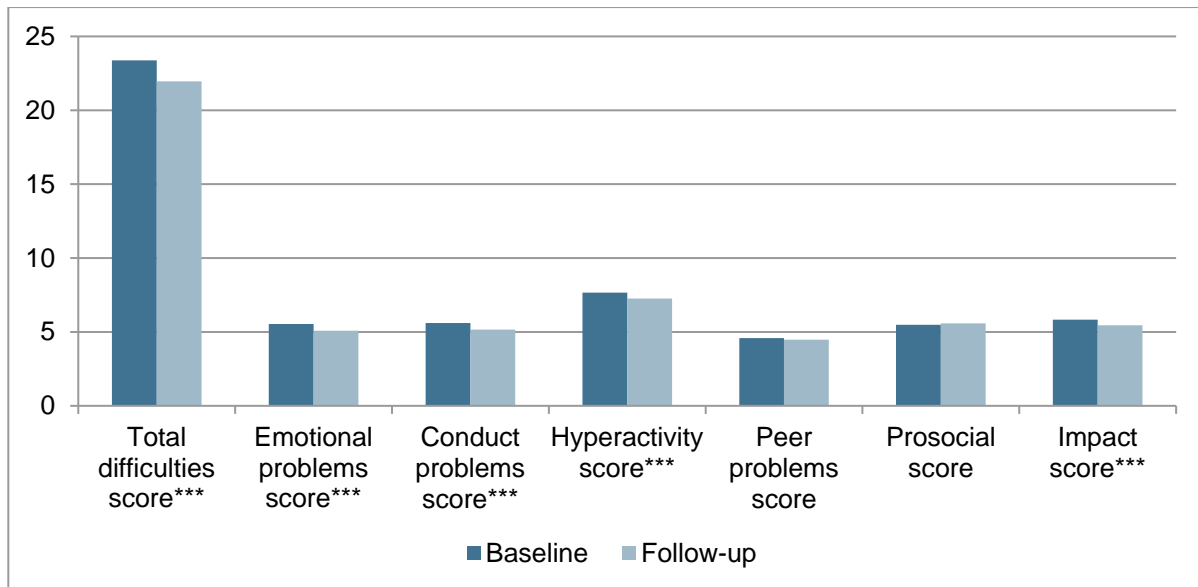
Table 5: Comparison of SDQ means of baseline and follow-up data

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

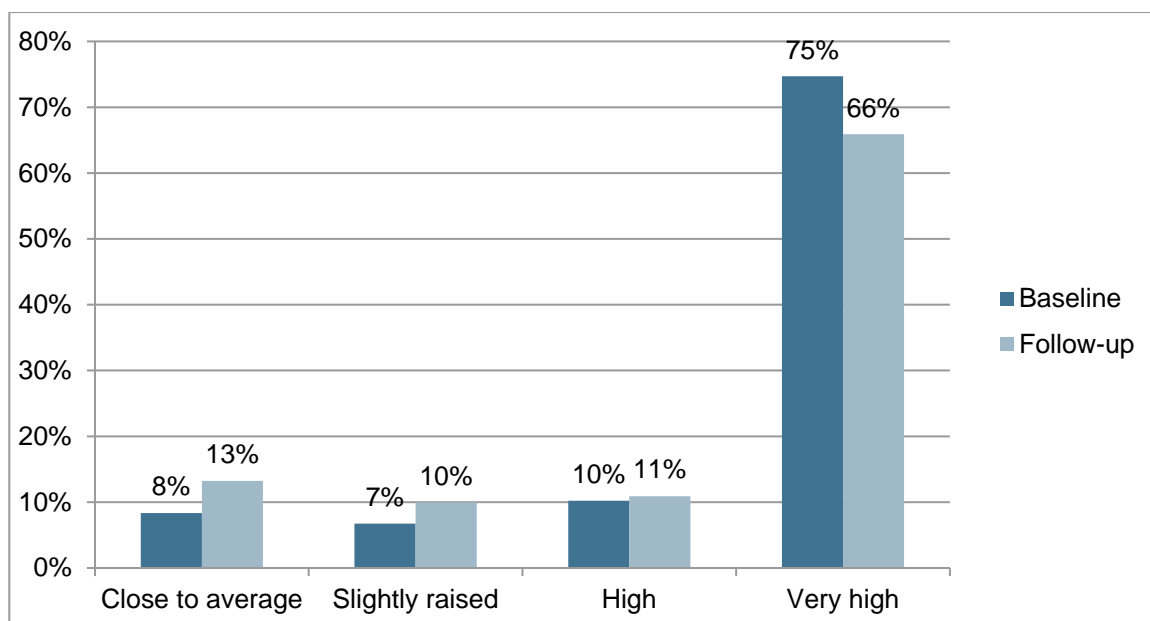
To help readers understand what the results of the above SDQ analysis mean, in addition to exploring the mean change on the total difficulties score of the SDQ, the SDQ responses were analysed in terms of the 4 part classifications provided by the scale developer. This classifies each child's total SDQ 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>

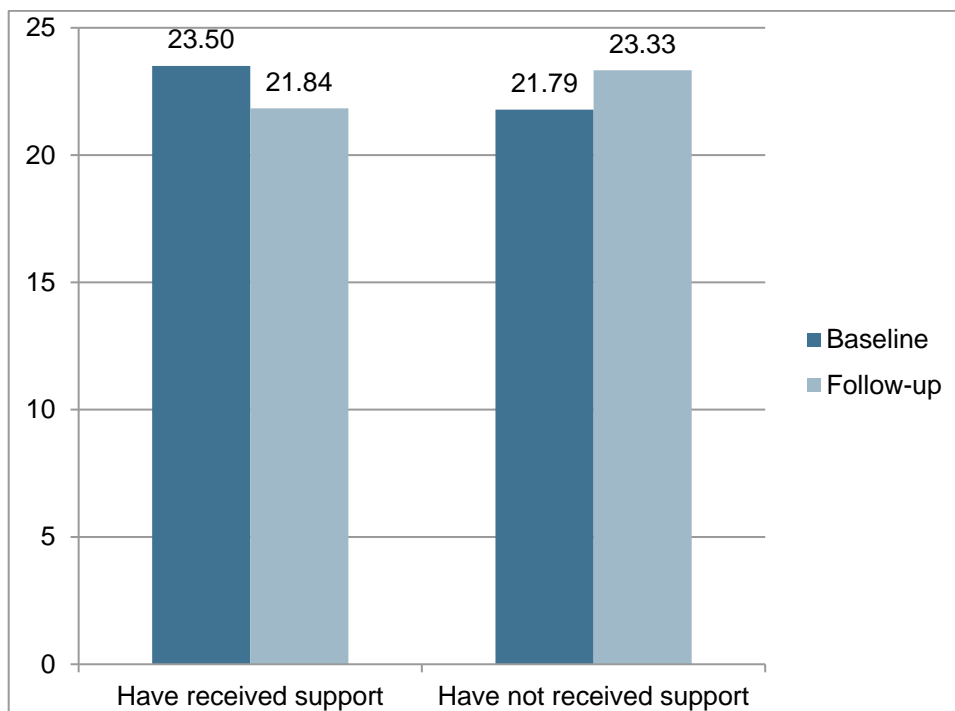
⁷⁸ Greater detail on this analysis and the context of the decision to reject its finding in this instance is elaborated in Appendix 1: Statistics in detail.

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)

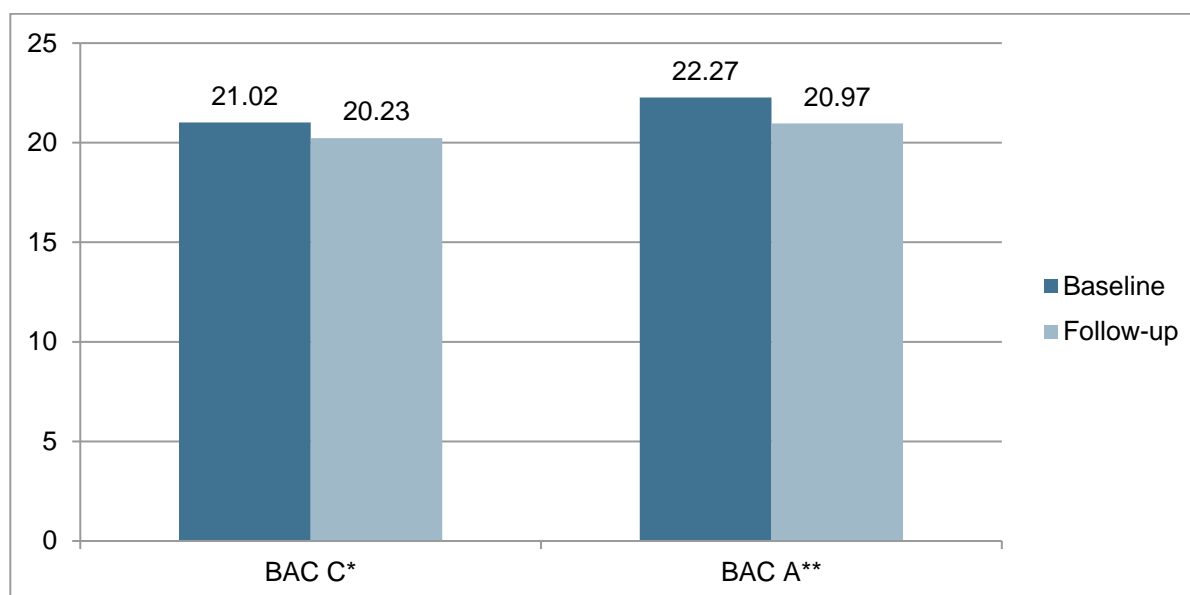
The BAC was deployed in the survey to complement the SDQ so as to give a more robust picture of children’s behaviour, development and mental health. In keeping with the results of the SDQ analysis, a statistically significant reduction in mean score was observed on both child and adolescent versions 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

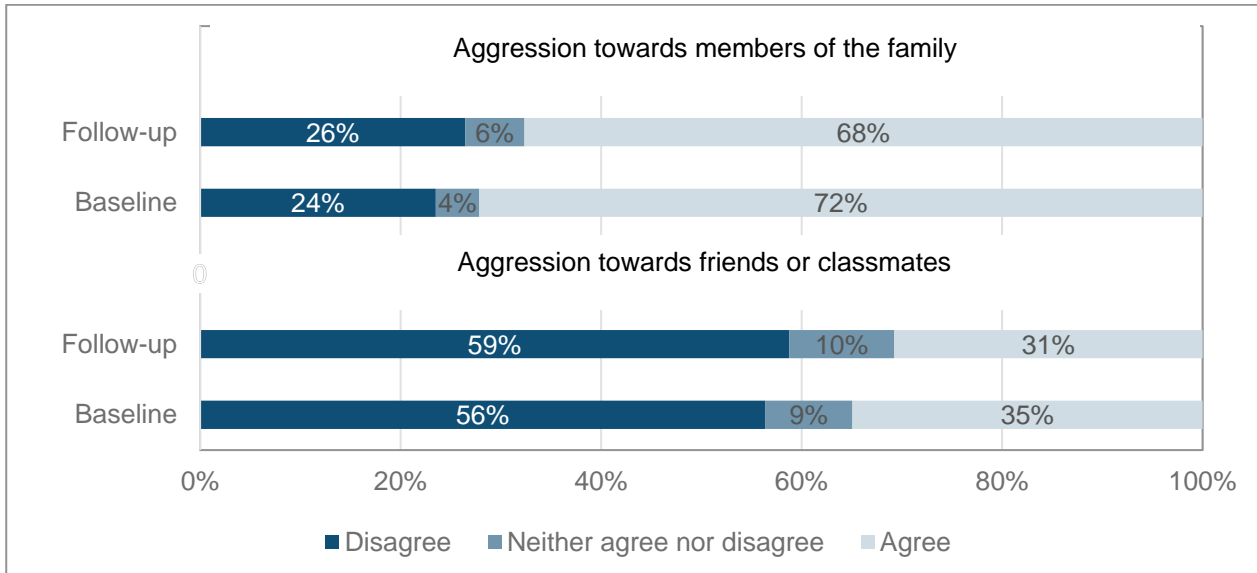
To supplement the validated scales outlined above, 2 additional questions on aggressive conduct were included in the longitudinal survey of adopted families at both baseline and follow-up. These 2 questions covered the aggressive behaviour of their child towards (i) friends or classmates, and (ii) members 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

⁸²Brodzinsky, 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.

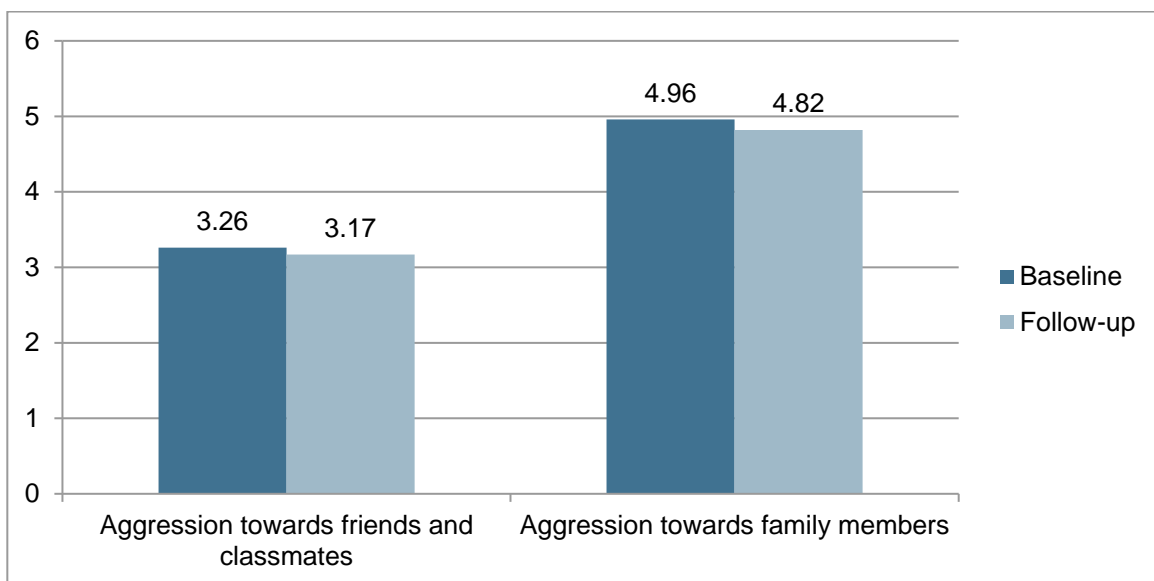
Figure 27: Comparison of aggression at baseline and follow-up



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

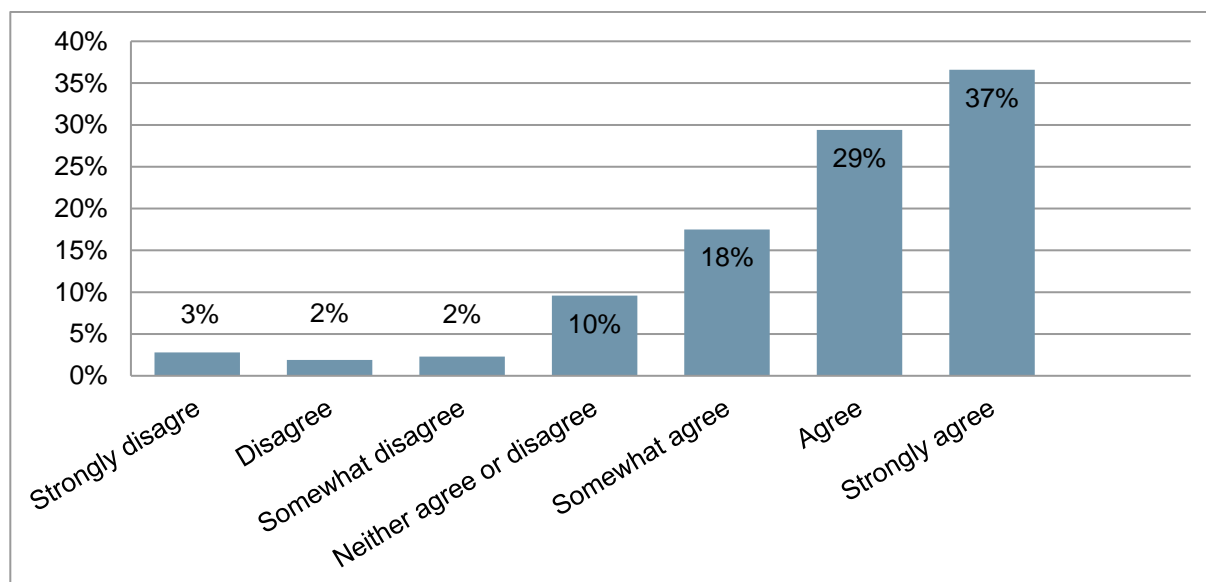
Question	Baseline Mean (SD)	Follow-up Mean (SD)	Mean Diff (CI)	df	p	Effect size d^{83}
Aggression towards friends	3.26 (1.94)	3.17 (1.84)	-.09 (-.24; .07)	434	.27	.05
Aggression towards family	4.96 (1.95)	4.82 (1.97)	-.14 (-.30; .02)	437	.08	.07

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



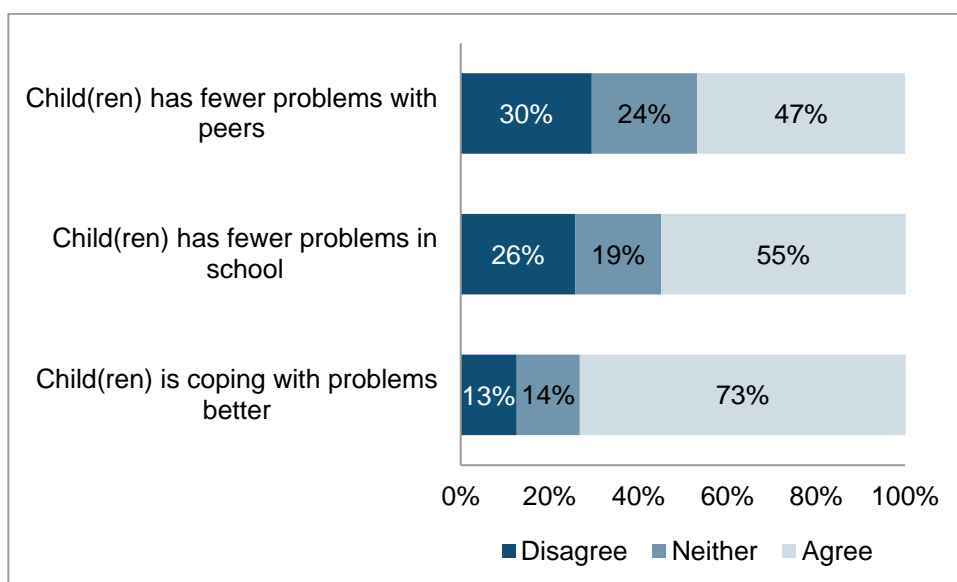
Note: N=429; Source: Follow-up survey.

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 health⁸⁶

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.

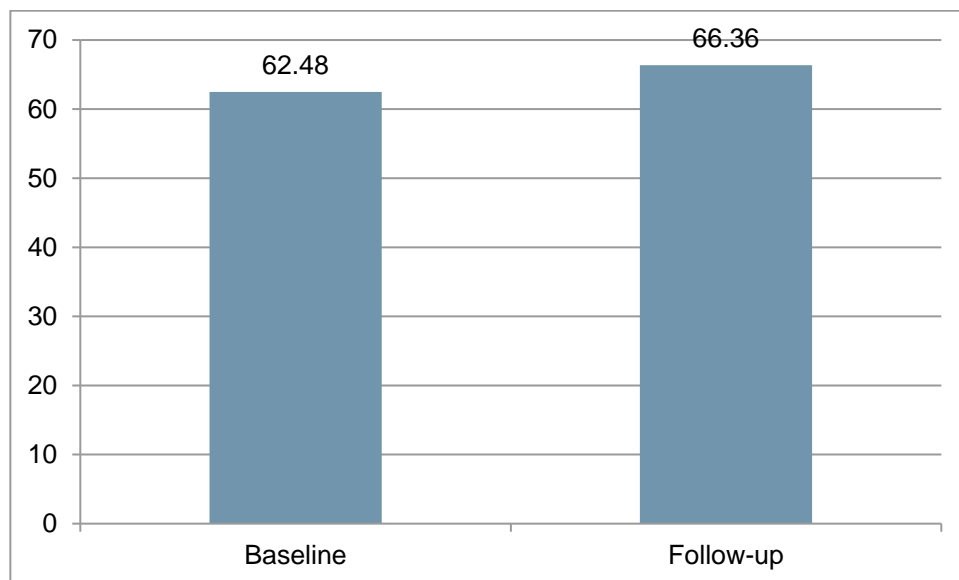
Table 10 and Figure 31 show the results of the analysis:

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.

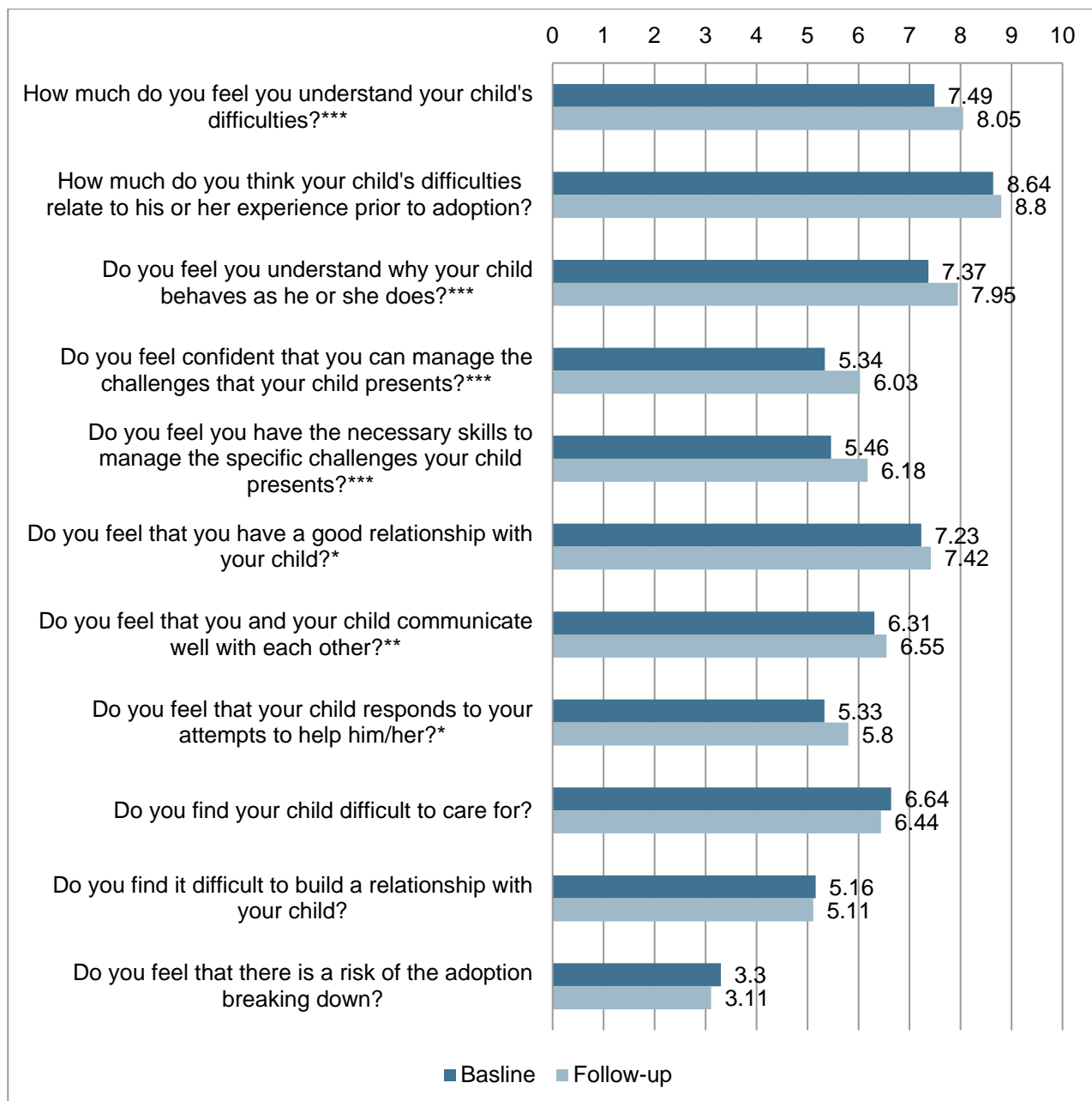
As the Carer’s Questionnaire is not a validated scale some caution must be taken when interpreting its total score.⁸⁹ Therefore change over time on each individual item was

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.



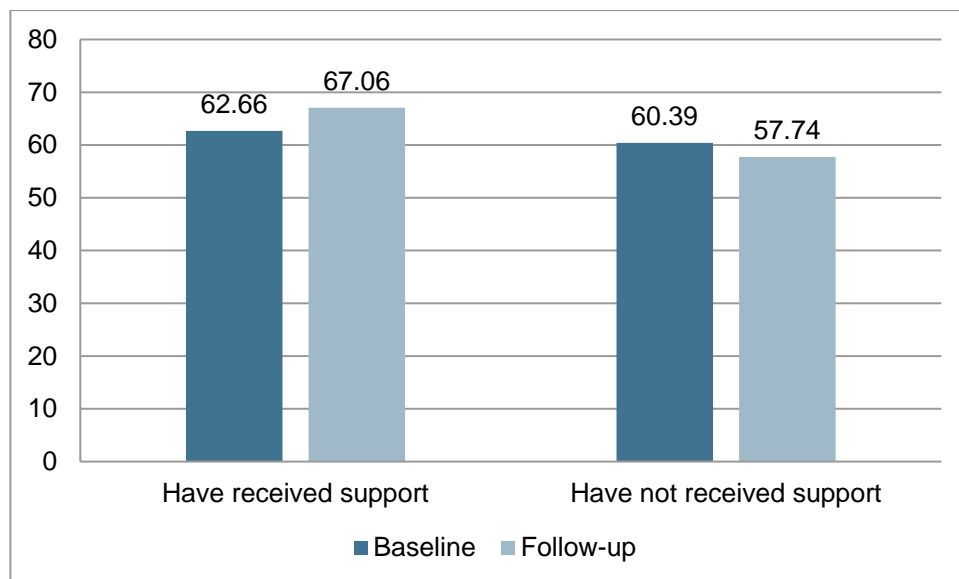
Note: N=435 to N=441 depending on item; Source: Baseline and follow-up survey; * indicates significance at $p < 0.05$ level; ** $p < 0.01$; *** $p < 0.001$.

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 through 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



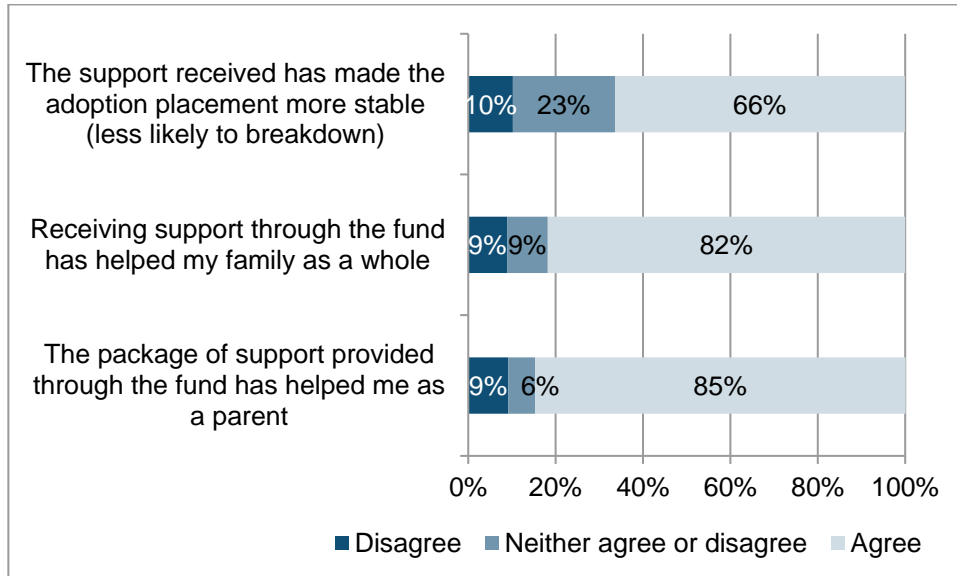
Note: N=428; Source: Baseline and follow-up survey.

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 the 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

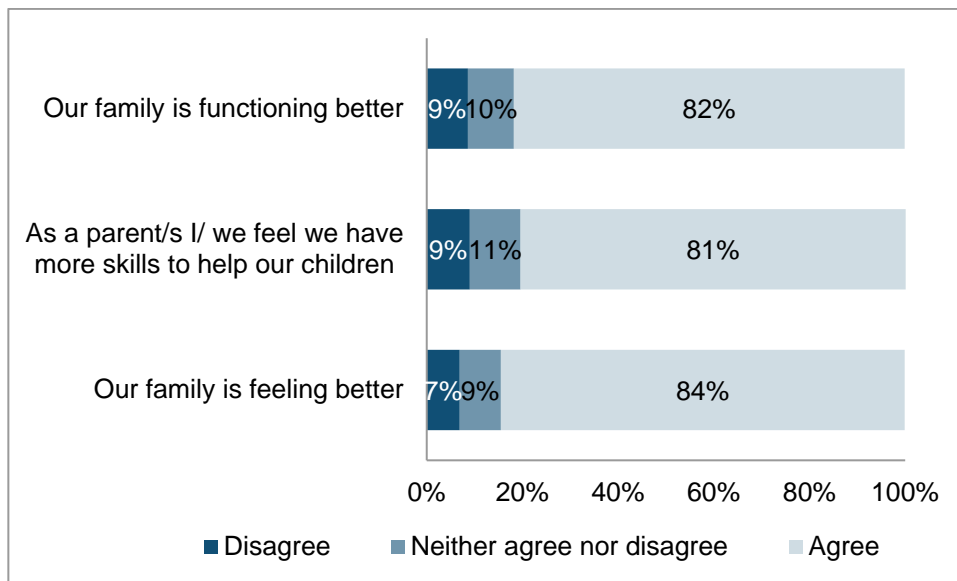


Note: N=428 to N=430 depending on item; Source: Baseline and follow-up survey.

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.

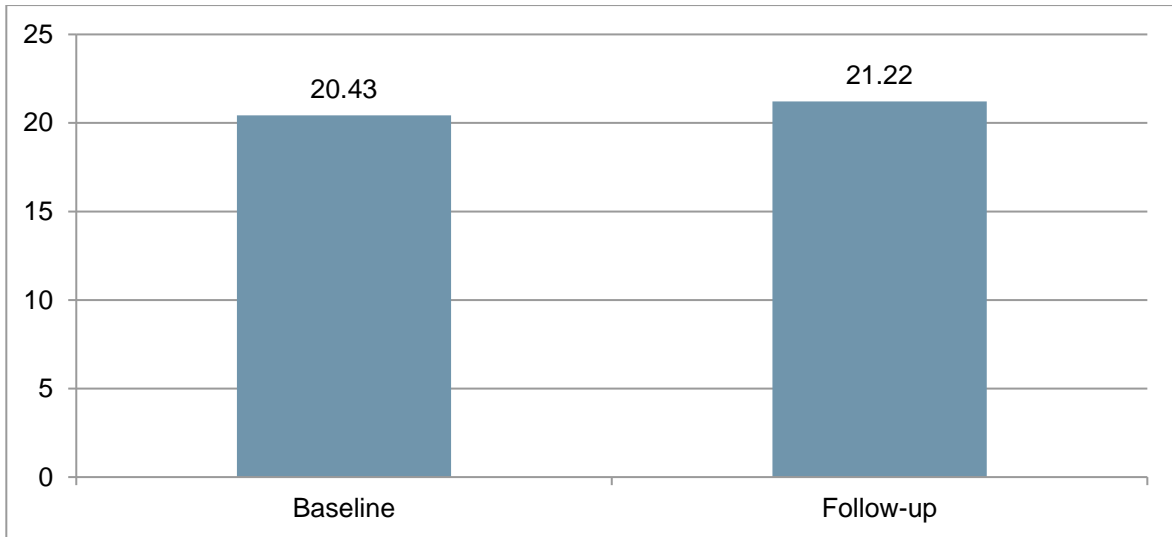
Table 11: Comparison of SWEMWBS means of baseline and follow-up data

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.).

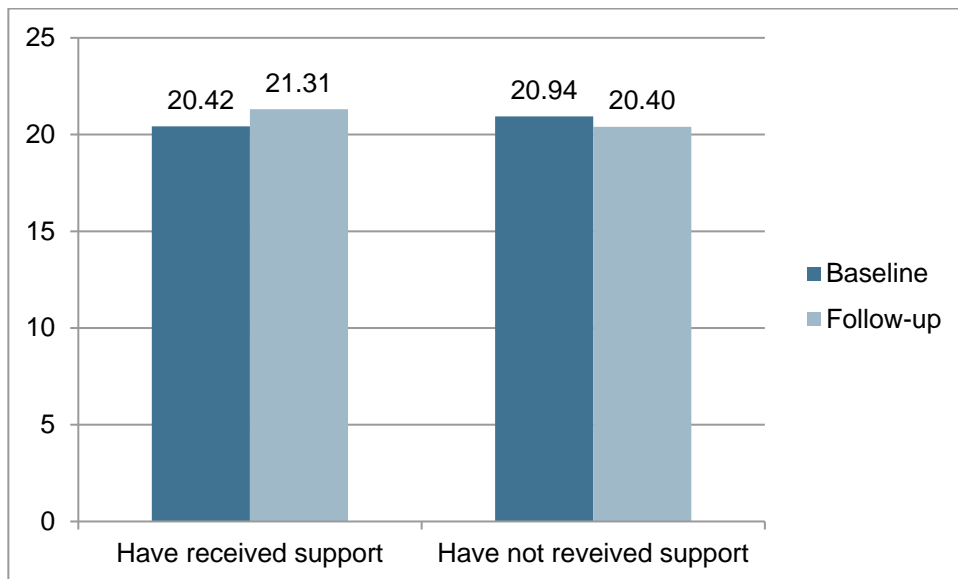
Figure 36: Mean scores of the SWEMWBS score at baseline and follow-up



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



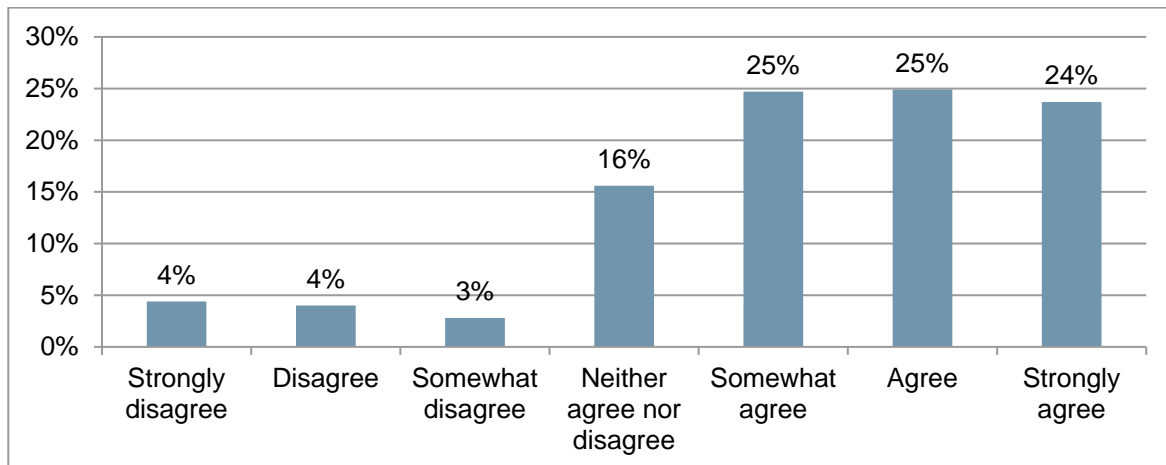
Note: N=419; Source: Baseline and follow-up survey.

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, Oxtou, 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 focused 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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for Education

The Evaluation of the Adoption Support Fund: Appendices

August 2017

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Social Science in Government

Contents

List of Figures	3
List of Tables	4
Appendix 1 – Methodology	6
1.1 Online surveys	6
1.2 Longitudinal survey	15
1.3 Local authority case studies and review of prototypes	41
1.4 Family Interviews	48
1.5 Triangulation of Data and Sense Making	51
1.6 Note on Presentation of Qualitative Data	51
Appendix 2 – Parental Information Sheet	53
Appendix 3 – Staff Information Sheet	56
Appendix 4 – The Survey	60
1.7 Online Survey of Adopters	60
1.8 Online Survey of local authority Employees	91
1.9 Online Survey of Service Providers	97
1.10 Baseline Longitudinal Survey	103
1.11 Follow-up Longitudinal Survey	119
Appendix 5 – 10 Local Authority Case Studies	121
Appendix 6 – 10 Local Authority Prototype Reviews	165
Appendix 7 – Family Sketches	193
Appendix 8 – Glossary	268

List of Figures

Figure 39: Region of respondents of the online survey of local authority staff	12
Figure 40: Balance between internal provision and external commissioning of therapeutic support of respondents of the online survey of local authority staff	12
Figure 41: Commissioned therapeutic services in scope of the ASF of respondents of the online survey of local authority staff	13
Figure 42: Services provided by organisations in scope of the ASF	15
Figure 43: Mean SDQ total difficulties scores at baseline and follow-up	28

List of Tables

Table 12: Comparison of sample statistics of the online surveys in 2011 and in 2016	10
Table 13: Comparison of age at placement: Online survey of adopters 2011 and 2016	11
Table 14: Response rates to the longitudinal survey of families	17
Table 15: Descriptive statistics of the added value score	27
Table 16: Correlation of the relationship subscale of 'The Carer Questionnaire' with SWEMWBS, SDQ, and BAC at baseline and follow-up	30
Table 17: Comparison of baseline respondents and follow-up respondents regarding gender of the adopted child	32
Table 18: Comparison of baseline respondents and follow-up respondents regarding ethnicity of the adopted child	32
Table 19: Comparison of baseline respondents and follow-up respondents regarding age of the end of the assessment of adopted child	33
Table 20: Comparison of baseline respondents and follow-up respondents regarding region	33
Table 21: Comparison of baseline respondents and follow-up respondents regarding service provider	34
Table 22: Comparison of baseline respondents and follow-up respondents regarding service provider	34
Table 23: Comparison of respondents and applicants regarding gender of the adopted child	36
Table 24: Comparison of respondents and applicants regarding ethnicity of the adopted child	37
Table 25: Comparison of respondents and applicants regarding age of the end of the assessment of adopted child	37
Table 26: Comparison of respondents and applicants regarding region	38
Table 27: Comparison of respondents and applicants regarding service provider	38
Table 28: Comparison of applicants and national statistics regarding gender of adopted child	40

Table 29: Comparison of applicants and national statistics regarding ethnicity of adopted child	40
Table 30: Comparison of applicants and national statistics regarding region	41
Table 31: Criteria for case study selection	43
Table 32: The ten case studies (by region and type of authority)	45
Table 33: Family Interviews sample details	49

Appendix 1 – Methodology

The evaluation of the Adoption Support Fund 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);
- A longitudinal 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). 30% 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 at wave 2.

Each method is described in detail in the following sections.

1.1 Online surveys

Design and Conduction

Three online surveys were conducted to explore the experiences and the impact of the ASF on adopters, local authorities and service providers.

The first survey was aimed at adopters and prospective adopters with the main aim of replicating the survey 'It takes a village to raise a child' conducted between October 2011

and January 2012 by Adoption UK.¹ By this means, the original survey in 2011 and the replicated survey in 2016 can be described as cross-sectional surveys at 2 points in time. In general, the samples were different, however, it cannot be ruled out that there are respondents that completed the both surveys. The survey was replicated in 2016 as part of this research study to assess if the adoption reform programme including the ASF has changed the experiences with adoption support services of adopters. The second aim was to explore the awareness of the ASF as well as the impact of the ASF on adopters. The survey conducted by Adoption UK in the UK received 455 responses representing 700 adopted children so that the aim of the 2016 survey was to reach a similar sample size in order to compare the results. Both surveys were available for all adopters and prospective adopters in the UK. However, for the purpose of the evaluation of the ASF only responses from England were included in the analysis.

The second survey was aimed at local authority employees and the third survey at service providers. The purpose of these 2 surveys was to evaluate the impact of the ASF on social workers and service providers in terms of their work load, assessments processes, and building relationships and to explore their views on the market development for adoption support.

The surveys can be found in Appendix 4.

All 3 online surveys were conducted between 14.09.2016 and 22.12.2016. The surveys were hosted on the Adoption UK website and the surveys were accessible online via SmartSurvey. Tavistock Institute and Adoption UK developed a communication strategy plan in order to promote the survey. This plan included news items and regular posts on Twitter. Adoption UK also published the surveys on related websites and in their in-house magazines. In addition to this, the Department of Education included the information about the surveys in a newsletter sent out to a range of stakeholders. Furthermore, Mott MacDonald sent out a newsflash with the links to the surveys to all local authorities.

Methodological limitations apply to the sample as it was a self-selected sample of adopters, service providers and local authorities. The sample is limited to those that access the different website or any of the other communication media that were used. Therefore, the sample may be subject to multiple sources of error. Hence, the sample cannot be treated as representative as such but due the large sample size the surveys are able to provide a good indication of the experiences in relation to adoption support.

Analysis

¹ The full report can be found here:

<https://www.adoptionuk.org/sites/default/files/documents/Ittakesavillagetoraiseachild-Report-June12.pdf>

All 3 online surveys were analysed in IBM SPSS and figures were created in Microsoft Excel.

For the survey of adopters only responses from England were included in the analysis. For the survey from 2011 this was determined by the postcode that respondents indicated. Respondents that had not reported their postcode were removed from the analysis. Respondents that indicated to be living in Wales, Scotland, Northern Ireland or overseas were also removed from the analysis. In the survey from 2016 the question 'Where do you currently live?' provided the necessary information about who to include in the analysis. The 2 data sets were prepared separately. This included renaming variables and coding responses in order to be able to merge the 2 data sets to one. As the main part of the survey was a replication of the original survey 'It takes a village to raise a child' questions from this survey were not altered. Several questions required the respondents to complete the question per adopted child, up to a maximum of 8 children. However, only responses for child 1 and child 2 were taken into consideration for the analysis as a very small percentage of adoptive parents reported having 3 or more adopted children. Respondents were asked how many adopted children they have. This information was coded and served as a filter variable when questions had to be answered per adopted child. All responses in 'Other (please specify)' were back coded for each question as large proportion of respondents selected this option to provide further information.

Chi-squared tests or Mann-Whitney U tests were used to compare the results of the survey from 2011 with the survey from 2016. In addition to that, effect sizes were calculated to judge how substantial an effect is. Effect sizes can be interpreted according to conventions. Conventions for Cramer's V depend on the degrees of freedom (df). In general, the higher the degrees of freedom the smaller the effect size, that can be considered as small, medium and large. For df of 1 Cramer's $V=.1$ are regarded as small, Cramer's $V=.3$ as medium, and Cramer's $V=.5$ as large. Same conventions are valid for Pearson's r . For Cohen's d , effect sizes of $d=.2$ are regarded as small, Cramer's $V=.5$ as medium, and Cramer's $V=.8$ as large. Test results including effect sizes are reported in footnotes in the main report.

Additional questions related to the ASF were analysed separately for the survey conducted in 2016.

The surveys of local authority employees and service providers were analysed separately.

Sample description

Adoptive parents and prospective adopters

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. Among

those, 11% were men and 89% were women. More than half (52%) were between 41 and 50 years old, 25% between 31 and 40, and 20% between 51 and 60. The majority of respondents (77%) were married and 15% were single adopter. Of all respondents, 89% were white British and 5% white from another background.

Half of the sample in 2016 reported to have one adopted children and also 42% indicated to half 2 adopted children. Only 6% of the sample indicated to have 3 or more adopted children and 3% had none, representing the prospective adopters and adopters thinking about an adoption. Around half of the sample (55%) was approved as adopters after 2010 and around two-third of all adopted children (67%) were between 5 and 15 years old. The age at placement varied from under 1 to over 10 years. However, most children were adopted at a young age with 55% of all adopted children in the sample were 2 or younger at placement.

In addition to the sample of adopters and prospective adopters living in England, 12 people from Wales, 20 respondents from Scotland and 4 respondents from Northern Ireland completed the survey.

The sample from 2011 of 455 respondents was reduced to 273 adopters from England as 138 did not provide information about their location and the other 44 respondents were living in Wales, Scotland, Northern Ireland or overseas.

Of the sample of 273 adopters, 93% was female and 7% male. The age profile was similar to the sample in 2016, more than half (52%) were between 41 and 50 years old, 23% between 31 and 40, and 24% between 51 and 60. Again, the majority of respondents (76%) were married and also 15% were single adopter. Of all respondents, 89% were white British and 6% white from another background.

Nearly half of the sample (44%) reported having one adopted children and also 44% indicated having 2 adopted children. Only 8% of the sample indicated to have 3 or more adopted children and 3% had none. Again, more than half (51%) were approved as adopters in the last 6 years before the survey. In line with the sample in 2016, two-third of adopted children (66%) represented in the sample were between 5 and 15 years old. Of all adopted children 59% were placed at the age of 2 or below.

Table 12 and Table 13 below show the detailed comparison of the sample in 2011 with the sample in 2016. The table highlight the fact that the sample in 2011 and 2016 are very similar in terms of demographic variables.

Table 12: Comparison of sample statistics of the online surveys in 2011 and in 2016

Gender		Male	Female			
	2011	7%	93%			
	2016	11%	89%			
Age		20-31	31-40	41-50	51-60	61-70
	2011	0%	23%	52%	24%	1%
	2016	2%	25%	52%	20%	2%
Marital Status		Lone/single adopter	Unmarried/cohabiting couple adopters	Married adopters	Civil partnership adopters	
	2011	15%	7%	76%	2%	
	2016	15%	5%	77%	3%	
Ethnicity		White British	Any other white background	Any other background		
	2011	89%	6%	5%		
	2016	89%	5%	6%		
Number of adopted children		0	1	2	3 or more	
	2011	3%	44%	44%	8%	
	2016	3%	50%	42%	6%	
Year of approval	2011	Before 1995	1995-2000	2001-2005	2006-2008	2009+
		5%	14%	29%	28%	23%
	2016	Before 2000	2000-2005	2006-2010	2011-2013	2014+
		4%	16%	25%	27%	28%
Age of adopted children		Under 5	5 to 10	11 to 15	Over 15	
	2011	22%	41%	25%	12%	
	2016	23%	46%	21%	10%	

Source: Online survey of adopters and prospective adopters 2011 and 2016.

Table 13: Comparison of age at placement: Online survey of adopters 2011 and 2016

Age at placement	2011		2016	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
0	65	17%	138	17%
1	105	27%	186	22%
2	60	15%	135	16%
3	43	11%	115	14%
4	25	6%	95	11%
5	36	9%	75	9%
6	23	6%	43	5%
7	15	4%	24	3%
8	7	2%	15	2%
9	4	1%	5	1%
10 (or older)	5	1%	2	0%
Total	388	100%	833	100%

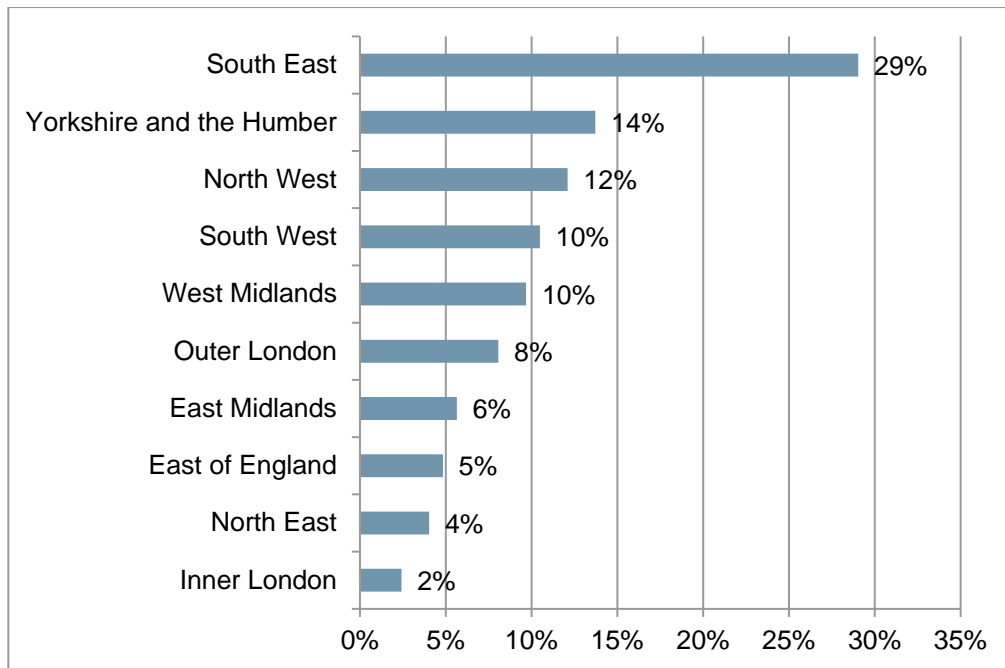
Note: N=243 and N=534; Source: Online survey of adopters 2011 and 2016.

Local authority

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 Worker and 6% were Senior Social Workers.

As it can be seen in Figure 39, nearly a third (29%) of the respondents were employed at a local authority based in South East. Less represented in the survey are local authorities located in Inner London or in the North East.

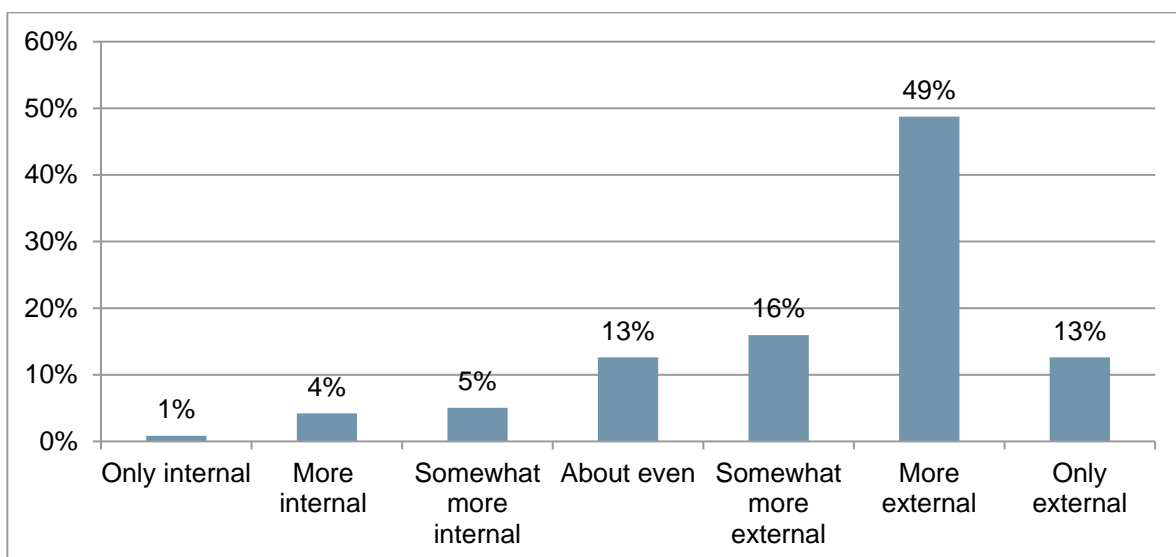
Figure 39: Region of respondents of the online survey of local authority staff



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

The local authorities represented by the survey respondents had a high level of external commissioning of therapeutic adoption support (see Figure 40). Only 10% stated that there is more internal provision, while 77% reported to have more external provision for therapeutic support.

Figure 40: Balance between internal provision and external commissioning of therapeutic support of respondents of the online survey of local authority staff

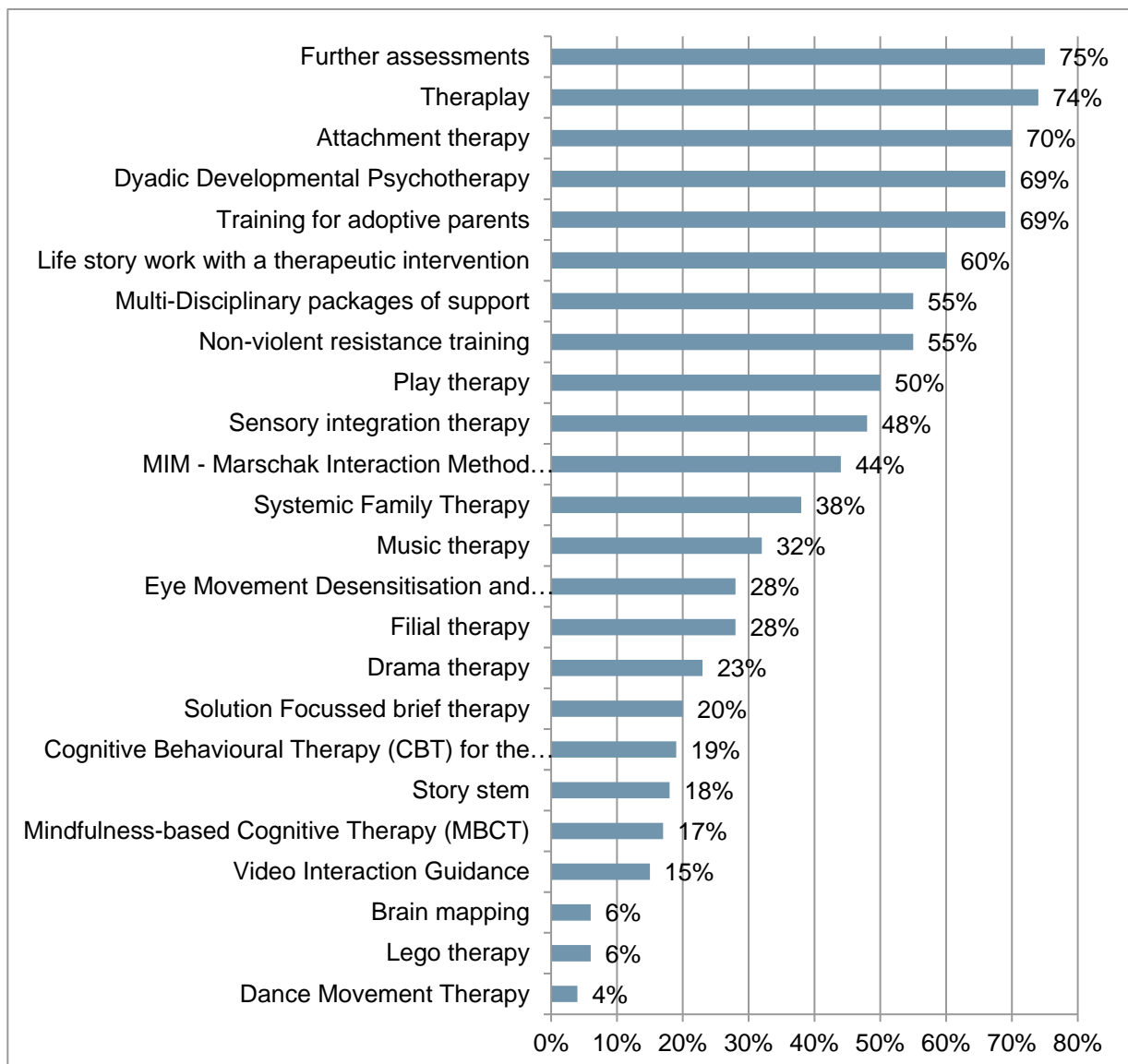


Note: N=119; Source: Online survey of local authority employees.

Of the whole sample, 81% of local authority employees stated that the local authority they are working at commission external providers to undertake adoption support while 19% do not do so.

Of the 101 respondents based in local authorities that do use external providers 75% commission further assessments and 74% Theraplay (see Figure 41). Less popular externally commissioned therapies are Brain mapping (6%), Lego therapy (6%) and Dance Movement Therapy (4%). Local authorities were commissioning 9.36 (SD=4.45) different types of therapeutic interventions on average.

Figure 41: Commissioned therapeutic services in scope of the ASF of respondents of the online survey of local authority staff



Note: N=101; Source: Online survey of local authority employees.

Service Provider

A total sample of 50 service providers completed the online survey.² Among those around half (54%) were private therapy providers and 30% voluntary therapy providers. Two respondents were directors of an adoption support agency and the other 6 respondents could not be clearly classified as private or voluntary service provider.

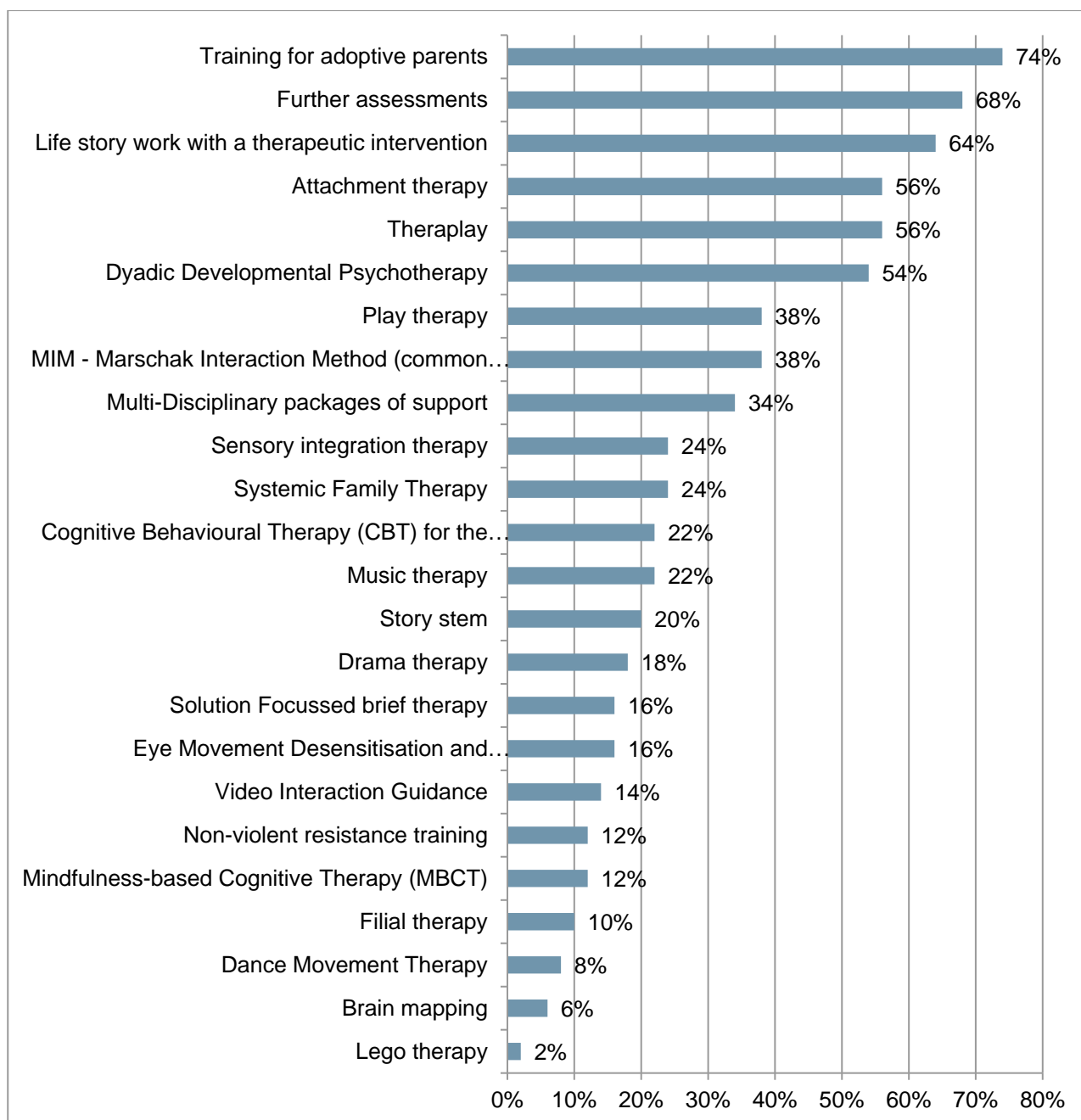
In terms of the location, 22% of the organisations were located in the North West of England and 20% in the South West. The third most represented region was Inner London with 16%. Six providers also indicated to either have clinics in several regions or to operate beyond regional borders.

There was a great variety in the number of staff that the responding organisations employed, ranging from 1 to over 60 nationally. More than a third of the respondents (34%) were sole practitioners or self-employed, an equal amount (34%) of respondents stated that their organisation employs between 2 and 10 staff and 32% were working for organisations with more than 10 employees.

As can be seen from the percentages in Figure 42, most organisations provided a number of different services. The most popular services that organisations offered were training for adoptive parents (74%), further assessments (68%), and life story work with a therapeutic intervention (64%). The average number of services provided by the surveyed organisations that are in scope of the ASF is 7 (SD=4.79), ranging from 1 to 19. As indicated by organisations in the 'Other' options, they do provide other services that are out of the scope of the ASF such as occupational therapy.

² 3 respondents stated to be local authority employees and were excluded for this reason

Figure 42: Services provided by organisations in scope of the ASF



Note: N=50; Source: Online survey of service provider,

1.2 Longitudinal survey

The aims of the longitudinal survey are to learn about adoptive families' experiences of using the Adoption Support Fund and to evaluate the impact of the therapeutic interventions that have been accessed using the ASF.

The design adopted is a two-wave longitudinal survey with a pre-intervention baseline survey and a post-intervention follow-up questionnaire to measure change over time in adoptive families accessing the ASF. The survey comprises 2 self-completion postal

questionnaires with the initial wave soon after approval of the application, and a second wave 7 months later. However, most families had not completed therapy at follow-up and a small proportion of adoptive families had not started therapy at follow-up.

The main aim of the baseline survey was to collect information about families' experiences of the Adoption Support Fund, such as of assessment and application, and to collect baseline information on measures about the child, parents and the family situation. The main aim of the follow-up survey was to collect follow-up measures on family's wellbeing and children's behaviour and development. The second survey also aimed at exploring families' experiences with the support they have received through the ASF.

Recruitment

Adoptive families were recruited onto the study by adoption support staff in each local authority in England at the point that their application was made to the ASF.

In preparation for their role in recruitment, adoption support team managers in each local authority were contacted at the point that the ASF was rolled out nationally to explain the research and ask for their support with recruiting families. Each adoption support team was emailed with a 'parental information sheet' (see Appendix 2) to help adoption support staff explain the research to adoptive parents. We also sent the adoption support team manager a 'staff information sheet' to be disseminated to the adoption support team (see Appendix 3). This sheet explained the evaluation and their role in the recruitment of participants.

The process of recruitment to the research built upon the application process to the Fund. At the point that families met with the adoption support team for needs assessment (necessary to make an application to the Fund) we asked adoption support team staff to introduce the research to parents and ask for their verbal consent to be sent a postal survey. This consent, if given, was then recorded by the adoption support worker as part of the online application to the Fund along with the name and home address of the parent.³

Once applications to the ASF were approved by the Fund administrator the contact details of parents who had provided consent were made available to Qa research (the survey administrator) via a secure online portal and first-wave surveys (see Appendix 4) were mailed within one week along with instructions to complete and return within the following 2 weeks. Parents who had provided initial consent, but did not respond to the first letter, were sent a reminder letter 3 weeks after the first.

³ At this point the consent was only for their contact details to be passed onto the research team and to receive a postal questionnaire; further details of the research and a further opportunity to opt out of the survey were provided as part of the introduction to the questionnaire itself.

Consent to participate in the survey was assumed at the point of receiving the completed questionnaire back from the parent. Parents who had completed the baseline survey were sent the follow-up survey 7 months after that.

Survey Sample

Our target population for the survey was all families accessing the Fund in its first year of operation, from May 2015 to May 2016. Using figures from the 10 prototype areas we estimated that 1850 families would access the Fund during this period. Based on an estimated response rate of 40% at baseline, we expect to achieve a sample of around 740 families completing and returning the baseline survey. Seven months later, all participants of the baseline measurement were approached again. With an estimated a response rate of 60% we expected to achieve a sample of around 444 families.

Response rates

Table 14 below provides an overview of the number of fund applications, contacts received, the number of surveys of the first wave sent and returned up to the end of June 2016 and the number of second wave surveys returned up to the end of January 2017.

Table 14: Response rates to the longitudinal survey of families

	Wave 1	
	Absolute Frequencies	Percentage
Number of approved applications to the Fund⁴	5287	
Number of approved applications with unique code	5088	
Number of surveys sent to people who consented and provided full contact details	1538	30%
Number of baseline surveys returned	792	51%
Number of follow-up surveys returned	481	61%

⁴ As of 31/05/2016

The procedure used to collect consent and contact details and to administer the postal survey creates 3 points at which attrition may occur: between application and consent and between consent and returning the first completed questionnaires; and between return the first and second questionnaires. Until the end of May 2,053 parents applying to the Fund also provided consent to be contacted which represents 40% of the number of approved applications with a unique code. Of this group, 1,538 provided full contact details. Overall our sample of completed and returned baseline questionnaires represents 15% of families with approved applications to the Fund and 51% of population of families who consented and provided full contact details. Of the families that completed the first survey 61% also completed the second survey representing 31% of the population of adopters that gave consent and provided full contact details.

Issues affecting response rate and remedial action taken

Over the first 9 months of the project there have been several factors that have affected the response rate of the baseline survey. Initially there was a delay in the finalisation of the first wave questionnaire meaning the survey went live in June 2015, 5 weeks after the Fund began. Despite this delay consent procedures and the collection of contact details started at the same time as the Fund went live so this did not adversely affect research participation. However for some of the early applicants it may have meant that they had started to receive the adoption support interventions before receiving the survey. As this is a risk for all respondents, not just early applicants to the Fund, this possibility was built into the design of the first questionnaire which records whether the intervention has started and volume of support already received at point of responding (see Q31 and Q32 of the Baseline Longitudinal Survey in Appendix 4), allowing for this factor to be controlled for in analysis.

Lower than anticipated consent rates: The proportion of those applying to the Fund who have consented to have their contact details shared with the research team has been considerably lower than anticipated at 40%. There are several possible reasons for this:

- Through attending the regional workshops for local authority staff the research team learned that the application process did not need the adoptive family to be present at the point of application reducing the possibility to gain consent at that stage. Instead staff need to ask for consent at the point of assessment which has proved less reliable; and,
- While information was sent to all adoption support managers we have learned that in some cases this information was not disseminated further within the team to those conducting the assessments and making the online applications to the Fund.

To address this issue we have monitored the application and consent rates to identify those local authorities with high numbers of applications to the Fund but low numbers of consents. In collaboration with the Department and the Fund administrator, we have then

contacted these authorities to ascertain the problem and attempt to remedy it. While this has been successful in some cases the consent rate remains low and work is ongoing to continue to improve it.

Even though the consent rate to the survey was lower than anticipated due to the higher than projected application rate to the Fund our desired sample of around 740 families in the first wave has been achieved. However it should be noted that this sample represents a lower proportion of fund users than expected. Therefore, the research team carefully examined differences between the survey sample and all fund applicants. Results of the comparison can be found in the section 'Comparison of profiles' below.

Research instruments

The research instruments employed for the surveys included a mixture of validated psychometric scales, non-validated scales and bespoke questions. The bespoke questions in the baseline survey aimed to obtain demographic information; information on current status and circumstances of the family and their historical support needs, explore their expectations of the interventions, and experiences of the assessment and application process. Bespoke questions in the follow-up survey aimed to collect information about changes in the family situation, information about the support received and experiences with the overall process as well as the received support. Full copies of the surveys are to be found in Appendix 4.

The standardised scales aimed to assess (1) child behaviour, development and wellbeing, (2) family functioning, parental efficacy, and parent-child attachment, and (3) parental wellbeing.

The standardised scales chosen for this study were:

- The Strengths and Difficulties Questionnaire (SDQ) – a 25 item behavioural screening tool plus impact supplement questions;
- The Brief Assessment Checklist (BAC-C/ BAC-A), (both Child and Adolescent versions depending on the age of the assessed child) - a 20 item psychiatric assessment scale;
- The Carer Questionnaire – an 11 item scale to assess parent child relationship; and,
- The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) – a 7 item mental wellbeing assessment scale.

Selection criteria

The 3 dimensions identified for assessment (child behaviour, development and wellbeing, family functioning and family attachment and parental wellbeing) were selected because

they reflected the central aspects targeted by the Fund. This, in turn, reflects the fact that these are known to be important factors in adoptive child and family outcomes and in the risk of adoption breakdown.

The key criteria that underpinned the identification and selection of suitable scales were:

- **Relevance** – the focus was on finding scales that measured the key constructs outlined above;
- **Brevity** – the need to design a research instrument which could be self - completed in about 20 minutes; and,
- **The mode of delivery** –that measures had to be in a format suitable for self-completion in a postal survey and that could be completed by a parent on behalf of their child where necessary.

Other important criteria, which related more to the quality of the measure, were:

- the face validity of the measure;
- common usage – due to the survey design lacking a control group, it was preferable to select scales regularly and recently used in the UK for research with this and comparable target groups. This leaves open the possibility of identifying norms against which we may be able to make comparisons;
- the applicability/relevance to the different interventions – given the wide variety of interventions falling within scope of the Fund and the wide range of possible issues faced by adoptive families the scales needed to be sufficiently generic to be able to capture meaningful change;
- the psychometric properties of the measure – to be selected, measures had to have been demonstrated to be reliable, valid and – a particular consideration in the current circumstances – to be sensitive to change, for example, as a result of similar types of interventions; and,
- the acceptability of the assessments (both individually and overall) to participants – in practice, this meant avoiding too negative a focus, or at least balancing negative with positive elements.

Selection process

The selection of the scales was undertaken against the above criteria and in consultation with both the Department and with the research steering group. The first step in the selection process involved the compiling of 'short-list' of possible scales for each construct. This was drawn from: a desk based online search against relevant search terms, review of comparable studies' methodologies, and interviews and consultation with key experts and adoption support staff. Key considerations at this stage were relevance and mode of delivery. This phase resulted in the identification of 10 possible

scales. These scales were then reviewed against the remaining criteria which led to the further exclusion of 2 on the basis of excessive length (Parent-Child Relationship Inventory (PCRI) and Child Behaviour Checklist (CBCL); 2 on the basis of insufficient age range: Parenting Dimensions Inventory and Pianta's Parent-Child Relationship Scale and 2 on the basis there was no evidence of their use in the UK in recent years: Family Assessment Device (FAD) and Feetham Family Functioning Survey (FFFS). The remaining 4 scales have all been included in the survey.

Child behaviour, development and wellbeing:

This construct represents the central indicator of impact for the evaluation of the ASF and it was, therefore, deemed necessary to measure it with 2 scales: the SDQ and the BAC.

- The SDQ met the above selection criteria and was recommended by both academics and practitioners. The scale is very widely used in research and practice in the UK leading to the establishment of 'norms'. This provides for the possibility of comparison between the ASF cohort and other groups, adding to the evidencing of impact. Despite its many strengths the SDQ is designed for general use with young people, rather than specifically for those with developmental or mental health problems and therefore may not be sensitive enough to detect change in cases of very high vulnerability;
- Because adopted children as a group are known to present significantly higher needs than the general population the BAC was deployed to supplement the SDQ. The BAC is a psychiatric rating tool designed for use with looked after, fostered, or adopted children. It is used predominantly in clinical screening and is, therefore, more sensitive to changes in reported mental health.

Family functioning, parental efficacy and family attachment

- Of the 3 outcomes constructs this was the most challenging for which to find an appropriate measure. A large number of family assessment scales were considered during design, such as the Family Assessment Device (FAD) and the Feetham Family Functioning Survey (FFFS), however none were satisfactory due to issues with the age range covered or the mode of delivery. For this reason the decision was made to use an invalidated scale 'The Carer Questionnaire'.⁵ It was deemed to be the most appropriate tool for the investigation of family functioning, parental efficacy and family attachment for this study due to it having been developed by clinical psychologists working with fostered, looked after and adopted children giving it a high level of face validity. However, no population norms exist

⁵ It should be noted that the research team made several minor adjustments, with the author's permission, to the original scale to improve its relevance and applicability to this study.

and the scale has not been used with a large sample before so that scores of our sample cannot be compared with norms or scores of another sample.

Parental wellbeing

- Parental wellbeing was included as a key construct to measure in this study for 2 reasons. The first is that it represents an important desired outcome of the ASF; that parents are coping better with the demands of adoptive parenting. We believe it also provides a proxy for overall family functioning and that it may be more sensitive to change than the more clinical tools. That while there may be no measurable change for some families on clinically significant symptoms as measured by the BAC, more subtle changes in the outlook of the family may be picked up by the self-reported wellbeing of the parent;
- SWEMWBS is a shortened version of the widely used WEMWBS. The rationale for its inclusion, as with the SDQ, is its wide use in the UK both in research and practice, and its relevance to the outcome we wished to measure. The shorter version was deployed so as to accommodate lengthier scales investigating child behaviour and wellbeing as it was felt that the increasing length of the questionnaire as a whole would begin to act as a deterrent to response.

Design challenges

- Some of the validated psychometric scales identified are age specific. Making the identification of measures that were sufficiently broad so as to be applicable to all (or most) families involved difficulty. This proved to be the case with the Brief Assessment checklist (BAC-A/C) which has a child version (between ages 4 and 11) and an adolescent version for those between 12 and 17. To overcome this we designed the survey in a way that allowed us to post surveys with the age-relevant measure on the basis of the age of the adopted children as recorded in the ASF application form;
- Where there is more than one adopted child this may have necessitated parents completing a survey (or section of the survey) for each child. This was deemed an excessive demand on respondents' time and was resolved by asking respondents to complete the relevant scales for the elder child in the case of multiple adopted children receiving support.

Analysis of quantitative data

The surveys' main aims were to:

- Learn about adoptive families' experiences of using the Adoption Support Fund; and,

- Evaluate the distance travelled by families during the time they have received support from the Adoption Support Fund.

The data from the baseline and the follow-up survey was analysed in order to answer the research questions of this evaluation. Data was analysed using IBM SPSS; Microsoft Excel was used to produce figures and tables.

The analysis involved combining the data set from the baseline survey and the data set of the follow-up with the Fund application form dataset according to the unique code of each respondent. As some families have applied to the Fund multiple times, information about these other applications was saved under the same ID. To prevent double counting of these families the analysis was based on the number of families that applied to the Fund and not on the number of applications in total. Next, the combined data set was prepared and cleaned, which included the assignment of missing values, deletion of irrelevant variables, recoding of items, and variable type changes.

After the preparation and cleaning of the combined data set the 3 validated and the one non-validated scale were computed both measurement points. In the case of the SDQ and 'The Carer's Questionnaire' this involved recoding of items.⁶ Scales were computed in line with the requirements made by the scale developers and where syntax for the computing of scales was available on the website of the scale, this was used. In the case of SWEMWBS this for example meant that cases with missing values were excluded from the calculation of the total score of the scale.

The analysis of research questions that focused on experiences or opinions at baseline stage (e.g., satisfaction with the assessment of needs) was based on responses of all respondents that completed the baseline survey. For research questions that addressed change over time only cases that have completed both, baseline and follow-up survey, were included in the analysis. As 39% of the respondents from the baseline did not complete the second survey logistic regression was used to determine if there were any variables that predicted the non-response (see section 'Comparison of Profiles' for results). Only variables that were metric or dichotomous were included in the regression. Categorical variables such as region were not dummy-coded due to the high number of categories but instead chi-squared tests were used to assess differences, if any, between respondents that only completed the first survey and respondents that completed both surveys.

Significance tests were used to detect changes over time on the validated and non-validated psychometric scales. Assumptions for significance tests were tested and for cases that did not meet the assumptions for parametric tests, non-parametric alternatives were used. Only when the sample size per group was large enough to justify parametric tests, even though the dependent variable was not normally distributed, parametric

⁶ For a discussion of 'The Carer's Questionnaire' see section 'The Carer's Questionnaire' below.

results are reported. We used a significance level of 5% and tested two-sided if not stated otherwise. Effect sizes are reported in addition to significance test results to judge about the magnitude of an effect.

Logistic regressions and chi-squared tests were used to determine if survey respondents are representative of the whole sample of applicants. The sample of applicants refers to the group of families that applied to the Fund between May 2015 and May 2016. Results are reported in the section below 'Comparison of Profiles'. However, it should be noted that this comparison is limited to the variables that were present for all applicants as well as for the survey sample. As there were significant differences between the survey sample and the applicants we used these demographic variables and a few additional ones from survey data to test for differences in terms of change over time. The variables that were included in the analysis were: Gender of child, ethnicity of child, age of child, region, service provider category, gender of parent that completed survey, relationship status of parent, ethnicity of parent and highest education level of parent. If any significant effects were found, they are reported in the main section of this report. In addition to that, differences between follow-up respondents and all applicants as well as between applicants and national statistics were explored and reported in the section 'Comparison of Profiles'.

The analysis reported in the section 'Has the ASF improved the lives of adopted children and families?' is only based on the group of respondents that completed baseline and follow-up survey. However, apart from not completing the follow-up survey there were a number of other reasons for exclusion from the analysis of particular questions. For every question in the follow-up survey it was decided which respondents should be excluded from the analysis. The 2 main reasons for exclusion were:

- the respondent to the follow-up survey did not remember who completed the first survey. It was seen as important that the person that completed the psychometric scales at the baseline stage also completed those 7 months later in order to explore the distance travelled. Respondents that did not remember if they completed the first survey were not excluded questions that did not require the same parent to complete the question (e.g., satisfaction with the support received).
- the child is not living with the adoptive parent(s) any longer. Respondents that reported that the child for whom they applied for support through the ASF was not living with them any longer were excluded from the majority of the questions.

Furthermore, age at baseline stage and follow-up stage was used as a criterion for exclusion as some of the psychometric scales demand specific age ranges. Age was calculated by the means of the date of birth and the date of completion of the corresponding survey. However, some respondents did not give indication about when they had completed the first and/or the second survey. For those, the date was estimated by the median of the dates for a certain number of respondents' data. For that the data

set was split into several subsets to obtain a good estimation of the date of completion. The estimated age was also compared with the age at assessment which was available from the application data set to ensure a good estimation of the survey completion date.

The time between the baseline and the follow-up survey was calculated and again, when date of completion was missing the estimated date was used instead. There was variation in the time between the completion of the baseline and the follow-up survey. For this reason the time interval was used as a variable in the subgroup analysis. However, no significant differences were found between respondents that completed the second wave survey in time and for those who took longer to complete the survey. For this reason respondents that took longer than 8 months were not removed from the sample.

In addition to the subgroup analysis already described, the research team used the information if the child was placed by a different local authority to the one that assessed them for post-adoption support to check for differences. Apart from that information about the completion and the quantity of therapy was used for sub-group analysis. Two-way ANOVA's were performed to compare respondents that started receiving support at baseline, respondents that started receiving support between baseline and follow-up and respondents that did not start receiving any support through the ASF at follow-up stage. However, post-hoc tests did not show any differences between respondents that started receiving support between baseline and follow-up and respondents that already received support at baseline stage. For this reason, there was no distinction made between these 2 groups of respondents. Relevant results of the comparison between adopters that received support through and those who have not yet are reported in the section 'Improving the lives of children and families'.

Furthermore, for The Strengths and Difficulties Questionnaire (SDQ) additional calculations were undertaken as available on the website (<http://www.sdqinfo.org/>).

- First, the added value score was computed in line with the provided formula to take into account that change happens over time without an intervention. Ford et al. (2009) describe the development of the algorithm and the evaluation of its effectiveness.⁷ The calculation was developed by the means of a regression analysis to predict the total difficulties score at follow-up based on all SDQ sub-scale scores at baseline. The formula is displayed below:

$$\text{Value added} = 2.3 + 0.8 * T1\text{Total} + 0.2 * T1\text{Impact} - 0.3 * T1\text{Emotion} - T2\text{Total}.$$

See the section 'Statistics in detail' below for a discussion of the application of the value-added calculation.

⁷ Ford, T., Hutchings, J., Bywater, T., Goodman, A., & Goodman, R. (2009). Strengths and Difficulties Questionnaire Added Value Scores: evaluating effectiveness in child mental health interventions. *The British Journal of Psychiatry*, 194(6), 552-558.

- Second, a computerised algorithm for predicting psychiatric disorders of the children and young people from the impact and the symptom subscale scores exists. The algorithm predicts the presence of a conduct disorder, an emotional disorder, a hyperactivity disorder and any psychiatric disorder in 3 categories, i.e., ‘unlikely’, ‘possible’ and ‘probable’. Goodman, Ford, Corbin, and Meltzer (2004)⁸ tested the validity of the SDQ predictions by comparing it with independent psychiatric diagnoses in a sample of 1,028 looked after children in England. Specificity and sensitivity of the predictions were above 80%, best prediction results were achieved when the SDQ was completed by both, parents and teachers. However, in our sample SDQ were completed by parents only. Therefore, the provided syntax on the website for the predictive algorithm was adapted to fit the completion by parents only. In more detail, this meant removing commands related to the teacher and self-reported SDQ scores.

In addition, it should be noted that responses to qualitative questions were coded and analysed separately.

Statistics in detail

As already discussed the design of the longitudinal survey does not permit the attribution of observed changes directly to the ASF. As Youthinmind, the developers of the SDQ, state on their website “high SDQ scores typically improve with time even when children receive no assessment or intervention, partly as a result of regression to the mean (an effect of measurement error) and partly as a result of spontaneous improvement.”⁹ This means that one would expect a certain degree of improvement on the SDQ without any support having been provided. To help address this issue Youthinmind provide additional resources for the calculation of the ‘added value’ provided by interventions. This calculation allows observed change in a sample to be compared against expected change without intervention.

Once this further analytic step was applied to the dataset the initially significant changes reported in the (above section – improving the lives of children and families) do not sustain and in fact the calculation returns a negative mean (see Table 15). This suggests that the scores in the survey show changes that are lower than would be expected if no intervention had been applied.

⁸ 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.

⁹ <http://www.sdqinfo.com/c5.html>

Table 15: Descriptive statistics of the added value score

	N	Minimum	Maximum	Mean (SD)
SDQ-Value added	430	-20.50	17.60	-1.46 (5.25)

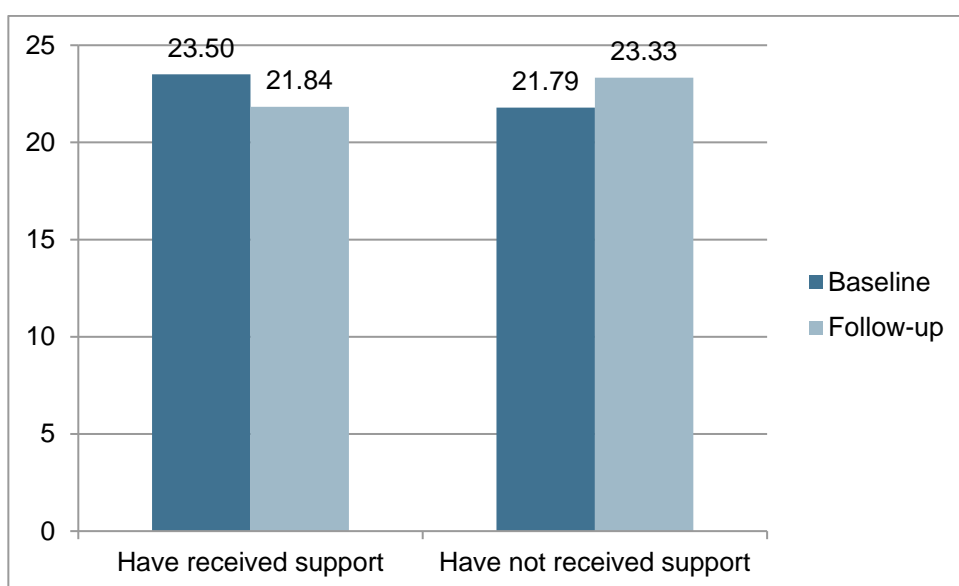
While this may appear to be a disappointing result, caution should be taken when interpreting the added value score as there are reasons to believe that the group used to develop the added value score may differ in important ways from the sample of children in this evaluation. The algorithm was developed based on sample (n=609) that was selected from the British Mental Health Survey (2004). The sample was selected on the basis that the children either had a psychiatric disorder or the parents had raised mental health concerns.¹⁰ As stated above the level of need within the sample of children in this study is extremely high and is likely to contain a high proportion of children who experienced early childhood trauma. The problems facing these children are known to be comparatively intractable and therefore the usually observed improvement without intervention may not apply in this instance.¹¹ We were able to explore this possibility by looking at the results of children from families where no one had received any support in between the 2 waves of the survey. For this group the SDQ scores showed an increase overtime whereas the added value calculation is based on the assumption that children's scores will reduce.

The figure below 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.

¹⁰ Ford, T., Hutchings, J., Bywater, T., Goodman, A. and Goodman, R., 2009. Strengths and Difficulties Questionnaire Added Value Scores: evaluating effectiveness in child mental health interventions. *The British Journal of Psychiatry*, 194(6), pp.552-558.

¹¹ Sonuga-Barke, E. J., Kennedy, M., Kumsta, R., Knights, N., Golm, D., Rutter, M., Schlotz, W., & 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*.

Figure 43: Mean SDQ total difficulties scores at baseline and follow-up



Note: N=427; 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 showed that it did not differ from the full sample in significant ways, other than the fact that these families had not receive services. This is to say that the children and families who did not receive services during the survey appear have similar characteristics to the whole sample, in terms of age, gender, ethnicity, region, and initial level of need. 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.

The Carer Questionnaire

As outlined above the applied family assessment scale 'The Carer Questionnaire' has not been validated. Validity of scales is a very important criterion as it indicates if the scale really measures what it states to be measuring. There are different forms of validity like construct validity and predictive validity. However, the relationship subscale of 'The Carer Questionnaire' has a high face validity and met most of the other selection criterion that were applied. For more information see section 'Research instruments'.

In order to determine if the scale is reliable, and if all items should be kept based on their psychometric properties, a scale and item analysis with the 11 items of the scale was

performed at baseline and follow-up stage.¹² Additionally, a factor analysis was performed to discover if all items have the same underlying factor. At baseline stage, the analysis yielded 2 underlying factors based on the scree-plot and Kaiser Criterion, with 2 items loading on the second factor and one item loading equally on both factors, indicating that the scale has 2 dimensions. The item analysis revealed that one item (How much do you think your child's difficulties relate to his or her experience prior to adoption?) had an item-total correlation below 0.2, indicating that the item does not measure the same construct as all other items, i.e. the relationship quality between child and parent.¹³ Additionally, the item difficulty was low as indicated by a high mean and a low standard deviation. Furthermore, the internal consistency improved from .857 to .873 when the item was deleted from the scale. The scale and item analysis with the follow-up data set yielded similar results. The same item had a negative item-total correlation and Cronbach's Alpha increased from .867 to .888. For these reasons, the item 'How much do you think your child's difficulties relate to his or her experience prior to adoption?' was removed from the scale leaving a remaining 10 items in the scale.

Repeating the scale and item analysis at baseline stage with the reduced scale of 10 items identified another item ('Do you feel you understand why your child behaves as he or she does?') that would increase the internal consistency if deleted from .873 to .874. However, given that the other psychometric properties were good, the item was kept in the scale. A factor analysis on the remaining 10 items identified again 2 factors. The 2 items ('Do you feel confident that you can manage the challenges that your child presents?' and 'Do you feel you have the necessary skills to manage the specific challenges your child presents?') that have high loadings on the second factor happened to correlate very strongly ($r=.730$).¹⁴ However, 2 further correlations of 2 items in each case were very large according to Rosenthal ($r=.820$ and $r=.821$). When removing one item per high correlation (i.e. 3 items) the corrected item-total correlation decreased for the remaining item that shows a high loading on the second factor falling below 0.4. With the further removal of this item from the scale, the internal consistency remained at .838, which is considered as good.¹⁵ However, such action would mean the removal of all items that loaded on the second factor from the scale and making the scale unidimensional, therefore it would change what the scale measures. Again, the analysis with the follow-up data yielded similar results. Given this rationale only one item as stated above was removed from the scale and reported separately. Ten items remained in the

¹² Peter, P. (1979) 'Reliability: A Review of Psychometric Basics and Recent Marketing Practices', *Journal of Marketing Research*, vol. 16, no. 1, February, pp. 6-17.

¹³ Coaley, K. (2014) *An Introduction to Psychological Assessment and Psychometrics*, SAGE.

¹⁴ Rosenthal, J. A. (1996) 'Qualitative descriptors of strength of association and effect size', *Journal of social service Research*, vol. 21, no. 4, pp. 37-59.

¹⁵ Gliem, R.R. & Gliem, J.A. (2003) 'Calculating, Interpreting, and Reporting Cronbach's Alpha Reliability Coefficient for Likert-Type Scales', Midwest Research to Practice Conference in Adult, Continuing, and Community Education.

scale with an internal consistency of .873 with the baseline data and .888 with the follow-up data.

While the objective of this research was not to validate the scale, correlations to the 3 validated scales were performed as it was expected that 'The Carer Questionnaire' relates to the other scales as it measures family functioning and parent-child relationship. All correlations were significant at a 5% level of significance, although they varied in their magnitude. All correlations were larger at follow-up than at baseline measurement. The highest correlation of the mean scores of the relationship subscale of 'The Carer Questionnaire' at baseline was found with SWEMWBS ($r = 0.488$), which is considered large.¹⁶ At follow-up stage correlations with BAC-C and BAC-A were even larger ($r = .526$ and $r = -.675$, respectively). All correlations are shown in Table 16 below.

Table 16: Correlation of the relationship subscale of 'The Carer Questionnaire' with SWEMWBS, SDQ, and BAC at baseline and follow-up

Scale		Measurement Time	N	r	p
SWEMWBS		Baseline	761	.488	<.001
		Follow-up	423	.519	<.001
SDQ	Emotional Symptoms	Baseline	761	-.098	.007
		Follow-up	429	-.224	<.001
	Conduct Problems	Baseline	761	-.438	<.001
		Follow-up	430	-.561	<.001
	Hyperactivity /inattention	Baseline	761	-.105	.004
		Follow-up	430	-.278	<.001
	Peer relationship problems	Baseline	761	-.213	<.001
		Follow-up	430	-.377	<.001
	Prosocial behaviour	Baseline	761	.406	<.001
		Follow-up	429	.427	<.001
	Total score	Baseline	761	-.326	<.001
		Follow-up	429	-.498	<.001
	Impact	Baseline	762	-.249	<.001
		Follow-up	427	-.395	<.001
BAC-C		Baseline	489	-.363	<.001
		Follow-up	263	-.526	<.001
BAC-A		Baseline	257	-.454	<.001
		Follow-up	135	-.675	<.001

¹⁶ Cohen, J. (1992) 'A Power Primer'. *Psychological Bulletin*, vol. 112, no. 1, July, pp. 155-159.

Comparison of profiles

Several comparisons were conducted in order to identify potential differences between the various groups, i.e. baseline respondents, follow-up respondents, all respondents, all of the ASF applicants and all adopted children in England. It is important to note that comparisons were only possibly based on variables that were available for all groups that ought to be compared. Therefore, other potentially relevant variables could not be included in the comparisons.

Comparison of baseline respondents and follow-up respondents

Two logistic regressions were conducted to detect potential differences between the sample of baseline respondents and the follow-up respondents and by this means detect a non-response bias. The first logistic regression was designed in line with logistic regressions conducted as part of comparisons of other groups, e.g. survey respondents and all applicants. Predictors of the first regression were gender of adopted child, age of adopted child and ethnicity of adopted.¹⁷ However, none of the variables had a significant regression coefficient indicating that they were not meaningful in predicting the participation of the follow-up survey. The second logistic regression further included all psychometric scales (i.e. SWEMWBS, BAC, SDQ total difficulties and the relationship subscale of The Carer Questionnaire) as well as the question to ascertain if respondents have been assessed by a different local authority to the one that placed their child. However, none of these variables were shown to be significant predictors of the participation of the follow-up survey. In addition, no differences between baseline and follow-up respondents were found for region and service provider.^{18,19}

Tables 17 to Table 22 contain information about the comparison of baseline and follow-up respondents in relation to all variables the comparison was based on. In summary, no differences were found between baseline and follow-up respondents.

¹⁷ Ethnicity of the adopted child was dichotomised combining all ethnicities but white.

^{18, 18} Inner London and Outer London were combined in order to reach a sample size above 5. There was no significant association between region and type of respondents (i.e., baseline only or both surveys), $\chi^2(8, N = 788) = 4.972, p = .761$, Cramer's $V = .079$.

¹⁹ There was no significant association between service provider and type of respondents (i.e., baseline only or both surveys), $\chi^2(3, N = 774) = 2.627, p = .453$, Cramer's $V = .058$.

Table 17: Comparison of baseline respondents and follow-up respondents regarding gender of the adopted child

Gender	Baseline Respondents		Follow-up Respondents	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Female	158	51.1%	221	46.1%
Male	151	48.9%	258	53.9%
Total	309	100%	479	100%

Source: Application data.

Table 18: Comparison of baseline respondents and follow-up respondents regarding ethnicity of the adopted child

Ethnicity	Baseline Respondents		Follow-up Respondents	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Asian / Asian British	2	.6%	9	1.9%
Black / African / Caribbean / Black British	3	1%	9	1.9%
Mixed / multiple ethnic groups	4	1.3%	7	1.5%
Other ethnic group	15	4.9%	33	6.9%
White	285	92.2%	421	87.9%
Total	309	100%	479	100%

Source: Application data

Table 19: Comparison of baseline respondents and follow-up respondents regarding age of the end of the assessment of adopted child

Age range	Baseline Respondents		Follow-up Respondents	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Under 5	31	10%	35	7.3%
5 to 10	146	47.2%	250	52.2%
11 to 15	119	38.5%	178	37.2%
Over 15	13	4.2%	16	3.3%
Total	309	100%	479	100%
	Mean	SD	Mean	SD
Age	9.49	3.83	9.66	3.52

Source: Application data

Table 20: Comparison of baseline respondents and follow-up respondents regarding region

Region	Baseline Respondents		Follow-up Respondents	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
East Midlands	23	7.4%	45	9.4%
East of England	30	9.7%	57	11.9%
Inner London	4	1.3%	16	3.3%
North East	13	4.2%	23	4.8%
North West	32	10.4%	52	10.9%
Outer London	13	4.2%	20	4.2%
South East	48	15.5%	60	12.5%
South West	56	18.1%	79	16.5%
West Midlands	42	13.6%	60	12.5%
Yorkshire and the Humber	48	15.5%	67	14%
Total	309	100%	479	100%

Source: Application data

Table 21: Comparison of baseline respondents and follow-up respondents regarding service provider

Service Provider	Baseline Respondents		Follow-up Respondents	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
ASA	47	15.3%	82	19.4%
CAMHS	3	1%	5	1.1%
Independent (commissioned through LA)	197	64%	285	60.1%
LA (internally delivered)	20	6.5%	26	5.5%
VAA	41	13.3%	66	13.9%
Total	308	100%	474	100%

Table 22: Comparison of baseline respondents and follow-up respondents regarding service provider

Scale	Baseline Respondents		Follow-up Respondents	
	N	Mean (SD)	N	Mean (SD)
SWEMWBS	299	21.06 (3.86)	469	20.55 (7.03)
Carer Questionnaire	306	62.43 (16.57)	477	61.99 (15.35)
SDQ Total Difficulties Score	310	22.58 (6.77)	479	23.25 (15.35)
BAC	302	21.72 (7.78)	476	21.50 (6.39)
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Placed by different Authority	128	41.8%	235	49.8%

Note: Age of adopted child was not used for the filter variable as all variables were entered to the logistic regression simultaneously. For this reason mean scores may differ to the mean scores reported in the main section of this report. Source: Baseline and follow-up survey

Comparison of survey respondents and all applicants

The survey sample was compared with the sample of all applicants to help identify differences and to decide if the survey sample can be taken as representative.²⁰ For the comparison a number of relevant variables were chosen that were available for both samples, including: gender of adopted child, ethnicity of adopted child, age of adopted child, location of family by region, and type of service provider commissioned.²¹ First, a logistic regression analysis was conducted to predict the participation in the survey using gender of adopted child, ethnicity of adopted child and age of adopted child as predictors. It was shown that only the age of the adopted child was a significant predictor, gender and ethnicity of the child did not predict the participation in the survey indicating that gender of adopted child and ethnicity of adopted child did not differ between the 2 groups.²²²³ However, when using chi-squared tests significant differences were found for region and service provider.²⁴²⁵

Tables 23 to Table 27 contain frequency information in relation to the 5 variables for all applicants and all respondents. In summary, the following differences were found between the survey sample and all ASF applicants.

- Children of respondents in the survey sample were slightly older than all applicants;
- Responses to the survey were higher from the South West, the West Midlands, and Yorkshire and the Humber regions and lower from the East of England, North West, and South East regions than predicted from the application data; and,
- More families in the survey sample were accessing services delivered by local authority staff or by ASA compared to all fund applicants. In contrast, fewer services were delivered by VAA and independent services provider within the survey sample than all applicants.

In addition to the comparison on these 5 variables we studied if survey respondents were more or less likely than the whole sample of applicants to have applied to the Fund more than once. Within the survey sample 4.3% of the families had 2 or more approved

²⁰ This refers to the approved applicants between May 2015 and May 2016. When several applications were made using same application code only the first application was kept in the data set for the comparison.

²¹ Age of adopted child refers to the age at assessment. Information about the age at placement or date of placement was not available for all of the applicants and respondents.

²² $\beta=0.023$, $p=.024$, $OR=1.023$.

²³ For the logistic regression ethnicity of the adopted child was dichotomised combining all ethnicities but white. However, when using chi-squared test to use the full information ethnicity of the child did not show a significant effect, $\chi^2(4, N = 5087) = 0.651$, $p = 0.957$, Cramer's $V=.011$.

²⁴ $\chi^2(9, N = 5088) = 52.499$, $p < 0.001$, Cramer's $V=.102$.

²⁵ $\chi^2(4, N = 5032) = 32.204$, $p < 0.001$, Cramer's $V=.080$.

applications and within the group of all applicants this percentage was slightly lower with 3.4%. However, this difference was not statistically significant.²⁶

Following the comparison it can be concluded that the survey sample is not representative of the population of applicants in terms of service provider, region, and age of adopted child. Despite significant differences it should be noted that due to the large sample sizes involved small differences may result in a significant effect. The effect size of the comparison of the type of service provider can be for example considered as small.

Table 23: Comparison of respondents and applicants regarding gender of the adopted child

Gender	Respondents		Applicants	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Female	380	48.1%	2353	46.2%
Male	410	51.9%	2732	53.7%
Transgender	0	0%	3	0.1%
Total	790	100%	5088	100%

Source: Application data.

²⁶ $\chi^2 (1, N = 790) = 2.17, p = 0.141$.

Table 24: Comparison of respondents and applicants regarding ethnicity of the adopted child

Ethnicity	Respondents		Applicants	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Asian / Asian British	11	1.4%	81	1.6%
Black / African / Caribbean / Black British	13	1.6%	75	1.5%
Mixed / multiple ethnic groups	11	1.4%	75	1.5%
Other ethnic group	48	6.1%	286	5.6%
White	707	89.5%	4570	89.8%
Total	790	100%	5087	100%

Source: Application data.

Table 25: Comparison of respondents and applicants regarding age of the end of the assessment of adopted child

Age range	Respondents		Applicants	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
Under 5	66	8.4%	514	10.1%
5 to 10	396	50.1%	2602	51.2%
11 to 15	297	37.6%	1697	33.4%
Over 15	31	3.9%	272	5.3%
Total	790	100%	5085	100%
	Mean	SD	Mean	SD
Age	9.59	3.64	9.30	3.86

Source: Application data.

Table 26: Comparison of respondents and applicants regarding region

Region	Respondents		Applicants	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
East Midlands	69	8.7%	331	6.5%
East of England	88	11.1%	697	13.7%
Inner London	20	2.5%	155	3%
North East	36	4.6%	239	4.7%
North West	84	10.6%	692	13.6%
Outer London	33	4.2%	307	6%
South East	108	13.7%	862	16.9%
South West	135	17.1%	733	14.4%
West Midlands	102	12.9%	494	9.7%
Yorkshire and the Humber	115	14.6%	578	11.4%
Total	790	100%	5088	100%

Source: Application data.

Table 27: Comparison of respondents and applicants regarding service provider

Service Provider	Respondents		Applicants	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
ASA	141	18%	716	14.2%
CAMHS	9	1.1%	93	1.8%
Independent (commissioned through LA)	493	62.9%	2918	58%
LA (internally delivered)	45	5.7%	501	10%
VAA	96	12.2%	804	16%
Total	784	100%	5032	100%

Source: Application data.

Comparison of follow-up respondents and ASF applicants

All applicants to the Fund until end of May 2016 were further compared to survey respondents that completed the follow-up survey. Results were similar to the comparison above. Logistic regression revealed that age of the adopted child was a significant predictor whereas gender and ethnicity of adopted child did not predict the participation in

the follow-up survey.²⁷ As above, significant differences were found for region and service provider.^{28,29}

Comparison of applicants and all adopters

After the previous comparisons we also sought to compare the profile of applicants with the profile of all adopted children in England in order to find out about potential differences in their profiles.

We used national tables and local authority tables from *Children looked after in England, including adoption* (DFE, 2013; 2015), which contain information for adopted children in England for each year. We found 3 variables in the tables for which information was also provided for all applicants to the Fund, these were: gender of the adopted child, ethnicity of the adopted child; and location of family by region. Chi-squared tests were used to identify potential differences between applicants and all adopters. The tests showed significant differences between the groups for all 3 variables.³⁰ Tables 28 to 30 present information about these comparisons for gender of the child, ethnicity of the child and region separately. Differences that were found between the groups included:

- There were slightly more male adopted children for whom an application to the Fund has been made than there were male children in the population of all adopted children.
- More white British adopted children were in the application population than in the population of all adopted children.
- More applications were made in the South East, South West and East of England and less in the North West and inner London than proportionately expected from the population of all adopted children.

No other information for variables such as family income and family structure was available for both applicants and all adopted children. However, the comparison showed that the population of children on whose behalf an application to the Fund had been made is not representative of the population of all adopted children in terms of gender, ethnicity and region.

²⁷ $\beta=0.028$, $p=.027$, $OR=1.028$.

²⁸ $\chi^2(9, N = 5088) = 29.370$, $p < 0.01$, Cramer's $V=.076$.

²⁹ $\chi^2(4, N = 5032) = 23.952$, $p < 0.001$, Cramer's $V=.069$.

³⁰ Significant differences were found for gender ($\chi^2(1, N = 5085) = 16.26$, $p < 0.001$), ethnicity ($\chi^2(4, N = 5087) = 770.92$, $p < 0.001$), and region ($\chi^2(9, N = 5088) = 940.52$, $p < 0.001$).

Table 28: Comparison of applicants and national statistics regarding gender of adopted child

Gender	Applicants		National Statistics
	Absolute Frequency	Relative Frequency	Relative Frequency
Female	2353	46.2%	49.1%
Male	2732	53.7%	50.9%
Transgender	3	0.1%	0.0%
Total	5088	100%	100%

Note: National Statistics refer to the weighted average of the years 2009 to 2015; Source: Application data and national tables (DFE, 2013, 2015).

Table 29: Comparison of applicants and national statistics regarding ethnicity of adopted child

Ethnicity	Applicants		National Statistics
	Absolute Frequency	Relative Frequency	Relative Frequency
Asian / Asian British	81	1.6%	1.7%
Black / African / Caribbean / Black British	75	1.5%	2.6%
Mixed / multiple ethnic groups	75	1.5%	10.9%
Other ethnic group	286	5.6%	1.4%
White	4570	89.8%	83.2%
Total	5087	100%	100%

Note: National Statistics refer to the weighted average of the years 2009 to 2015; Source: Application data and national tables (DFE, 2013, 2015).

Table 30: Comparison of applicants and national statistics regarding region

Region	Applicants		National Statistics
	Absolute Frequency	Relative Frequency	Relative Frequency
East Midlands	331	6.5%	8.8%
East of England	697	13.7%	9.8%
Inner London	155	3%	5.6%
North East	239	4.7%	7.4%
North West	692	13.6%	16.4%
Outer London	307	6%	6.5%
South East	862	16.9%	13.1%
South West	733	14.4%	8.3%
West Midlands	494	9.7%	11.7%
Yorkshire and the Humber	578	11.4%	12.7%
Total	5088	100%	100%

Note: National Statistics refer to the weighted average of the years 2009 to 2015; Source: Application data and national tables (DFE, 2013, 2015).

1.3 Local authority case studies and review of prototypes

Introduction

A case study methodology was designed to provide an in-depth exploration of the evaluation questions, from the point of view of those implementing the ASF. Ten local authorities were selected in order to capture the situation from the point of view of key stakeholders and explore: the range of adoption support assessment practices; the experience of implementing the ASF (successes and challenges); how the ASF is affecting local authority spending on adoption support; and how the market is developing.

The case study work was designed to be longitudinal, which involved visiting a selection of local authorities twice over the course of the evaluation. The evaluation team conducted the first wave of interviews (via case study site visits) between December 2015 and January 2016 (circa 6 months post roll-out) and the second wave between July and September 2016.

The sections that follow will provide detail of:

- The case study selection process;
- The data collection process (including information on the numbers of people interviewed across sites and on the research tools used); and,

- Our approach to data analysis (how the data were analysed).

Selecting the local authorities

The case studies were selected in a two-stage process:

Stage one involved setting criteria for selection;

Stage two involved developing a long-list of local authority areas, on the basis of the criteria, and identifying the preferred ten.

These are described in detail below.

Stage one: setting the criteria

On the basis of the ITT and in consultation with the DfE, the case studies needed to represent a mix of local authorities in order to reflect the range of different sizes, regions and practices. Following conversations with the Department, we developed a set of core criteria, highlighted in the table overleaf:

Table 31: Criteria for case study selection

General criteria	<ul style="list-style-type: none"> • Local authority size with no. of adoptions per year • Geographic spread across England
Local authority type	<ul style="list-style-type: none"> • County Council • Metropolitan • London Borough
Number of adoptions from care and number of applications to the ASF³¹	<ul style="list-style-type: none"> • Mix of cases with Medium/High volume of no. of adoptions per year • Selection of some cases with high numbers of adoptions and low numbers of ASF applications
Delivery set up / model	<ul style="list-style-type: none"> • Range of set-ups: local authorities involved in regional consortia / partnerships or not
Type of interventions	<ul style="list-style-type: none"> • Range of therapeutic interventions provided
The ten prototype authorities and authorities with intervention measures were excluded from the selection.	

We also considered the percentage of consent rate at the application stage, in order to facilitate the sampling of, and access to, families.

Once the selection criteria were agreed, a database was created, displaying all local authorities in England against the criteria, highlighting the local authorities that needed to

³¹ In discussions with the DfE we agreed that the cases selected should be from those with medium and high level of adoptions per year. To do this, we looked at the adoption statistics by LA (2009-2013, released in 2014) and identified the average number of adoptions per year, per LA. This enabled us to cluster 'low', 'medium' and 'high' levels of adoptions. Data sources included: adoption statistics (2009-2013), in order to identify low, medium and high numbers of adoption per year (<https://www.gov.uk/government/publications/children-in-care-and-adoption-performance-tables-2013>) and programme-level data on number of applications to the ASF (and consent rate).

be excluded from the selection process (those with 'low' levels of adoption per year, the ten prototype authorities and authorities with intervention measures).

Stage two: the selection process

This stage involved creating a 'long' list of 15 potential case study authorities by looking across the spreadsheet and choosing the ones that best matched the criteria, while representing a good spread: geographical spread; a mix of local authorities with medium and high adoption numbers, including some with high ASF applications; mix of local authority types and delivery set-ups. The aim of the long list of 15 local authorities was to help the evaluation team and the DfE select ten as case studies.

The 'long' list was then discussed with the DfE and The Fund Manager in order to supplement the above formal criteria with the tacit knowledge held by those having worked with local authorities over a number of months. These discussions concluded with the selection of the ten preferred local authority sites, listed in Table 32 below against the major selection criteria. All these local authorities accepted the invitation to participate.

Table 32: The ten case studies (by region and type of authority)

Region	
South West	1
South East	1
London	1
East Anglia	1
East Midlands	1
West Midlands	1
North West	2
Yorkshire and Humberside	1
North East	1
Type	
County Council	4
Metropolitan	2
Unitary	3
London Borough	1

Data collection

The evaluation team conducted a one day site visit to 9 out of the ten local authority case study areas.³² The purpose of the site visits was to undertake face-to-face interviews and/or focus groups with key local authority staff involved in the implementation of the ASF. Follow-up telephone interviews were carried out with staff who were not available on the day. In collaboration with the Team Leaders, the evaluation team also identified, approached and interviewed local providers, either face-to-face (if they were available on the day) and / or via follow-up telephone interviews. The purpose of provider interviews

³² Two of the case study visits were undertaken via phone interviews, due to the availability of staff.

was to get their views on how the ASF is impacting on their work, in order to get a rich picture from the view of all the key stakeholders.

The number of interviews varied depending on the size and composition of the team and model of post-adoption support delivery in each case study location. Overall, between 4 and 9 interviews (either face to face interviews or group interviews) were conducted in each case study site.

In total across the 10 sites, the evaluation team interviewed **53** local authority representatives (which included staff of different levels and roles across service delivery, strategy, and procurement / finance) and **33** external providers –for a **total of 86 interviews** across the 10 areas.

Interviews followed a topic guide (see Appendix 4) around specific areas of inquiry; for local authority staff, these were designed to explore:

- Background (structure of the team, how the services were delivered prior to the ASF implementation);
- The range of adoption support assessment practices;
- Successes and challenges around the ASF implementation;
- The impact of the ASF on spending; and,
- The development of the local market.

For local providers, the topic guide (see Appendix 4) was designed to broadly explore the impact the ASF is having on their interactions with the local authority and their business and their views on how the ASF might be stimulating the market to ensure appropriate support is accessible for all adopted children and their families.

The interviews were semi-structured, allowing us to also explore issues raised as relevant by each interviewee.

Data from the case study visits were then used to create a standard template, in order to provide a snapshot of the ASF implementation across the sites. The interview data were supplemented with information from available documents (e.g. on adoption provision, local need and the ASF implementation) which were collated for each case to build a holistic picture of the local context, barriers and enablers and how each local area has attempted to implement the Fund to meet local need.

Thematic Content Analysis

A Thematic Content Analysis (TCA) of first and second interviews was conducted through a researcher workshop followed by coding and an iterative process of building,

checking and reviewing themes between 2 qualitative researchers. TCA involves organising the data, generating themes, coding the data, testing the emergent themes and searching for alternative explanations of the data (Marshall and Rossman; 1999).

The ten case studies (see Appendix 5) that follow are the result of a longitudinal case study in 2 phases. They stand alone as examples of how the ASF has unfolded in different types of areas and illustrate report themes, particularly in terms of the development of local markets.

Prototype reviews

The 10 local authorities that were prototypes for the ASF the year prior to national roll out, were contacted for a short review of their progress. The intension was to gauge whether these local authorities had any further progress. Each adoption support lead for the 10 authorities participated in a telephone semi-structured interview. The interview schedule included questions around the following areas:

- Service Delivery
- Implementation of the ASF
- Assessments
- Delivery and partnerships
- Purchasing and funding

The interviews were analysed alongside the case studies and provide evidence for the implementation part of the evaluation. An attempt was made to engage wider staff in the review by placing a summary online and requesting staff further commentary. This was abandoned as staff comments were too few and this did not prove to be a very robust way to collect qualitative data. As a result only the initial depth telephone interviews provide the data for the review of the prototypes in Appendix 5.

1.4 Family Interviews

Purpose and design of the family interviews

The aim of the family interviews was to collect in-depth qualitative family case-studies to bring to the forefront, and better understand, the experiences and view-points of adopted children and their parents of the Adoption Support Fund. These 20 interviews were longitudinal to complement the family survey by tracing family journeys in receiving adoption support at 2 time points and from multiple family perspectives. The interviewers undertook semi-structured interviews, face to face and spent up to 5 hours in total with each family to elicit rich narratives of family situations, the support needs of adoptive families, their journeys of service engagement and impact, to highlight the 'human story' of the evaluation. Although the research was designed to include whole family and/or interviews with children, where appropriate, through ethical review it was decided to interview only the parents in both rounds of interviews. The sampling, profile summary of families, methods and analysis process are detailed below.

Sample

Families were recruited by an opting in process from participants of the round one longitudinal survey. Twenty families were recruited to ensure a range of family experiences were gathered. Purposive sampling was used based on the demographic statistics of survey sample in order to capture a range of experiences from different regions of England, with different family configurations, and accessing different types of support. The aim was to interview families before therapy began. However, this was not always possible as some of the applications to the ASF had been processed a number of months after therapy started, some of the families recruited had already engaged in a range of therapies and in some cases many months of therapy. At the time of first interviews, 11 families were yet to start therapy or were still waiting for an assessment or information about whether they had been successful in gaining funding towards therapy. At the time of second interviews, 4 of the 20 families were unable to be interviewed in the second round, resulting in 16 second interviews. 14 of these families had received some form of ASF support; 4 of the 16 families were waiting for ongoing therapy to begin.

Table 33: Family Interviews sample details

Family interviews sample details			
Summary of children for whom the ASF funding was applied for (n=27)		Summary of provision funded	
Age at placement		Type of services funded (n=31)³³	
0-2 years	9	Psychotherapies (DDP, Family, sensory processing etc.)	15
3-4 years	9	Creative and play therapies	5
5-6 years	5	Therapeutic assessments	6
7 years +	4	Therapeutic respite break	1
		Parenting training/courses	4
Age of child at assessment of adoption support needs		Length of therapeutic support funded (n=20)³⁴	
0-5 years	2	0-20 sessions	3
6-10 years	13	21-40 sessions	4
11-15 years	10	40 sessions +	3
16 years +	2	Open-ended ³⁵	6
		Unknown	4
Child gender		Value of the ASF applications made per family³⁶	
Female	16	Under £5,000	13
Male	11	£5,000 - £10,000	3
		£10,001-£15,000	2
		£15,001 - £20,000	1
		£20,001 +	1

Methods

Families were contacted between November 2015 and July 2016 and again between November 2016 and February 2017 to arrange first and second interviews. First face-to-

³³ Some families received more than one type of funded support. This number does not include those yet to begin therapy or who were waiting for confirmation. Some therapies were for whole family and so include siblings. Other families received different therapies for each child.

³⁴ This relates to ongoing therapy programmes offered and excludes therapeutic assessments.

³⁵ These families expected to receive therapy for as long as needed, often for over a year.

³⁶ This information was gathered through the ASF application dataset and does not include new, pending applications.

face interviews were conducted with parents between February 2016 and September 2016 and second interviews took place between November 2016 and March 2017.

Families were sent information sheets about the research and interviews in advance, covering confidentiality and informed consent. This information was also discussed at the first interview, topic guides shared with parents and written informed /consent gained before interviews were recorded. One second interview was undertaken by skype, and 15 undertaken face to face. All interviews were audio recorded and transcribed verbatim.

Topic Guides

Semi-structured interviews were designed to be conducted with both or single parents. The first interview topic guides covered the current situation of the family, previous help-seeking experiences, experience of the assessment and satisfaction with the services proposed. The second interview topic guides covered experience of the intervention provided through the ASF and perception of impact.

Analysis

Following transcription of the interviews by TIHR researchers and an external transcription service, all interviews were listened to and transcriptions read in order to generate initial emerging themes. Two key approaches were then used in the analysis of family interviews. Firstly, a thematic analysis was undertaken of interviews, coding inductively from the data using QSR NVivo , generating basic themes.³⁷ Basic themes were grouped into organising themes, and subsequently into global themes. Themes generated were then matched to the research questions through a thematic mapping process and interpretations developed. This work was done using NVivo and Microsoft Excel. Throughout the process, raw data was revisited to check and review codes and themes identified, with further refining of themes, in order to validate interpretations made within the final report.

Secondly, a narrative analysis of each family's story was undertaken through the writing of family sketches, which looked for key milestones or influencing factors during the adoptive and the ASF-support seeking journey of each family, and summarising some of the key conclusions made by families as a result of their experience. All sketches were sent to families for review and fact checking, as well as to the family interviewers (that were not involved in interview analysis). Each story was then reviewed again to ensure rigour and to identify how themes generated within the statistical and thematic analyses were experienced in family lives. 12 in-depth parent interviews were used as the basis for

³⁷ Attride-Stirling, J. (2001) Thematic networks: An analytic tool for qualitative research. *Qualitative Research*, 1(3), 385-405

‘vignettes’, providing a more focused description of a particular aspect of the family’s experience.

A ‘light-touch’ content analysis was finally undertaken, to help quantify the frequency of some of the experiences and views expressed within interviews, and to identify further patterns that might exist within and across the families interviewed. Comparisons were looked for between families’ experiences, age of children and age at adoption, as well as therapeutic interventions provided and other support in place.

1.5 Triangulation of Data and Sense Making

In order to triangulate the data from the different strands of the evaluation and build an picture to address the key research questions a practical evaluative framework was adopted known as ‘Rubrics’.³⁸ This was used to make evaluative statements about the effectiveness of the ASF, its processes, its short and medium term impacts and potential long term impacts. The rubric was also a working tool for research team to collaborate across, the different methodological strands of the research, The process normally involves drawing up a list of criteria against each intended then ranked for the strength/appropriateness of the data and then finally defining what the performance looked like at each level, e.g. poor, adequate, good, and excellent. In this evaluation where many of the outcomes were to be described and evaluated qualitatively, for example ‘the development of a local market’ the role of the rubric was as a sense making tool that provided the ‘story’ of the intervention rather than an incremental measure of performance.

1.6 Note on Presentation of Qualitative Data

Throughout the report the presentation of the qualitative data from the local authority case studies and the in-depth parent interviews makes frequent use of concepts to present scale rather than numbers. For example, ‘widespread’, ‘many’, ‘the majority’, ‘a minority’, ‘a few’. In the construction of the evaluative rubric scales or descriptions with numerical values, were, where appropriate, allocated for transparency and to maintain quality assurance between researchers carrying out the analysis. For example, where the report refers to ‘a widespread opinion’ from a case study this represents a view that was expressed within at least 70% of the case studies by at least 70% of the individuals interviewed. This was not however, an exact science which would be an inappropriate strategy for the analysis of qualitative data. This is because this kind of “quasi-statistics”

³⁸ E.g. Davidson, J., Wehipeihana, N., & McKegg, K. (2011) Evaluative Rubrics a Method for Surfacing Values and Improving the Credibility of Evaluation Available at: file:///C:/Users/SKing/Downloads/374-1266-1-pb.pdf

can be useful to proportion scale to the qualitative data for transparency and consistency in analysis, but in the presentation of qualitative data it distracts from the exploratory value of the data e.g. how and why something is being implemented, and the lived experience of beneficiaries. There are 2 specific reasons why more interpretive concepts are more appropriate, and convey clearer meaning, than numbers in the context of this qualitative data on a complex, early phase evaluation such as this evaluation of ASF. Firstly, the data is derived from semi-structured interview schedules designed to illicit narrative. In the case studies the semi-structured interviews were applied as both focus groups, paired conversations and as one to one interviews, thereby creating variation in-depth and scope of the answer. If an opinion was given as a response to an open ended question by several respondents this may, as part of the analysis, translate into a finding. However, representing that finding as a number is misleading as it doesn't mean that this opinion was not held by respondents in the case studies where that opinion did not emerge. For example had they been specifically asked that). Secondly, in situations that are complex, where the systems under study are changing as we work (which is typical in the early days of an intervention) those changes and early outcomes are often better understood with concepts that can describe trajectories with more flexibility than can be achieved with numbers that are more likely to tell a misleading tale of failure or success.³⁹

³⁹ Further reading: J. A. Maxwell (2010) Using Numbers in Qualitative Research Journal of Qualitative Inquiry (16,6) Available at: <http://journals.sagepub.com/doi/pdf/10.1177/1077800410364740>

Appendix 2 – Parental Information Sheet



Department
for Education

THE
TAVISTOCK
INSTITUTE®

Dear Parent

Supporting Adopted Families

The Department for Education (DfE) is funding the Adoption Support Fund to help adopted children and their families access therapeutic post-adoption support. We hope that this support will improve the wellbeing of adopted children and families.

The DfE have commissioned us, The Tavistock Institute (www.tavinstitute.org) to carry out research to find out how useful this Fund is and how it should be developed in the future. The research will help build evidence about what support adopted families like yours need. As part of this study, the research team are asking adoptive parents to fill in 2 questionnaires that will be sent to them and returned by post. The first will be sent and returned before you receive support through the Fund and the second at a later date to find out what you thought about the support and whether it has made a difference.

At this stage all that is needed is for you to agree for a member of the adoption team to pass on your contact details and the basic information that will be contained in your application form to our research team. This is so that we can send out the survey to you by post and link your answers to basic information such as what service your family is getting and the ages of your children. We will **not** know the names of your children or any confidential or sensitive information such as that contained in a psychological assessment. If you agree to take part we will send you a copy of the first postal survey which will contain more information about the research.

Anything you tell the researchers in the survey will be treated in the **strictest confidence (and will not be directly reported to the DfE)**, you can drop-out at any time and your details will not be shared with any other party.

We hope that you will be happy to take part in this research. It is very important for the researchers to hear from a wide range of families about the new Fund and what can be improved to better support adoptive families like yours in the future. We know from previous research studies that most people taking part in this kind of research find it interesting and valuable.

If you would like more information about this important research study, you can contact either us at the Tavistock Institute on 0207 4170407 or email asfevaluation@tavinstitute.org leaving your name and telephone number and we will respond as soon as we can. If you would like to speak to someone at the DfE please call Gail Peachey on 0207 340 8008

With thanks and best wishes

Dr Sadie King

A handwritten signature in black ink, appearing to read 'Sadie King', with a long horizontal flourish extending to the right.

Senior Researcher, the Tavistock Institute of Human Relations

Frequently asked questions

Who are the research team?

The Tavistock Institute is an independent research organisation based in London which has been carrying out research for over 60 years. A lot of this research is with children, young people and families. We are working with the Centre for Longitudinal Studies (<http://www.cls.ioe.ac.uk/>) and Qa Research (<http://qaresearch.co.uk/>) both experts in doing large surveys with children and families.

Do I have to take part?

Whether or not you decide to take part is entirely your choice. You will be offered all the same services even if you decide not to take part.

Will what I say be reported back to the service provider?

Everything you say will be treated in strict confidence by our researchers and not passed on to anyone else. We will report back in general terms about what parents tell us – using percentages for the survey – but will not use anyone's name or details that could identify them to others.

When will I be contacted?

If you agree to be contacted, a letter with the survey will be posted to you in the next few weeks. A pre-paid envelope will be provided so you can post back the survey. We will then contact you again later with a follow up survey to see if the service made a difference.

How long will filling in the survey take?

Each questionnaire will take about 15 - 20minutes to complete.

Is there anything else involved?

We will also be doing in-depth face to face interviews with a small number of adoptive families who have completed and returned the survey. When you complete the survey, we will ask you if you are also happy to be contacted about being involved in these depth interviews. But again this is entirely voluntary and you do not have to decide now.

Appendix 3 – Staff Information Sheet



Dear Sir or Madam

Re: Request for Support with the Evaluation of the Adoption Support Fund

This letter is to seek your support with the evaluation of the Adoption Support Fund. As you will know the Fund has been made available by the Department for Education (DfE) to adopted children and their adoptive families and aims to improve access to therapeutic services and support (www.adoptionsupportfund.co.uk).

Why research? The Department has commissioned us, The Tavistock Institute (www.tavistock.org), to conduct an independent evaluation of the Fund, to find out whether it improves the wellbeing of adopted children and families. This research will be used to directly inform future government policy and spending decisions on adoption support.

What does the research involve? The evaluation will involve a postal survey of all adoptive families receiving support through the Fund to see if it has made a difference to their lives. Families will be contacted twice - at the start of their support and then again after the support is finished. **The survey will be confidential and has been designed by experienced researchers skilled in working with vulnerable families.**

What do we need you to do? We have tried to minimise the research burden on local authority staff, but to enable us to carry out this study, **it is essential to have your help in gaining the consent of parents to participate in the survey.** This will involve the following steps:

1. During the Adoption Support Fund assessment please tell adoptive parents about the evaluation and **ask for their agreement to take part in the survey.** We need parents' consent for you to share the following information with us:
 - their **contact details** so we can send the postal survey to them.
 - the **information contained in the Adoption Support Fund online application form.** (As you know this is only basic information such as the services they are getting, its cost, and their children's ages. We will **not** know children's names or any sensitive information such as that contained in a psychological assessment.)
2. If parents agree, please tick the box when you apply online to the Fund and enter the parent's contact details. If you have not yet asked parent's consent when applying please telephone them to ask for their consent.

We have also provided a consent form for parents (attached to the same email as this letter) to assist you in gaining their informed consent, however it is not mandatory to use this and do **not** need to send signed consent forms on to us. This is provided for your own records if you deem it necessary.

Please make clear to parents that **hearing their views on the Fund is vital** for the DfE to be able to improve the Fund and improve services for adoptive families, but that their involvement in the research is voluntary. Whether or not they choose to participate in the research will not affect the services they receive and they can change their mind at any time.

Also attached is an information sheet for you to give parents when explaining the research. Please print copies of this document to provide to families and below are answers to several FAQs. If you

have any further questions please contact Matthew Gieve or Laura Stock from the Tavistock Institute research team on 0207 417 0407 or email asfevaluation@tavinstute.org and we will respond as soon as we can. We very much hope you will be able to assist us with this important study to inform future government policy and spending for adoptive children and families and would like to thank you in advance for your support.

Yours sincerely,

Dr Sadie King

A handwritten signature in black ink, appearing to read 'Sadie King', with a long horizontal flourish extending to the right.

Senior Researcher, the Tavistock Institute of Human Relations

Frequently asked questions

What is the Adoption Support Fund?

The DfE is aware that adoptive children sometimes have very difficult starts to their lives and they often need short and long term therapeutic support. The Adoption Support Fund (www.adoptionsupportfund.co.uk) aims to improve adoptive families' access to therapeutic support, to support their wellbeing and family relationships.

Why is the Department for Education funding this research?

The aim of the research is to ensure that the Fund is effectively supporting families to receive the therapeutic support they need. This evaluation will build the evidence base to inform future funding and improvements in policy and practice for adopted families.

Who are the research team?

The Tavistock Institute is an independent research organisation based in London which has been carrying out research for over 60 years. A lot of this is with children, young people and families, including in sensitive areas such as mental health. We are working with the Centre for Longitudinal Studies (<http://www.cls.ioe.ac.uk/>) and Qa Research (<http://qaresearch.co.uk/>) both experts in doing large surveys with children and families.

What do I need to do?

When you assess adopted children and their parents and plan to apply to the Adoption Support Fund, we need you to tell them about the research and gain their consent for you to share their contact details and basic application details with the research team so that they are able to participate. We have written a letter and information sheet for you to share with parents that will explain the research. **Your help in gaining consent is vital to the research** – if too few families consent we will be unable to assess whether the Fund has made a difference to families, and will not be able to inform future spending decisions to improve support for adopted families.

Why does the research team need parents' contact details?

The research team needs parents' details so they can send out the survey to them by post.

Why do we need access to their application data?

This will be used to understand which service(s) the family have accessed, the duration of the service and demographic information such as the ages of their children. We will **not** know the names of their children or any confidential or sensitive information such as that contained in a psychological assessment.

Do families have to take part?

Whether adoptive parents decide to take part in the research is entirely their choice. They will be offered all the same services even if they decide not to take part.

Will what families say be reported back to the service providers?

Everything families say will be treated in strict confidence by our researchers and not passed on to anyone else. We will report back in general terms about what parents tell us – using percentages for the survey – but will not use anyone’s name or details that could identify them to others.

When will parents be contacted?

If parents agree to be contacted, a letter with the survey will be posted to them within a few weeks. A pre-paid envelope will be provided so that they can post back the survey. We will then contact them again later with a second survey to see if the service made a difference.

How long will filling in the survey take?

Each questionnaire will take about 15 - 20minutes to complete.

Is there anything else involved?

We will also be conducting in-depth face to face interviews with a small number of adoptive families who have filled in the survey. If parents do fill in the survey, we will then ask them if they are also happy to be contacted about being involved in these depth interviews. But they do not have to decide now.

Appendix 4 – The Survey

1.7 Online Survey of Adopters

It takes a village to raise a child 2016

1. It takes a village to raise a child 2016: A survey about adoption support

Hello,

Thank you in advance for your time to participate in this survey. This survey is aimed at adopters, prospective adopters and individuals thinking about adoption. The purpose of this survey is to investigate the understanding and needs of adopters and prospective adopters for adoption support services, and their access to these services. For those living in England the aim is to further explore awareness and experiences related to the Adoption Support Fund. The Adoption Support Fund is an important new initiative introduced by the Department for Education (DfE) to help families with their therapeutic adoption needs. As far as possible, please answer all questions in the survey. It can take up to 45 minutes to complete the questionnaire.

The survey is being carried out by the Tavistock Institute on behalf of the Department for Education. The Tavistock Institute is a registered charity and independent research institute (<http://www.tavinstitute.org>). All the answers you give will be completely confidential and no identifiable information about you will be passed on to the Department, local services or any other person or organisation. Everything you say remain strictly confidential and handled in accordance with the Data Protection Act 1998. This survey will be used solely for research purposes and taking part is completely voluntary.

1. Please indicate that you agree to participate in this survey: *

- Yes
- No

2. About You

2. Where do you currently live? (tick one box only) *

- England
- Wales
- Scotland
- Northern Ireland
- Other (please specify):

3. Which one of the following roles apply to you? (tick one box only) *

- Prospective adopter – currently going through the assessment process
- Prospective adopter – approved as adopters but not having a child placed with me/us
- Individual/ family thinking about an adoption
- Parent with adopted child(ren)

3. Your Understanding

Please answer questions 4 to 10 based on your overall adoption experience or where it is more appropriate, your most recent experience. If you would like to include further comments, please do so in the boxes provided.

4. Do you understand or know about your entitlements to adoption support services? *

- Yes
- No

Please use the space below to expand further upon your answer, if you wish to do so

5. How would you rate your understanding about your entitlements to adoption support services? (tick one box only) *

- Non-existent
- Poor
- Good
- Excellent

Please use the space below to expand further upon your answer, if you wish to do so

6. Has your agency informed you about the adoption support services it provides? *

- Yes
- No
- Not applicable

Please use the space below to expand further upon your answer, if you wish to do so

7. Whether or not you have been informed by your agency, do you know what adoption support services your agency provides? *

- Yes
- No
- Not applicable

Please use the space below to expand further upon your answer, if you wish to do so

8. What support services does your agency provide? (please tick all that apply) *

- Services to enable discussion of matters relation to adoption (e.g., support groups)
- Assistance and support in relation to contact arrangements
- Therapeutic services
- Training
- Respite care
- Services to assist in cases of disruption
- Counselling, advice and information
- Financial support (including cash payments)
- Educational support services (e.g., via schools or an educational psychologist)
- Mental health services (e.g., CAMHS)
- Unable to answer/don't know

Please use the space below to expand further upon your answer, if you wish to do so

4. Your Understanding

9. Has your agency informed you about your right to request an assessment for adoption support needs? *

- Yes
- No

10. If your agency did inform you, how were you informed of this right and at what stage of the adoption process or journey were you informed?

5. Your Understanding

11. Does your agency have an Adoption Support Services Adviser?

- Yes
- No
- Don't know/ can't remember

6. Your Experience

Please answer questions 12 to 16 of this section thinking about your adoption experience as a whole or if you have adopted multiple children, please think about your most recent experiences. From question 17, you will be asked to answer questions according to each child adopted.

12. When you first enquired about adoption were you given information about adoption support? *

- Yes
- No
- Don't know/ can't remember

13. As a prospective adopter, did your agency provide you with the information listed below? (please tick all that apply) *

- General details of children the agency has placed for adoption or of children who need adoption, such as their age ranges, backgrounds and characteristics
- How to apply to the agency for an assessment of their suitability to adopt

- What happens when an application is accepted by the agency, including an Explanation of why checks, references and full health information are needed
- The decision-making process and their rights to make representations to the agency or apply for an independent review if they are considered unsuitable to adopt
- Adoption support and the matching process including the use of the Adoption Register
- Did not supply any information
- Don't know/can't remember

Please use the space below to expand further upon your answer, if you wish to do so

14. How was the information listed in question above provided to you? (please tick all that apply) *

- Orally
- In writing
- Both
- Don't know/can't remember
- Not applicable, as I did not receive the information

7. Your Experience

15. As part of your adoption preparation and home study, was adoption support discussed or covered? *

- Yes
- No
- Don't know/ can't remember

16. During your time as a prospective adopter, do you feel that you understood the importance of adoption support? *

- Yes
- No

Please use the space below to expand further upon your answer, if you wish to do so

17. How long did your preparation and assessment process take?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Up to 2 months								
More than 2 months, but less than 4 months								
More than 4 months, but less than 6 months								
More than 6 months, but less than 12 months								
More than 1 year, but less than a 18 months								
More than 18 months but less than two years								
More than two years								
Still undergoing preparation and assessment								
Don't know/can't remember								

Please use the space below to expand further upon your answer, if you wish to do so

8. Your Experience

18. When was adoption support discussed? (tick all that apply)

Child 1 Child 2 Child 3 Child 4 Child 5 Child 6 Child 7 Child 8

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
During assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-approval as suitable to adopt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-matching/linking with child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not discussed at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. When were you approved as an adopter?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Before 2002	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2002 – 2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2006 – 2007	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2008 – 2009	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2010 – 2011	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2012 – 2013	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2014 – 2015	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2016	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Were you approved by:

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
A local authority (LA) agency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A voluntary adoption agency (VAA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Your Experience

21. When you were matched with your child(ren), did the adoption placement report or similar document cover the provision of adoption support services?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. How would you describe your relationship with your current adoption agency? *

- Excellent
- Good
- Average
- Poor
- Non-existent

Please use the space below to expand further upon your answer, if you wish to do so

10. Your Experience

23. Do you currently receive adoption support services?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No* If you have answered 'no' for all your children, please move on to the next page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. If yes, what support services do you currently receive and who supplies these services?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Services to enable discussion of matters relation to adoption (e.g.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
support groups)								
Assistance and support in relation to contact arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services to assist in cases of disruption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling, advice and information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial support (including cash payments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational support services (eg, via schools or an educational psychologist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services (eg, CAMHS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to answer/don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

25. How long have you been receiving those support services?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Services to enable discussion of matters relation to adoption (e.g. support groups)								
Assistance and support in relation to contact arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services to assist in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
cases of disruption								
Counselling, advice and information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial support (including cash payments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational support services (eg, via schools or an educational psychologist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services (eg, CAMHS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Your Experience

26. Whether or not you receive or have received support services, in your view, does your child(ren) have special needs that require greater support services?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/Not sure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

27. Whether or not you currently receive support services, have you received adoption support services in the past? *

- Yes
- No

12. Your Experience

28. If yes, what support services did you receive? (please tick all that apply) *

- Services to enable discussion of matters relation to adoption (e.g. support groups)

- Assistance and support in relation to contact arrangements
- Therapeutic services
- Training
- Respite care
- Services to assist in cases of disruption
- Counselling, advice and information
- Financial support (including cash payments)
- Educational support services (eg, via schools or an educational psychologist)
- Mental health services (eg, CAMHS)
- Unable to answer/don't know

29. If yes, for how long did you receive those support services? *

- Up to 2 months
- More than 2 months, but less than 4 months
- More than 4 months, but less than 6 months
- More than 6 months, but less than 12 months
- More than 1 year, but less than a 18 months
- More than 18 months but less than two years
- More than two years
- Don't know/can't remember

13. Your Experience

30. Have you ever requested an assessment of your/your family's needs for adoption support services?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No* If no, please move on to the next page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. If yes, what was the response to that request?

- An assessment was carried out
- Request for an assessment was refused

- No response was received
- Other (please specify):

32. If the request for an assessment was refused, why was it refused?

14. Your Experience

33. Whether or not you requested an assessment, have you or your family ever had your adoption support needs assessed by a local authority? *

- Yes
- No
- Don't know/can't remember

15. Your Experience

34. If yes, what was the result? *

- Support needs were identified
- No support needs were identified
- Don't know/can't remember
- Other (please specify):

16. Your Experience

35. If support needs were identified, please list what they were (tick all that apply) *

- Services to enable discussion of matters relating to adoption (e.g. support groups)
- Assistance and support in relation to contact arrangements
- Therapeutic services

- Training
- Respite care
- Services to assist in cases of disruption
- Counselling, advice and information
- Financial support (including cash payments)
- Educational support services (e.g. via schools or an educational psychologist)
- Mental health services (e.g. CAMHS)
- Unable to answer/don't know

36. Did the agency agree to meet those needs? *

- Yes
- No
- Don't know/can't remember
- Other (please specify):

37. Did the local authority create a plan outlining your support needs? *

- Yes
- No

38. If yes, did it include?

- Services to enable discussion of matters relating to adoption (e.g. support groups)
- Assistance and support in relation to contact arrangements
- Therapeutic services
- Training
- Respite care
- Services to assist in cases of disruption
- Counselling, advice and information
- Financial support (including cash payments)
- Educational support services (e.g. via schools or an educational psychologist)
- Mental health services (e.g. CAMHS)
- Unable to answer/don't know

17. Your Experience

39. If your adoption support needs were assessed, did you receive the services that were identified?

- Yes - in full
- Yes - in part
- No
- Other (please specify):

40. Who received those support services? (please tick all that apply)

- Adopted child(ren)
- Birth child(ren)
- Adoptive parent(s)
- Whole family
- Other relative

41. If you have received any adoption support services, whether through assessment or otherwise did they help you and your family? *

- Yes*
- No*
- Not applicable/did not receive support services

*If yes, please detail how they helped; if no, please detail why not

18. Your Experience

42. On receiving adoption support services, how did you rate the quality of these services? *

- Excellent
- Good

- Acceptable
- Poor
- Not applicable/did not receive support services

Please use the space below to expand further upon your answer, if you wish to do so

43. From where did you receive these adoption support services? (please tick all that apply) *

- Local authority adoption agency
- Voluntary adoption agency
- Independent adoption organisation
- Child and Adolescent Mental Health Services (CAMHS)
- Therapist
- Counsellor
- Education service
- Health service
- Not applicable/did not receive support services
- Other (please specify):

44. Have you asked for adoption support services from anyone else? (please tick all that apply)

- Via assessment (at my/our request) by local authority
- Via a voluntary agency
- Via an independent agency (e.g. Adoption UK)
- Via the NHS
- Privately
- Through other adopters
- Not applicable
- Other (please specify):

19. Your Experience

45. Have your requests for, or the provision of, adoption support services required joint work or collaboration between different adoption agencies? (e.g. due to the agency that approved you as an adopter being different to the one from which your child(ren) was/were placed, or due to your subsequent move from one local authority to another, or because of the need for services from social care, education and mental health services etc) *

Yes

No

Don't know/Not applicable

20. Your Experience

46. If yes, how would you rate the working relationship between the different agencies?

Excellent

Good

Acceptable

Poor

Please use the space below to expand further upon your answer, if you wish to do so

47. Where responsibility for support transferred from one agency to another, was there continuity of support services?

Yes

No

Don't know

Not applicable

Please use the space below to expand further upon your answer, if you wish to do so

21. Education System

48. In your view, do you or did you believe that your child(ren) needs/needed educational support at school?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

49. Did you receive assistance with accessing educational support for your child(ren)?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

50. Does or did your child(ren) receive any educational support in school?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes* Please use the space below to expand on your answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No* Please use the space below to expand on your answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

22. Adoption Allowances

Please answer questions 51 to 56 based on each child you have adopted

51. Do you receive a regular adoption allowance?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No* If no, please move on to the next page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

52. If yes, what is the weekly amount of that allowance?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Up to £70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£71 - £80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£81 - £90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£91 - £100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£101 - £110	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£111 - £120	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£121 - £130	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£131 - £140	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£141 - £150	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£151 - £160	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£161 - £170	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£171 - £180	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
£181 - £190	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£191 - £200	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£200+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

53. How long have you been in receipt of that allowance?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Less than one year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One to two years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Three to five years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Six to 10 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 years or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Adoption Allowances

54. At anytime during your adoption journey, have you received any assistance/help to access other welfare benefits/tax credits to which you are/were entitled?

- Yes
- No
- Don't know/can't remember

Please use the space below to expand further upon your answer, if you wish to do so

55. Did you or, where relevant, your partner/spouse receive adoption pay and leave when your child(ren) was/were placed?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know/can't remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

56. If yes, was this equal to you/your spouse's employer's policy on maternity pay and leave?

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Adoption Support Services

57. Have there been any barriers regarding your access to adoption support services? (please tick all that apply) *

- Ethnicity
- Language
- Geography (distance)
- Money/finance
- Relationship with your social worker
- Relationship with other professionals (please specify)
- Working relationships between different agencies
- Level of understanding and experience of adoption among professional staff involved
- Time
- Didn't like what was offered
- Fear of being seen as a failure
- Agency didn't understand your problem
- Conflict between your needs and your adopted child(ren)'s needs
- Not sure
- Not applicable
- Other (please specify):

58. If you would like to add any additional information about your experience of adoption support, please use the space below to do so. This could include detailing resources or support providers that you have successfully accessed and that have not been included in this survey.

25. Your View for Change

59. In your view, does the current adoption support system need improving? *

- Yes
- No

Please use the space below to expand further upon your answer, if you wish to do so

26. Your View for Change

60. What service(s) would best help you to support your child(ren)? *

- Services to enable discussion of matters relating to adoption (e.g. support groups)
- Assistance and support in relation to contact arrangements
- Therapeutic services
- Training
- Respite care
- Services to assist in cases of disruption
- Counselling, advice and information
- Financial support (including cash payments)
- Educational support services (e.g. via schools or an educational psychologist)
- Mental health services (e.g. CAMHS)
- Unable to answer/don't know
- Other (please specify):
-

Please use the space below to expand further upon your answer, if you wish to do so

27. Therapeutic Parenting

61. Have you attended a course for therapeutic parenting? *

- Yes
- No
- Can't remember/ don't know

62. The following statements seek to understand your knowledge and experience with regards therapeutic parenting. Please indicate how far you agree or disagree to the following statements: *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know	Not applicable
I feel I understand what therapeutic parenting is about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't see the value of therapeutic parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel prepared to practice therapeutic parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Awareness of the Adoption Support Fund

63. Before answering this questionnaire, had you ever heard about the Adoption Support Fund? *

- Yes
- No

29. Awareness of the Adoption Support Fund

64. How did you first hear about the Adoption Support Fund? (Please select one) *

- Social Worker direct contact

- Local Authority Newsletter for Adopters
- Local Authority website
- First4Adoption website
- Social media from adopters
- A poster or leaflet in a public place
- A meeting arranged by the council
- Voluntary adoption agency (VAA) or adoption support agency (ASA)
- Friends with adopted children
- News
- Other (please specify):

65. If you have heard about the Adoption Support Fund from a voluntary adoption agency (VAA) or adoption support agency (ASA), please state from which one (e.g., Adoption UK)?

30. Awareness of the Adoption Support Fund

66. Since hearing about the Adoption Support Fund for the first time, have you heard about it from another or multiple sources? (Please select all that apply)

- Social Worker direct contact
- Local Authority Newsletter for Adopters
- Local Authority website
- First4Adoption website
- Social media from adopters
- A poster or leaflet in a public place
- A meeting arranged by the council
- Voluntary adoption agency (VAA) or adoption support agency (ASA)
- Friends with adopted children
- News
- I have only heard about it once
- Other (please specify):

67. If you have heard about the Adoption Support Fund from a voluntary adoption agency (VAA) or adoption support agency (ASA), please state from which one (e.g., Adoption UK)?

31. Impact of the Adoption Support Fund

68. The following statements seek to understand what has been the impact, if any, of the Adoption Support Fund on you and your family!. Please indicate how far you agree or disagree to the following statements: *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Not applicable
It has (or would have) encouraged me to think about an adoption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It has (or would have) encouraged me to proceed with an adoption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It makes me feel less confident about my decision on to adopt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Impact of the Adoption Support Fund

69. Has your local authority made an application on your behalf to the Adoption Support Fund? *

- Yes
- No
- No yet, but our Local Authority is planning to
- Don't know

33. Impact of the Adoption Support Fund

70. If your local authority has not applied on your behalf, why not? (please select all that apply) *

- I don't feel we need support at the moment
- I don't know how to apply to the ASF
- The services I think we need are not covered by the ASF
- We are already receiving the support we need
- We are not eligible for support from the ASF
- Our Local Authority might apply in the future
- Other (please specify):

34. Impact of the Adoption Support Fund

71. Have you/your child(ren) received any support through the Adoption Support Fund to date? *

- Yes
- No
- Don't know

35. Impact of the Adoption Support Fund

72. The following statements seek to understand what has been the impact, if any, of the Adoption Support Fund on you and your family? Please indicate how far you agree or disagree to the following statements As a result of the Adoption Support Fund: *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't know	Not applicable
We were able to receive support which was previously unavailable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We were able to get a specific service which was previously unavailable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

73. The following statements ask about the impact, if any, of the services funded by the Adoption Support Fund on you and your family? Please indicate how far you agree or disagree to the following statements As a result of these services funded by the Adoption Support Fund: *

	Strongly disagree	Disagree Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know	Not applicable
Our family is feeling better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our family is functioning better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren) is coping with problems better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren) has fewer problems in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren) has fewer problems with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a parent/s I/ we feel we have more skills to help our children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to expand further upon your answer, if you wish to do so

36. Impact of the Adoption Support Fund

74. Whether or not you heard about, applied to, or received services through the Adoption Support Fund, how far do you agree or disagree that the provision of adoption support has improved since 2015? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please give a reason for your answer

37. About You

Please note: the following questions are optional.

75. Gender

- Male
- Female

76. Age

- 20-30
- 31-40
- 41-50
- 51-60
- 61-70
- 71+

77. Postcode

78. Marital status

- Lone/single adopter
- Unmarried/cohabiting couple adopters
- Married adopters
- Step-parent adopter
- Civil partnership adopters

38. About You

79. Ethnic origin (where this survey is being completed by a couple, then please indicate the ethnic origin for both partners in the couple.)

	Person 1	Person 2
White British	<input type="checkbox"/>	<input type="checkbox"/>
Any other white background (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Caribbean British	<input type="checkbox"/>	<input type="checkbox"/>
African British	<input type="checkbox"/>	<input type="checkbox"/>

	Person 1	Person 2
Any other Black background (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Indian British	<input type="checkbox"/>	<input type="checkbox"/>
Pakistani British	<input type="checkbox"/>	<input type="checkbox"/>
Bangladeshi British	<input type="checkbox"/>	<input type="checkbox"/>
Any other Asian background (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Chinese British	<input type="checkbox"/>	<input type="checkbox"/>
Any other Chinese background (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Any other ethnic background (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Mixed - white and black Caribbean	<input type="checkbox"/>	<input type="checkbox"/>
Mixed - white and black African	<input type="checkbox"/>	<input type="checkbox"/>
Mixed - white and Asian	<input type="checkbox"/>	<input type="checkbox"/>
Any other mixed background (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="text"/>	

80. Religion (where this survey is being completed by a couple, please indicate the religion for both partners in the couple.)

	Person 1	Person 2
Bhuddist	<input type="checkbox"/>	<input type="checkbox"/>
Christian	<input type="checkbox"/>	<input type="checkbox"/>
Hindu	<input type="checkbox"/>	<input type="checkbox"/>
Jewish	<input type="checkbox"/>	<input type="checkbox"/>
Muslim	<input type="checkbox"/>	<input type="checkbox"/>
Sikh	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="text"/>	

81. Sexuality (where this survey is being completed by a couple, please indicate the sexuality for both partners in the couple.)

	Person 1	Person 2
Heterosexual	<input type="checkbox"/>	<input type="checkbox"/>
Lesbian	<input type="checkbox"/>	<input type="checkbox"/>
Gay	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>	<input type="checkbox"/>
Transgender	<input type="checkbox"/>	<input type="checkbox"/>

82. Do you or your partner have a long standing illness, disability or infirmity? Long-standing is anything that has troubled you over a period of time or that is likely to affect you over a period of time. (Where this survey is being completed by a couple, please answer for both people in the couple.)

	Person 1	Person 2
Yes	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>

39. About You

83. Number of children adopted

84. Ages of adopted child(ren) at placement

85. Ages of adopted children as of Sep 2016

86. Number of birth children

40. Further Information

87. In which year were you first approved as an adoptive parent?

88. By which agency?

Local authority

Voluntary adoption agency (VAA)

Adoption support agency (ASA)

Other (please specify):

41. About You

89. Do you currently have children placed with you that are awaiting a full adoption order?

Yes

No

90. If yes, how many children have been placed with you?

42. About You

91. Prospective adopters (including foster carers) - has your application to be assessed as an adoptive parent been formally accepted by your adoption agency?

Yes

No

Not applicable

92. If yes, by which agency?

- Local authority
- Voluntary adoption agency (VAA)
- Adoption support agency (ASA)
- Other (please specify):

43. Further Information

93. Have you previously taken part in the postal questionnaire “Evaluation of the Adoption Support Fund Survey”?

- Yes, in the first survey
- Yes, in the first and the second questionnaire
- No
- Don't know/can't remember

44. Comments

94. Is there anything you would like to add about any of the topics covered in this questionnaire?

1.8 Online Survey of local authority Employees

Adoption Support Fund - Local Authority

1. Adoption Support Fund

Hello,

Thank you in advance for your time to participate in this survey. This survey aims to understand if the implementation of the Adoption Support Fund has led to changes in the way Local Authorities provide support to adoptive families. The Adoption Support Fund is an important new initiative that has been introduced by the Department for Education (DfE) to help families with their therapeutic adoption needs.

This survey is aimed at professionals based in England only, as this reflects the scope of the Adoption Support Fund. As far as possible, please answer all questions in the survey. It will take only about 10 minutes to complete the questionnaire.

The survey is being carried out by the Tavistock Institute on behalf of the Department for Education. The Tavistock Institute is a registered charity and independent research institute (<http://www.tavistock.org>). Your responses are completely anonymous. This survey will be used solely for research purposes and taking part is voluntary.

1. Please indicate that you agree to participate in this survey: *

Yes (I agree)

No (I do not agree)

2. Impact of the Adoption Support Fund

2. The following statements seek to understand what has been the impact, if any, of the Adoption Support Fund on your work and wider team. Please indicate how far you agree or disagree with the following statements. As a result of the Adoption Support Fund: *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
Our work load has increased*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We have increased our training in therapeutic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of need processes have improved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The council has developed new relationships with service providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If your work load has increased, in what why?

3. Are there any other changes for you and your wider team that you have experienced due to the Implementation of the Adoption Support Fund?

4. Does the Local Authority you are working at commission external organisations to provide adoption support (private or voluntary)? *

- Yes
- No

3. Impact of the Adoption Support Fund

5. If yes, what types of services does the Local Authority you are working at commission to external organisations?

- Training for adoptive parents
- Further assessments
- Multi-Disciplinary packages of support
- Psychotherapy
- Attachment therapy
- Solution Focussed brief therapy
- Cognitive Behavioural Therapy (CBT) for the child
- Brain mapping
- Systemic Family Therapy
- Video Interaction Guidance
- Mindfulness-based Cognitive Therapy (MBCT)
- Dyadic Developmental Psychotherapy
- Theraplay
- Filial therapy
- Creative Therapies
- Play therapy
- Music therapy
- Drama therapy
- Lego therapy
- Dance Movement Therapy
- MIM - Marschak Interaction Method (common theraplay)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Sensory integration therapy
- Non-violent resistance training
- Extensive therapeutic life story work
- Life story work with a therapeutic intervention
- Story stem
- Other (please specify):

4. Impact of the Adoption Support Fund

6. For this question please think about your own experience with your local authority for the external provision of adoption support. Please indicate how far you agree or disagree that the Adoption Support Fund has improved the following aspects of adoption support with regards to external provision (private and voluntary). *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't know
Geographical coverage of therapies in your area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of therapies potentially available to your adopters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to therapies potentially available to your adopters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of therapies that you have accessed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Costs for therapies that you have accessed*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of external providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timeliness of support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of therapies (Extension of the length)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship between external providers and council	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Please explain your response. In what way have the costs improved or not improved?

5. Provision of therapeutic adoption support

7. How far do you agree or disagree that the Adoption Support Fund has helped/ is helping to increase provision of therapeutic post-adoption support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How far do you agree or disagree that the Adoption Support Fund has helped/ is helping to increase provision of therapeutic post-placement support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How far do you agree or disagree that at this stage there is not enough provision to meet the demand for therapeutic post-adoption support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How far do you agree or disagree that at this stage there is not enough provision to meet the demand for therapeutic post-placement support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Local Authority

11. Thinking about the local authority you are working at, how would you describe the balance between internal provision of therapeutic support and external commissioning of therapeutic support? *

Only internal	More internal	Somewhat more internal	About even	Somewhat more external	More external	Only external	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

12. What is your role in the Local Authority (e.g., social worker)?

13. In which region is the Local Authority you are working at located?

- North East
- North West
- Yorkshire and the Humber
- East Midlands
- West Midlands
- East of England
- Inner London
- Outer London
- South East
- South West
- Other (please specify):

14. Is there anything you would like to add about any of the topics covered in this questionnaire?

1.9 Online Survey of Service Providers

Adoption Support Fund - Service Provider

1. Adoption Support Fund

Hello,

Thank you in advance for your time to participate in this survey. This survey aims to understand if the implementation of the Adoption Support Fund has led to changes in the way private and voluntary services provide therapeutic adoption support. The Adoption Support Fund is an important new initiative introduced by the Department for Education (DfE) to help families with their therapeutic adoption needs.

This survey is aimed at professionals based in England only, as this reflects the scope of the Adoption Support Fund. As far as possible, please answer all questions in the survey. It will take only about 10 minutes to complete the questionnaire. During the questionnaire when we refer to "your service" or "your organisation" this refers to your employer or the organisation through which you provide adoption support. If you are a sole trader or self-employed, please take this to refer to yourself.

The survey is being carried out by the Tavistock Institute on behalf of the Department for Education. The Tavistock Institute is a registered charity and independent research institute (<http://www.tavinstitute.org>). Your responses are completely anonymous. This survey will be used solely for research purposes and taking part is voluntary.

1. Please indicate that you agree to participate in this survey: *

- Yes (I agree)
- No (I do not agree)

2. About You

2. Which one of the following roles apply to you?

Working at a private therapy provider
(Please specify your role, e.g. psychologist)

Working at a

voluntary
therapy provider
(Please specify
your role, e.g.
psychologist)

Other (please
specify)

3. Impact of the Adoption Support Fund

3. The following statements seek to understand what has been the impact, if any, of the Adoption Support Fund on your organisation. Please indicate how far you agree or disagree with the following statements. As a result of the Adoption Support Fund: *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
My work load has increased*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Procurement procedures are more formalised	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional monitoring and reporting is required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Team is expanded	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional training is undertaken to enhance skills (e.g. innovative therapies)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catchment area has expanded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If your work load has increased, in what why?

4. Are there any other changes for your organisation that you have experienced due to the Implementation of the Adoption Support Fund?

4. Impact of the Adoption Support Fund

5. For this question please think about the external provision of adoption support in your region. Please indicate how far you agree or disagree that the Adoption Support Fund has improved the following aspects of adoption support with regards to external provision (private and voluntary). *

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't know
Geographical coverage of therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Range of therapies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Access to therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of therapies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Costs for therapies*	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Number of external providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timeliness of support	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Duration of therapies (extension of the length)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Relationship between external providers and council	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

*Please explain your response. In what way have the costs improved or not improved?

5. Provision of therapeutic adoption support

6. How far do you agree or disagree that the Adoption Support Fund has helped/ is helping to increase provision of therapeutic post-adoption support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How far do you agree or disagree that the Adoption Support Fund has helped/ is helping to increase provision of therapeutic post-placement support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How far do you agree or disagree that at this stage there is not enough provision to meet the demand for therapeutic post-adoption support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How far do you agree or disagree that at this stage there is not enough provision to meet the demand for therapeutic post-placement support? *

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Service Provider

10. Has the proportion of your work on adoption support increased as a result of the implementation of the Adoption Support Fund? *

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know

11. What services does your organisation offer?

- Training for adoptive parents
- Further assessments
- Multi-Disciplinary packages of support
- Psychotherapy
- Attachment therapy
- Solution Focussed brief therapy
- Cognitive Behavioural Therapy (CBT) for the child
- Brain mapping
- Systemic Family Therapy
- Video Interaction Guidance
- Mindfulness-based Cognitive Therapy (MBCT)
- Dyadic Developmental Psychotherapy
- Theraplay
- Filial therapy
- Creative Therapies
- Play therapy
- Music therapy
- Drama therapy
- Lego therapy
- Dance Movement Therapy
- MIM - Marschak Interaction Method (common theraplay)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Sensory integration therapy
- Non-violent resistance training
- Extensive therapeutic life story work
- Life story work with a therapeutic intervention
- Story stem
- Other (please specify):

12. In which region is your organisation located? *

- North East
- North West
- Yorkshire and the Humber
- East Midlands
- West Midlands
- East of England
- Inner London
- Outer London
- South East
- South West
- Other (please specify):

13. How many staff does your organisation employ? *

14. Has the number of staff increased as a result of the Adoption Support Fund? *

- Yes
- No
- Don't know

15. Is there anything you would like to add about any of the topics covered in this questionnaire?

1.10 Baseline Longitudinal Survey



THE
TAVISTOCK
INSTITUTE



Evaluation of the Adoption Support Fund Survey

Hello,

I am writing to ask for your help in assessing how well the Adoption Support Fund (ASF) works. The Adoption Support Fund is an important new initiative that has been introduced by the Department for Education (DfE) to help families with their post-adoption therapeutic needs, for example, therapy, therapeutic parenting, DDP or creative therapies.

When your social worker applied for the fund they requested your consent to participate in a survey to help us assess how well the fund is working for families. I am now asking all these families if they could fill in this survey now and then a follow up questionnaire in six months' time. We anticipate that it will take about 20 minutes to fill in the questionnaire.

The survey is being carried out by the Tavistock Institute and Qa Research on behalf of the Department for Education. The Tavistock Institute is a registered charity and independent research institute (<http://www.tavistock.org>). All the answers you give will be completely confidential and no identifiable information about you will be passed on to the Department, local services or any other person or organisation. Everything you say will be treated in strict confidence and in accordance with the Data Protection Act. This survey is in no way an assessment of need and will be used solely for research purposes. Taking part is completely voluntary and your application to the fund is not at all dependant on completing the survey.

I would like to take this opportunity to say that if you do participate, the information you provide will be invaluable in assessing how well the fund is working and how to improve it in the future. Please can you complete and return the survey as soon as possible (preferably within two weeks).

Thank you again and if you have any questions at all about this evaluation, please contact me at S.King@tavistock.org or on 020 7457 3917 for further information.

Kind regards

Sadie

Dr Sadie King

Senior Researcher/Consultant

The Tavistock Institute of Human Relations

This evaluation is being carried out within the ethical guidelines and code of conduct of the UK Evaluation Society (of which the Tavistock Institute is a member) and the Market Research Society (of which Qa is a member).

Evaluation of the Adoption Support Fund Survey

To be completed by the main caregiver.

(If both parents give an equal amount of care, either parent can complete this form, but please remember who did it so that the same parent can complete the follow up survey. Thank you.)

Q1a Enter today's date:

QAID: <<QAID>>

DD / MM / YYYY

Section one: You and your family

Q1b First of all, some questions about you and your family. We need this information so that we can tell if the Adoption Support Fund and our survey are being accessed by all types of adopters.

Please tick ✓ here if there is no co-parent

1

Sex	You	Your co-parent
Male	1	1
Female	2	2

Age (in whole years)

You

Your co-parent

Relationship Status	You	Your co-parent
Married	1	1
In same-sex civil partnership	2	2
Cohabiting	3	3
Separated	4	4
Single	5	5
Steady relationship without co-habiting	6	6
Other: please ✓ box and write in below	7	7

Highest educational qualification	You	Your co-parent
Degree or equivalent or above	1	1
2+ A levels or equivalent	2	2
Apprenticeship	3	3
5+ GCSEs or equivalent	4	4
1-4 GCSEs or equivalent	5	5
Other qualifications	6	6

No qualifications	7	7
Ethnicity	You	Your co-parent
White		
British (English, Welsh, Scottish, N. Irish)	1	1
Irish	2	2
Gypsy or Irish traveller	3	3
Other White background	4	4
Mixed/multiple ethnic group		
White and Black African	5	5
White and Black Caribbean	6	6
White and Asian	7	7
Other Mixed/Multiple ethnic background	8	8
Asian/Asian British		
Indian	9	9
Pakistani	10	10
Bangladeshi	11	11
Chinese	12	12
Other Asian background	13	13
Black/African/Caribbean/ Black British		
African	14	14
Caribbean	15	15
Any other Black/African/Caribbean background	16	16
Other ethnic group		
Arab	17	17
Any other ethnic group	18	18

Details about the children in your household

Sex	Child 1	Child 2	Child 3	Child 4	Child 5
Male	1	1	1	1	1
Female	2	2	2	2	2
Date of birth					
Is this child adopted? (please tick ✓)	1	2	3	4	5

If you have more than five children, please fill in their details (gender, month and year of birth and adoptive status) here:

Section two: About you

We would now like to ask you a few questions about yourself to see how you feel at the moment. You will be asked these questions again in the second survey to see if things have changed.

Q2

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

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

"Warwick Edinburgh Mental Well-Being Scale (WEMWBS)
© NHS Health Scotland, University of Warwick and University of
Edinburgh, 2006, all rights reserved."

Section three: Your child

Now some questions about your child.

In this section, we would like you to answer questions about the child for whom you have applied for adoption support. This will be the child who was assessed by the Local Authority (since March 2015). **If more than one of your children has been assessed and deemed eligible for post-adoption support please complete the questions for the eldest.**

In this section, we are asking you to provide information about your child so that we can compare these answers to those you give in the follow-up questionnaire. This will help us to understand whether there have been changes in the child's behaviour and well-being over the course of the support.

The answers that you give will be kept completely confidential and not be shared outside the Tavistock research team so please answer the questions as honestly as possible as this will give us the best opportunity to understand the needs and circumstances of adoptive families.

- Q3** Was your child placed by a different Local Authority to the one that assessed them for post-adoption support? (Inter-agency)
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |

Q4.

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please complete this for the eldest of your children who was assessed and accepted for post-adoption support. Please give your answers on the basis of the child's behaviour over the last six months.

Child's date of birth: MM/YY

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q5.

BAC-C Brief Assessment Checklist for Children (ages 4 to 11)

Here are some statements that describe children's behaviour and feelings.

For each statement, please circle the number that best describes your child in the last 4 to 6 months.

- circle **0** if the statement is **not true** for your child in the last 4 to 6 months.
- circle **1** if the statement is **partly true** for your child in the last 4 to 6 months.
- circle **2** if the statement is **mostly true** for your child in the last 4 to 6 months.

- | | | | | |
|-----|----------|----------|----------|---|
| 1. | 0 | 1 | 2 | Can't concentrate, short attention span |
| 2. | 0 | 1 | 2 | Craves affection |
| 3. | 0 | 1 | 2 | Eats too much |
| 4. | 0 | 1 | 2 | Fears you will reject her/him |
| 5. | 0 | 1 | 2 | Hides feelings |
| 6. | 0 | 1 | 2 | Is convinced that friends will reject her/him |
| 7. | 0 | 1 | 2 | Lacks guilt or empathy |
| 8. | 0 | 1 | 2 | Prefers to be with adults, rather than children |
| 9. | 0 | 1 | 2 | Relates to strangers 'as if they were family' |
| 10. | 0 | 1 | 2 | Seems insecure |
| 11. | 0 | 1 | 2 | Startles easily ('jumpy') |
| 12. | 0 | 1 | 2 | Suspicious |
| 13. | 0 | 1 | 2 | Too dramatic (false emotions) |
| 14. | 0 | 1 | 2 | Too friendly with strangers |
| 15. | 0 | 1 | 2 | Too jealous |
| 16. | 0 | 1 | 2 | Treats you as though you were the child and she/he was the parent |
| 17. | 0 | 1 | 2 | Uncaring (shows little concern for others) |

For each of the following statements:

- circle **0** if the behaviour **did not occur** in the last 4 to 6 months.
- circle **1** if the behaviour **occurred once** in the last 4 to 6 months.
- circle **2** if the behaviour **occurred more than once** in the last 4 to 6 months.

- | | | | | |
|-----|----------|----------|----------|--|
| 18. | 0 | 1 | 2 | Distressed or troubled by traumatic memories |
| 19. | 0 | 1 | 2 | Does not show pain if physically hurt |
| 20. | 0 | 1 | 2 | Sexual behaviour not appropriate for her/his age |

There are some specific issues that we know children in adopted families sometimes experience which we would also like to ask you about. Please answer the following questions by reflecting on your child's behaviour in the past few weeks. Try not to be influenced by single incidents when answering but base your answers on how you think things are generally. Please tick ✓ one box for each statement.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
Q6 My child is often aggressive or violent towards friends or classmates.	1	2	3	4	5	6	7
Q7 My child is often aggressive or violent towards members of our family.	1	2	3	4	5	6	7

Q8 **Excluding** those services provided through the Adoption Support Fund, are you or your family currently receiving any of the following types of service? (Please tick ✓ all that apply)

Adoption Support and Social Care

- Local Authority Children's Social Services? 1
- Local Authority Adoption Support Team? 2
- Voluntary Adoption Agency Support Team? 3
- A support group for adoptive parents? 4
- Informal contact with other adoptive families? 5
- Support for contact with birth families? 6
- Respite or day care/ recent or planned activity based holiday? 7
- Parenting skills training? 8
- Life story work? 9
- Letter box? 10

Healthcare

- NHS provider (G.P., Hospital (out or in patient), health visitor/community nurse) for health needs on a regular basis 11
- Child and Adolescent Mental Health Service (CAMHS)? 12
- Private provider of therapeutic services for which you pay? 13

Educational or school-based support

- Educational psychologist? 14
- SENCO? 15
- Special school/ special unit? 16
- After school club? 17

Other: please ✓ box and write in below 18

Section four: About you and your child

Now, we'd like to ask you a few questions about your relationship with your child. Again, please answer these questions for the same child who you have answered for in the previous section. Again, we will compare the answers you give here to those in the follow up survey to see if things have improved as a result of the support. As before, the answers that you give will be kept completely confidential so please answer as honestly as possible.

Please answer the following questions by reflecting on yourself and your child during the past few weeks. Try not to be influenced by single incidents when answering but base your answers on how you think things are generally. Please tick ✓ a number for each statement.

Q9 How much do you feel you understand your child's difficulties?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q10 How much do you think your child's difficulties relate to his or her experience prior to adoption?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q11 Do you feel you understand why your child behaves as he or she does?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q12 Do you feel confident that you can manage the challenges that your child presents?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q13 Do you feel you have the necessary skills to manage the specific challenges your child presents?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q14 Do you feel that you have a good relationship with your child?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q15 Do you feel that you and your child communicate well with each other?
Not at all Very much
1 2 3 4 5 6 7 8 9 10

Q16 Do you feel that your child responds to your attempts to help him/her?
 Not at all Very much
 1 2 3 4 5 6 7 8 9 10

Q17 Do you find your child difficult to care for?
 Not at all Very much
 1 2 3 4 5 6 7 8 9 10

Q18 Do you find it difficult to build a relationship with your child?
 Not at all Very much
 1 2 3 4 5 6 7 8 9 10

Q19 Do you feel that there is a risk of the adoption breaking down?
 Not at all Very much
 1 2 3 4 5 6 7 8 9 10

Section five: The assessment of need

The next questions are about your knowledge of the Adoption Support Fund and the recent assessment for the post-adoption support that you and your child underwent with the Local Authority. (The assessment we are referring to here will have taken place since March 2015.)

This information will help us understand your experience of getting support through your local authority.

Q20 How did you first hear about the Adoption Support Fund?
 (Please tick ✓ one)

- Social Worker direct contact 1
- Local Authority Newsletter for Adopters 2
- Local Authority website 3
- First4Adoption website 4
- Social media from other adopters 5
- A poster or leaflet in a public place 6
- A meeting arranged by the council 7
- Adoption UK 8
- I had not heard of it until receiving this survey 9
- Other: please ✓ box and write in below 10

Thinking about the assessment itself, how far do you agree or disagree with the following statements? Please tick ✓ a number to indicate.

Q21 It was easy to get an assessment for post-adoption support.

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Q22 Waiting for an assessment took too long.

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Q23 In the assessment of post-adoption support, I did not feel that my views and preferences were taken into consideration.

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Q24 The social worker talked with me about the commitment that taking up the post-adoption support would involve (for example - time, emotional or financial).

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Q25 The assessment did not identify the needs of my child and family.

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Q26 Overall I was happy with the assessment process.

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Q27 Please use this box to tell us anything more about the assessment: how it made you feel, if it was useful, or any recommendations that you would offer to improve the process.

Section six: Your post-adoption support

The questions below are about what you think about the therapeutic post-adoption support that you have been offered following your recent assessment; for example, therapy, therapeutic parenting, DDP or creative therapies.

Q28 Were you offered a choice between different providers of therapeutic post-adoption support?

- Yes 1
- No 2

Q29 Do you know what kind of therapeutic post-adoption support you will be getting?

- Yes 1 **If yes, continue to Q30**
- No 2 **If no, go to Q31**

Q30 How satisfied do you feel with:
(Please tick ✓ one only for each row that most applies to you)

	Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Neither satisfied or dissatisfied	Somewhat satisfied	Satisfied	Very satisfied
a. How quickly you will receive the support after the assessment	1	2	3	4	5	6	7
b. The choice of support provider or therapist	1	2	3	4	5	6	7
c. The type of support that will be provided	1	2	3	4	5	6	7
d. The frequency of support/therapy sessions you will receive	1	2	3	4	5	6	7
e. The duration of each session	1	2	3	4	5	6	7
f. The overall number of sessions you will receive	1	2	3	4	5	6	7
g. The location of the support/therapy	1	2	3	4	5	6	7

Q31 Have you or your family members started your therapeutic post-adoption support, following your recent assessment?

- Yes 1 **If yes, continue to Q32a**
- No 2 **If no, go to Q33**

Q32a How many sessions of support have you/your child had to date? _____ sessions
(please write in the box to the right)

Q32b When did this start? _____ / ____ / ____
(please write the date in the box to the right)

Section seven: Prior support needs

The questions below are about your therapeutic adoption support needs before your recent assessment (i.e. prior to March 2015). This will help us understand the needs of families.

Q33 When did you first consider that your child (for whom you have completed the previous sections) needed therapeutic adoption support?
(Please tick ✓ one only)

Pre-placement	1
At the beginning of the placement	2
During the placement	3
At the point of the adoption order	4
In the year after the adoption order	5
More than one year but less than three years after the adoption order	6
More than three years after the adoption order	7

Thinking about the last time you approached your local authority prior to your recent assessment (discussed in section 5), please answer the following questions:

Q34 Prior to your most recent assessment had you approached your local authority for an assessment of need?

Yes	1	If yes, continue to Q35a
No	2	If no, go to Q36

Q35a How many times did you approach them?

Once	1
Between 2 and 4 times	2
Five or more times	3

Q35b When did you last approach them?
(please write the date in the box to the right)

/

Q35c Did you receive an assessment?

Yes	1	If yes, continue to Q35d
No	2	If no, go to Q36

Q35d Did you then receive any therapeutic adoption support?

Yes	1	If yes, continue to Q35e
No	2	If no, go to Q36

Q35e How far do you agree or disagree that this package of support met your child's and family's needs?

Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

- Q36** Have you previously paid for therapeutic adoption support yourself?
- | | | |
|-----|---|------------------------|
| Yes | 1 | If yes, go to Q38 |
| No | 2 | If no, continue to Q37 |

Q37 If you have not previously received any therapeutic adoption support, why not?
(Please tick ✓ all that apply)

- | | |
|--|----|
| I did not feel we needed it until recently | 1 |
| I felt we could cope on our own | 2 |
| It was not available | 3 |
| It was not in a convenient location | 4 |
| The times of the sessions were not convenient | 5 |
| I could not afford it | 6 |
| I did not think about it until the fund became available | 7 |
| I did not think we were eligible for support | 8 |
| I did not know where to go for support | 9 |
| My concerns were not taken seriously by services | 10 |
| The waiting list for support was too long | 11 |
| I was worried about getting social services involved | 12 |
| I did not think therapy was for us | 13 |
| I saw asking for support as a sign of weakness | 14 |
| I felt that we had already had too much contact with services through the adoption process | 15 |
| Other: please ✓ box and write in below | 16 |

Q38 Looking back, when do you think it would have been best for the therapeutic support to start?
(Please tick ✓ one only)

- | | |
|---|---|
| Pre-placement | 1 |
| At the beginning of the placement | 2 |
| During the placement | 3 |
| At the point of the adoption order | 4 |
| In the year after the adoption order | 5 |
| More than one year but less than three years after the adoption order | 6 |
| More than three years after the adoption order | 7 |



Q39 Is there anything you would like to add about any of the topics covered in this questionnaire?

Thank you for your time and support in completing this survey. Please return it in the FREEPOST envelope provided. There is no need to use a stamp.

We will send a follow-up survey to you again in a few months' time to check whether the support/therapy has made a difference for you and your family.

As part of the wider evaluation of the Adoption Support Fund we are undertaking a small number of interviews with families who are using the fund. If you might be interested in taking part in one of these please tick the box below and leave us your email address or telephone number. By ticking the box you are not consenting to take part in the interviews but simply consenting for us to contact you with further information at which point you would be asked if you and your family are happy to participate.

I consent to be contacted by the research team about further participation in the evaluation

Email:

Phone number:

1.11 Follow-up Longitudinal Survey



Evaluation of the Adoption Support Fund Survey

QAID: <<QAID>>

Hello,

Seven months ago you completed and returned to us a questionnaire about your application to the Adoption Support Fund (ASF). The purpose of this was to understand the circumstances of your family, your reasons for making the applications to the fund, and also to hear about your experiences of applying for support. I am now writing again to ask you to complete a further questionnaire. The purpose of this is to find out how you have got along since then, what your experiences of the ASF have been and the support that it can provide, and whether your family's circumstances have changed.

We are particularly interested to find out how the child for whom you applied for the support is getting on. It is important that when you are asked about the experiences of your child, that you refer to the same child that you answered the questionnaire about last time. To remind you, if you applied to the fund for two or more adopted children, we asked you to complete the questions for the eldest, please do so again. As with the previous questionnaire we anticipate that it will take about 20 minutes to fill in.

The survey is being carried out by the Tavistock Institute of Human Relations and Qa Research on behalf of the Department for Education (DfE). The Tavistock Institute is a registered charity and independent research institute (<http://www.tavinstitute.org>). All the answers you give will be completely confidential and no identifiable information about you will be passed on to the DfE, local services or any other person or organisation. Everything you say will be treated in strict confidence and in accordance with the Data Protection Act. This survey is in no way an assessment of need and will be used solely for research purposes. Taking part is completely voluntary and any application to the ASF is not at all dependant on completing the survey.

I would like to take this opportunity to thank you for your participation in the previous round of the survey and to say that by providing information here you will allow us to better understand how the ASF is working, whether it is helping families like yours, and help us to make recommendations to the DfE about how it could be improved in the future. Please can you complete and return the survey using the accompanying FREEPOST envelope as soon as possible (preferably within two weeks).

Thank you again and if you have any questions at all about this evaluation, please contact me at S.King@tavinstitute.org or on 020 7457 3917 for further information.

Kind regards

Sadie

Dr Sadie King - Senior Researcher/Consultant, The Tavistock Institute of Human Relations

This evaluation is being carried out within the ethical guidelines and code of conduct of the UK Evaluation Society (of which the Tavistock Institute is a member) and the Market Research Society (of which Qa is a member).

Evaluation of the Adoption Support Fund Survey

Please ensure that this questionnaire is completed by the same parent that completed the first one. If you cannot remember which parent filled in the first one please can you tick the box below and then the main caregiver complete the rest of the questionnaire. Thank you.

Please tick ✓ here if you cannot remember who completed the first questionnaire 1

Enter today's date:

Q1a

/ /

Section one: You and your family

Q1b

First of all, some questions about you and your family. We need this information to see if anything has changed in your family in the last seven months.

Please tick ✓ here if there is no co-parent 1

Relationship Status	You	Your co-parent
Married	<input type="checkbox"/> 1	<input type="checkbox"/> 1
In same-sex civil partnership	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Cohabiting	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Separated	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Single	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Steady relationship without co-habiting	<input type="checkbox"/> 6	<input type="checkbox"/> 6
Other: please ✓ box and write in below	<input type="checkbox"/> 7	<input type="checkbox"/> 7

Q1c

In the last seven months has the composition of your household changed? (Please tick ✓ one)

- Yes 1 **If yes, continue to Q1d**
No 2 **If no, go to Section 2**

Q1d

How has it changed? (Please tick ✓ one)

- New members have joined 1
Members have left 2
Members have left and others have joined 3

Q1e

Please describe the change (who has left and/or joined?) in the box below:

Appendix 5 – 10 Local Authority Case Studies

Case Study 1: Bridmouth County Council

Context
<p>Bridmouth County Council has a population of around 600,000. It is a predominantly rural county with a large geographical area and low population density. Overall the county is in the least deprived quarter of all local authorities in England however a small number of its wards fall into the 20% of most deprived areas on the indices of multiple deprivation. The county has an older population than national averages that is over 90% White British. Bridmouth County Council has medium levels of adoption by national standards.</p>
The picture of local provision in the first year
<p>Shortly prior to the introduction of the ASF the adoption services in Bridmouth underwent a change which saw the statutory responsibility for family finding, recruitment and assessment and post-adoption support transferred from the county council to a new entity run by a voluntary adoption agency.</p> <p>At the inception of the Fund the post-adoption support service comprised a relatively large multi-disciplinary team made up of social workers, a clinical psychologist, a family and child worker, and a birth family outreach worker. The clinician and social workers were trained in the provision of various forms of psychotherapy, parenting training, and life story work. The team had begun to adopt a systemic way of working supervised by their clinician.</p> <p>Early on in implementation the Fund did not lead to major staffing changes to the team, with the exception of increasing the post of the clinician from part to full-time. However at the second interview the team was in the process of recruiting new staff so as to grow internal capacity. Their intention was to hire 2 new full-time social workers, 2 junior clinical assistants and 2 (Band 7) clinical psychologists and one full-time business support assistant. The growth of the team was not entirely attributed to the ASF as these appointments were also to help fulfil a new contract with a neighbouring local authority for the provision of adoption support services. All the new appointments were going to on a year long contract which will be renewed on a rolling basis due to uncertainty about the future funding situation.</p>

Prior to the introduction of the Fund almost all post-adoption support was provided in-house however since the Fund became available the team has begun to commission external services. This has been in order to cover specialist needs, to make up for their lack of in-house creative therapies, and to address the increase in demand that has resulted from the availability of the Fund. At both time points staff estimated that about half of their case load was catered for by in-house services and the other half commissioned out. However at the second interview staff talked of internal targets to increase the proportion of in-house provision. These targets correspond with a programme of recruitment and with increased staff training in therapeutic techniques so that the team's capacity to deliver post-adoption support permits them to provide more services in-house.

Commissioning services and market development

The post-adoption team, led by the clinician, and with support from Mott Macdonald, undertook a series of "provider open days" to which they invited external providers so as to inform them about the Fund, and about the credentials required to be commissioned by the post-adoption team. On the basis of these days the team compiled a 'provider list' with the types of therapy each are able to provide. The team then undertook a process of screening providers to make sure they had the appropriate qualifications, DBS checks, and insurance. The list is kept under review on the basis of families' experiences of using services. Knowledge of the external market in post-adoption support has continued to improve over the first year of implementation with new providers coming to the attention of the team by word of mouth and through approaches by providers.

As a result of this the team had developed their knowledge of the local market for post-adoption support and judged it to be well developed, particularly in the county town. More remote rural areas were felt to be less well served by external provision which sometimes entailed applying to the Fund for travel costs.

Implementation of the Adoption Support Fund

The team reported a significant increase in demand for their services as a result of the Fund which has resulted in both an increased work load and the increased commissioning of external services. The process described above of developing commissioning criteria, identifying and vetting external providers was also said to have been time consuming however it was felt to be necessary and worthwhile. The Fund has also led to the team developing new finance arrangements including the

establishment of a dedicated bank account for the proceeds of the ASF funded in-house services.

The team reported the ASF application form to be relatively easy to use although they sometimes found it hard to understand the reason for applications being returned. After an initial spike in requests from families for support at the beginning of the introduction of the ASF, the level of demand remained relatively stable however repeat applications for families whose initial support had been completed has added to the caseload as the year has progressed. As a result staff capacity stretched with all staff reporting substantial, though manageable workloads.

Due to the size and skills of Bridmouth's team at the inception of the Fund they have been able to fund in-house staff to provide post-adoption support using the Fund. In turn this has allowed the unit to increase its revenue and re-invest funds back into the team. These additional resources have been used to further train staff in the therapeutic techniques and recruit new staff to handle the increased demand for services. The increasing capacity of the team has seen a broadening of their post-adoption offer, most notably in the provision of therapeutic parenting groups funded through group application to the Fund. The additional income has also been used to fund work with school teachers, which does not itself fall within the scope of the Fund. Staff have also received a range training to improve their practice.

During the first year of implementation of the ASF a number of changes were made to the scope of the Fund and the process of application, most notably the extension of the Fund to pre-order placements and to children on Special Guardianship Order (SGOs), and a new requirement for new applications to be made within 3 months of the last assessment. Staff also found that applications were being more closely scrutinised than at the start and were more frequently rejected or returned for amendments.

The extension of the Fund to SGOs and pre-adoption order necessitated new processes to be developed to work with the teams responsible for these cases so that applications could be made for these families. At the point of the second interview a small number of applications had been made for pre-order children. Staff described the benefits of working with the Looked After Children Unit on pre-order applications to the Fund. This allowed the post-adoption team to get to know families at an earlier stage aiding continuity for the family and giving the Post-adoption Team an insight at an earlier stage. At the second interview no applications had been made for children on SGOs as these cases are held by a different team within the local authority and a process had not yet been developed for them applying to the Fund.

The increased need to amend applications that were returned by the Fund manager also added to the administrative burden on the team, who reported sometimes being

confused why some application were rejected while others were not. However they found the Fund manager helpful in responding to application queries and felt that they were improving in their understanding of the process.

Assessments

The assessment process works as follows: after a referral arrives it is allocated to a worker within 2 days, with a target for a member of the team to meet the family within 5 days. The allocated worker then undertakes a full assessment, often over a series of visits. In cases where the social worker is unsure of an aspect of the family situation the clinician may sit in on the assessment. Once the assessment is complete the responsible team member presents the case at the weekly team meeting, it is here that the decisions is made as to whether intervention is necessary and which type to recommend. The team use an assessment form based on the BAAF form with several amendments, including the recent addition of information required by the ASF application process.

In some cases the application will involve a formal diagnosis of a mental health condition which will be undertaken by the in-house clinician. The team was fairly confident that the assessment process led to appropriate referrals to therapeutic support services although acknowledged that their understanding of the case may change and may lead to alterations to the original plan of support.

The tightening of the application criteria as the year progressed was felt to have increased the administrative burden for staff involved in the application process. The 3 month rule requires more frequent assessment however this was partly mitigated by the team developing an assessment review process that precluded the need for a new full assessments. Not only was this seen to reduced administrative load but also to be less disruptive to the families involved.

The overall impact of the Fund in the first year

Overall the team rated this provision as high, in terms of the range, the quality and the timeliness of the support they were able to offer either in-house or externally. They felt that the Fund had significantly improved what their overall offer by allowing a greater quantity of support of a wider variety and of a greater duration and intensity than before the Fund.

Staff described the impact of the Fund to date as having:

- Led to a substantial increase in referrals

- Permitted a greater range of support to be offered in-house
- Permitted a greater range of external services to be commissioned
- Helped build knowledge of and relationships with external providers
- Allowed them to re-invest the proceeds of the Fund into training staff

Staff also noted possible negative impacts of the Fund such as:

- An increased administrative burden on the team of the application process
- An increase in inappropriate referrals from other services
- A fear of staff roles being reduced to administering assessments and applications to the ASF rather than working with families

Case Study 2: Dunbria County Council

Context
<p>Dunbria is a unitary authority area, with a population of around 140,000. Around 35% of its residents are aged 0 to 19, making it one of the highest proportions of young people in England and Wales. The Index of Multiple Deprivation ranked the borough as the 17th most deprived authority in England (on the rank of average score), with a third of residents living in areas classified as being in the most 10% deprived in England. About a quarter of the borough's population are from Black and Minority Ethnic groups. Post-adoption work has been a growing area over the past few years.</p>
The picture of local provision in the first year
<p>The post-adoption team at Dunbria is part of the council's wider adoption team. It is composed of the Adoption Team Manager; 3 post-adoption social workers; a Child Support Officer and a clinical psychologist. The latter 2 are part of the Fast-Track Permanence Adoption Team, which exists primarily to work with children and families to achieve permanence from a psychological perspective. The structure and staffing of the team remained unchanged over the first year of the fund</p> <p>In-house support services for adoptive families delivered by the council, included: coffee mornings, providing support groups including groups for young people, training sessions (e.g. on how to talk to children), liaising with education and therapeutic services; mailbox services, which allow adopted children to remain in contact with their birth families in a safe way.</p> <p>One of the characteristics of Dunbria is its size: it is a small area and therefore most children are placed out of borough. Although there is a trained psychologist on the team, which means some work can be met locally, most of the therapeutic services are commissioned externally through mixed provision (independent and voluntary / statutory sector). Prior to the introduction of the Fund, however, the council's ability to commission therapies, particularly specialist interventions, was very limited, due to a pressure on public sector resources. Since the introduction of the Fund the range of support they can offer has substantially increased.</p>

Commissioning services and market development

As noted above, the council had a mixed provision in terms of post-adoption support and the majority of the therapeutic services were commissioned externally, particularly given that the majority of children are placed out of borough. Some social workers had Theraplay training and one was trained in DDP. However, the local authority had not been able to deliver a lot internally, due to the challenge of finding professional supervision for social workers.

They commissioned Theraplay and DDP mainly, as these interventions were felt to allow working with the parents as well as the child. Although these were areas of internal expertise, the choice of therapy was driven by the assessment and subsequent analysis of needs, looking at where the child is, and what they can cope with. Staff were also learning about new therapies, such as sensory integration therapy which they had increasingly commissioned as the year had progressed.

On the whole, the introduction of the ASF had enabled the team to provide support that they weren't able to provide before, due to restrictions in funding. Examples include (but not limited to): delivering training for adopters, running nurturing and attachment groups and undertaking many more assessments (e.g. psychological and emotional assessments), and being able to extend the duration of support and commissioning specialist therapies.

Commissioning services occurred mainly via spot purchasing, given the nature of their adoptions (which are geographically spread out). The team had a list of providers to access, which had been developed drawing on the collective knowledge of peers in their regional networks. The networks also provided a regular space to share ideas, experiences, and to discuss current practice issues. This enabled the team to learn more about "what is out there", which staff felt had been particularly valuable for the implementation of the ASF so far.

While the team had not experienced particular difficulty in finding providers, they had noticed a marked decrease in provider availability, since the introduction of the ASF.

Quality assurance procedures included: requesting an up to date DBS, references, and copies of qualifications, if the provider is not affiliated to a particular professional body.

Implementation of the Adoption Support Fund

The team prepared for the ASF by raising awareness of the Fund to adopters. This was done through a mixture of formal communication mechanisms (e.g. sending letters via the council's mailing list; disseminating leaflets and raising awareness through the council's Facebook page / website), and more informal ones (raising awareness of the ASF at coffee mornings and other sessions). This generated a steady case load of people requesting support. The team proactively sought to "get the message out there", encouraging adopters to request support rather than wait until the child is in an adolescent phase, which makes support harder.

For Dunbri, therefore, the ASF dovetailed with a process of change that was already taking place. As noted earlier, prior to the implementation of the Fund, all areas of the processes and systems had been reviewed. As a result, new systems for recording and allocating referrals, creating files, recording case notes, recording assessments and ensuring timely closure of cases once work is complete were developed.

In terms of the team structure, the growing increase in demand (which was occurring already prior to the ASF), coupled with the recognition of the further increase that would be brought about by the ASF, has meant that the team has grown in size. In addition, use is being made on a case by case basis of the Fast Track Support Worker and the Fast Track Clinical Psychologist to complement and support the work done within post-adoption support, which gives an added source of valuable expertise to the service.

In addition, in recognition of the ASF, council resources were invested to train the post-adoption support team (in level 1 Theraplay and DDP training). This investment is likely to continue although the council is limited in the supervision available for some of the therapies.

On the whole, despite the increase in assessments, the team felt able to manage the workload and no particular difficulties were raised in terms of the implementation of the Fund. Despite the fact that the ASF was viewed as transformational for the service, staff also expressed the view that the ASF represented a trade-off in terms of social workers' role, which has moved from direct delivery to a more administrative role. As the year had progressed and the criteria for accessing the Fund had tightened this shift towards administrative roles led staff to question their suitability for the new contracting and commissioning tasks.

At first the team found the application process, the speed of response and the implementation to be quick, however changes in the Fund requirements slowed this considerably. One staff member noted that changes in fund criteria were hard to track and felt like "*they keep on moving the goal posts*". Nevertheless the team were happy with the overall process of application and felt satisfied with the relationship with those who manage the Fund, which they find helpful, clear and prompt.

Assessments

Strengthening assessments was part of the already mentioned review of processes that the council was going through. Staff spoke of having moved from a more “indefinite” model of support, which was the result of not having a structured way of assessing, to providing a more structured service for families.

Now, the team is doing more formal assessments. Different forms were trialled and the BAAF form was chosen. The length of the assessment process depended on the family. As the majority of children were placed out of borough, social workers tried 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. Staff felt pleased with the BAAF form and their ability, having slightly modified parts of it to better suit their needs.

Overall the team felt very positive about the scope of the Fund, particularly because it was enabling the service to provide support that the council wasn't able to provide before. In addition, the recent expansion of the Fund to cover pre-order was widely welcomed. In terms of areas of interventions it was felt that there were still some gaps that are not covered by the Fund, thoughts included: support for schools that have a number of adopted children (e.g. provision of training for teachers) and counselling services. In addition the team felt that if there were something in the Fund that enabled training to be claimed back, it would be very beneficial. However, staff acknowledged the substantial benefits that the ASF is bringing.

The overall impact of the Fund in the first year

The view across the team was that the ASF had been very beneficial. Staff described the impact of the Fund to date as having allowed them to:

- Increase the choice of therapies and match them to families' needs;
- Gaining more knowledge about new and different therapeutic interventions;
- Increase provision overall, including more complex assessments and holistic support;
- Improve the timeliness, quality and duration of support, which is particularly important when placing children out of borough;
- Feel more confident about their jobs, in the knowledge that there are the means to support families' needs.

While the impact on families has been hugely beneficial, as outlined above, staff reflected on the impact that the ASF is having on their roles, which is now focussed on undertaking assessments.

Case Study 3: Estborough City Council

Context

Estborough City Council covers a large urban area with close to a million inhabitants. It is among the 5 largest cities and local authorities in the country. The population is multicultural, with significant Asian and Black demographics. Whilst showing steady improvements, the city rates as one of the top 5 most jobless areas in England, ranks highly on most measures of multiple deprivation and has recently had a significant reduction in public sector funding. Estborough City Council has a high number of adoption cases and has seen a significant increase of special guardianship and adoption cases year on year.

The picture of local provision in the first year

For the past 7 years Estborough have had a holistic adoption support service grant funded by the Department for Education. This has allowed a large team to develop of 7 employees, including a head of adoption support, 5 adoption support workers and an agency social worker. The team has had a clear focus on attachment-based therapies since inception. Staffing levels and roles have not changed in the first year of implementation.

Prior to the Fund the Estborough post-adoption support team offered multi-level support aimed at teachers, parents, adoptees and local businesses. Estborough social workers provided self-soothing workshops, trauma workshops and a parenting programme based on attachment principles, alongside an ongoing race, identity and attachment programme for adoptees from different ethnic backgrounds. All staff have training in level one Theraplay but do not have the video and observational facilities to offer a full Theraplay service. Two staff have been trained in DDP over the course of the year.

Given this comprehensive support before the ASF, local provision has expanded rather than transformed what services are offered locally. For more complex cases the team would work closely with CAHMS (and more had recently begun to consult an external provider).

With the ASF, local provision had shifted so that “*Our main responsibility is now to assess*”. Staff in this authority felt that this was problematic for a team of workers who mostly delivered services. In-house provision was described as covering “*the basics*” whilst more specialised provision was commissioned to external providers.

Over the first year of delivery the local team had changed from almost entirely providing services in-house to almost entirely commissioning out services.

Commissioning services and market development

The internal team said that the ASF has allowed the team to “*branch out*” to learn new therapy types from the range of therapies available in the external market. For example, one provider alone offered around 50 types of therapeutic interventions for post-adoption support. These included, but are not limited to, therapeutic life story work, sensory therapy, play-therapy, filial therapy, music therapy, Safebase parenting programme, therapeutic retreats, and DDP.

The 2 providers interviewed were the main external ASF-commissioned services: a centre of excellence for post-adoption support and an independent post-adoption agency. Both providers had either expanded their therapeutic post-adoption services or were in the process of expansion. They were both transitioning from a grant-funded service to contractual funding, a process facilitated by the ASF. Both services were concerned about the lack of Service Level Agreements as case-by-case funding (‘spot funding’) makes sustainability planning difficult. For one provider offering therapeutic breaks, recruitment of parents used to be direct; with the ASF, each child needs to be assessed by the local authority, approved by Mott MacDonald, and referred to the service. Commissioning services individually was seen as inefficient as therapists may need to travel to and from the destination for each therapy session, rather than having one day with several sessions.

Overall the team described the market in post-adoption support in their area to be quite under-developed, although they also acknowledged that their knowledge of the market was not comprehensive as they had been unable to conduct a full review due to limited capacity. The external providers known were not always located within the local authority but rather in neighbouring towns and cities meaning that families often had to travel to receive specialist services. This was seen to be a particular challenge now that SGOs had been included in the scope as the profile of these families tend to be more socio-economically disadvantaged and less able to travel.

As the year progressed team members and external providers had noted the increased waiting times for external services as a result of the demand outstripping supply, one staff member stating: “*all providers are reaching capacity*”.

From the local authority perspective, the question of monitoring was prominent in focus group discussions. Whilst the team had some quality assurance mechanisms they said they were not well placed to evaluate the appropriateness of some external providers so they tended to commission familiar services or those vetted by Ofsted.

They are currently editing their approved suppliers list whilst building up a directory of services available across the region.

Currently the internal team do not self-commission their own services though they are considering it due to lack of clarity around the rules regarding this and due to lack of capacity to complete the extra applications.

Implementation of the Adoption Support Fund

In the early stages implementation was widely seen as positive. After the ASF, Estborough were able to broaden their offer for families to include a range of previously unavailable therapeutic interventions. While attitudes towards the Fund have remained largely positive the administrative burden of applications and managing commissioned services have steadily increased as demand has grown and more families have begun to receive services.

The team did highlight a number of issues with the early implementation of the Fund. Besides the ASF's gaps in over-18 provision and funding training, the decision to make parents ineligible for one-to-one support was mentioned as particularly damaging. In Estborough there had already been one example of a successful parent therapy: one parent did not attach to the child and underwent one-to-one psychotherapy with positive results. This parent's therapeutic support funding was cut after the eligibility changes.

The centre of excellence provider was concerned that the commissioning process tempted social workers to escalate recipients to one-to-one therapies straight away, rather than starting at the bottom of the 'ladder' with therapeutic family training. This external partner said they have been sent applications for 6 Theraplay sessions when "*often it's parenting that needs to be addressed before escalating.*" The ASF's approach of empowering parents to decide on their therapy type is likely to preference parent/child therapy rather than training parents or teachers skills in dealing with the child themselves. In effect this may create a dependency on therapy that is unnecessary. Such dependencies on external therapists disempowers parents whilst taking away some of their responsibility within the family dynamic. By only commissioning child services, and focusing on individual therapies, the ASF risks pathologising the child's behaviour rather than giving equal responsibility to the child, parents, school and wider system.

Since the ASF the adoption support workers now spend most of their time doing assessments when before they were delivering therapies. Also the head of post-adoption support is now "*chasing around invoices, and doing administration.*" There was agreement that this situation is not ideal, and agreement that the fact all

assessments had to come from the Local Authorities was seen as providing extra work that could be done other ways.

Assessments

Whilst all the team had BAAF enhanced training, Estborough had a range of assessment methods besides BAAF. Often various assessments had been carried out by different local authority departments and these were sometimes sufficient. Whilst they tried to avoid an undue burden on families through unnecessary assessments, the team always aimed to answer the question “*what does this family need, and are those needs adoption specific?*” At times EHAT (Early health assessment), CIN (Child in Need) or the post-adoption assessment itself was sufficient to answer this question without a BAAF assessment being required. The CIN assessment is particularly used when the adoption itself is not the issue, for example with many teenagers.

The external providers were affected by this local authority-led process as they often carried out their own assessments which were sometimes more in-depth than the Local Authorities’ own assessments (incorporating video, parent reflection and observation). However, third-party assessments are not valid for the ASF. As not-for-profit providers, “*It would be so good if as voluntaries we could make applications. For some applications we’ve been ready for months and the local authority haven’t been able to submit the application for months.*” It was suggested that these third-sector assessments could be vetted by the local authority.

For providers, it was seen as “*quite scary to refer parents onto social workers instead of carrying on with the voluntary services. It can be an anxious experience. Loads of families will disengage. If it was the parents’ choice to go through a voluntary agency, putting them through statutory services could be a conflict of interest.*”

The overall impact of the Fund in the first year

As a provider of many services prior to the ASF, the main impact for Estborough was considered to be on families with complex needs. These families can now receive additional support that meets more nuanced needs, whilst the Estborough team cover the ‘basic’ therapies.

Secondly, it was felt that the ASF has empowered parents to choose their own services, and has given a larger quantity of non-statutory choices.

Thirdly, providers had expanded their services. New services were being offered according to both the needs of the families and new opportunities to adapt services to the requirements of the ASF to secure a steady income flow. Providers were worried at losing beneficiaries through the local authority assessment process and the lack of service level agreements (SLAs) has meant the financial sustainability of external providers is not guaranteed by the ASF.

Finally, staff also highlighted the possible negative effects on team morale of the increased administrative burden and decreased therapeutic work. This also entails the risk of staff becoming deskilled as they are less frequently worked therapeutically.

Systemically, the senior manager noted that the ASF was the result of a particular policy agenda that had gained influence within central government, but this agenda should be sense-checked with a wider selection of stakeholders. Her aspiration was that *“You need a conversation from policy makers where people consult at senior level across the country”*.

Case Study 4: Newingham County Council

Context

Newingham County Council is a unitary authority covering both urban and rural areas. Serving a population of around 500,000 people, it is one of the most populous Local Authorities in England and is also one of the top ten largest Unitary Authorities by area. Whilst only barely in the top 25% percentile for multiple deprivation, employment rates are disproportionately low - Newingham County has one of the lowest employment rates in England.

Newingham has a high number of adoptions. After a slow start, since November 2015 the number of the ASF applications in Newingham has increased significantly.

The picture of local provision in the first year

On the whole, adoptions and support were kept within the region due to the high capacity for care in the local authority: *“we place children locally because we know we can offer extensive and good quality services.”* This was described as being due to a strong core service and the presence of a relatively large internal organisation within Newingham council which works as an integrated, multi-professional team managed through Fostering and Adoption, and Looked After Services. This internal team has around ten staff, including 5 therapeutic social workers, a clinical nurse specialist, an Occupational Therapist, and a clinical psychologist who works with those who have suffered trauma and abuse which is affecting their daily life.

Newingham offered a comprehensive range of therapies and support, including individual consultations, family therapy, EMDR, life story work, attachment-based sensory work, non-violent resistance, and cognitive, attachment and more complex assessments. Since the ASF began the team had been able to train staff in DDP and Theraplay and these were now also offered locally. Since the Fund's inception the team has recruited new staff, including administrative and business support and new therapeutic staff to cope with the increased demand from families.

The Post-adoption Support team described a close relationship with CAHMS. A clinical nurse was seconded from CAHMS and their psychologist was funded through council health services. The Newingham team had strong links with their regional Consortium, which provided a space to share practice and knowledge.

Commissioning services and market development

Because the core of the council's services for post-adoption support were provided internally, this reduced the need to commission from external providers. However, Newingham did have contracts with independent providers as well, who they commissioned as an 'arms-length' for particular services (examples include, but not limited to: file reviews, support with indirect contact issues, and independent support to birth parents). Most often they would contract out services if the child in questions had been placed out of borough. The majority of therapies provided were attachment-based.

As the team had historically provided a broad and comprehensive range of therapeutic services, the ASF has not changed the service dramatically. However, it had enabled them to offer additional interventions that hadn't been offered before, therefore further strengthening their support. For example, the team was now able to offer Theraplay and DDP more widely.

The local market was viewed as being generally underdeveloped in the region. Staff also acknowledged the challenge when placing children out of borough: the introduction of the Fund had increased pressure on colleagues in other areas and on an already under-developed local provision. This was creating a challenge for the team when placing children in areas where they do not have as much local knowledge.

Implementation of the Adoption Support Fund

The team raised awareness of the ASF through various means: via formal communication methods (e.g. contacting adopters through the internal database; the council's website) as well as more informal ones (e.g. holding a meeting for adopters, to encourage them to pass on the information to people they knew and who might need support but may have not asked for it in the past). "*We're meeting our requirements in the safest way that we can and the best way is actually word of mouth.*" Staff felt that "word was getting out" through these efforts.

Structurally, the introduction of the Fund meant additional duties for the team, rather than requiring changes. In order to manage the additional duties, the team successfully adapted their processes by dedicating time 'upfront' to finding the most efficient way to manage the increase in administrative tasks. This included: continuously adapting assessment forms to suit the management requirements of the Fund, which ensures that the team automatically collected the right information for applications, reducing potential delays; and absorbing tasks in existing roles.

Staff felt that dedicating the time to adapting their processes, has laid strong foundations for an effective way of managing the extra administrative demands of the Fund. The relationship between the team, who are co-located, was also seen to be an important success factor.

The presence of a strong 'core provision' and a relatively large internal, therapeutically-trained team, meant that, initially applications were low, due to Fund not initially covering services that were part of a core offer. This was then revised, which enabled Newingham to further strengthen an existing service by investing internally to broaden the team's expertise in particular areas and the support offer (e.g. training staff in, and offering, DDP and Theraplay, which weren't offered before).

While no considerable challenges had been experienced, the introduction of the ASF has increased demand for referrals, including from those who the council may have not supported before. As the year progressed the demand steadily increased putting pressure on the team's capacity and leading to increased staffing.

Even though Newingham had a strong core service, staff felt that the funding of pre-orders was very beneficial and appreciated the fact that the ASF can fund transport costs, which is particularly important for accessibility. In addition, they felt it was important to think about the sustainability of the ASF and ensuring that support will be around in the longer term.

At the first interview staff positively rated the management of the Fund. They particularly appreciated "being kept in the loop" as well as the speed and seamlessness with which applications are processed. However at the second interview due to changes in the way the Fund was managed they felt the process had become less clear and more bureaucratic.

Assessments

The team carried out 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 take about 8 weeks, and are a more structured way of addressing different areas of child functioning. Third, *complex assessments*, which may include 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 will input into the process.

There was no waiting list for assessments: the team started within 5 days of receiving a request and from allocation they have 20 working days to start the

assessment process. The straightforward assessments are likely to be completed in about 20 days, whilst complex cases may take a number of months. Treatment plans are made in discussion with the parents.

The capacity of the internal support organisation had been stretched and much of this additional work is administration, relating to assessments and applications. However, the service had dedicated time and effort to find strategies to successfully manage the extra work. The Business Support Manager helped adapt their administrative forms to fit with the ASF requirements which saved some time. All internal staff involved in the ASF were putting aside 2 days a week for the administration work.

The overall impact of the Fund in the first year

The team viewed the ASF as an important intervention, in that it recognises the needs of adopters and adoptive children is encouraging adopters come forward and come at the right time.

With a strong existing core service, the ASF is, on the whole, mainly being used to fund existing services. However, it is also enabling the council to further extend their offer. Benefits of the ASF to date were seen as being related to:

- Bringing in DDP and Theraplay, thus extending the skills of the team and the service;
- Helping maintain, and ensure the viability of, an important service that might have otherwise been at a greater risk of being reduced, due to the strain on public sector resources.

The team discussed their concerns that further restriction to the Fund may reduce their ability to support families in need and also makes harder the process of long term planning.

Case Study 5: Norchester City Council

Context

Norchester is among the 15 largest cities and local authorities in the country and has a population of around 500,000. It is a predominantly urban area, with the Norchester local authority area accounting for almost 70% of the total population of built-up area of the city.

Norchester has a relatively young age profile and the proportion of the population who are not 'White British' has increased from 12% to 22% of the total population. Overall, the city has a rapidly growing and changing population, especially in the inner city, causing pressure on services. The population is projected to increase by 10% in the next 8 years.

Norchester City Council has a medium level of adoptions which is increasing.

The picture of local provision

The post-adoption support service was made up a small team of 3 social workers: one adoption support manager (part but not all of this post) and 2 part-time adoption support social workers. Two of the team had only been in post less than a year, including the manager following the retirement of the previous manager shortly after the Fund began. Across the first year of delivery the staff team remained unchanged.

The support team had limited capacity to deliver support and most of their time was spent making assessments and commissioning external services. Before the ASF, the adoption support workers ran an annual 10-week parenting workshop but this year it was cancelled due to the increased workload from the ASF. As the year has progressed the pressure on staff time of the Fund has steadily increased. This was both the result of a slight increase in demand for the Fund from families and an increasing overall number of cases held by the team leading to the need for re-applications to the Fund and managing of contracts with providers.

CAMHS services in Norchester were described as limited and little used by the team. This included a service for looked after children; psychologists in this service offered some limited support to adopted families in the form of consultation, advice and limited therapeutic services. The team had an agreement with a young people's psychological service for half a day a week that provided psychological assessments and therapeutic services to their families. Thus far this has not been funded via the ASF but through

the team budget however they were exploring whether the Fund would cover these services.

Commissioning services and Market Development

Prior to the ASF, the adoption support team were focused on commissioning external services and this role has been expanded considerably by the ASF. Before the ASF, “*we used to use very few providers and we couldn’t respond to every request for services*”. Due to their limited annual budget, the support team tried to serve their clients by sending quite a few families to one tranche of sessions (12 weekly therapeutic sessions) with no follow-on therapy. This compromise meant that several families could be reached but they would only begin to explore family problems rather than resolve them. This sometimes left families in a worse position that they started.

The volume of commissioning had increased substantially. Throughout the year Norchester commissioned a wider choice of therapy types, including creative therapies (music, drama and art), sensory processing, psychotherapy, Foetal Alcohol Syndrome assessment, NVR, and DDP. The scarcity of some therapy types provided within the local authority, particularly Theraplay and DDP, meant that these were very rarely commissioned, and only when providers had a rare unfilled spot.

The demand for post-adoption therapy outstripped the supply of services in Norchester: “*The reality is there’s not much of a market locally*”. Interviewees saw evidence that many local services had been increasing their prices in response to this imbalance. In one case, a provider charged the maximum capped price for services and then charged the same amount for travel. As that service was needed and no other provider was available, the team were forced to accept the price increase.

At the second interview team members spoke the local authority commissioning department having tried to develop a preferred providers list but that this had been of limited use. Staff suggested that guidance from the DfE or the Fund managers about the suitability of providers, therapies and qualifications would help them select and commission providers.

Over the year staff noted a slight development in the local market of post-adoption support with some providers hiring new staff and others setting up new organisations in the area, however despite this they viewed the range and volume of support as poor and insufficient to match the demand from families.

Implementation of the Adoption Support Fund

The number of assessments and applications had increased in Norchester to the extent that the volume had an impact on their capacity to do development and therapeutic work. This was particularly acute during the summer when “*we felt overwhelmed, lots of families were getting in touch.*” Despite the increased workload, there had not been an increase in staff. Staff offered advice and support to adoptive families but were not able to offer specific therapies themselves so cannot commission their own services through the ASF.

Initially the application process was seen as good, as the Fund managers responded quickly, in a helpful and friendly way. Later the team found the Fund criteria becoming more stringent with an increase in applications being returned for amendments or rejected. This added to the administrative burden on a small team. Staff also complained about only having one log-in for the application portal which sometimes caused delays.

Norchester have allowed parents more of a say than previously in their choice of service. They see the ASF as being about “*giving the family some power and control*”. This control was not possible before due to the small budgets. With the funding, the support team advertised therapeutic services more widely and involved parents in the decision much more.

The implementation of the Fund is experienced as a widening of types of intervention. Some of the gaps reported are:

- Opportunities to fund respite breaks (which is only funded if it's therapeutic respite) and care for the child within the home providing respite cover remained an issue; and
- Not being able to respond to educational issues, bringing attachment and emotional understanding into schools, because attachment training for teachers cannot be paid for.

Assessments

Assessments for post-adoption support in Norchester were undertaken by the 2 part-time adoption support social workers. The time required for the assessment process depended on the nature of the issues confronting the family. Some assessments can be completed in one visit. However, other families may require up to 3 visits. Staff used the BAAF form, which was implemented prior to the introduction to the ASF,

and staff hadn't reported any particular issues with it. The general view was that assessments should not be too onerous.

Even though other professionals inputted into the assessment process (for example teachers and/or current therapists that the families may be seeing), staff felt that having a psychologist or therapists as part of the post-adoption support team would be a great asset, and that this might become a possibility through the regionalisation process.

Overall, the ASF increased the amount of assessments being undertaken, with an impact on staff's capacity to do development and therapeutic work directly. However, staff recognised their ability to be able to offer more therapy and a wider variety of therapies because of this.

The overall impact of the Fund and the future aspirations

Staff described the impact of the Fund to date as having allowed them to:

- Expand provision, particularly for creative therapies, and expand the range of providers due to the increase in funding;
- Provide longer and more intense packages of support, which are better able to meet the need of families (prior to the ASF, packages would rarely exceed 12 weeks of support);
- Be more preventative: prior to the ASF, the team had to be more focused on families in crisis whereas now, the ASF is providing the opportunity to prevent families from going into crisis.

However, staff also highlighted that there was a limited market for therapeutic services and that the demand outstripped supply, which remains a concern, as it means there currently is not enough choice or competence in the area.

Case Study 6: Northburn County Council

Context
<p>Northburn County Council has a population of around 1.5 million. It is a geographically large county with a mixture of urban and rural areas. Overall the county is in the least deprived third of all local authorities in England but some parts fall into the 20% of most deprived areas on the indices of multiple deprivation. The county has a younger population than the national average and is predominantly White British in ethnicity (over 90%). Northburn County Council has high levels of adoption.</p>
The picture of local provision over the first year
<p>The post-adoption support service was made up of a relatively new multi-disciplinary team of clinicians and social workers. This was a new service shift moving from a social-worker led service to one which offered therapeutic provision in-house. While initially the team was managed by a third-sector partner, changes over the first year saw control return to the local authority. This also involved the recruitment of an internal clinical lead to oversee and supervise the team. The team consisted of an adolescent psychotherapist, a systemic family therapist, 8 part-time music therapists, 2 social workers and a part-time social work team manager.</p> <p>Post-adoption support was largely provided internally, including child psychotherapy, therapeutic parenting training, systemic family therapy and social work support. External commissioning was used when specialist work was required, such as Theraplay and Foetal Alcohol Syndrome alcohol assessments, or when there was no internal capacity. Until earlier in the year, the post-adoption team included an additional 3 members of staff who left their post. This has meant that, as a result, there have been some staffing gaps. The service also provided a preventative service offer of parenting groups and parents' seminars on topics such as life story work, and actively engaged adopters through the Adoption Advisory Board. CAMHS services have higher thresholds of need with waiting lists and their involvement in adoption and fostering is currently primarily on a consultancy basis.</p>
Commissioning services and market development
<p>The council had tried to minimise buying external services because of the difficulty of assessing quality and the complications around supervision, accountability and</p>

contracting issues. However, due to increased demand and staff shortages, they began to commission externally. It was estimated that around two-thirds of their applications to the Fund were for in-house services. There had been difficulty in finding specific therapies. This was due to the large size of the county, where some therapies might not be available in particular areas. In addition, local providers and procurement rules limit contracting services above £8K.

Staff reported limited knowledge of the local market of therapeutic support beyond what is offered through in-house provision. Although the local market (provision from the voluntary and private sectors) is viewed to be limited there was acknowledgement that more strategic work (mapping and relationship building) needed to be carried out.

The service was orientated towards psychodynamic approaches and there was considerable scepticism around the clinical evidence for interventions such as Theraplay and short-term CBT for children/families with complex needs. Staff reported commissioning services through existing relationships with providers and a reluctance to commission an unknown provider. This was exacerbated by a feeling that some interventions are provided by individuals who have received limited training in therapy (Theraplay was a particular concern).

Implementation of the Adoption Support Fund

The team prepared for the ASF by inviting the Fund managers to 2 seminars for parents to raise awareness of the new policy. There was a bit of work at the beginning to talk to families and reach that understanding *“that this is available but it’s not a pick and mix”*. *“It was a bit scary at the beginning because families thought they could access the cash.”*

Structurally, the introduction of the Fund did not necessitate substantial changes to the service or affect the approach of the team. The additional administrative tasks involved in assessing need and applying to the Fund were covered by a single administrative role. At first the team found the application process manageable and noted that the application form itself was brief and easy to complete. However, the increasing number of live cases and the continued, steady demand combined with an increasingly detailed application process had led, by the second visit, to a substantial administrative workload for the team, which was felt to be detracting from their work with families. Moreover, team members noted that much of their work with parents was now being challenged at application stage leading them to suggest that *“there is a tension between a systemic model and the model of the Fund”*.

The key challenge in implementing the Fund has been around capacity (both in-house and in local independent provision). There have been staff shortages due to

unfilled positions and difficulties in identifying appropriate external service providers in cases where the therapy needed is specialist. Both these factors, as well as increased demand for services, have resulted in a waiting list for post-adoption support in the borough.

Assessments

The team recently introduced a new tiered assessment process. Parents were referred or self-referred to the team where the first step would be advice and guidance to parents or signposting them to relevant services. Following this, a social worker or clinician would filter out those referrals that need to be responded to by other agencies (e.g. in the case of child sexual abuse families will go to a specialist service provided by the NHS). Then the most appropriate member of staff to do the initial assessment would be allocated. If therapeutic support was deemed necessary the staff member responsible would refer the case to the team meeting and an initial consultation of 3 to 6 sessions would follow. At review this is often felt to be sufficient for families' needs, however if not an application would be made to the ASF to fund further work.

Team members noted a rise in demand for assessments since the introduction of the Fund, which they attributed to their improving reputation among adopters due to their increased capacity to provide services. This has resulted both from the relatively new therapeutically led team and the introduction of the Fund.

Overall the scope of the Fund was experienced as a widening of types of intervention. One of the gaps reported was work directly with parents whose mental health needs emerged in the process or post-adoption, particularly as adopting and adoptive parents find it hard to show vulnerabilities. The team expressed the need to assess need before placement as vulnerabilities in a potential adoptive family can sometimes be predicted and an intervention in place could be preventative. It was also felt that ambiguities around the definition of 'therapy' also may create a gap, for example, life story work does not only have to be therapeutic in definition to have an impact on the mental wellbeing of the child. The same issue was raised around respite breaks.

This team expressed a concern about therapeutic knowledge generally. It is essential for post-adoption support teams to have a good understanding of both the family needs and evidence for the types of interventions available

The overall impact of the Fund in the first year

Staff described the impact of the Fund to date as having allowed them to:

- explore the needs of families more thoroughly than before;
- provide more in-depth support where necessary (medium or long term, as opposed to the 3 or 6 session previously available);
- improve the timeliness of their services through the relatively quick application process; and
- improve the geographical spread of services to reach the border areas of the county that previously had been neglected.

Staff reported that adoptive families were very satisfied with the new state of affairs and showed increased confidence in the team to be able to help. Staff did note that the Fund hadn't substantially increased the range of types of support they could offer and also that partially as a result of increased demand on their services they had now developed a 3 month waiting list.

The main challenge noted was the tension between their preferred way of working (with parents or with the whole family) and the Fund criteria which focus more on services directly for children.

Case Study 7: Osterland City Council

Context
<p>Osterland City Council covers a large urban area with a population of more than 700,000. It is among the 10 largest cities and local authorities by population in the country. A significant majority of Osterland's population defines themselves as White British (over 85%). The city's employment rates are in line with both regional and national averages however it still ranks in the third most deprived local authorities in the country. Osterland City Council has historically had comparatively high levels of adoption.</p>
The picture of local provision in the first year
<p>At the inception of the Fund the post-adoption service in Osterland comprised of a large team made up of an adoption support manager, 9 senior adoption support social workers, a teacher and an experienced admin support team, which included 2 archivists. The manager and social workers between them were trained in a wide range of therapeutic techniques, including Theraplay, AdOpt and Non-violent Resistance, DDP and EMDR. Prior to the Fund, the majority of service provision was in-house, where they would offer 'stay and play' sessions to all new adoptive families, as well as individual and group Theraplay based sessions. While the team continued to have significant capacity to deliver support in-house, since the introduction of the Fund an increasing proportion of their time became spent undertaking assessments and commissioning external services. At the second interview the team reported having recruited a new member of staff to help support assessments and applications for the Fund.</p> <p>The adoption support team historically had a close working relationship with CAMHS involving multi-disciplinary working around adoptive families. However, this cooperation had reduced in recent years as a result of the diminishing resources of CAMHS.</p>
Commissioning services and market development
<p>Prior to the introduction of the ASF, the team felt they had a strong support offer and a broad range of skills and experience. However they also talked about awareness of gaps in their service, particularly around specialist assessments of need and complex cases. In these cases the team would commission external specialists</p>

using a budget of around £100,000 a year that was kept aside for this purpose. This could be accessed through application to an internal panel.

Since the Fund has become available the volume of commissioned external services increased, both in quantity and range, in line with levels of referrals. Osterland particularly looked to commission specialist assessment such as sensory integration, Story Stem and Clinical Child Assessments, as well as increasing provision of expressive therapies. At the first interview commissioning arrangements tended to be spot purchasing, but were aiming to improve contracting. However at the second interview all services were still purchased on a one-off basis.

The team sought to improve their knowledge of, and relationships with, local providers through work with regional partners and through hosting a series of open days in the region. They aimed to develop a list of local providers. Despite growing provision it was still felt that demand for services outstrips the local market's ability to provide therapeutic services. As a result of the greater demand many of the local providers had developed significant waiting lists by the second interview. This presented problems for the families facing crises and required the adoption support team to provide more informal support while the families waited to receive their commissioned services.

Implementation of the Adoption Support Fund

The implementation of the Fund has led to a significant increase in the volume of referrals for post-adoption support, which were said to have roughly doubled. This in turn has led the team to formalise processes and procedures. The presence of the Fund meant the team had to formally identify administrative support which has meant they have additional duties and workload. Significant changes to the adoption support assessment process have also been made to accommodate the increased volume of assessments (further details in the next section).

At the second interview the team had begun to fund the provision of in-house services through the ASF. This was in the form of 3 parenting courses based on nonviolent resistance (NVR). There were also plans to begin delivering Theraplay and therapeutic life story work however these were yet to start. The team believed these courses would better value for money than externally commissioned services, citing that their costings were half that of some external providers. Funding in-house services through the Fund would allow them to make some revenue for the team to fund further training and work that falls outside the scope of the Fund itself.

The team has sought to increase awareness of the ASF through a number of means including: advertising it through their newsletter and on their website; introducing

parents to it through their parenting programmes and workshops; and raising the awareness of other relevant services such as CAMHS and education.

At the start the team reported finding the application process manageable and relatively quick however over the year changes to the Fund and the increased scrutiny of the applications has meant the process has become more time consuming with applications more frequently sent back for amendments.

Assessments

The introduction of the Fund necessitated a major change to the way the adoption support team worked around the assessment of need. Before the need to identify specific services and make applications to the Fund the team used an extensive assessment process, embedded in its interactions with the family. Since the introduction to the Fund this process has become briefer, more standardised, and more focused on the identification of services: *“They have to be a lot quicker and more streamlined and all together turned round in a much quicker way.”* To compensate for the loss of depth in the assessment process the team implemented a systematic process of review. The staff also noted the inclusion of the 3 monthly assessments rule for the Fund had significantly increased their workload as well as proving sometimes to be an impediment to their building a relationship with a new family.

A positive consequence of the new assessment process is that social workers felt that they could track the experience of the family through the adoption support process better: *“We track them better now through our ASA assessments and the ASF applications. We have received some good feedback, via evaluations”*. There was however some concern expressed in the team that the increased volume of assessments was having a negative effect on the job satisfaction of the workers, taking them away from working directly with families as they had done before.

The overall impact of the Fund in the first year

The team described the impact of the Fund so far as having allowed them to:

- Expand provision, particularly for specialist assessments and expressive therapies, as well as expand the range of providers due to the increase in funding;
- Provide more timely support and longer and more intense packages of support, which are better able to meet the need of families; and

- Staff also suggested that the Fund has been received as a form of recognition of the challenges facing adoptive families and may be empowering for them in their interactions with other services, particularly with schools.

However, staff also highlighted the possible negative effects on team morale of the increased administrative burden and decreased family work.

Case Study 8: Oxton Borough Council

Context

Oxton is a London Borough with a population of around 190,900. It is a relatively diverse borough when compared with England and Wales as a whole, but is one of the least ethnically diverse boroughs in London. It is also one of the least deprived areas in the country. Oxton does not place its children in the same borough as it is geographically small and therefore the risk of birth family having unplanned contact with children placed for adoption is high. The vast majority of adoption support work involves supporting local residents who have children from other boroughs and counties placed with them for adoption.

The picture of local provision in the first year

The Adoption Support Team is made up of 3 social workers and the core service is made up of the following:

- Support group for under 10s
- Support group for over 10s
- Independent birth family counselling- offered to any birth parent or family member affected by adoption
- Provision of one to one counselling
- Adoption drop in-for adopters and children under the age of 5

Overall, the ability of the council to provide therapeutic interventions was limited, due to financial resources. The therapeutic support was offered in-house and by the adoption support social workers. In addition, contact with CAMHS was limited, due to the fact they are a stretched service and have very strict criteria for referrals. The team had good links with the LAC service.

Most of the support was delivered through the support groups mentioned above. However, the specialised support required by many families was not available in-house due to limited resources (financial and human) and limited skills to support complex needs. The introduction of the ASF meant this could be addressed. However staffing losses and recruitment problems in the first year created excessive workloads.

Commissioning services and market development

The service is being extended through the ability of the team to now commission the therapeutic interventions required to support families. Initially the organisations commissioned were the ones that the team had used in the past, which also included a number of local child psychotherapists who they had worked with over a long period of time and with whom there was a well-established relationship. Gradually the team began to expand the range of providers they were using.

The overall view was that the market was under-developed and that more professionals are needed to meet the demand, particularly for interventions that require specialist skills and expertise. There were concerns that not all practitioners are registered with Ofsted. There were also concerns raised about increases in pricing and a lack of regulation and formal monitoring processes. On the second case study visit the team raised concerns about the capacity of the larger providers and reported that there were now long waiting lists due to increased demand.

Implementation of the Adoption Support Fund

The team raised awareness of the ASF through their support groups and adopters' word of mouth. They also publicised the ASF at the Annual Families Day. Schools and other agencies, such as health and CAMHS, have also raised awareness of the Fund, which created a "domino-effect".

Structurally, the introduction of the Fund has not required changes to be made to the team. The main challenge experienced was the rapid increase in volume of assessments, which occurred following the awareness-raising activities of the team and other agencies. This has resulted in a significantly increased workload.

Through the ASF, the council had been able to offer a lot more help than had previously been possible through, for example, more, and higher quality, packages of support and commissioning the expertise that is not available in-house. It was also felt that families were feeling more contained and supported. However, direct work with families had been reduced, due to the additional administrative tasks required through the ASF, thus creating a shift in social work practice and a decline in job satisfaction for the team.

The increased demand had also resulted in some pressure on local provision, although the ASF has meant that providers were able to extend their services and work with families for longer and more intensively. The introduction of the ASF is also beginning to strengthen relationships between providers, adoptions services

and adoption networks more widely, and the team felt there was generally more of an attempt to jointly meet needs.

This local authority team felt that gaps in therapeutic support for adoptive families that were not addressed by the Fund were: training for schools, support for therapists to develop the required skills and techniques for specialist interventions (e.g. EMDR for children); lack of provision to help with marital problems ; basic life story work and the provision of more training for Adoption Support Workers themselves.

The management of the Fund is experienced as helpful and efficient though recent restrictions to the application process had resulted in increased time needing to be dedicated to administrative tasks.

Assessments

There were no changes to the assessment process. The assessment process can take 3 to 4 months to complete. This process was described as: taking self-referrals from adopters or referrals from other agencies (schools or youth services); the social worker then undertakes the assessment (through use of the BAAF form) of need through several meetings / visits with the families, which includes meeting the child and generally helps to establish a relationship. Other professionals will also input into the assessment (schools, health, LAC service) and there may also be professional meetings. The assessment would then be shared with the family and they would be offered a package of support via the ASF.

The overall impact of the Fund in the first year

The introduction of the ASF was experienced as transformative for the service in the following ways:

- The quality, duration and range of support increased, enabling the team to provide services they were unable to provide before;
- It has raised the confidence of practitioners, who improved their ability to meet the needs of families;
- It drove the strengthening of relationships between providers, adoptions services and adoption networks more widely, and enabled the team to broaden the scope of their work.

The team and local providers were experiencing pressure on their capacity to manage the increased demand and the associated increase in assessments. A concern of social workers is that their role is changing to one of commissioning or brokering and that they may have less opportunity to use their therapeutic and casework skills.

Case Study 9: Westfolk County Council

Context
<p>Westfolk County Council is predominantly rural with a population of approximately 800,000. The county is dealing with a range of poorer than national average health outcomes but better than average youth outcomes. Although the county has some better than national average health and economic outcomes there are considerable inequalities within the county. For example, children entitled to free school meals, unemployment and benefit claimant rates vary greatly between wards. Fuel poverty, debt levels and the proportion of low paid low-skilled occupations are other indicators of economic deprivation. Westfolk County Council has high levels of adoption by national standards.</p>
The picture of local provision over the first year
<p>The Westfolk Adoption Support Service had the equivalent of a full time Team Manager, 5 FTE social workers and 2 FTE non-social work staff who supported birth parents through the adoption process and letterbox service and ran a group for adopted children. Most of these posts were temporary. There was no psychological professional within the team. Across the first year of the Fund, the make-up of the staff team did not change. There had been plans to recruit staff but due to the temporary nature of many of the posts and uncertainties around regionalisation it had been difficult to recruit permanent staff. The team aspired to have more therapeutic skills and knowledge to support with making choices about therapy and supervision of staff. The social work team considered itself stretched in its ability to work across a large geographically spread out county.</p> <p>In the past therapeutic support was provided by CAMHS but 4 years ago a new specialist NHS psychological service was created and commissioned by the authority to address the specific issues of meeting the needs of children in care or adopted children (particularly attachment difficulties). Until this year this was limited to where the child has been adopted for less than 3 years. Since the establishment of the specialist service, CAMHS has only been used by the team if there is a clear mental health issue.</p>
Commissioning services and market development
<p>Without therapeutic skills in-house Westfolk had used the Fund exclusively to pay for</p>

external therapeutic providers. The types of therapies commissioned were DDP, bespoke courses or groups, therapeutic parenting training, Theraplay, EMDR, narrative therapy and compassion focussed therapy and more recently therapeutic life story work and MBR. Westfolk also regularly used the Fund to commission in-depth psychological assessments from their NHS partner. The team described using a review process as a means of quality control which involved periodically checking with the family how the therapy is going and whether they felt it was meeting their needs

As the team began to explore a more diverse market they standardised their routine requirements for references, insurance, DBS checks, testimonials and proof of qualifications. Because of previous dependence on a newly developed NHS service, the team had limited experience of provider availability across the county. At both interviews they expressed a need to better understand the local market in order not have to rely on the same few providers that are trusted. However, existing relationships with providers were seen to be important, as this provides a 'quality assurance' mark. At the same time, known providers were themselves experiencing pressure on their capacity, due to the rise in demand. This was also partly seen to result from the under-developed market in the region.

Team members expressed concerns over the value for money of some of the services on offer, and said that external providers had been raising their rates over the year. They attributed these rises directly to the availability of the Fund. Some suggested that investment in the team's skills and recruitment of therapeutically trained staff may in the long term be a more beneficial and sustainable use of funds.

Implementation of the Adoption Support

The service had developed strong links with adoptive parents in recent years as improvements had been made. The team used their regular events and communication channels, such as newsletters, to promote the Adoption Support Fund and also felt that Adoption UK had a significant impact on raising awareness.

The increased recognition of adoption support services resulted in increased workload. There were challenged to completing assessments both in terms of time, limited resources (relatively small team covering a very large area) and the correct skills. The increase in administrative burden had not been addressed with increased resources from the local authority because of substantial funding cuts. The increased workload has had a negative effect on staff job satisfaction. And while the number of applications for the ASF funded services is relatively stable, the total number of families receiving support is growing and this can see some families making repeat applications for top-up support, all of which puts a strain on the team.

As in other areas the team had noticed a tightening in the oversight of the Fund by the Fund manager resulting in applications being returned for amendments or rejected more frequently. Due to applications bouncing back the application process is now taking substantially longer which was seen as a problem for families at crisis point. While the Fund manager was seen as helpful in responding to queries some staff complained of too many updates and messages from the Fund manager leading to confusion over the scope of the Fund. Staff asked for more clarity about the application process. Team members particularly queried the exclusion from the scope of the Fund of equine therapy and individual therapy for adoptive parents.

Staff reported feeling limited in their ability to advise families on suitable therapies due to the lack of clinical training however they also felt this may have the benefit of being able to remain open-minded to a range of possible approaches.

Assessments

Westfolk County Council team initially used the BAAF assessment form to inform the application to the Fund. As new assessment of needs are taking place they have made amendments to this form that reflect the information needed to complete the ASF application form. There has been a rise in assessments due to adoption support now having higher public profile since the ASF. This they believed created higher expectations of services of parents. Social workers reported being under more pressure to support the demands of the parents that was difficult to challenge without more therapeutic expertise within the team.

The overall impact of the Fund in the first year

The team rated their offer to families as high quality and stated that the quality and timeliness of their offer had improved as a result of the Fund. The Adoption Support Fund removed the barrier of fighting for funding from the local authority for each case and families have become aware of their entitled to support and the money is ring-fenced. Staff also felt that the funding represented public recognition of the challenges many adoptive families face which in the past may have been lacking. Social workers reported that in some cases access to the Fund has prevented adoption breakdowns and school exclusions. There was also the suggestion that the presence of the Fund may facilitate the placement of more complex cases with the assurance that support would be available.

Some concerns were raised about the impact of the Fund. Staff noted that there was now a danger that families approaching the service would be escalated into therapy which may not be the answer in all cases.

Staff reported excessive workloads particularly for those team members responsible for entering the application onto the portal. It was felt that changes in working practices due to the Fund also risked de-skilling some staff, particular who are likely spend more of their time completing application than on face to face work with families.

Case Study 10: Westfordshire County Council

Context
<p>Westfordshire is a non-metropolitan county, with a two-tier structure local government. It is divided into a number of districts, each with their own district councils. It has a population of around 530,000 and the majority identifies as 'White British' ethnic group. At a county level, Westfordshire is amongst the 20% least deprived areas in England according to IMD rank of average score. Westfordshire are currently one of the local authorities who make most use of the ASF.</p>
The picture of local provision over the first year
<p>The adoption team at Westfordshire was composed of ten social workers and, of these, 2.75 (FTE) posts are directed to Adoption Support. This included the team leader and 3 social workers. The service involved working with families, administering the Fund process and covered all adoption support activities. They worked closely with the Children's Team.</p> <p>The service covered all of Westfordshire, and the social workers' role was described as quite broad. Services delivered internally include (but are not limited to): supporting families post-adoption; delivering training for families; running support groups; providing attachment courses based on PACE, attachment through play training; running a mentoring scheme; life story work, and a range of courses to meet the needs of the adoptive parents.</p> <p>The council had mixed provision in terms of post-adoption support. Some services are delivered by statutory / voluntary sector organisations and some from the independent sector, with which there were service level agreements in place. The latter provided services including: supporting matches, pre-placement, providing consultations for adopters prior to a child being matched and then in the early stages of placement; and providing post-placement support further on down the line.</p>
Commissioning services and market development
<p>The council had a mixed provision in terms of post-adoption support and the majority of the therapeutic services were commissioned externally. The team of social workers were highly experienced and skilled and had Theraplay and DDP training. Despite this, the team had not been able to deliver a lot internally. The key</p>

challenges were finding professional supervision for social workers to practice, particularly for the most specialised therapeutic interventions (e.g. DDP).

The local market was also viewed as limited and there were doubts as to whether this would grow to the extent to which it would need to in order to meet the need for support. While staff felt the ASF had stimulated some growth, it appears to have done so mainly by generating a change of working practices (e.g. people setting up their own businesses or working as consultants). At the second case study visit the team reported problems with some regular local providers becoming overstretched due to the rapid increase in demand stimulated by the Fund.

Despite the overall limited market, the team was making new connections with different providers and had plans for more strategic work (mapping and relationship building) would be carried out. Provider days had taken place as well as discussion with neighbouring local authorities. At the second visit, however, the team suggested that some neighbours were reticent to share the details of their providers and felt that this indicated that the regional market in providers had become saturated.

In general, staff tended to commission therapies that look at the whole family. Overall, the choice of therapy depends on the history of cases, with the added advantage that the Fund is also enabling an expansion of types of therapy that can be provided (e.g. drama therapy, music therapy), which diversifies the service's offer.

Westfordshire had a framework agreement in place for providers, with neighbouring councils. Commissioning services occurred via some spot purchasing and some invoicing (if the council wants to commission a provider outside their framework, it would be through spot purchasing). Staff reported preferring to commission services mainly through existing relationships with providers. This has however created challenges in terms of backlog, and providers are finding themselves stretched with the growing number of referrals. This was exacerbated by a feeling of not always knowing whether an 'unknown' provider is able to provide a high-quality service.

There was also an overall view that there has been an increase in the price being charged by some providers. Staff felt that more checks needed to be in place to ensure that public money continues to be used effectively.

Implementation of the Adoption Support Fund

The team prepared for the ASF by raising awareness of the Fund to adopters. This was done through a mixture of formal communication mechanisms (e.g. adoption quarterly newsletters, leaflets and the council's website), and more informal ones (raising awareness of the ASF at support groups/training run for families, through

CAF teams and the Children's Team). Other statutory providers have also been promoting the Fund.

Structurally, the introduction of the Fund and the additional tasks required did not necessitate substantial changes to the service. The main change was the re-direction of staffing hours –in other words, designating existing staff to new tasks. This has resulted in an increase of some of the team members' social work hours and ring-fencing a set amount time for the ASF. In recognition of the ASF, council resources were put into training the team (Theraplay and DDP training). Investing in training was a way to enable the service to meet some of the need in-house, should the Fund not have continued.

The main challenge in implementing the Fund was the pressure on capacity (both in-house and in local independent provision). The substantial increase in assessments created an expansion of the service in terms of social work hours to do the assessments and secure the services for families. The increased demand is beginning to result in a backlog and a waiting list for services.

In addition, staff reflected on the impact of the ASF on social work practice: in order to undertake the assessments, highly experienced and qualified staff were unable to deliver the work with families themselves, which was seen as a concern. However, staff felt that with the assurance that the Fund would continue for the next 4 years, the council is in a better position to think strategically about how it will move forward to accommodate the increase in assessments and felt positive about the flexibility of their service. They also aimed to start charging out in-house provision to the Fund but have yet not been able to do so due to their staff being occupied in the commissioning and contracting of external services. The imminent regionalisation of adoption might also bring different opportunities.

At the start the team has found the application process, the speed of response and the implementation as quick, even if *"we are supporting double the people"*. They felt satisfied with the relationship with those who manage the Fund, which they find helpful, responsive and informative. As changes to the Fund criteria and scrutiny were introduced staff reported greater dedication of time put towards the application process with more being returned by the Fund manager for additional information

Assessments

The assessment tool has gone through an evolution, upon recognition (prior to the ASF) that there wasn't a 'formal' assessment structure. A new assessment form was

therefore piloted (single assessment form), which was then formalised upon the introduction of the ASF and is now being used across teams.

The assessment process was described as follows: social workers undertake the assessment of need. This also included talking to other professionals, so that their view is represented in the single assessment; asking parents what kinds of help they think they need and discussing what therapies are most appropriate, making it “*all part of a discussion*”. The social worker’s assessment report would then be 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. Two applications are made to the Fund: the application for consultation, and then for the treatment (once the plan is agreed).

The continuation of the Fund also enabled providers to potentially undertake extended assessments before completing a treatment plan (e.g. meeting the child for a few hours before deciding on the specific treatment).

Overall the team felt very positive about the scope of the Fund, particularly the widening the types of intervention and substantially increasing the team’s ability to commission services that they were able to do in only a limited way before. In addition, the recent expansion of the Fund to cover pre-order was widely welcomed, as staff felt it would make a big and positive difference to families who have children with particularly complex needs.

Views on areas of intervention that remained challenging, and which were not funded included: respite breaks, relationship couple work, revisiting life story work (which could be provided in-house but currently struggling to, due to the increase in assessments) and parenting strategies. However, staff recognised that “*it is not possible to fund everything*”. The biggest area of unmet need was viewed as the current lack of opportunity and resources to train up internal staff to deliver the services in-house.

The overall impact of the Fund in the first year

The view across the team is that the ASF has been very beneficial. Staff described the impact of the Fund to date as having allowed them to:

- Provide therapeutic services the council wasn’t previously able to provide;
- Fill gaps in access to particular therapies –for example play therapy and drama therapy;
- Work with different providers, enabling staff to increase their knowledge of different types of interventions what services are “out there”;

- Improve the timeliness of their services through the relatively quick application process;
- Develop even closer relationships with known providers; and
- Raise the profile of, and promote, adoption support internally.

While the impact on families was described as hugely beneficial, staff reflected on the impact that the ASF is having on the capacity of social workers and on their roles, which is now focussed on undertaking assessments.

Appendix 6 - 10 Local Authority Prototype Reviews

Prototype Local Authority 1

The picture of local provision
<p>This large rural local authority consisted of a multi-disciplinary adoption team that had been expanded to meet the increasing workload. It had increased its capacity to deliver therapeutic interventions internally and had in the second year recruited a life story worker and 2 reviewing officers for children subject to Special Guardianship Orders. Staff had also been trained in particular therapies. For example, one social worker was trained on therapeutic life story work and the play therapist underwent training for another intervention to enhance her play therapy work.</p> <p>They also commissioned various external providers and CAMHS in very complex cases.</p> <p>The trajectory of development can be described as mixed.</p>
Implementation of the Adoption Support Fund
<p>The continuing implementation of the ASF had resulted in the ability to provide specific support at the right level (dosage) that addressed the needs of adoptive families as a result of;</p> <ul style="list-style-type: none">• Increased confidence in the availability of support since Ministers provided assurances that the Fund would be secured at least until 2020;• The possibility to apply for the Fund at an early stage of the adoption process; and,• The amount and the strength of partnerships between organisations increased. New protocols between partners to ensure good working-relationships had been introduced. <p>At the same time, several challenges continued or appeared post-national rollout :</p> <ul style="list-style-type: none">• Higher rates of rejected applications which increased the cost of reviewing and resubmission of applications. Often, applications were returned more than once during the process because of minor issues (e.g., mathematical errors or leaving first names in the application instead of initials);

- Finding alternative therapeutic support in cases for which the initial support is no longer funded. This is for example valid for psychotherapy for adults which was not included when the ASF rolled out nationally but was at the prototype phase; and
- The availability of external providers was still a challenge as the demand for therapies continued to grow.

Good connections with other local authorities and VAAs were in place. However, this was less so with CAHMS, which had long waiting lists. The team worked closely with 3 neighbouring local authorities and also used/shared each other's services (e.g. an attachment workshop).

Awareness of the ASF was raised through newsletters, talking about it on the preparation day for new adopters and at their parties twice a year. They have also included it in the support book which they give out to adopters.

Assessments

No changes had been required in the team's assessment processes for post-adoption support which was felt to produce timely and quality assessments.

The number of assessments had continued to increase in the second year and they were working at full capacity to meet the demand. Increased workloads had also been seen since the pre-order had been included within the scope of the Fund.

In complex cases they would commission a specialist assessment, but very often their own psychologist provided the advice on appropriate support.

Purchasing and funding

Knowledge of the local market was developed in the early stages of the Fund and they were surprised how much was out there. In the second year of implementation, the Council had expanded the number of providers they were working with, but not the type of providers. It was felt that the local market was expanding but there was a need for further growth particularly due to the rural and wide geographical coverage of this local authority. They described families having to travel 1.5 hours to get to provision.

Key learning and the overall impact

The key learning points and overall impact from this local authority prototype included:

- The need to invest resources in a strong application process;
- Ability to procure service providers needs support;
- Considerable benefits for the families having unmet needs addressed;
- The ASF had allowed the team to be creative with their choice of support and increased their resources to help a great number of families; and,
- Although the Fund had been secured until 2020, for new adopters there was still no assurance that there was support for them available in the future.

Prototype Local Authority 2

The picture of local provision

This local authority extended the number of staff that were working within adoption support from 3 to 4 part-time workers. The key development in the second year of the implementation of the Fund was the establishment of a multi-disciplinary looked after and adopted children team that worked as an in-house CAMHS team and consisted of a variety of professionals including psychologists, therapists, nurses and social workers. In addition, members of the adoption support team completed a variety of training including DDP Level 1, life story work, and systematic practice and Theraplay Level 1.

This local authority could be described as having developed an in-house trajectory of delivery of therapeutic support (including providing parenting courses for other local authorities). While they did commission particular types of therapy (e.g. play or music) and worked with new providers, it was challenging for them to find providers in the region.

Implementation of the Adoption Support Fund

In particular this local authority valued the extension of the ASF to the initial placement phase rather than having to wait until a child had been adopted. In complex cases, this allowed for the application of support packages centred on the family to provide support and reassurance. They also welcomed that the ASF was secured until 2020. These 2 aspects have increased the confidence for adopters but also for the council.

Another benefit experienced was the improved timeliness of completing an assessment and receiving support. This was driven by the increased demand for assessments due to the availability of the ASF. Families valued the short waiting times for support.

The online applications to the ASF continued to be time-consuming and they struggled to have the resources to do individual applications for each case. They were looking for ways of increasing applications and streamlining processes.

Another challenge was finding enough local providers to deliver therapeutic services. For example, there was no registered DDP-therapist and no NVR providers in their area.

This adoption support team raised awareness of the ASF by including information on their website and talking about it during information evenings with adoptive parents.

Assessments

This local authority adapted the BAAF assessment form that they had begun using during the prototype phase. They also introduced group supervision to ensure consistency and deal more effectively with complex cases. They found that it improved the quality and efficiency of assessments.

The number of assessments was still increasing. Specialist assessments were completed in-house but before doing so the team always first approached the looked after and adopted children team. When they did not have capacity or the particular expertise they would commission an external provider. They also had close links with the Educational Psychologists Service.

Purchasing and funding

It was felt that knowledge of the local market had developed a little bit since the introduction of the Fund. They were about to create a commissioning network of providers so that they would have a list of agreed providers that they could work with.

The team had established effective partnerships with CAMHS and educational psychology. They also had close relationships with the other local authorities within their consortium and had, for example, conducted joint training in DDP. This local authority was part of a forum for adoption support which consists of local authorities as well as independent organisations in the wider area. The aim of the forum was to share knowledge and good practice, also related to the Adoption Support Fund.

Since the Fund was implemented, these links had become stronger and more formalised. The forum met quarterly and had regular telephone calls with other members to exchange ideas.

Through the ASF they had extended the use of different types of therapies and they delivered therapeutic parenting courses in-house. Therapies they were commissioning included: family-therapy, play therapy, music therapy, attachment-focused therapy, resilient therapy and DDP. They identified new providers throughout the implementation of the Fund with the help of the consortium of

neighbouring local authorities and existing providers. They conducted reviews to evaluate the services provided by providers.

Key learning and the overall impact

The key learning from the second year of the ASF implementation was:

- Take a preventive approach and 'prioritise' new placements to have robust support packages in place when the child is placed rather than wait until a crisis occurs. The expansion of the ASF to the time of placement made this possible;
- The resources to complete the online applications remained a challenge;
- There was still scope for expansion, and if the needs could not be met by external commissioning, additional in-house training would be required; and,
- Although the Fund had enabled this local authority to support adoptive families more effectively, some confidence in the ASF had fallen since the Fair Access Limit was introduced.

Prototype Local Authority 3

The picture of local provision

At the time of the pilot the team was offering support to LACs, adopted children and had responsibility for all post-adoption support (hence not only therapeutic interventions). This included ongoing support and delivering universal services. The team was, and is still, currently made up of 10 staff: 6 social workers, 2 mental health practitioners, a children support worker and an adoption support worker, all working in post-adoption support.

This local authority was developing along an in-house trajectory of therapeutic provision. They had strong internal provision and strong joint working with CAHMS (e.g. when people don't meet CAHMS criteria, discussions take place and the development of joint plans of actions, including having regular joint assessment meetings), which had been very useful for the implementation of the ASF. This increased their confidence in assessments, as well as enabling them to cover specialist assessments in-house.

The team also commissioned externally via mainly private, independent therapists, as children were rarely placed in this city.

Implementation of the Adoption Support Fund

For this local authority the continued benefits of the ASF included:

- Access to extended and timely therapeutic support, which better met the needs of families, including offering assessments at transfer point (when the child moves into another local authority). Overall, the team were able to provide a set of packages of support which were more comprehensive than might have otherwise been the case;
- Increased staff morale, in the knowledge that they could continue to offer support;
- Enabling the team to broaden their knowledge: staff were trained in Theraplay and DDP and had some training around play therapy. Over time, the ASF enabled the team to better understand when these were best used and most effective. They also expanded their knowledge of interventions such as filial therapy, music therapy, sensory assessments and sensory integration; and,
- Learning about commissioning frameworks, and quality assuring external providers.

Challenges for this local authority included:

- The saturation of provision: there were a limited number of therapists;
- The language used through the adoption process was felt to be centred around the child. The team had taken a holistic view of the complex issues of adoptions, and felt this was sometimes at odds with the therapies provided through the ASF;
- The ASF shifted the role of social workers, which raised a question about whether the team were gatekeepers or facilitators of support;
- The inclusion of SGOs was predicted to increase all capacity issues. and the extension of the scope of the ASF to increase the age range;
- The regionalisation drive, which had put a pause on things they would have otherwise done (e.g. developing a regional commissioning framework); and,
- Tensions between voluntary agencies and the local authority, because the latter had access to the Fund. These issues were, however, being explored as part of their regional meeting arrangements.

Assessments

Since the national roll out of the ASF nothing had changed in the assessment process. The BAAF form was still being used. However, staff had become more familiar and more confident in identifying the right therapy. Complex cases requiring specialist assessments were referred to CAMHS. Demand had increased in peaks and troughs mainly from placements outside of the area.

Purchasing and funding

The internal resource challenge came from: the additional procurement and commissioning tasks, which had impacted on delivery time; the complexity of some cases and the longer and more comprehensive, therapeutic packages requiring more work. The team continued to increase their knowledge of the local market over the course of the ASF implementation (e.g. making connections through the training sessions attended, previous provider days and through regional meetings with peers). While the market had developed overall, the region was felt to be still significantly lacking in therapeutic providers especially for the more specialised and complex interventions. For example, it remained challenging to find someone with expertise in both Theraplay and DDP within a relatively short distance.

There had been no major change in the types of therapies delivered/commissioned which included: Theraplay, play therapy, systemic family therapy, intensive therapeutic parenting and life story work, which remained the key ones. More recently, the team had commissioned sensory integration assessments.

One of the challenges for growth was the time required to train and qualify in the evidence-based therapeutic interventions. In addition, the existing providers were increasing charges as a result of the increased demand.

Key learning and the overall impact

The ASF was enabling families access the help required and to meet their needs earlier. Through the ASF, the team had expanded their knowledge and experience of interventions, including the more complex assessments, and developed their learning about procurement and commissioning processes. While the team had strong internal provision, the market was still not developed enough for the more complex and specialised interventions and it had taken time, on occasion, to identify the right provider.

Prototype Local Authority 4

The picture of local provision

The post-adoption team structure was 6 part-time workers (including one independent worker). While no changes had been made to this structure since the prototype year, some assessments of need were now being undertaken by independent workers, due to the pressure on capacity stemming from the increased demand.

This local authority was developing along an external trajectory of service provision.

There was some therapeutic provision in-house, but only in a basic form. Staff were trained to level one in some therapies, which meant that they were not able to deliver these therapies directly (as this would require more training). Most of the provision was therefore externally provided. One of the challenges was the local market which was not developed enough to meet some of the therapeutic need. For example, there was a lack of therapists with specialist skills in life story work, DDP and Theraplay.

Implementation of the Adoption Support Fund

Right from when the ASF was first implemented during the prototype year, it increased staff morale and confidence because it enabled the team to feel they had something to offer. Over the course of implementation, this continued to be the case. In addition, the continued benefits of the ASF included:

- Enabling the team to use the Fund preventatively, putting in place packages of support that were able to prevent breakdowns;
- Being able to think creatively and flexibly about how best to meet need through a range of interventions suited to the families, giving people more choice and control; and,
- Training staff in therapeutic parenting. This had started in the pilot phase and continued post-national rollout.

While staff knowledge of individual therapies had increased considerably since the ASF was first implemented, what remained challenging was how to decide which intervention may be the best one. There was an acknowledgement that it would still take time for staff to become familiar with therapies. Another key challenge was that changes to the scope of the Fund, had resulted in more time-consuming applications. To attempt to address this increased demand on staff capacity a

temporary administrative post had been created. Independent providers (which the team used more frequently) were finding the detailed paperwork required for the application to the Fund challenging. This sometimes resulted in rejected applications.

Adopters had been made aware of the ASF, through sending out letters and information on newsletters. Recently this had also included informing people about the Fair Access Limit. Additional activities planned to continue to raise awareness included: developing booklets for prospective adopters and for when the child is placed.

Assessments

The BAAF assessment form used in the prototype phase had been refined to focus more on particular aspects (for example: the problems being experienced by parents. The form was then sent to the parents to review. A questionnaire for children was also developed, if parents did not think meeting the child at this point was appropriate.

Overall, the demand for assessments had been continuing to increase in a similar, regular trend. Although the need for expansion of the team was recognised, it was felt that with the plans for regionalisation (still in their early days) there could be different options on how to manage and deliver this work.

Purchasing and funding

Staff had actively sought to continue to increase their knowledge of the local market. Providers either approached the local authority because they had heard about the Fund or they had been accessed through snowballing (i.e. recommendations of other therapists). Overall, the view was that the market could be better developed

Since the prototype phase, the team had expanded the types of therapies commissioned (such as creative therapies -art, music and drama-, Theraplay and DDP; some mindfulness, NVR, filial therapy, solution-focussed therapy and therapeutic life story work) as well as well as commissioning specialist assessments (e.g. Sensory attachment, storysystem and cognitive assessments). There was an acknowledgement that more could be done in terms of relationships with CAHMS.

Key learning and the overall impact

Before the Fund there were limits to what could be offered to families. The prototype phase enabled them to put in the right level of support, and this had continued over the course of implementation.

The increased demand created pressure on capacity. There was an acknowledgement that once regionalisation plans were in place, different options of on managing this pressure would be available.

Prototype Local Authority 5

The picture of local provision

This local authority could be described as having evolved a mixed trajectory of adoption support with increased training of social workers in therapeutic interventions. The team were described as being in a “temporary structure” due to the imminent regionalisation process. All staff were trained in Theraplay but they were providing the service at full capacity. They would require clinical supervision to increase in-house provision such as in DDP.

Implementation of the Adoption Support Fund

The implementation of the ASF had increased social workers time spent on commissioning external services. There had been a high take up of families of therapy funded through the ASF and families were now taking up the services much earlier and there were fewer applications for families in crisis. Overall it was felt the service was now able to respond in a more timely way to the needs of adoptive families. The aspiration of the service was that through the ASF they could better create a holistic therapeutic service in partnership with therapeutic parents that can predict needs and plan for them.

The service had raised awareness about the ASF at a high level in the prototype phase including local authority cabinet members and senior managers.

Key challenges in the implementation of the ASF had been:

- Changes to criteria;
- Different interpretations of criteria by different assessors or different outcomes for very similar cases; and,
- Software issues of the application process.

Gaps in the Fund scope were highlighted:

- Short breaks because this local authority believed they had an important therapeutic impact and wanted to make more use of these;
- Relationship support for adoptive parents; and,
- Training for schools.

Assessments

The BAAF assessment tool was being used and an allocated social worker led the assessment of need. They found that when an application for the ASF was suggested it was often brought up by the families who had a good awareness of their needs. In the cases of crisis or complex needs a triage appointment with a clinician would be arranged for a further assessment.

There had been more applications for assessments since the introduction of the ASF and the whole team had become experienced in making the applications.

Specialist assessments were now commissioned fairly routinely and the quality was regarded as high although there were issues raised about the high cost of specialist assessments.

Purchasing and funding

This team were purchasing a range of therapies including: DDP, family therapy, art therapy, life story, SafeBase, Theraplay, music therapy and weighted blankets for anxiety. NVR was identified as appropriate to meet the needs of families but was not available locally.

It was felt that the contracts with providers needed to be improved with better monitoring built in but that the team did not have the capacity to engage as much as they would like with their providers.

There were some framework agreements (e.g. a 3 year contract for SafeBase) and some spot purchasing. The ASF had increased their spot purchasing.

The in-house provision now funded through the ASF was Theraplay but the funding had greatly increased the depth and dosage of this. Also the specialist assessment for ASD was now much quicker.

Key learning and the overall impact

Overall this local authority had been able to expand its service to better meet the needs for therapy of adoptive families. At this point in time there were many changes being grappled with locally which were preventing the service from fully taking up the opportunities of the ASF.

Balancing the ASF scope and criteria with the needs of families was not always straight forward.

The needs of families were being met earlier than before the introduction of the ASF (prototype)

Prototype Local Authority 6

The picture of local provision

There were 4 staff dedicated to adoption support within a wider adoption team. Three were part-time social workers and there was one full-time administrator dedicated to adoption support and dealing with the rise in administration caused by increased assessments and applications for services through the ASF. These 4 staff had become experts on the provision of therapeutic support for adoptive families during the prototype phase but since then the expertise had spread wider in the adoption team. The team did not cover SGOs. This local authority aspired to have an in-house multi-disciplinary team model.

Implementation of the Adoption Support Fund

It was felt that the ASF enabled the service to provide a wider range of therapies such as NVR, music therapy, DDP and others. However, there were other therapies that they found met needs that were no longer in scope after the prototype phase such as therapy for the parents. The focus purely on the needs of the child without considering the therapeutic needs of the adoptive parents was described as limiting to their understanding of the centrality of family dynamics in the outcomes for adopted children “...it's not systematic”.

The ASF meant that families were able to access higher and longer dosages of therapy, however the Fair Access Limit now meant that expectations had to be better managed. The extension to pre-placement adoptions was also welcomed and described as “...good for continuity”.

Assessments

Assessments for adoption support were coming in mainly as self-referrals though the duty desk that dealt with adoption support including adopted adults. There had definitely been an increase in requests for assessment of need since the introduction of the ASF. It was felt that families were still coming to the team as a result of crisis.

The Adoption Support Service Advisor would then screen the requests and if eligible for support a social worker would visit and sometimes, if the case was complex, 2 social workers would visit. They used their own assessment of need form. The parents would then agree the assessment and the potential providers would also be involved. This process was described as ‘a conversation’ which was led by the

CAMHS adoption service to 'determine the pathway'. Regular reviews of post-adoption support were implemented.

Gaps identified in the assessment of need process were:

- Lack of resources to meet the demand in a timely way (there was a wait of 4-6 weeks); and,
- Not always being able to make a decision on support required that is screened by a therapist. Social workers would prefer that every assessment of need and application to the ASF had been screened by someone with clinical expertise.

Purchasing and funding

Identifying the right providers was still a challenge and this team had concerns about how this would become more of an issue with the extension of the Fund to SGOs. This issue had been escalated to senior management in the local authority. However, overall it was felt that knowledge of external providers had improved and this was ongoing as relationships and exchanges of information were improving with neighbouring local authorities.

Commissioning was on a spot purchasing basis but there was a desire for more planned commissioning. For example, the team had recently put in an ambitious retrospective application to the Fund to finance the CAMHS adoption service (established through the Adoption Reform Grant) to provide services for a large number of named children. This had been previously working on a case by case basis funded jointly by CAMHS and the local authority. They had believed that this would establish a preventative service that would meet needs in a more timely way. This was unsuccessful.

Specialist assessments were funded through the ASF for complex cases including cases where there was a paediatric assessment for ADHD or Foetal Alcohol Syndrome.

The team had been working closely with the education service through the virtual school and described the schools and virtual school as a good pathway for referrals. Building on this the ASF was used to commission training of parents in identifying blocks to learning.

Independent providers were checked for their OFSTED registration, qualifications and references. Experience of working with looked after children was a pre-requirement.

There was a concern from this local authority that some providers were capitalising on the Fund and the lack of competition, and that prices were rising without just cause. There was also a general issue raised about accountability and checks by the Fund management on audit of local authorities on their allocation of the ASF.

Key learning and the overall impact

The ASF had enabled the adoption support service to meet the needs of many more families and extend their influence of other statutory services (e.g. schools) to better support adopted children.

With the scope changes that had emerged between the prototype phase and the roll-out and during the early phases they had learnt to continually think about what was possible with the resources available to best meet the needs of local families.

Prototype Local Authority 7

The picture of local provision

This local authority prototype was a multi-disciplinary team of one full time and one part-time and it was incorporated with the adoption team, and integrated with CAMHS (through a Post-Adoption Psychology Service), other local authority services and a voluntary sector adoption support agency.

This local authority was developing a mixed delivery trajectory with strong in-house provision and commissioning of therapeutic services externally.

Implementation of the Adoption Support Fund

No changes had been made in terms of team size, although 2 staff were assigned from other teams such as family finding to the ASF tasks to manage the increased workload. One member of staff was assigned on a full-time basis, while the other staff were part-time. Apart from that the Post-Adoption Psychology Service had a small amount of time dedicated to the adoption support team within the local authority.

Staff completed online training for the ASF, but apart from that they followed a self-learning approach. Since the implementation of the Fund the team had learned a great deal about different types of therapies and in what cases they are appropriate, and about local service providers and how to liaise with them.

The whole process was described as being much tighter and formalised with a target time frame for each stage of the process, e.g. time between case allocation and contacting families. These changes in reference to timelines were made as part of a learning process to be able to manage the increased number of assessments in response to the ASF. To be able to track the journey from assessments to commissioning service provider a spreadsheet was set up which included information about the family, the service provider and information about costs.

To support the implementation of the ASF they also had started having more communication in the form of regular meetings with the finance team and the business support team. Additionally, they had newly established working agreements with the service providers and assessment of need expectations.

Improvements attributed to the ASF were:

- Assessments and services had become more child-centric than before the ASF;
- The local authority was able to offer services with a higher dosage, which offered the potential to improve the life of the children and families in a positive and long-term way; and,
- The process had become more adopter-led than before the implementation of the Fund with more regular communication with adopters throughout the assessment and application process.

Ongoing and new challenges included:

- As this was a larger local authority bringing relevant departments together, having regular communication was a challenge;
- The application website caused problems and occasionally it was difficult to complete the application;
- More resources were needed to meet the demand remained a problem. The admin team within the department was not large enough to take on the ASF related administration work in addition to the regular adoption administration work;
- They continued to experience challenges with some providers being oversubscribed. Well-known service providers had very long waiting lists, but other providers were able to meet the demand; and,
- The absence of regulations on service charges was also seen as an ongoing issue.

Assessments

Following the implementation of the Fund, assessment processes were tightened. Assessments for therapies within the scope of the ASF were undertaken via telephone and only in complex cases would a family visit be required.

The number of assessments continued to increase. Despite the challenges regular internal meetings and supervisions as well as the spreadsheet for the organisational level were helping them to keep on top of applications.

They had begun commissioning specialist assessments for complex cases to inform the type of therapy required, especially educational psychology assessments and holistic assessments provided through CAHMS.

This local authority had raised awareness on the professional side as well as on the adopter's side. In terms of the professional side they communicated this within the

department of social services as a whole and within their multi-agency safeguarding hub.

On the adopters side they had included information about the ASF in the adoption support package so that adopters were aware of the Fund as early as possible. The team also discussed the Fund during information evenings and preparation groups.

Purchasing and funding

It was felt that this local authority had a good and constantly improving understanding of the local market that is meeting demand.

As part of the ongoing implementation of the Fund they had increased the strength and the quantity of partnerships with other organisations (e.g. local service providers and CAHMS). As part of the preparation for regionalisation their relationship with other local authorities was also improving. It was felt that the team were satisfied with the provision of post-adoption support in terms of timeliness, duration, quality and type of support.

The use of different types of therapies had grown with increased knowledge Play-therapy was particular popular especially with younger children. Other therapies that were commissioned included filial therapy, Theraplay, therapeutic short breaks, music therapy, further assessments, therapeutic life story work, and SafeBase. Therapeutic parenting was delivered in-house through adoption psychology team.

Key learning and the overall impact

Key learning points for this local authority included:

- Putting in clear processes with timescales, even though they may need to be adjusted;
- Have regular communication with adopters to minimise anxiety and vulnerability;
- Be prepared for the time each application will take;
- Have as much knowledge as possible about therapies, what will be funded and about local providers;
- Have a good link with CAHMS; and,
- Undertake training to be able to deliver services in-house.

Future plans included:

- Visit every family to have the face-to-face contact;
- Embed signs of safety within the assessment of needs;
- Have an admin team that performs the administrative work; and,
- Regionalisation arrangements would provide life story training.

Prototype Local Authority 8

The picture of local provision

This adoption support team was small because it placed most children out of borough. There was a manager and 3 full time social workers. When the ASF was extended to pre-order this expanded the work. In-house provision of therapeutic support had always been strong with most staff trained in one or more therapeutic interventions and clear access to a specialist CAMHS team. There was less use of external commissioning except for out of borough placements. When adoption support expanded the team began to make more use of independent providers. Overall they provided a mixed trajectory of the ASF implementation of in-house and external services.

Implementation of the Adoption Support Fund

The team had recent training in Theraplay, story stem, life story and enhanced parenting. This had been planned before the ASF. The ASF represented a major benefit to a service that had been hit by austerity measures.

The administration of the Fund had been experienced as bureaucratic. Particular issues were:

- Overly cumbersome IT systems; and,
- Lack of ability/skills of the Fund assessors to grasp complexity of some cases

This local authority had a greater experience of SGOs and they had already extended their adoption support services to meet their needs. There was a concern here that there was a low level of awareness in this group of the ASF and the entitlement to the Fund. There had been a move towards group based therapeutic support since the ASF.

It was felt that CAMHS should be more proactively engaged with the adoption support team and that their support could have been more flexible.

They had good links with neighbouring local authorities.

Assessments

A combination of BAAF and the in-house assessment forms were used. They also used the MIM <http://www.theraplay.org/index.php/the-mim-assessment> to capture

the child's perspective. They had a 3 week turnaround target but this was not always possible. If urgent it would have been dealt with in a week.

Staff in this local authority felt that complex assessments were becoming more common since the introduction of the ASF.

Purchasing and funding

The external provision available in this local authority was described as "swamped" and it was felt that more support was needed in identifying quality providers locally. There was a review of the provision process and this was driven by value for money requirements.

Key learning and the overall impact

Because this team was small and most of their placements were out of borough they did not experience the ASF as having a great impact.

Prototype Local Authority 9

The picture of local provision

Prior to the ASF this local authority had restructured their team: from working generically on adoption, the team was assigned to specialist areas such as adoption-support and family finding. The re-structure did not happen as a result of the ASF, but it helped to embed the ASF and to be clear about what services could be offered. One social worker was reallocated from family finding to adoption-support to manage the increased work load within adoption support.

Most therapy was provided by the internal team but they also commissioned therapeutic services to external providers.

Staff were trained in Theraplay and Group-Theraplay at the start of the implementation of the Fund and they were about to receive training in DDP.

The ASF had created more administrative work and this increase had continued.

Implementation of the Adoption Support Fund

The major benefit of continuing to implement the ASF identified in this local authority was the ability to offer more therapeutic services to families and more flexibility to families. As a result of the ASF the staff had increased knowledge and expertise of different types of therapies which had improved quality and efficiency. Staff felt that benefits for families receiving support through the ASF were better outcomes for children and increased understanding and awareness of behavioural challenges of the children from the parental perspective.

On the other hand, one of the key challenges was the question around how the local authority could be more closely integrated in the triangle between service provider, child and parents.

Awareness of the Fund was raised through newsletters and information on their website and discussion at events and during the preparation training for parents.

As a result of the ASF the adoption support service were working more closely with the providers. They had also increased the links with other local authorities, CAMHS and colleagues across the region.

Assessments

At the beginning of the ASF, they had developed their own comprehensive assessment tool after reviewing their previous one and the one provided for by the ASF. This consisted of an initial assessment and a CORE assessment. In some cases the initial assessment was sufficient to identify appropriate support, in all other cases the CORE assessment provided an in-depth insight of the needs of children and families. In more complex cases CAMHS supported assessments.

Since the introduction of the ASF, the number of assessments had increased but it was felt that the number was beginning to level out. The ASF had driven a more efficient and outcome focussed assessment process.

Purchasing and funding

When the ASF was first introduced, they did not have a very developed market for therapeutic interventions. As part of the local authority consortium group (founded in preparation for regionalisation) they founded a procurement project team to establish an Approved Provider List (APL), which included information about what the providers offer, the costs, and the location. Due to this early work which included marketing events to support the development of the APL they were confident about their knowledge of the local market and about the capacity of the local market to meet the demand for therapies.

From the early stage of the APL they had extended the number of external providers they worked with and were able to form good working relationships with therapeutic service providers.

Key learning and the overall impact

Although the ASF had improved local services this local authority raised concerns about the Fair Access Limit and its impact on the development of the local market.

Prototype Local Authority 10

The picture of local provision

The adoption support team comprised of 6 full time social workers and there were a large number of adoptions in this local authority. Prior to becoming a prototype for the ASF there had been investment in training of staff (e.g. Theraplay) and in-house capacity had been expanding since.

This local authority was developing along a trajectory of in-house provision.

Implementation of the Adoption Support Fund

This local authority had been finding the scope changes challenging, in particular providing support for secondary trauma of adoptive parents when support for parents did not continue after the ASF rolled-out nationally. The founder view was that the boundaries of scope of the Fund were not in-line with the needs of adoptive parents and that the lines between therapy and physical support needs were somewhat arbitrary. For example, a Foetal Alcohol Syndrome assessment could only take place as part of a multidisciplinary assessment.

The team were having problems with the applications resulting in many being rejected.

Capacity of the service was a growing problem as parents' expectations had grown.

Assessments

In the prototype phase the team used a BAAF assessment but later, decided to use their own which they considered more holistic. The assessment had a waiting time of 6-8 weeks for the first appointment but was then taking approximately 10 days to complete. The demand for assessments had been increasing.

Purchasing and funding

Spot purchasing had been the method of commissioning service and there was still work in progress around aligning this with wider local authority procurement best practice. A key challenge identified in this local authority was finding providers. Sensory integration therapy was in high demand from families, and therapeutic parenting, play therapy and DDP were showing increased demand as a result of the

ASF. Waiting lists for the ASF provision had developed. The relationships with providers was described as good and they regarded them highly but felt there was a negativity promoted towards the local authority by external providers. It was felt that the position of providers was ambiguous as they advocated for services for families and also provided that service,

It was felt that there could be more support provided on commissioning through the Fund.

Key learning and the overall impact

The experience in this local authority had been mixed. Whilst they had seen major benefits to families since the ASF including definite avoidance of adoption disruption they were still struggling with implementation. There was considerable concern around the extension of the Fund to SGOs.

Appendix 7 – Family Sketches

1. The Anderson Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Eleanor and Geoff had a birth daughter, 12 year-old Natalie and adopted 7 year-old Daniel when he was 16 months old.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Having had 2 previous foster placements, Daniel arrived exhibiting aggressive behaviour and physical outbursts towards others continued as he started nursery and primary school.</p> <p>The family sought and was offered help from a variety of areas. When Daniel was a toddler, he and Eleanor attended a toddlers group for adoptive children, but this was stopped due to funding cuts. Eleanor and Geoff attended parenting training and courses on subjects such as Foetal Alcohol Syndrome (FAS). Eleanor also attended a support group for adoptive parents, as a result of asking the Adoption Support team at the local authority for help. Daniel was offered one-to-one art therapy through his school, following an assessment by an educational psychologist, as well as Occupational therapy assessments through the health service. Although the Art therapy lasted 18 months and the parents used techniques recommended by the Occupational therapist (OT) team, the problems with Daniel's violence and aggression towards others continued.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>Eleanor heard about the Adoption Support Fund through word of mouth and approached her social worker, who was aware of the family already, and who visited Eleanor to discuss an application and assess the family's needs. This first meeting took place within a few weeks. At the meeting, Theraplay was suggested by the social worker as appropriate, and after doing some independent research, Eleanor agreed this was what she would like to access for Daniel. However, there were no Theraplay therapists within the local area so the social worker instead suggested an Occupational Therapy assessment.</p> <p>Eleanor had previously met an occupational therapist (OT) who she respected and so this therapist was approached. An initial assessment was done through</p>

completion of a form by the parents and Daniel's school, followed by Daniel and Eleanor meeting the OT for an in-depth assessment. A report was then compiled by the OT, which identified Daniel's difficulties and gave dyspraxia and sensory processing disorder diagnoses. The report recommended 2 different programmes for Daniel, including a sensory processing therapy. It took between 3 to 4 months between the social worker visit and the assessment meeting. At the time of the first interview in February 2016, the family were waiting for funding to be awarded for Daniel to attend ongoing therapy, 2 months since the assessment.

Eleanor had not received any further information about the therapy or how long it might last for. Although pleased with being offered this therapy, Eleanor believed it would have been helpful 2 years before. However, at this age it would be better than later in Daniel's life. Other support that Eleanor believed would be useful included groups or events where adoptive families could meet up, where the children's behaviour was understood and offered a more relaxed environment than mainstream family provision. Additionally, Eleanor wanted to see specific support for birth children of adoptive parents, as Eleanor believed the needs of these children could be ignored. Meeting others with adoptive siblings would be helpful.

Eleanor hoped that as a result of receiving therapy, Daniel would gain a better understanding of himself and that she and Geoff would learn some new tools for dealing with his behaviour.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

The family were unable to be interviewed due to family ill-health.

Recommendations and final views on the ASF

Eleanor thought families could be put off from asking for help because they might feel they didn't deserve it and might be considered a fraud by the services.

2. The Davidson Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Sandra and Ed Davidson are parents to their 15 year-old birth son, Andrew and 9 year-old adoptive son, Richard, adopted at the age of 5.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Removed from his birth family at the age of three and a half, Richard had experienced significant neglect and chaos during his early years alongside his 8 half-siblings. His birth mother died of a drug overdose at the time Richard was adopted. On being placed, Richard displayed a range of disturbing behaviours, including violence and aggression, compulsive lying, stealing, an inability to allow other people control and sexualised behaviour. It took a long time to piece together Richard's history because of poor administration and record-keeping. However, the placing authority provided ongoing, regular visits from an independent social worker, which have continued since. Sandra also attended a support group for a while. Apart from this, the family felt they were left to manage alone and didn't consider approaching the post-adoption team for help.</p> <p>Gradually, home life did settle down and some of Richard's behaviour calmed, but the aggression and sexualised behaviours continued, and were becoming increasingly unmanageable. Despite their support, the school felt it had no option but to temporarily exclude Richard. Sandra and Ed were aware that a permanent exclusion was possible if things continued but were struggling to cope, which was then affecting their relationship. In Summer 2015, their social worker was due to visit to discuss life story work, but by this point, Sandra and Ed felt the adoption was at risk of breaking down.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>At the planned meeting with the social worker, Sandra and Ed discussed the problems they were facing and the ASF was suggested by the social worker, who made a referral to the local, host area's post-adoption team. They met with Sandra and Ed and organised the ASF application quickly. A referral was made to a psychotherapy agency, that assessed the family within a few weeks and the ASF funding was awarded in October 2015 for open-ended Dyadic Developmental Psychotherapy (DDP) and Drum therapy. However, Richard made an allegation during one session and so a social care investigation had to be undertaken. Once this was concluded, 5 months later Sandra and Ed began 6 sessions with the DDP</p>

therapist, which were underway at the time of the first interview, and would be followed by ongoing sessions with Richard. They also expected to receive between 30 to 40 sessions of family drum therapy, which would also include Andrew.

Sandra and Ed felt they were well supported by workers within both their placing and host authorities, although administrative burdens and safeguarding procedures were slow and cumbersome. They thought it would be better if responsibility was handed from the placing to the host authority more quickly following adoption. They trusted their social workers to suggest the appropriate therapy, but felt more could have been explained about the different therapy choices available. However, despite the wait for therapy and a concern that sessions with Richard could have started sooner if the social care investigation had been quicker, Sandra and Ed were pleased to receive support and felt that some things had improved already. They felt they were coping better, and hoped that Richard would understand and cope with his feelings and relationships better. They feared that without support, the consequences would be horrendous. They hoped that support would be beneficial to the family as a whole, including their marriage.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Nine months later, the family had received about 20, usually weekly, DDP sessions and 5 Drum Therapy sessions, which were stopped because of the Fair Access Limit being brought in. Although they still faced daily challenges, life felt calmer at home and violent episodes were less frequent. Sandra felt less depressed and more empowered and confident as a parent. Both parents felt better equipped to cope with Richard's behaviours and felt that Richard had greater self-awareness and sensitivity to the effects of his behaviour on others.

Although the drum therapy gave some enjoyable time for the family as a whole, Sandra and Ed were not worried by it stopping, particularly because the drum therapist wrote a report at the end of therapy, which indicated a poor understanding of their situation. Post-adoption workers agreed that it wrongly focused on parenting rather than the range of complex issues faced by the family. Sandra and Ed complained about the report and felt let down by the therapist. In contrast, they felt very well supported by the DDP therapist, who wrote notes following sessions and shared these with the post-adoption team and family. Richard built a good bond with the DDP therapist, who changed mid-way through, and this enabled Richard to express his sadness at the time. Sandra and Ed wanted to be able to apply for further funds, and had discussed with social workers what would be needed in the future. However, they understood that social workers

were stretched because of the increase in families asking for support and having to re-submit the ASF applications, leading to delays. They were concerned as to whether the ASF funding would continue to be there for them in future years. Sandra and Ed thought that some families who did not have the right social worker support, might not get the help they needed.

Recommendations and final views on the ASF

Sandra and Ed believed that pre-adoption all families should be talked to about future support needs and discussions about potential challenges made more explicit. They thought a standard support package should be in place for everyone, and the ASF should be more flexible in what could be funded such as additional tutoring to support education. A barrier for families was seen by Sandra and Ed as being the lack of information given about the ASF to families and their fear that they might be judged if they were struggling. Sandra and Ed also raised the issue that if adoptions increased, there will be a greater demand for the ASF support and this needed to be considered. Additionally, families needed good social worker support to be able to identify the right support package for them and make successful ASF applications.

3. The Taylor Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Sonia and Neil adopted siblings, 11 year-old Craig and 9 year-old Simone when they were aged 6 and 3 respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Craig and Simone were removed from their birth family when Simone was newly born, and moved to a foster home with their older brother, while their younger brother was placed elsewhere. Because Craig and Simone's older brother had taken on the role of a parent, it was decided it was best for him to be adopted separately. However, contact has been maintained with him since. The children had been severely neglected due to their parents' drug and alcohol addictions. On adoption, Sonia and Neil were given very little information about Craig and Simone's past. It was only as they witnessed the children's extreme reactions to minor events, that they became aware of the trauma previously experienced, which had included witnessing parental violence. Sonia and Neil felt that perhaps information had been withheld by the authorities in order to progress the adoption. However, they got on with parenting the children and felt they were managing until Simone started school and was about 6 years old.</p> <p>Unbeknownst to Sonia and Neil, while Simone's behaviour was fine at home, she was increasingly getting into trouble at school. She struggled to concentrate in class and was verbally aggressive to her peers, which led to her newly qualified teacher punishing Simone, for example by sending her to the back of the class. Simone's behaviour got worse. After 6 months, Sonia and Neil became aware of this at a parents' evening and spoke with the teacher to encourage them to take different approaches in dealing with Simone's behaviour, but this had no effect. The teacher continued with traditional approaches, including shouting at Simone which resulted in Simone dissociating. Despite the parent's continued attempts to resolve issues with the school, things didn't change and the relationship between parents and school became increasingly hostile. Sonia and Neil approached the post-adoption team for help. Another 7 months went by before help from social workers was provided.</p> <p>A family liaison worker, who knew the children prior to their adoption, arranged meetings with the school, a psychologist to train teachers about appropriate behaviour management for children like Simone, and an educational assessment, which identified that Simone was educationally able to achieve. The situation at school immediately improved, avoiding a school change. Sonia and Neil felt</p>

vindicated in having challenged the school and supported by social care in getting the school to listen. However, both parents recognised that Simone was continuing to experience underlying anger issues. About a year later, in winter 2015, Simone started to have daily outbursts of rage at home, which she seemed unable to control. She also appeared extremely anxious, demonstrated through an inability to control her toileting, particularly around school-times. When there were school holidays, these problems disappeared.

Whilst they had been prepared, at the time of adoption, for Craig's behaviour to be more problematic because he was older, Sonia and Neil experienced the opposite of this, with Simone seeming to be more affected by early experiences. Sonia and Neil thought, on reflection, that perhaps Simone's memories were more unconscious and therefore harder for her to process and understand.

Since adopting Craig and Simone, Sonia and Neil funded private tuition for each child at different stages as they could see both children were struggling educationally, in comparison to their peers. Additionally, they funded a range of after-school clubs, which they saw as essential to support socialisation and confidence building. However, they couldn't afford all of these activities and tuition for both children at the same time and were frustrated that Pupil Premium couldn't be used to support adopted children in this way. Their experience was that Pupil Premium raised expectations of additional support but once it reached the child, it didn't provide what that individual needed, with funding allocation determined by the school.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

In Winter 2015, Sonia contacted the family liaison worker they knew from the post-adoption team to ask for help. The worker suggested that the ASF could support them and explained that it could fund a range of different therapies. Sonia and Neil felt hopeful that they would be able to access some consistent support and that creative therapies could be ideal for Simone. However, there were a number of barriers to this support. For example, both Sonia and Neil were employed in shift-work and so they weren't able to take Simone to a local creative therapies group offered for children on a weekly basis and so didn't access this provision. Having been sent a brochure of different training for adoptive parents, they did access some of this for themselves, and were referred to a trainee psychologist who was allocated to do life story work with Simone at home.

Sonia and Neil didn't find the training offered by their local authority very helpful as they already knew the information being shared and they seemed more tailored to foster parents. The psychologist met with Simone 3 times, and the work started

well, with Simone enjoying the visits, engaging with life story work. Neil and Sonia were pleased with progress. However, on the third session, the trainee informed them that her placement was finishing and she would no longer be working with them. A follow-up review meeting was held with Sonia and Neil, where they asked for work to continue as it seemed to be going well. The worker again suggested a range of different therapies and this was followed by an email suggesting mentalisation therapy for Simone and informing that someone would be in touch. At the time of interview, about a month later, no further contact or support had been received. Sonia and Neil believed that the post-adoption services thought that their situation wasn't so bad to need help, and it appeared to them that they needed to be at a crisis point, to receive help. Although they felt that individual workers were responsive and tried to help, the system was not set up to help prevent crises. Although they knew they could contact the workers when they needed support, they would prefer their case to be kept open and to have a regular review with workers that was planned rather than depending on them making contact with already stretched workers.

At the time of the first interview, Sonia and Neil were preparing to make contact with the post-adoption team again. They felt that their expectations had been raised by the potential of the ASF support, only to be deflated. They also felt that although the 3 life story sessions had gone well, these were only just beginning and that a more creative form of therapy might help Simone in addressing and coping with some of her feelings. Simone's underlying anger, her behaviour and toileting had not been explored. Sonia and Neil believed that Simone was feeling the effects of the sudden disappearance of the psychologist, who had subsequently sent a letter to Simone, but Simone refused to read it. They were currently waiting for a meeting with a specialist paediatrician in the hope to find support for Simone with her anxiety and toileting.

Sonia and Neil felt that the ASF provision so far had been very inconsistent, without clear communication on what they could and couldn't have access to. They wanted a plan of some kind, with reviews in place that enabled them to access the support needed before a crisis point was reached. They also thought the ASF could help fund a wider range of support, and work better with Pupil Premium to meet the range of educational and emotional needs of adopted children.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

The family were unable to be interviewed because of family ill-health.

Recommendations and final views on the ASF

Sonia and Neil believed that the system in general was set up to deal with crises rather than prevent them. With relatively small amounts of money, and more thorough assessments, children like Simone could be supported before the situation becomes more damaging. Sonia and Neil thought that the ASF could support an annual review for families, to give parents an opportunity to discuss how things were going, let off any steam and think about and plan for any support that might be needed. They also thought that the ASF provision should be transparently promoted and explained to adoptive families, as many wouldn't know about it if they did not ask for help.

4. The Baker Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Janine and Samuel adopted 9 year-old Terry, when he was 21 months old.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
Terry was placed in foster care from birth until being placed with Janine and Samuel, at which point contact with both birth and foster families stopped. Although initially quiet and compliant, as Terry got nearer to starting school, he displayed signs of anxiety and anger. A therapist was provided by the placing authority and this helped Terry at the time. However, when changing schools at the age of 6, Terry became more violent and so a post-adoption worker undertook some life story work with him. Janine was told that Terry's behaviour wasn't bad enough for a CAMHS referral. Whilst Terry was well-behaved and compliant at school, he struggled to sleep at night, became over-excited at new events and increasingly hit out at his parents. Christmas 2014 was incredibly difficult and life continued to get harder. The family felt close to breaking down.
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>In April 2015, Janine and Samuel contacted the local authority for help and were told about the ASF. The post-adoption worker discussed what could be applied for and arranged an application. They and a clinical psychologist also visited the school to explain reasons behind Terry's behaviour, which was a big support for the parents, and the post-adoption worker continued some life story work with Terry. A referral was made for Janine to receive filial therapy and for the whole family to receive Dyadic Developmental Psychotherapy (DDP). Filial therapy began in January 2016 and DDP began with just Janine and Samuel before the first interview in May 2016. Terry would join them later on.</p> <p>Janine and Samuel felt it took too long between asking for help and therapy starting, especially as they needed help a couple of years before. However, they felt involved in the process of choosing the most appropriate therapies and already felt that life was improving. Having learnt new techniques through filial therapy and used these at home with Terry, Janine felt that her understanding of Terry's trauma increased and that she was able to help Terry express some of his emotions in a safe environment. The DDP sessions were also helping Janine and Samuel understand the link between their past experiences and current responses</p>

to Terry. Going through family therapy required significant commitment from both parents and Samuel was grateful that he had a supportive and flexible employer.

School staff participated in training on attachment issues and the family were feeling more supported by them. Janine and Samuel were hopeful that Terry's next transition at school would be smoother and that other children dealing with loss or trauma would also benefit. They hoped that as Terry got older he would be better able to cope with challenging life changes and avoid poor life outcomes. However, they understood that this would need continued support and that things might get worse before they got better.

Janine and Samuel felt that through the ASF support, they and their family's needs were being understood for the first time.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Seven months later, although the Baker family continued to face challenges and periods such as Christmas could still be difficult, Terry's outbursts were fewer and he was able to talk more about his feelings rather than act them out. Because the filial therapy had been so useful for Janine, Samuel had since undertaken the same training himself and Janine had also attended attachment training. The DDP was continuing and now involved Terry. Both parents were really pleased with the support received although it was very demanding. Janine had to attend the therapy centre 3 times a week at times. They agreed that the process was proving beneficial for Terry but it was also sad to see the trauma he had to deal with. Janine and Samuel believed that they had developed their skills, were able to reflect more and felt that they were getting better at therapeutic parenting, which was subsequently helping Terry articulate himself. However, they also commented that it was painful when they knew they had made a mistake, because of their increased awareness.

Unfortunately, since the first interview support from the school had deteriorated. Since the new school year, the family were struggling to get the understanding and help within education, because it seemed that Terry behaved well at school. Additionally, the family's post-adoption worker had been withdrawn as the family had been told their needs were not high enough. However, they knew they could contact them if needed and that their DDP therapist was supporting them through their ongoing therapy. Although pleased with the support and the ASF process they had experienced, Janine and Samuel were concerned that families could be put off from applying, because it could be so difficult to get contact with over-stretched social workers. They also thought that having to ask for help could itself be a barrier, when it was difficult to admit there were problems that were difficult to manage alone.

Janine and Samuel were relieved that their package was awarded before the cap came in, but were aware of other families who were unable to access funds to meet their needs. They hoped that they would have support as long as it was needed.

Recommendations and final views on the ASF

Janine and Samuel were delighted and relieved to have the ASF support and believed that without the ASF, the adoption could have broken down. They believed strongly that all adopters should undertake in-depth attachment training following adoption. Although aware of funding restrictions, Janine and Samuel also thought more support for parents was needed, such as specialist childcare, or respite breaks.

5. The Wilson Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Suzanne adopted siblings, 16 year old Lorraine and 13 year old Dean, when they were 8 and 6 years old respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Dean was aggressive from early on in the placement. This was linked to a birth family experience, characterised by neglect. Lorraine was quieter and seemed to settle quickly. Dean's behaviour improved though, as he responded well to Suzanne's parenting and music therapy input arranged by his adoption agency social worker when he was 6. He formed a positive attachment to Suzanne and was not accessing the ASF support. At age 11, Lorraine's behaviour changed, becoming physically and verbally aggressive. Although the family had settled periods over the next 4 years, there were increasing episodes of aggressive, often violent behaviour from Lorraine towards Suzanne. A short programme of therapeutic support was provided through CAMHS for Lorraine in 2012, alongside some advice for Suzanne, which was experienced as unhelpful because the professionals lacked understanding and implied she was to blame. By Summer 2015, Lorraine's oppositional behaviour was getting out of control and difficulties included self-harming, lying, stealing, demanding to go into care, coming home late, resulting in police involvement.</p> <p>Suzanne found reading about early trauma and neglect increased her understanding of the impact of Lorraine's earlier childhood experiences on her behaviour. Suzanne also maintained contact with the original adoption agency which had provided support for the past 8 years. She was also well supported by a close group of friends.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>In autumn 2015, Suzanne approached her post-adoption worker for support, who suggested and arranged an ASF application. In September, there was an assessment meeting with the local authority and adoption agency. By November, Suzanne had met and had the family's situation assessed by a therapist, and in December family therapy began for Lorraine and Suzanne. After a few months of regular therapy, attachment issues were revealed as well as serious disclosures from Lorraine that she was in regular contact with her birth family through social media. In spring 2016, following several</p>

reported incidents to the police of violent threats from Lorraine, an urgent request was made by Suzanne for Lorraine to be placed in temporary foster care. However, Suzanne experienced a slow response from the local authority social worker who took no action until Suzanne was physically assaulted in April and Lorraine was arrested. A referral was made to the youth offending team (YOT) and Lorraine was placed in foster care. One YOT worker supported Suzanne, whilst another supported Lorraine. These meetings helped Suzanne realise that she could no longer accept Lorraine's violence. At the time of interview, in May, Lorraine and Suzanne were about to meet again at their first therapy session since March.

Suzanne was anxious about how the session would go, but was hopeful that the therapy would help (until the package was due to end in July), while Lorraine was in foster care. The therapy helped Suzanne better understand Lorraine's behaviour and provided strategies to manage the behaviour. However, Suzanne was worried that the help may have arrived too late to help Lorraine and enable her to return to the adoptive family home. On reflection, Suzanne could see that there were signs of attachment issues in Lorraine's earlier childhood behaviour but that this had not been obvious at the time. Suzanne reflected that it might be useful to get some ASF support for Dean in the future to deal with the disruption to their family and any bottled up feelings he may have about his early childhood experiences.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Six months later, Suzanne recalled that the therapy session with Lorraine did take place at a friend's house as a neutral venue. Lorraine didn't want to attend but did reluctantly. It was agreed to cease therapy because Lorraine didn't want to engage. Lorraine remained with the same foster carer, who Suzanne felt could do more to encourage Lorraine's engagement with therapy. However, Suzanne continued to meet with the therapist, on one occasion with Dean. Although reluctant to engage, with encouragement from Suzanne, he did. Since the package of support ended in July, Suzanne had received telephone support as needed. The therapist completed a report following the therapy, which was being used to inform Lorraine's long-term care plan, who was now officially recorded as being looked-after. The report also recommended continued support for Suzanne and Dean, in dealing with their loss and grief for Lorraine. However, so far Dean seemed to be coping well but Suzanne was aware that support may be needed in the future.

A number of multi-agency Looked-After Child (LAC) meetings had taken place but Suzanne had found these unfocused, with professionals lacking understanding of

the family's history, situation and issues. Phone contact had continued with Lorraine (mainly Lorraine ringing Suzanne), but these had been difficult because Lorraine was still angry and verbally abusive towards Suzanne. Suzanne had ensured that Lorraine had contact with Dean e.g. visits to the cinema, and contact with their 3 other adopted siblings had been maintained. The social workers had not arranged for any structured contact between Suzanne and Lorraine while Lorraine was in care.

Professionals at LAC meetings and the foster carer felt that Suzanne should take Lorraine back home, because Lorraine expressed a wish to return home. As much as Suzanne missed Lorraine, Suzanne was aware that Lorraine could not return to her adoptive home before Lorraine received a lot of therapeutic support to deal with the attachment issues driving her violent behaviour, which had impacted on Suzanne's emotional and mental health. The YOT support was continuing, and following individual support for Suzanne and Lorraine, the next stage was meant to bring mother and daughter together through mediation work. However, this work stalled, due to a lack of social worker support. It was hoped that this work would take place in the future.

In the meantime, Suzanne was concerned that without therapeutic support, Lorraine was at risk of continuing to engage in unhealthy behaviour, having contacted her birth mother and her partner. To safeguard Dean, the siblings were not allowed unsupervised contact. Lorraine had been referred to a therapist through CAMHS. Suzanne was not sure if therapy had started and hoped that, when it began, it would help Lorraine process everything she was going through.

Although Suzanne was still grieving for Lorraine, she felt that the therapy through the ASF had been invaluable in managing this devastating experience. It had helped her understand that, although Lorraine's behaviour was driven by attachment issues linked to early trauma, it was not acceptable for Suzanne to be verbally and physically abused. The therapy had helped her reassure Suzanne that her parenting was not to blame. It had helped her understand that parenting of the extreme behaviours exhibited by Lorraine, required a different order of support. Suzanne had been able to continue loving and supporting her daughter despite the difficulties.

Whilst Suzanne had valued the ASF support, earlier intervention might have prevented this situation happening. Additionally, the local authority's adoption team department had been experienced by Suzanne as disorganised and inadequate, in their processing of the ASF application, the lack of urgency to provide therapeutic support for Lorraine in foster care and unsatisfactory management of LAC meetings. Suzanne recently complained to the local authority because there seemed to be no social worker visits to Lorraine since being in foster care. Suzanne had to chase the local authority social workers, experienced poor

communication from her daughter's social worker and line manager, which had left her feeling frustrated and marginalised. The lack of follow-up actions after meetings was concerning. However, Suzanne was grateful for the ongoing support from the adoption agency who did respond and supported wherever they could.

Recommendations and final views on the ASF

Suzanne suggested that social workers needed more training around completing the ASF paperwork to avoid delays and that all adoptive families should be offered some form of support and ongoing contact, ensuring early intervention to prevent crises.

Suzanne hoped that the ASF continued and that it would be there if needed in the future. It was also recommended by Suzanne that:

- mainstream services for children and young people become better equipped to work with adoptive families, especially those with teenagers. Targeting of contact and support at these important times would help.
- Post-adoption support is made mandatory for both services and families to engage in – such as an annual review and better signposting to support.
- Professionals need to be better trained to improve their understanding of the difficulties faced by parents, caring for adoptive teenagers with extreme behaviours.

6. The Sayer family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Karen and Jonathan Sayer adopted 9-year old Steven when he was 6 years old.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Since being removed from his birth family aged between 2 and 3, Steven lived with one foster carer, a time split by an adoptive placement that broke down after a few months. The foster placement went well and contact with the foster family was maintained. Steven began school just before being placed with Karen and Jonathan and had been identified as behaving hyperactively because of anxiety. Steven struggled with bonding, in particular with Karen, from the beginning. Additionally, Steven struggled to play alone and would rapidly shift from expressing affection to anger, particularly when he couldn't be in control, or had to do homework or get dressed for school. A post-adoption team psychotherapist visited the family a couple of times. Although Steven didn't engage, Karen and Jonathan received some advice but felt this wasn't sufficient.</p> <p>The school arranged for an assessment for ADHD, which Steven was diagnosed with. Karen and Jonathan felt that Steven's attachment difficulties were more of a challenge for them. However, Steven received teaching support in school and access to after-school clubs, and he was achieving well academically. Karen rang the post-adoption team for help intermittently but nothing was available. Steven's behaviour became increasingly challenging.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>Karen contacted the post-adoption team for help in July 2015. A social worker visited the following month and suggested that Theraplay might be suitable. They organised a Theraplay practitioner within the team to visit and assess the family in Autumn 2015, who agreed to undertake a longer assessment, including school visits, before Christmas. However, due to the therapist's ill-health, this wasn't completed until February 2016. Theraplay sessions began but the therapist was due to retire, and so the post-adoption worker suggested an application to the ASF to support the therapist's continued work with the family as an independent practitioner. Karen and Jonathan had not heard of the ASF until then. After 4 sessions, the therapist retired, and there was a break until funding was approved in April 2016. At the time of the first interview in June, another 4 sessions had</p>

taken place involving the whole family and another 8 sessions were expected. Both parents were hopeful that they could apply for another package when this was completed.

Karen and Jonathan were pleased with the support so far and felt their needs were being understood by the therapist. Sessions were more regular now, Steven enjoyed going to them and both parents felt they were getting as much out of the therapy as Steven was. Jonathan acknowledged that he hadn't felt the need for this support prior to starting, but had found it beneficial, with both parents learning new tools and coping strategies. They also felt the therapy was helping Steven attach with Karen, and Steven's concentration was improving.

It was hoped that Steven would improve his social skills and anger management through Theraplay, leading to better relationships, a calmer response to events and a smoother transition to secondary school. Whilst they didn't know whether to expect longer-term change, both parents were happy the support was in place and helping them now. However, they felt that the post-adoption worker could have explained more about the ASF and the choices of therapy it funds.

The school also started providing Lego Therapy, which Steven took part in with other children.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

The family were unavailable to be interviewed for the second interview.

Recommendations and final views on the ASF

At the time of the first interview, Karen and Jonathan thought the biggest barrier to families accessing the ASF was lack of knowledge about it. They believed that all adoptive families should receive information about help available and what it involves automatically. This should also include information about other support such as Pupil Premium. They also felt that support should not be reliant on families chasing it and they raised concerns that cuts to social care were leading to expertise being lost.

7. The Connolly Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Samantha and Joe Connolly adopted 7 year-old twin sisters, Robyn and Tamara when they were 3 and a half.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Samantha and Joe initially faced challenges associated with being new parents, as their lives changed considerably after Robyn and Tamara arrived. Samantha stopped employment to be at home, which meant a reduction in disposable income, the family moved to a bigger house and from the start, the parents noticed unhealthy attachment behaviour from both girls, but which manifested in unique ways. Whereas Tamara was quiet and withdrawn, struggling to express her feelings, Robyn struggled to regulate her emotions, whether anger or excitement. This provided parenting challenges as Robyn got more attention as a result. Special events such as birthdays and holidays were particularly difficult for the sisters and they both struggled with building friendships. Pre-adoption, telephone support was provided but this wasn't experienced as helpful because Samantha and Joe felt the pressure to demonstrate that they could cope and would be good, adoptive parents. This support stopped at adoption and the family felt left to carry on alone, not considering to ask for help as they were so busy coping from day to day. They had also seen how difficult the girls found all of the professional visits during the adoption process. Bringing more support in wasn't something that the parents would have encouraged because of the potential disruption, as well as their own fears of being judged as unable to cope. The first 6 months post-adoption were traumatic for Samantha and Joe as they started to see how traumatised their children were. Although they didn't know what to do, they did know that traditional parenting styles were not going to work. Without networks of support around them, they felt isolated and looking back could see that additional support was needed the early stages of adoption.</p> <p>Before starting primary school, Robyn and Tamara were given social worker support from a pilot programme, funded by the local authority and the Department of Health, to support this transition. It enabled the family and school to agree on how best to support both girls within education and led to the implementation of a Reducing Anxiety Management Plan (RAMP). Support continued until Summer 2015 when funding ceased. The family found this programme and the school to be very supportive. However, it focused only on the children within education, and so no help was provided for the family's challenges at home, which Samantha and Joe believe related to anxiety around school. For instance, both girls resisted</p>

going to bed at night, exhibited distressed behaviour in the morning and as they were getting older, seemed increasingly immature next to their peers. Therefore, in summer 2015, the school contacted the local (host) authority and Samantha contacted their adoption agency to request additional help. As they were within 3 years of adoption, the family were advised to approach their placing authority for the ASF support. The school struggled to get help from the local authority because of the responsibility held by the placing authority. Nonetheless, somehow the school and local authority organised an educational psychologist assessment. The psychologist looked at the girls' files, but didn't meet the family. They suggested that the girls might need diagnoses of dyslexia and/or dyscalculia and recommended play therapy.

Samantha and Joe don't know how the support was funded and found the experience very disjointed, without clear communication about what was going on. The play therapy was provided at school but at the time of the first interview, Samantha and Joe didn't really feel that this met the girls' needs.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Following the request in Summer 2015 for help, a social worker from the placing authority visited Samantha to assess the family for the ASF support in February 2016. They then applied for the funds and referred the family to their adoption agency for the ASF support. A worker from the adoption agency visited the family a few weeks before the interview, in May 2016. Samantha and Joe mentioned Theraplay and the worker suggested they be referred for Theraplay and Life story work. They discussed a programme of therapy which would start with 6 sessions for the parents alone, followed by 21 whole-family sessions. Samantha would have liked to have been offered some therapeutic support herself as well but was hopeful that support for the girls would also help her in her role. At the time of interview, the support had not been confirmed in writing and so Samantha and Joe were unclear if they would be getting this.

So far, Samantha and Joe did not feel the assessment process had been holistic or thorough enough. They didn't feel that their families' needs had been fully understood or met as yet. They were concerned that the therapies identified might not be appropriate. Theraplay was their suggestion but they knew they were not experts. They therefore requested a multi-agency assessment involving the placing and host authorities, the school, the adoption agency and parents. This was due to take place at the time of the first interview and it was hoped that the therapy programme would be confirmed and start following this.

Now that the adoption agency was involved, Samantha and Joe were feeling better supported and hopeful that the therapy provided would help Robyn and Tamara's confidence and self-esteem increase, as well as give Samantha and Joe new strategies, increasing their skills in being able to support the girls. They hoped that the support would continue for as long as necessary.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Six months later and life had improved both at home and school. The multi-disciplinary meeting took place as planned and the ASF support was confirmed as therapeutic life story work and therapeutic parenting support. The play therapy at school, funded through Pupil Premium, had been taking place weekly for one hour with each child separately. This would stop as soon as everyone involved believed it had achieved as much as it could for now. Robyn and Tamara were happier and more relaxed, as were Samantha and Joe. So far, 5 sessions of the life story work had taken place approximately every other week, involving both sisters and Samantha, and had focused on building the relationship with the therapist. Samantha and Joe felt that the work was only now really starting, and the girls looked forward to the sessions. However, they were unclear as to how much support was funded, as it had not been confirmed in writing. As far as they had been told, there would be 12 sessions in total and they were unsure as to what might happen after this. Samantha suspected that the work would not be complete by then.

Another multi-disciplinary meeting had more recently taken place, where responsibility was handed over from the placing to the host authority. However, the family had been informed that upcoming regionalisation would affect the support available from the host local authority. They were concerned that regionalisation could mean that their local authority's good standards drop in order to become equivalent with other nearby local authorities that they believed didn't offer the same high quality of support. Whilst pleased with the support they had, Samantha and Joe wished the communication could have been clearer and not so reliant on the parents doing the chasing and liaising between different agencies.

Recommendations and final views on the ASF

If Samantha and Joe hadn't kept informed on adoption issues, they wouldn't have known about the ASF. They believed services could be better at telling families about the ASF, what it was and who was eligible. They also believed that therapeutic support for parents would help as adoption could have unnoticed impacts on the parents' mental health. Finally, Samantha and Joe raised the concern that a rush to access and spend funding while it was available, could mean that assessments for

the ASF support did not take a holistic, multi-agency approach to understanding what the problems were and identifying the best support in the circumstances. As a result, they thought that money could be wasted on inappropriate therapies. If assessors were knowledgeable about different therapies and who they may work best for, and involved the different relevant agencies, this potential waste could be avoided.

8. The Bolton Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Petra and David adopted siblings Simon, aged 14, and Luke, aged 12, when they were 5 and 3 years old respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Simon lived with the boys' birth mother for a year but moved a number of times before going into care and experienced at least 19 foster placements. Luke went into care after 6 weeks with the birth mother and had at least 12 foster placements. Simon and Luke demonstrated significant emotional and sensory issues from the start of the adoptive placement. They could be extremely violent, had low self-regulation and were both incontinent. It took the first 2 years of the pre-adoption placement, to piece together their history and identify what help was needed through a range of paediatric, social care and CAMHS assessments. Through this process, the parents learnt that these issues had pre-dated the adoption and were not as a result of being adopted or the parents' fault. Simon was given 4 years Theraplay as part of his post-adoption order. Because he was too young, Luke had a commitment of therapy within his adoption plan for a later, more appropriate time. Theraplay helped Simon and gave Petra and David skills and tools that they could also then use with Luke. Life became a lot easier for Simon, who was also diagnosed with Asperger's Syndrome, but over the years Luke's behaviour became more uncontrollable. At about the age of 10, Petra and David contacted the post-adoption team regarding the therapy that had been committed for Luke. However, they struggled to get hold of social workers and the therapy was no longer available. Instead, a worker began weekly life story work with Luke, which was helpful, but had to stop, because Luke was displaying increasing distress which required more specialist support. Luke was assessed and put on a waiting list for therapy in 2014. Petra also accessed support groups for adoptive parents, but other families were not experiencing the same levels of problems.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>When Luke began secondary school in September 2015, although his behaviour at school was good, he was physically and verbally abusive to Petra and David on a daily basis. The situation was becoming dangerous and when Luke started to use sharp instruments, the police had to be called. The family was reaching crisis point, with Petra and David becoming increasingly exhausted. Petra contacted the</p>

post-adoption team, was told about the ASF and that the family were at the top of the list. They did not need to be assessed as this had already happened the year before. In November 2015, weekly 1-hour sessions of Dyadic Developmental Psychotherapy began. However, after a few sessions it needed to be paused, because Luke was finding it too intense and became violent in one session. The therapist then focused on supporting the parents in communicating with the school and training staff in understanding Luke's needs. As a result, the SENCO and a teaching assistant accessed further training about attachment issues and cascaded their learning amongst staff. The school worked with Petra to adjust their approaches with Luke, leading to him getting greater support at school for dealing with anxiety. His behaviour at home improved and he re-started DDP (summer 2016) on a bi-weekly basis for 20 minutes. Therapy was play-based, and it was planned that sessions would lengthen and begin to explore Luke's past and his feelings more.

Additionally, Petra and David were referred for telephone peer support, run by a national support organisation, funded by the local authority, and delivered by a very experienced adopter who had had similar experiences. They found the once a week hour-long phone calls invaluable, not only in helping deal with day-to-day issues, but in guiding them towards other support and advising about potential future needs. The family was very pleased with the support provided by their adoption agency and therapist. However, because they waited for a long time for support, the family was near to breaking point since September 2015. The adoption agency made further referrals to education support, which was unhelpful because it was tailored to deal with poor parenting and not their situation, and more recently a multi-agency team. The parents hoped that Luke would be given a mentor to support him and help in accessing social and sport activities. Petra and David wished that preventative support could have been provided earlier rather than getting help only once they reached crisis. However, they hoped that support would help Luke get through his teenage years, develop emotionally and avoid making negative life choices. Their biggest fear was that the help might be too late. Whilst frustrated that they knew that Luke needed help for a long time and felt the situation didn't need to reach this point, they were relieved that help was finally available.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Six months later (and a year since DDP first started), Luke had continued with DDP therapy, for 30 to 40 minutes every 2 weeks. The therapist also met Petra and David separately and phoned every week before each session, to find out how things were and tailor sessions accordingly. The family's social worker was looking into art therapy which may suit Luke better and help him open up more in relation

to his feelings. The peer support phone calls had now stopped because funding had run out.

Although there had been some spikes in behaviour, e.g. recently over Christmas, home life had calmed down a lot. Luke was able to calm down more quickly following events, was socialising more and things had improved at school. The school supported Luke in the transition to Year 8, although changes in teachers had led to inconsistent behaviour management from the school. Petra and David hoped that there would be some improvements here following recent meetings. They had to increase boundaries for Luke since he had engaged in some risky behaviour with friends unknown to them, and had sought additional support, in the hope of a multi-agency strategic overview of Luke's needs. This hadn't happened as yet. They were also hoping for further telephone peer support. As well as improvements for Luke, Petra and David felt they could more easily communicate with him when he was distressed.

Simon had now started to lash out, and struggled with managing his anger and personal care. He had recently walked out of school. Following a request for help, Simon was now receiving life story sessions, with Petra, led by a social worker bi-weekly for 20 minutes to half an hour long. They believed this was funded through the ASF. Petra and David had found that the system was too reliant on parents seeking support, when they didn't have the time or energy. They found out about the ASF by accident because they were desperate for help.

Recommendations and final views on the ASF

Petra and David were pleased the ASF existed, but thought there could be better signposting for families to the support available. They believed the services should have been more proactive in offering support to adoptive families, for instance producing a guide on what support is available, where to go for it, and who is eligible.

They also believed that the ASF should be delivered through one central system, which families can directly access, rather than going through local authority teams. Support should be 'global' with services collaborating more.

9. The Parker Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Marie and Clive Parker adopted siblings 5 year old Isabelle and 3 year old Chloe, at the ages of 3 and one respectively. However, Isabelle had been placed since the age of one and Chloe shortly following birth.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Since Isabelle was placed, Marie and Clive noticed a number of worrying signs, which Chloe then also displayed. These included poor eyesight, not eating or eating everything, not putting on weight, becoming ill, and seriously ill, quickly. Isabelle was also behaving aggressively towards Chloe, and both girls exhibited feral behaviour. Marie and Clive were busy trying to cope day-to-day, whilst attending appointments with many different professionals, including CAMHS and NHS paediatricians and dieticians, to work out what was happening. They had been prepared for attachment issues to arise and their adoption workers weren't concerned. Therefore, before adopting, both parents assumed that their love and stable environment would eventually have beneficial effects. However, at the point of adoption, following numerous hospitalisations for chest infections, a Paediatrician diagnosed both girls with Foetal Alcohol Syndrome (FAS).</p> <p>Marie and Clive had never heard of this condition and although the pre-adoption report on the girls identified that their birth mother may have drunk, this had not been flagged up. However, they were awarded an adoption allowance for Chloe as Marie was unable to return to work, and on reflection Marie and Clive felt the adoption team either knew more about the girls' problems and withheld information, or were not aware themselves of FAS symptoms. Both parents began a journey of learning what FAS was, researching what they could do and attending a variety of training and therapeutic parenting courses. They since learnt that Isabelle and Chloe have lower immune systems and higher levels of stress hormones, which helped explain both their susceptibility to illness and some of their obsessive and violent behaviours. Both before and after adoption, Marie and Clive requested help, but were only supported with attachment issues and struggled to find the right support. When they told professionals about their children's problems and spoke of their concerns, Marie and Clive felt that professionals thought that they were being overly anxious. At an evening adoption support group meeting and a seminar, Marie was recommended to explore sensory processing therapy as potentially useful for their children. This was shortly followed by the launch of the ASF in April 2015, when Marie was invited by the local authority to a meeting to find out about it. At the meeting, social workers</p>

encouraged Marie to apply for the funding but Marie wasn't certain whether sensory processing would be the right support. Both Marie and Clive felt uncertain as to whether they should just try and get on and cope as best they could and whether it was realistic to expect improvements when their children had brain damage and other serious medical complications.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

By early 2016, and without additional support, Isabelle and Chloe were becoming ever more aggressive and uncontrollable, physically attacking Marie and regularly breaking things. By this time, the ASF was confirmed to continue until 2020, and so Marie and Clive felt that it might provide the level and length of support needed and so could be worthwhile applying. Marie called the post-adoption team, met with a social worker and they agreed that sensory processing therapy was worth exploring. The social worker organised the ASF application for Isabelle and Chloe to have a therapeutic assessment. Although approved in February 2016, due to the girls' ill-health, the assessment didn't take place until May 2016. At the first interview in June 2016, the assessment report had just been received, which recommended a programme of sensory processing therapy and ongoing occupational therapy.

Although uncertain as to what would be offered through the ASF funding, Marie and Clive were delighted to have had a thorough assessment, and they could see how helpful the report recommendations would be in helping meet Isabelle and Chloe's needs as well as in communicating with other services about those needs. For instance, the school were not flexible in how absences were managed and this caused a lot of stress for Marie and Clive. They hoped that by sharing the report with the school would help them understand the seriousness of the girls' health problems.

Marie and Clive found the ASF application process smooth, simple and quick. This they thought might have been easier for them than other families because they were already in close contact with the post-adoption team. The proactive encouragement by the post-adoption team to apply was also important in enabling the family to consider the ASF. However, if Marie had been unable to attend the ASF information meeting, they might not have registered that this help was available. Marie and Clive also have friends with different cultural backgrounds and thought that there could be some cultural barriers to asking for or accepting help. Marie suggested that the ASF could support some form of mentoring for adoptive parents, with attention given to encouraging those from different minority groups, and supporting parents with different access needs, to apply for the Fund. This might help reach those families who might be isolated. Another factor was the

commitment needed by parents to attend therapy. For instance, even if training or therapy was funded, it would cost more for self-employed parents to attend than employees who could take paid leave.

Marie and Clive were looking forward to a follow-up meeting with the assessing therapist, and for a further ASF application to be made for long-term, ongoing sensory processing therapy. They were finally feeling understood by professionals and hoped that therapy would make a big improvement to the family's lives. Whilst understanding that Isabelle and Chloe would need ongoing medical and emotional support, Marie and Clive felt more hopeful that they could survive the challenges ahead, with the support in place. However, they thought that those staff working with adoptive families needed more training on attachment issues and FAS, as they had experienced some unprofessional and unskilled communications by those who were supposed to be helping them. They were fearful that whatever they did might not prevent poor life outcomes for Isabelle and Chloe and were concerned that this could lead to lives involving crime and prison.

At this stage, Marie and Clive thought that if they had not accessed the training courses, their marriage could have broken down, even though they felt their relationship was strong. They also felt the benefit of continuing to attend different training courses, as these helped reinforce learning as well as develop new skills.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Nine months later, Marie and Clive reported that following the therapeutic assessment, a further application for ongoing therapy was submitted and therapy began during the summer holidays in 2016. Thirty-eight sensory processing therapy sessions were offered, which began with 8 days of intensive therapy over the holidays, and regular weekly sessions starting in October. The family were currently about half way through the package of support. It took some time for things to settle, particularly for Isabelle, as the girls were seen separately from each other, which meant that Chloe stayed with the therapist from the summer holidays, but Isabelle had a new therapist. However, this relationship wasn't working well and another new therapist was allocated. Four months later and Marie and Clive believed that Isabelle was starting to attach to the therapist.

Life at home was feeling a lot better, with Marie and Clive believing that their increased knowledge and skills meant they responded differently to situations and behaviours and this then had a positive effect on how the children behaved. Isabelle and Chloe were still violent and erratic in their behaviour, but incidents were not as frequent. Additionally, the parents were better able to divert their daughters' attentions, and provide different sensory input, which helped calm

difficult situations. Both daughters were better able to express feelings, including affection for their mum, which had not happened previously.

A sensory processing therapist had also visited the school, which purchased some sensory equipment as a result. An EHCP was due to be applied for by the school, to ensure additional support for Chloe, but not for Isabelle as she was assessed as under the threshold for this. Marie and Clive struggled with communicating with the school, who seemed not to respond to requests for information, and it was unclear how Pupil Premium was benefiting their children.

Although things at home had improved, Marie and Clive had found the experience incredibly demanding. Before Christmas, as therapy was addressing difficult emotions, they would face incredibly challenging behaviour at home following sessions. Additionally, the hour-long journey each way to the therapy centre plus consecutive one-hour therapy sessions for each child (to enable both parents to be present for each) meant that Saturdays were dominated by therapy. Before Christmas, both parents were uncertain of how helpful therapy was going to be in their circumstances. However, a couple of months later and both felt that improvements were clearer to see and that they might be 'turning a corner'. The therapy centre suggested some physical activities such as 'wheelbarrow racing' when they got home and being able to implement these had made a big difference to life at home. Additionally, to make things easier for Marie and Clive, Isabelle and Chloe now had their sessions at the same time, one parent with each child and rotating parents each week. This was feeling more manageable.

Whilst Isabelle and Chloe continued to behave erratically and were likely to experience significant medical, emotional and educational challenges in the future, Marie and Clive felt that the ASF funded support had made a huge difference for them. They felt well supported by their therapists and social workers. However, they spent a long time themselves and working with professionals, investigating what might be appropriate support for their children and expressed concern that if appropriate research and assessment wasn't undertaken, the ASF funds could be spent on the wrong support for families and therefore wasted. For instance, they would have liked to have been able to access Dyadic Developmental Psychotherapy (DDP). From training they had attended, they had learnt some DDP techniques to use, but through research, decided that sensory therapy would be most appropriate for them.

Finally, Marie had been involved in an online FAS parents group, and had helped initiate a meeting in her local region. This was also proving invaluable in helping increase knowledge and reducing feelings of isolation. Support from the post-adoption team was less available, which they understood was because of understaffing and pressures on social worker time due to the demand for the ASF.

Adoption support group meetings had been moved from the evening to daytime and were no longer accessible.

Recommendations and final views on the ASF

FAS was a condition that needed more focus within pre- and post-adoption training for families, according to Marie and Clive, as well as for social care, education and health professionals. There was not enough expertise on FAS and families were left struggling as a result.

Marie and Clive felt that the ASF needed to be in place for the long-term, as families were going to need ongoing support. However, they were incredibly grateful to have received support and had realised in the process that they were likely to need support for a good part of the children's growing up.

Finally, Marie and Clive thought that adoptive parents should have regular, mandatory training and that work should be done around perceptions of parenting and behaviour management. This would help adoptive and other families get wider support and understanding from society, and reduce the stigma of feeling judged as bad parents.

10. The Sheehy-Russo Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Six year-old Fleur was placed with Caitlin and Luca, at age 4 and ½ years. The adoption was formalised in between the first and second interview. Luca also has an older son, living in another European country, who they see during the year.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
Having been removed from her birth parents aged 13 months, due to emotional and physical deprivation, Fleur spent the next 3 and a half years in 2 foster placements, in between which she lived with her grandparents and half-siblings. The grandparents formally adopted Fleur's siblings. Although there were challenges when Fleur was placed with Caitlin and Luca, these got worse when she began school. Caitlin and Luca sought help from the adoption team as both they and the school were struggling to cope with Fleur's erratic behaviours, and seeming lack of emotional and physical control. An adoption worker witnessed Fleur's behaviour, could see how extreme it was and supported Caitlin and Fleur to access further assessments, and find out more of Fleur's history. NHS Occupational therapy and other assessments were undertaken, but these were minimal, didn't take account of Fleur's early deprivation and didn't identify how to deal with problems being faced. However, a diagnosis of ADHD was suggested. Caitlin and Luca accessed their own training, as traditional parenting techniques were not working. The school, who had some knowledge and training in the area, suggested that sensory processing therapy might be needed. Caitlin and Luca knew they needed a more comprehensive assessment and additional support, but nothing was agreed within the post-adoption plan. They therefore felt they couldn't go ahead with the adoption, until they knew more and had more help. Caitlin and Luca were fearful that once they adopted, they would be left to cope alone.
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
In April 2015, a letter was sent by the local authority, inviting Caitlin and Luca to a meeting about the ASF. However, being so busy coping day-to-day, it didn't register until Caitlin was asked by a friend, another adopter, if she was going. Caitlin went along but at this time the ASF was not available for families pre-adoption. Caitlin and Luca had a dilemma. If they adopted, they could access this support, but they didn't know if they would get it or if it would be sufficient. They would not have the social work support they currently had. Therefore, they asked if

Fleur could be assessed for the ASF pre-adoption, so they could get support set up as quickly as possible post-adoption. Between June and July 2015, a post-adoption worker assessed the family for support and reviewed Fleur's post-adoption plan. A therapist was identified who undertook a thorough assessment with the family in August, visited the school and recommended twice a week sensory therapy. The local authority offered to fund once a week therapy from September 2015 because the family was not eligible for the ASF support not having formally adopted yet. Caitlin and Luca agreed, thinking that twice weekly would be too intense. The school also referred Fleur for assessments and arranged for play therapy at school which started in the new term. Sensory processing therapy began in September. In January 2016, a new social worker visited and the ASF was now available for pre-adoptive families. With all the information already held, the social worker made an application for the ASF to continue funding therapy.

Three months into therapy, Fleur's behaviour got worse, and Luca questioned whether the therapy was working, as things weren't improving. The family contacted another agency to see if they could fund another assessment themselves as they were worried about progress. There was a 7 month waiting list though and they were advised by social workers to give therapy more time. By the first interview, 9 months since therapy started, Luca could see that things had improved considerably and that the earlier dip was due to a lot of complex emotions being triggered. Both parents reflected on whether twice a week therapy would have been better, as they had since learnt a lot about the depth of the problems from Fleur's early years and felt they now understood better that it would take a long time for deep-seated issues to be addressed. However, already they could see that Fleur was more able to express her feelings, was using sensory toys to build her physical control and had improved balance. Although really pleased with the support being provided, Caitlin and Luca believe it took too long to identify the issues and put support in place. They thought that a thorough holistic assessment should be undertaken for every adopted child, then more complex issues could be picked up at an earlier stage. Caitlin and Luca believed that because most post-adoption support is set up to address attachment issues and disorders, the fewer families facing a complexity of medical and emotional issues were left struggling for longer.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

At the second interview, 7 months later, the once-a-week therapy had concluded and a second application for twice-weekly therapy was submitted, which was successful. The adoption was then formalised in August 2016. The play therapy in school stopped, with everyone's agreement, and the twice-weekly sensory

processing therapy began in September 2016, alongside an additional half-an-hour session in the sensory room with a teaching assistant at school. On the school's insistence, Fleur had also been assessed for and diagnosed with ADHD, and began medication in August 2016. This was used only during school times, and so Fleur's behaviour was still erratic at home. Although un-medicated during therapy sessions, Fleur seemed better able to concentrate, appeared a little less clingy than before and had better sensory regulation. The extent of the improvements was a matter of debate for Caitlin and Luca though. Whereas Luca believed it was significantly better, Caitlin felt this might be more to do with the medication and that things were still very challenging. However, they both agreed that Caitlin was able to process things more, outbursts seemed to resolve more quickly and were less violent, and repetitive actions, like spinning, were reduced. Friendships were still difficult. Fleur struggled to share control and decision-making, and could behave roughly towards others, but was now demonstrating more awareness of this.

Twice weekly sessions meant that less sensory input was needed at home and both parents felt the benefit of having more intense support. It continued to be a slow process and was incredibly demanding, particularly for Caitlin, because of the additional commitment and organisation required, but Fleur enjoyed going to therapy and the small changes felt very positive. Caitlin also had 6 one to one sessions with a psychologist within the post-adoption team, which she was half way through and was finding useful. Caitlin wished for this to continue as it felt as if this was just getting started, but it was unknown yet what was ahead and both parents were aware of the new fair access limit. Both parents hoped that support for Fleur continued, with reviews. They could see that as sensory issues were being addressed and Fleur got older, more emotional issues might need support. For instance, Fleur was due to start a new, bigger school in September which might be a difficult transition.

Although pleased with support given, Caitlin and Luca felt more alone since adoption and uncertain about the future. Looking back, although regular social worker visits pre-adoption could be painful, the support with thinking about and planning what was needed was valuable. Now they did not have any of this kind of support and didn't know the post-adoption workers. Caitlin did attend a peer group when possible and was getting informal and professional advice there. The school was also hopefully going to apply for an education, health and care plan to support transition to the new school.

Caitlin and Luca believed that the sensory processing therapy had been vital for Fleur but were more ambivalent about the play therapy provided in school, partly because the feedback from sessions was minimal.

Recommendations and final views on the ASF

Caitlin and Luca thought there needed to be more training for schools and other mainstream services on the needs of adopted children. Families would also benefit from a named post-adoption worker contact for parents so they know who to approach for advice and support. They had found the ASF-funded support to be fantastic. However, it required parents to ask and keep pushing for help. Additionally, Caitlin and Luca had paid for a number of expensive, specialist toys and other equipment for Fleur, which they thought other families might struggle to afford.

11. The Matthews Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Siobhan and Graham adopted 18 year-old Peter at age one and 15 year-old Martin, when he was 3 years old.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>The adoptive journey was relatively smooth for Peter, who needed no additional support and was progressing towards adulthood successfully. However, from the time of Martin's placement, Siobhan and Graham became aware of difficulties. Although they knew about Martin's previous neglect and chaotic home environment, they weren't told about the potential effects of these. To begin with, they got on and did their best to cope but soon found out that traditional parenting techniques weren't working. Martin became increasingly angry and violent, compulsively lying and stealing, and his behaviour was difficult to manage for his nursery school. Things didn't get better on attending primary school, but Siobhan and Graham had a lot of support from their church and friends. However, things deteriorated further when Martin moved from year one to two. Because of his behaviour in school, Martin was sent home a number of times but this was counter-productive as he wanted to be at home. He was referred to an educational psychologist and the parents asked for a referral to CAMHS, where some tests were carried out. Additionally, their GP referred Martin to a Paediatrician. However, all the professionals believed that with Siobhan and Graham's good parenting, Martin's problems would soon resolve. One person did mention potential brain damage as a result of neglect, which resonated with Siobhan but nothing was taken further.</p> <p>By chance, the family's priest mentioned to Siobhan and Graham that he had heard of a local therapist, who specialised in work with adopted children. Siobhan made contact but there was a year's waiting list. At the age of 7, Martin was assessed by the therapist who identified that Martin was perhaps trying to re-create his birth family environment with his adoptive family. After another year's waiting, the family began ongoing psychotherapy which they self-funded as there was no support available from the post-adoption team. Therapy took place between once and 3 times a week for 5 years, with additional appointments to help the family get through difficult times such as Christmas. Martin was diagnosed with post-traumatic stress and dissociation. Progress was not smooth, but gradually Martin became able to settle at night and was able to explore his feelings of abuse by his birth family and the social care system. Siobhan and Graham's understanding of Martin's trauma and therapeutic parenting skills were developed</p>

through attending therapy. Despite the difficult times, there were also some incremental improvements, leading to a much calmer home life. By the age of 12, things were a lot better and it was felt that therapy had achieved what was needed for now and the next few years were quite settled. Siobhan and Graham believed that investing in therapy at a younger age, even though they would have liked it earlier, had perhaps prevented more serious problems when Martin reached adolescence, which he navigated relatively well. The therapeutic process was incredibly demanding and challenging for the whole family, but Siobhan and Graham felt lucky to have been able to afford it and that as a result Martin had attached to them and felt secure.

However, following Martin's therapy, Siobhan was physically and mentally exhausted and needed to access a therapist, to help recover from what had been such a challenging and intense time. Siobhan continued to access support as and when needed, for instance around Christmas times which, because they were difficult times for Martin, would also affect Siobhan's mental health.

When Martin was aged 15, his behaviour began to deteriorate at home and school. Whilst it wasn't a crisis situation, as Martin reached Year 11 and GCSE's were getting nearer, Siobhan and Graham worried that anxiety about the exams could have a detrimental effect on Martin's attainment and transition into adulthood. In November 2015, Siobhan called the therapist who had worked with the family before, and asked for help, expecting to self-fund. The therapist informed Siobhan of the ASF and advised her to approach the post-adoption team.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Following the therapist's advice, Siobhan contacted a social worker who met with the family and spoke to the therapist. Recognising the need to get support in place quickly, and that it was clear the parents knew what was needed, the social worker completed the paperwork and processed an ASF funding application. While this was happening, Siobhan and Graham decided, in February 2016, to self-fund therapy whilst waiting for the ASF support. Then in April 2016, funding was approved and the ASF continued to fund therapy.

Sessions took place for Martin alone with the therapist on a weekly basis leading up to his GCSE's. At the time of the first interview, Martin was underway with his exams and seeing the therapist bi-weekly. Siobhan and Graham expected therapy to stop during the holidays and resume in September to support Martin's transition to college. Whilst they did not know how much support was being funded, they hoped that it would be there as long as needed. The previous 4 months of therapy had, Siobhan and Graham reflected, helped Martin deal with his anxieties and life

was calmer at home and school. They hoped that Martin would achieve the grades he wanted in his exams but didn't know what to expect at that stage.

Siobhan and Graham were delighted to get help from the ASF but would have valued it being back-dated to February. If they had waited for the ASF before they accessed therapy, it might have been too late for Martin's GCSEs. They feared that if Martin didn't achieve his GCSEs, this could reinforce his low confidence in his academic ability and cause a downward spiral as independent adulthood approached.

Whilst pleased with the support given, Siobhan and Graham identified a number of barriers for families needing help. Families were so busy coping day-to-day they didn't have time to research help available. Additionally, most families adopted out of area, which meant that if they needed help later on, there was no known contact at their local post-adoption team. Siobhan and Graham reflected that if they hadn't previously gained support, it would have taken a lot longer to identify where to go for help and by the time support came through it would have been too late.

Finally, Siobhan and Graham observed that the therapist seemed stretched to meet the demand of adoptive families. From their experience of previous waiting lists and their therapists' current limited capacity, they felt there were not enough trained therapists and investment in the workforce was needed. They felt grateful that they happened to live near a specialist provider as they knew families had to travel from across the country. Additionally, Siobhan and Graham felt strongly that if they hadn't funded therapy when Martin was younger, they would have been dealing with the police and probation services now. Instead, they were facing relatively minor challenges, with a son that had bonded well with them and his brother. Siobhan and Graham hoped that Martin would get the grades he needed for his preferred college and experience a relatively smooth transition into a productive and meaningful adulthood.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Seven months later, Martin had settled into his preferred college well, having achieved enough grades at GCSEs. Although he hadn't done as well in some subjects, he had done better than expected in others and was able to secure a place on a 3 year programme which would prepare him for work. So far he had made good friends, was thriving educationally and had taken some exams already which he had dealt with well. Therapy had stopped over the holidays but picked up again on a weekly basis just before GCSE results came out, when Martin began to get a little anxious. This continued until October to support the college start, and began again just before Christmas. Martin had recently found a birth sibling

through social media, and having reluctantly spoken to his adoptive parents about this, they suggested working with the therapist. Martin and Siobhan saw the therapist and discussed contacting Martin's birth family. The therapist agreed to explore what information might be held by the social care department. Sessions were about to start again following a Christmas break.

Aside from this, both Siobhan and Graham felt Martin was thriving at college and although he didn't want to spend as much time with them, they felt this was very much like usual teenage behaviour. There were times that Martin struggled compared to his peers, for instance when staying at friends or travelling independently to an unfamiliar area. However, both parents had also noticed that Martin was able to articulate his feelings and so could express himself when he found things difficult.

Recommendations and final views on the ASF

Siobhan and Graham recommended that all adopted children should have social worker support until the age of 18, with responsibility handed from the placing authority to the host authority at the time of adoption. Additionally each adopted child should have a thorough therapeutic assessment, so that support needs could be identified early on. They also thought there should be quarterly reviews in place, to help address and identify support needed. From their experience, Siobhan and Graham felt strongly that early intervention prevented greater costs at a later date for society through, for instance, prison places.

Siobhan and Graham also felt that more work needed to be done in getting the adoptive family seen and represented more generally, including through the media, so that awareness and understanding about the adoptive experience is increased, to help make society more welcoming for adopted families. Finally, Siobhan and Graham emphasised the value of what they have learnt and experienced with Martin, but also the mental health impacts, particularly on the parent who takes on more of the day-to-day parenting. They suggested that the ASF needed to consider how parents were supported outside of sessions with the child, as even the therapeutic process can be extremely draining for parents.

12. The Simmons Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Anna and Fergal Simmons adopted Charlotte, aged 6, and Billy, aged 2 and a half, when they were 2 and 9 months old, respectively. Because Fergal works incredibly long hours, parenting from Monday to Friday was undertaken solely by Anna, who was interviewed alone for the evaluation.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Anna and Fergal experienced challenges with Charlotte since the time of adoption, with problems getting worse when Charlotte started nursery school. Charlotte displayed erratic outbursts, struggles to obey any rules and had frequently bitten, hit out and pinched her peers at school. Whilst academically bright, Charlotte demonstrated a greater immaturity than others of her age, becoming anxious when faced with new situations, exhibiting hyper-vigilance and extreme insecurity. Although Billy was showing some withdrawn behaviour, Anna and Fergal did not feel he needed additional support yet.</p> <p>Help was first sought when Charlotte was 3 and a half. Anna and Fergal began privately funding ongoing support from a psychologist, to help them as parents, which continued for two and a half years. Charlotte's first year at primary school was incredibly difficult and led to a change of school, in the past year, in order to find a more supportive environment. However, challenging behaviour continued and the psychologist recommended that the family seek further support through the ASF. Although the family received local adoption services newsletters and were aware of local support groups, they had not previously considered approaching the post-adoption team for support.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
Having read about the ASF in a newsletter, and having received advice to apply for support, Anna contacted her adoption social worker, with whom they had maintained some contact. Anna and Fergal recognised that they needed additional support to help them face the challenges of Charlotte's behaviour. It took chasing before the assessment took place, 3 or 4 months after the initial call. However, since then the process was smooth. Because the social worker already knew the family, and there was an existing good relationship, as well as Anna's own proactive involvement in getting the application completed, the assessment was done in one home visit and the application submitted quickly afterwards. The

social worker recommended a family therapist and an occupational therapist (OT) for Charlotte. A six-week therapeutic assessment process, with Charlotte and Anna, began quickly with the family therapist and was completed by the time of the first interview. This was due to be followed by 3 sessions with just Anna and Fergal, followed by ongoing family therapy. It took longer to access the OT support, which needed some additional efforts from the social worker and Anna, but this was in place at the first interview, with sessions taking place with Charlotte at school.

Having researched therapies herself, Anna was pleased with the provision offered and felt her family's needs were understood through the assessment of adoption support needs process. Although unclear about how long the ASF support would last, Anna believed it would be ongoing, as needed. The assessment process had been difficult emotionally for both Charlotte and Anna, as Charlotte reacted angrily to the therapist having control within sessions. Nonetheless, Anna hoped that the family therapy would support Charlotte to build secure, trusting relationships with others, and that the OT would help her develop better sensory regulation. Already, Anna felt that some good progress had been made.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Six months later, Charlotte and Anna were a few months into PACE Psychotherapy, which took place once a week, involving play activities. Both parents attended one review session every 2 months, and Anna attended a monthly review session without Charlotte and could access additional telephone support from the therapist. Charlotte's behaviour had deteriorated, potentially because Charlotte had reached a stage of rage in expressing her grief and loss of her birth family. At school, Charlotte was taught in isolation and was supported by a teaching assistant, funded by the parents. The school had applied for an Education, Health and Care Plan, and the parents were aware that she may need to be moved to a more specialist school.

Despite this, the family had experienced positive progress. Anna recognised that she was increasingly using therapeutic parenting techniques, and had become better able to manage her own feelings and distinguish these from Charlotte's. Charlotte was beginning to articulate her feelings, and when she had a good day at school, home life was calmer, but this was still unpredictable. Anna was also accessing a local support network, which was helpful. However, with Billy at home still, it wasn't possible to access the available training days for parents, and Anna felt that some respite support for parents was needed.

Although delighted with support provided by both the family therapist and OT, Anna felt that support from the post-adoption team could be better. Anna believed that having to approach the local authority for support and navigating the bureaucracy of the ASF could be a barrier for some families. Although this support would have been helpful a couple of years ago, Anna was pleased it was in place now and believed that 6 is a good age for Charlotte to receive support. At this early stage though, the family felt as if they were just about coping from day-to-day.

Recommendations and final views on the ASF

Anna believed that the ASF had stretched the capacity of local authority staff, who were struggling to respond to families' requests for help. Anna recommended that the Fund was administrated centrally and independently, so that families could apply directly rather than approaching local social workers and facing a 'postcode lottery'. The ASF should also include professional respite for families and although with the fair access limit, the ASF was still highly valuable, Anna thought it should be removed.

13. The Stewart Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Dawn and Paul Stewart adopted 13 year-old Daisy when she was 3 years old.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Fostered at birth, Daisy was returned to her birth mother aged 14 months for a year, before being removed and placed again with the same foster family, following abuse and neglect. Daisy's 10 birth siblings had also been removed and there was a history of autism and ADHD in the family, which Dawn and Paul discovered much later. On first being placed with Dawn and Paul, Daisy settled but when she began school, her behaviour at home became more challenging, but not unmanageable. However, at school, Daisy was violent to her peers and teachers. Dawn and Paul found the local school unhelpful and unable to cope with Daisy's behaviour. They were using traditional behaviour management techniques which weren't working. They were also unreceptive to Dawn and Paul's attempts to explain Daisy's needs. Dawn and Paul approached their local CAMHS and MP for help. Aged 6, Daisy was given an educational statement for emotional, social and behavioural needs and diagnosed with ADHD, Dyspraxia and reactive attachment disorder. However, even after this, she was temporarily excluded by the school. It took persistence from Dawn to ensure that Daisy's support hours were maintained as the school wanted to reduce these as soon as Daisy appeared 'better'. Additionally, the family heard rumours of staff physically handling Daisy to control her. At this point the family requested a statement review, and CAMHS sent a psychologist to visit the school, as a result of Dawn having to push for help. This wasn't a service usually available for families. After the visit, the psychologist recommended a change of school to best meet Daisy's needs.</p> <p>The local authority wanted Daisy to attend a local special school for children with behavioural difficulties, but Dawn and Paul felt that another mainstream primary school, experienced in supporting children with diverse needs, would be best for Daisy. With the right support at school, it was felt that Daisy could cope in this environment. However, because the local authority did not support this move they refused to fund Daisy's transport. Despite this, Daisy started the new school, was given good support and provided with art therapy at school by CAMHS for 2 years. CAMHS also provided training for the school around adopted children's needs, which they incorporated into their work with Daisy. The therapy seemed to help Daisy understand herself and her family more and she was able to achieve more academically. Medication for ADHD also helped Daisy be calmer at school and home. At the same time, Dawn and Paul sought support privately from a</p>

psychologist, which helped them deal with their different views on parenting and gave them different parenting techniques to use with Daisy. This support was incredibly useful and has since stopped, but is still available if they need it.

Daisy went on to secondary school, supported by her statement and received additional teaching support through Pupil Premium. Although contact with birth siblings continued for a number of years, another adoptive family eventually stopped this contact. This was experienced as a rejection for Daisy, even though Dawn and Paul reflected that the contact was perhaps not useful for Daisy either. Daisy seemed to be coping at school, achieving academically and was accessing summer drama and music activities which she enjoyed. Friendships and dealing with any changes continued to be problematic for Daisy though. As she moved towards teenage years, her behaviour at home began to deteriorate. Going out to different places became more of a challenge as Daisy's behaviour was unpredictable and often ended in tantrums. Dawn and Paul decided to move to a detached house, to give more space to Daisy and with support from the Disability Living Allowance, they bought a caravan. This helped provide a more consistent environment for holidays, as Daisy's behaviour was often volatile on holiday.

Daisy's anger was becoming more uncontrollable, as she began breaking things at home and being verbally abusive to both parents, but particularly Dawn. By summer 2015, Dawn and Paul knew they needed more help.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Dawn telephoned the post-adoption team in summer 2015 and was told by a social worker about the ASF, who suggested Equine Therapy for Daisy. Neither Dawn nor Paul thought this was suitable, but were not given other options to consider. The social worker sent the family an assessment form, which Dawn completed and returned, but the family decided not to follow this up as there didn't seem appropriate help available. Things at home settled for a while but by Christmas, life was becoming unmanageable again and in the new year, Dawn called the post-adoption team to see if they could offer other support. After a lot of chasing, in March 2016, a psychologist called Dawn, reviewed the previous assessment and discussed Daisy's needs. As Daisy seemed to enjoy music, the family requested music therapy and the psychologist agreed to make a referral. At the time of the first interview, in June 2016, the family were still waiting to receive further information, not knowing whether or not the therapy or the ASF funding was confirmed. Dawn and Paul were hopeful that with music therapy, Daisy would develop the ability to express and communicate her feelings better, self-regulate more and be able to take a step back before reacting. However, they were concerned that if therapy took place at school, time was running out for it to start

before the summer holidays. They were becoming despondent that the help would not be in place to help Daisy with her transition to the new school year.

At this point in the process, the family felt their needs were well understood by the assessing social workers, but Dawn thought this was because the parents knew what might be best for Daisy and that other less well informed families might not get the appropriate support. As with previous support, the ASF process seemed to rely on the parents continuing to chase. Whilst waiting for the ASF support, Dawn and Paul asked for a referral to CAMHS but this was refused because they were going to get help through the ASF. In the meantime, the family were managing as best they could without any support, and were chasing their therapy referral. They felt that there should be guidelines over the waiting times between assessment, funding notification and therapy, so that families knew what to expect. They also felt there should be an independent route to following up the ASF applications, as it seemed that local authorities were not being held to account for their responsibilities. Although worried about pressures on the ASF, Dawn and Paul were relieved that there was something in place for adoptive families. They believed there should be more help available for parents, and consistent, proactive support for adoptive families, so that people were not left alone to cope.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Following the first interview, Dawn chased the post-adoption team about Daisy's therapy referral and having had no updates, complained to the national adoption support team. The local authority then contacted Dawn and arranged for a music therapist to begin work with Daisy. This started with 2 sessions before the summer holidays and continued in the September. At the time of the second interview in November, there had been approximately 10 sessions. Dawn and Paul were hopeful that these would continue for the school year, but were uncertain whether this would be the case. They were aware of the fair access limit that had been brought in.

Music therapy took place with Daisy during school time for half-an-hour per week. Daisy enjoyed going, although this was partly because she got to miss P.E. lessons. So far, Dawn and Paul believed that the sessions had been useful for Daisy and were appropriate for her. They knew that she played a variety of instruments in them, but otherwise did not know what was discussed.

Although it was too early to know whether the therapy was responsible, both parents could identify small improvements. For instance, during the summer holidays, they were able to have some time alone while Daisy spent time with Dawn's parents, siblings and Daisy's cousins. Although Daisy continued to have

outbursts, these seemed to calm more quickly. However, her behaviour was still challenging, as Daisy resisted doing homework and giving up her technology at agreed times. Dawn and Paul were uncertain how much of this was usual teenage behaviour and what was related to Daisy's background. Although they had approached the school to help with this, Daisy had been at risk of detentions, and the parents had to anticipate problems and initiate contact with the school to avoid or deal with these. An EHCP was due to be implemented.

Daisy seemed to be building more friendships, although was more comfortable playing with younger children. Daisy still had problems with sharing control, concentrating, being aware of the consequences of her actions and responding to boundaries being set. Daisy also struggled to acknowledge enjoyable times that the family had. ADHD medication helped keep Daisy calm although Dawn and Paul debated whether upcoming school performances would over-excite Daisy and cause difficulties for bedtime and school in the morning. Paul felt that this would be manageable. They were also aware that Christmas was coming up at the time of interview and this could be a cause of Daisy's increasing anxiety.

Paul and Dawn reflected that whereas Daisy's previous outbursts had been related to them as parents, the outbursts now were more related to school and technology. Her tantrums in public were also reducing, though they thought this might be because Daisy was getting older. They felt that the assessment of adoption support needs could be more thorough and that adoptive children needed more holistic assessments to understand what help might be relevant for the individual child. At the time of interview, they were hoping to receive an update from the therapist on how sessions were going with Daisy and if there was anything they could implement at home. They hoped that therapy would enable Daisy to take a moment to stop and think before reacting to situations. They feared that if help was not available for as long as needed, Daisy would struggle as an adult, with work and life. They were concerned that if help was needed in the future, it might not be available, because of funding restrictions.

Finally, Dawn and Paul discussed how they were beginning to get a little more time together at home as Daisy grows up but were unable to rely on family members for help or get time out as a couple because of Daisy's needs.

Recommendations and final views on the ASF

Dawn and Paul wished that post-adoption services would be more proactive in assessing adoptive children and offering preventative support to avoid future problems. Post-adoption teams could give more practical help through the adoptive journey, such as helping identify appropriate schools and undertaking annual reviews. Getting the right school and ensuring that all professionals working with adoptive children have appropriate training, was critical in supporting families.

Dawn and Paul would have appreciated knowing how much funding they had left so they could work with the services to prioritise support in the best way for Daisy. They also thought those assessing families for the ASF support could be better informed about different therapies, so that families knew they were accessing the most appropriate support at the right time, without money being wasted. Training for parents could have been more tailored rather than taking a blanket approach to parenting. They were concerned that the requirement for local authorities to co-fund larger packages of support would not be viable due to funding cuts. Both parents felt that adoptive parents, who were over the tax threshold to receive child benefit, should not have to return it, because of the additional costs of being an adopter.

Finally, they suggested that parents were often pleased to no longer have social workers in their lives, which could be a barrier to seeking help. The Adoption Support Fund might be better offered through a central body, rather than post-adoption teams.

14. The Ewens Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Shauna and Nick adopted 16 year-old Monica and 8 year-old Amelia, when they were 10 and 5 years old respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Previously long-term foster carers, Shauna and Nick adopted Monica following a chaotic background of significant neglect. Monica had previously lived with her birth mother, was removed following the birth of step-siblings and moved into foster care. Ongoing birth family contact continued up until the point of adoption. On arrival, Shauna and Nick were aware Monica was absorbed with her birth family and was physically small, but otherwise nothing of concern was apparent. Two years later, the family began the process of adopting Amelia, which Monica was actively involved in and which took about a year. During 2013, a year after Amelia moved in, problems began to escalate when Monica became overwhelmingly envious of Amelia. Over the course of the next 2 years, this behaviour became ever more violent and risky. Shauna and Nick tried their best to support Monica and demonstrate fair treatment to both daughters, but Monica couldn't believe this and became more focused on being moved back into care, and began to run away. When Shauna and Nick first sought help, Monica was still within the responsibility of the placing authority in another UK country.</p> <p>Shauna contacted both the placing authority and the local host authority's post-adoption team (who took on responsibility for Monica during this period) but struggled to get any help. Monica's running away became more dangerous, the police became involved and Monica expressed suicidal wishes. The family was in crisis. Although the services they contacted discussed help that could be provided, nothing materialised. Additionally, individual workers gave ill-informed advice, which was unhelpful. In December 2015, Monica ran away and was found in a remote, life-threatening location by a passer-by. At this point, Shauna and Nick were at the point of despair and felt that if the adoption broke down, they might get help. Monica was placed on a 3 week respite break and things seemed to calm down. However, Monica traced her birth family through social media during this time, which Shauna and Nick later found out about. Monica returned home and the family was offered intensive therapy, but Monica refused to attend. It was agreed that Monica be placed on a 3 month temporary care order, and Monica agreed to attend a therapeutic assessment. As a result, it was recommended that communication between Shauna, Nick and Monica was kept to therapy sessions.</p>

However, there were complications with the funding of therapy and it was never provided. Therefore, there was no way that Shauna and Nick could engage with Monica and no other support was provided to bring the family together. Monica was provided with individual therapy through CAMHS but this stopped as she began GCSEs. Shauna and Nick tried to regain contact with Monica and get help but felt completely unsupported by the social care teams and in mid-2016, the care order for Monica was formalised, who has since remained in foster care.

Removed from her birth family aged 19 months, Amelia was placed in foster care before being placed for adoption in December 2012. The placement broke down within a few months and Amelia returned to her foster carer before being placed with Shauna and Nick in summer 2013. Amelia initially settled well and made friends easily, but struggled educationally. Shauna and Nick tried to communicate with the school but found their support to be inconsistent and Amelia relied on being supported by another child's teaching assistant. As well as her own early experiences of neglect and disruption, Amelia was also affected by the experience with and loss of Monica. Since Monica first moved out, Amelia's anxieties and concerning behaviours became increasingly apparent. Amelia seemed unaware and didn't complain if she hurt herself badly but over-reacted when she had a minor graze and was increasingly impulsive, taking risks without being aware of the consequences. Likewise, she seemed fearful of being put into care if she was naughty and was scared of Monica, even though they were not in contact. Amelia was diagnosed with poor memory, struggled with exams at school and sharing control when playing. Additionally, Amelia was unaware of her strength, could unintentionally be rough with and hurt others during play and had little spatial awareness.

Having had therapy offered as part of the adoption order, Shauna contacted the placing authority, in another UK country, having heard about the ASF through a friend living in a pilot ASF area. Shauna also attended a local meeting about the ASF. At this stage, the ASF was not available for children adopted within 3 years from another UK country, and so this was not available. The placing authority provided some play therapy but this was offered in 6 to 8 week packages and at the end of each package, Shauna had to chase workers in order to get more therapy. Shauna and Nick knew the family needed intensive therapy but it was not forthcoming. The play therapy was beginning to raise issues for Amelia and her behaviour began to deteriorate. The therapist didn't want to work too deeply with Amelia as intensive therapy would hopefully be provided, which could more safely support Amelia.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Shauna approached the local authority in February 2016 as the 3 years post-adoption period was nearly complete, in order to get an ASF application ready in time for submission in March 2016, just before they expected the ASF to close, as the commitment of funding until 2020 hadn't yet been made. The post-adoption team was very helpful, arranging the application quickly and once the 3 years was reached, the application was submitted and the family referred for an intensive therapeutic assessment. The assessment took place in April 2016 and, at the time of the first interview in June 2016, the family were waiting for the therapist's report to arrive. Following this, they planned to apply for further ASF support to fund the recommended therapy, as the Fund had now been extended until 2020.

The therapeutic assessment involved a half-day session involving individual work with Amelia, and both Shauna and Nick completing extensive forms. The school also completed an assessment. The therapist fed back the outcomes of the session with Amelia and a week later, Amelia had a sensory processing assessment.

At the time of the interview, Shauna and Nick were chasing the therapeutic assessment reports and were aware that it would be difficult to arrange sessions because of the therapist's stretched capacity. However, they were hopeful they would receive at least a year's intensive therapy and were hopeful that this would help Amelia process her birth experiences and understand her emotions. Shauna and Nick wanted Amelia to be able to develop both socially and educationally. They feared that without help, Amelia might not achieve her educational potential, could become a very young parent and/or get involved in crime. They were also fearful that without help, the adoption might break down.

Because of their experience with Monica, Shauna and Nick did not like social workers visiting their home, and thought that the ASF would be better dealt with centrally, with funding paid directly to providers. Although expecting the therapy to be incredibly demanding for the family, Shauna and Nick were more worried about what the effects would be if therapy were not provided.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Six months later, Shauna and Nick were still waiting for therapy to start. Following the first interview, they continued to chase the reports. The intensive therapeutic assessment report arrived in the summer and an ASF application was submitted, but returned and re-submitted a number of times before being approved, about a week before the Fair Access Limit was implemented. They believed that approximately £19,000 of therapy had been approved. Following some chasing, Shauna and Nick met with the therapist a few days before the interview, to discuss

plans for therapy which was due to begin in January 2017. Sessions were to begin weekly with the aim of having a five-day intensive during school holidays. Alongside sessions would be an extensive assessment of Shauna and Nick so that they could be supported to explore their own parenting styles and develop new tools and strategies, as needed. Shauna and Nick were hoping that the therapy would support them to talk to Amelia about her life story, as they were particularly concerned that Amelia's birth mother had had another child, who was living with her and the maternal grandmother. They didn't want Amelia to find this out in an uncontrolled way as it could have terrible effects on her and their relationship with her if she felt they had withheld it.

The sensory processing assessment report arrived in November 2016, with recommendations sent to Amelia's school for supporting her sensory regulation. Shauna and Nick were waiting to meet the sensory therapist but were aware of exercises to be done at home and equipment needed for sensory processing.

Since their referral for the ASF support, the play therapy for Amelia had stopped and no other support had been provided in the meantime. Although Amelia used to ask about her therapist, this had now stopped and she seemed reluctant about attending upcoming therapy. Shauna and Nick felt that their situation had not particularly changed, although as Amelia was getting older her behaviour was becoming more oppositional and recently had become more distressed and insecure. However, she had become more aware of the effects of her rough playing but could not understand why she was hurting others.

Shauna and Nick were uncertain whether the effort of trying to get help, if it continued to be sporadic and inconsistent, was worth the inevitable disruption it would bring. They felt that the 9 month gap since the play therapy stopped had been counter-productive and although they understood social care and therapy providers were stretched, this was unhelpful for families. They were also concerned that the ASF funding would run out and that something would be started that then stopped, which could be even more damaging.

Finally, Shauna and Nick debated the value of maintaining letterbox contact with birth families as this could be difficult for adopted children when they reach 18 and have access to these records. They felt that advice was very mixed about how best to manage this and they would have liked to help Amelia contact her birth family if she wanted to, but were concerned that their previous contact might be damaging to this. They felt that, as a policy, this needed more thinking through and support for this, with flexibility to meet the needs of different children.

Recommendations and final views on the ASF

Following years of seeking help, Shauna and Nick felt that waiting lists were too long and the ASF application process too protracted and not flexible enough for

the needs of adoptive families. They recommended that funding assessors were more knowledgeable about therapies and the needs of adopted children.

They hoped that the Fund would continue and thought that all children should have a plan and support from the moment they were removed from their birth family and throughout their childhood, regardless of whether they were fostered or adopted.

Shauna and Nick believed that having to approach social care services for the ASF support was a barrier for many families, as was the perception that parents had to beg to get any help. They felt that applying through local authorities was unnecessary, even though they might be still involved in the process.

Finally, Shauna and Nick were aware of upcoming regionalisation and were concerned that if therapeutic support was provided internally by the new regionalised bodies that it would result in under-qualified practitioners providing therapy and poorer outcomes for families.

15. The Frazer Family

Family set up (who's in the family, numbers of children, ages, age at adoption):

Alysoun adopted siblings, 12 year-old Charlie and 10 year-old Thomas, when they were 8 and 6 years old respectively. Alysoun's 24 year-old birth daughter, Keeley, had been away at University but at the time of second interview had returned to the area and was living nearby. Alysoun also had Celine, a foster child aged under a year old, living with the family on a short-term placement.

Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences

Alysoun was a foster carer, first fostering Charlie and Thomas from birth to the ages of 3 and 2 respectively. Charlie returned to his birth mother for 3 months during his first year, and both boys had contact with their birth family in these years, and still saw their birth father every year. They then went to live with their birth aunt under an SGO. Contact with Alysoun was maintained for a while but was then withdrawn by the aunt. Alysoun found out after 3 and a half years that the placement had recently broken down due to physical abuse and the boys had been moved into foster care. Alysoun was successful in getting Charlie and Thomas returned to her, and went through the adoption process soon afterwards. Because of Alysoun's job, she and the boys have had consistent contact and support from social workers.

Alysoun recalled that both boys displayed some worrying signs in their formative early years. For instance, Thomas exhibited physical, learning and emotional developmental delays, and was seen by a physiotherapist and speech and language therapist. However, professionals believed that these difficulties would improve and he was discharged from services. Charlie exhibited distress and clinginess as a baby, being physically ill frequently, screaming when put to bed and was very difficult to settle at night, but otherwise his mood, behaviour and eating all seemed fine. Behaviour at night seemed to be worse ahead of contact with the birth mother.

On their return, Alysoun began to seek further support for Thomas through social care. Thomas was referred for CAMHS assessments, further physiotherapy and speech and language therapy, and after 2 years, at the age of 8, a diagnosis of autism and an associated 'statement of needs' to support his education were given. Although Thomas did struggle with his behaviour and learning at times, and was at risk of running off if unsupervised, this was manageable overall for Alysoun and for his school.

Challenges faced with Charlie had become more difficult to manage, both for his school and Alysoun. Increasingly explosive, violent outbursts had threatened his own and others' safety, school staff had refused to be alone with him and Alysoun had had to occasionally call the police and social workers for help. Additionally, the time it took for Charlie to calm down had lengthened. Although sometimes Alysoun could walk away from conflict with Charlie, at other times she did get embroiled in arguments with him.

Charlie's school referred him to a Targeted Mental Health in Schools (TAMHS) project, which provided regular art therapy. Alysoun and Charlie's social worker had been chasing an ADHD assessment for over a year, which was still outstanding. Whereas Alysoun had found CAMHS to be unresponsive and unhelpful, the support provided by social workers and post-adoption workers had been essential for Alysoun and the boys. Alysoun had been able to call social workers for informal advice and help when situations had been getting out of control. However, Alysoun had previously resisted additional help suggested or offered, believing that she could and should be able to cope alone.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Eight months previous to the first interview, the post-adoption worker identified a therapeutic respite break for adopted children, which Alysoun agreed could be useful, and they made an application to the ASF to fund it. Alysoun wouldn't have known of the ASF if her worker hadn't recommended it and if she had known, would not have considered asking for the ASF support. However, home and school had reached crisis point and the family desperately needed help. Because there was a lot of ongoing contact, workers were able to complete the ASF paperwork quickly and the funding came through within a few weeks. Alysoun was delighted both with the application process and the support provided.

Alysoun was also very impressed with the depth of contact and information shared before the break, including a pre-residential introductory day. Charlie thoroughly enjoyed the two-day respite break, which included outward-bounds activities and Alysoun believed that the break helped calm the situation down for both her and Charlie. She hoped that Charlie would be able to learn how to handle his attachment issues better and express his emotions, but also wanted to know how to handle things better herself. Before the camp, Alysoun was worried that Charlie would behave badly and be sent home, but that didn't happen and although she didn't know what was discussed at the camp, felt it was beneficial. Charlie had become calmer and there were some behavioural improvements. The post-adoption worker had put in another application to fund Charlie's attendance at a

therapeutic break in the summer holidays, but the outcome of this was as yet unknown.

At the time of the first interview, Alysoun was not aware of what else the family might be able to access through the ASF, what was on offer or whether multiple applications could be made. However, she felt that if they could continue to access the therapeutic respite breaks, this would be good.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Seven months later, Alysoun reported that Charlie did get the ASF funding to participate in the summer holiday two-day therapeutic respite break. Additionally, he received an Education, Health and Care plan which supported his transition to secondary school and provided him with 1-1 support in his classes. The ADHD assessment was still to be undertaken, though CAMHS had offered an appointment, the same day of the interview, so the assessment might happen soon.

Additionally, Alysoun couldn't remember exactly when, but following an episode after which Alysoun spoke to social workers about getting nearer to breaking point, and handing Charlie back to social care, the family were referred for a therapeutic assessment. This was delivered by a national provider, who provided a psychologist to meet with Charlie at school and Alysoun separately at home for 12 weeks. The sessions took place in 2016, once to bi-weekly, culminating in a report, recommending a longer programme of therapy. Alysoun also attended some parenting training courses, including a ten-week attachment course.

Since support was provided, Alysoun could identify improvements, including her own increasing ability to stay calm when Charlie had an outburst. However, this took practice and she knew that sometimes she responded in an unhelpful way. Secondary school was not as problematic as primary school was, though Charlie still struggled with sustaining friendships. Alysoun would have appreciated more support from the school in communicating with her so that she could support Charlie with his homework amongst other things. Likewise, she was aware of some bullying at the school, had informed school staff and was concerned about Charlie's mental health. Alysoun was concerned Charlie could be a suicide risk, partly due to recent suicides of other children within the school. There had been a couple of occasions where Alysoun had gone away for a short while (for instance to her daughter's graduation) and although Charlie was well behaved for the people looking after the boys, when she returned, Charlie's behaviour was horrendous.

Having found the 12 sessions useful and with Charlie having begun to bond with the therapist, nothing had happened since, and Alysoun understood that they had

exceeded their funding allowance for the year. For the same reason, no further therapeutic breaks had been provided. Despite improvements, Alysoun could see that difficulties were returning and felt that they could soon be back in a crisis situation. Alysoun was frustrated that having been given some helpful support, which took a long time to acknowledge as necessary, it had effectively been withdrawn just as it was getting started.

Recommendations and final views on the ASF

Alysoun reflected that after 14 years as a foster carer, she felt she was only now getting a full understanding of the impact of the system on looked-after children's lives. Frequent social worker changes could make life difficult for parents and children as well. Whilst Alysoun was really pleased with the help received, she thought the fair access limit needed to be withdrawn so that families like Alysoun's were not let down by the ASF.

16. The Paige Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Debbie and Phillip Paige adopted siblings Sonia, aged 8, and Mark, aged 7 when they were 3 and 2 respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
Removed from their birth home when Sonia was one year old, both children experienced global developmental delays as a result of early deprivation. Debbie and Phillip found Sonia's behaviour more challenging, as she struggled to self-regulate, could be physically violent to her parents, brother and school friends and got very distressed when encountering new situations or unexpected changes. Following a difficult start at school, speech and language therapy were provided and Debbie attended an 18-week attachment course and Non-Violent Resistance training supported by the post-adoption team. The family also accessed informal family events and coffee groups in the past. However, things were getting worse at school and by Autumn 2015, Debbie and Phillip knew they needed more help.
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>Debbie heard of the ASF at a coffee morning but hadn't registered it as a support option and so contacted a therapist who used to work at their placing authority, for advice. The therapist directed Debbie to her local post-adoption team and the ASF. A social worker met with both parents within a couple of weeks of Debbie's call in December 2015, where they discussed the family's challenges, the effects of trauma and potential therapies available. They also visited the school and this led to a Common Assessment Framework (CAF) being arranged within a couple of months. Debbie and Phillip mentioned play therapies and the social worker suggested drama therapy might help. Since the assessment of adoption support needs, a long wait ensued. The application to the ASF was rejected initially and had to be re-submitted. It was finally approved and at the time of the interview, in June 2016, the family had received the first of 2 therapeutic assessment sessions from one therapist and were due to receive 38 weeks drama therapy with a new therapist.</p> <p>Whilst happy with the provision so far, the family felt the process was too long and communication could have been better. The family had to chase social workers, who were dealing with staff shortages. They believed that having to contact social workers could feel stigmatising and was a barrier to seeking help. However, they</p>

were delighted with the length of support being provided, the communication and skills of the assessing therapist and were hopeful that Sonia would develop greater self-regulation and learn new coping mechanisms. Apart from mild concerns that Sonia would miss education to attend therapy and might not engage with the therapist, both parents were hopeful that the package provided was substantial enough for productive work to take place.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

At the time of interview in January 2017, the family were mid-way through drama therapy. Provision comprised of regular sessions at school with Sonia, 2 family sessions and 2 review sessions just with Debbie and Phillip. Sonia seemed to enjoy the sessions and Debbie and Phillip were pleased with the therapist's work and communications.

Both parents had noticed that Sonia had matured, seemed to be processing her feelings more and was playing more easily with friends and Mark. Life at home and school was better as a result. Meltdowns now occurred once or twice a week instead of daily. However, in December the therapist moved jobs which seemed to lead to Sonia's behaviour temporarily worsening. Christmas was a difficult time. Also, as Sonia's behaviour had generally improved, Mark was expressing feelings of anger and distress and an application to the ASF was being made to support him. The family had been told that this package would be smaller because of the fair access limit. They also hoped to apply for more support for Sonia in April, as they believed this work would need to be ongoing. A new therapist was due to continue the current package.

Overall, the family was happy with the support provided although since the initial assessment they had little contact from the social worker and felt that reviews would be useful. They were uncertain about whether the fair access limit would limit the impact of the Fund. Social worker changes also meant that the family believed they would be starting from scratch when applying for more ASF support.

Recommendations and final views on the ASF

The family believed the ASF should be managed by an independent agency as many families didn't want social care back in their lives. Having to repeat the same story to different professionals could also feel like a waste of time and un-coordinated.

The application process could have been quicker and less bureaucratic and communication from social workers could have been better, reducing the need for families to repeat their story continuously.

17. The Carter-Harrak Family

Family set up (who's in the family, numbers of children, ages, age at adoption):

Penny Carter adopted 2 brothers, 15 year-old Mehdi and 13 year-old Karim, with her then husband, Nabil, when they were 3 years old and 7 months old respectively.

Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences

Mehdi was removed from his birth parents aged 15 months and Karim was removed aged 3 days. The birth parents were involved in drug misuse, drug-dealing, were verbally abusive and neglectful. After removal, both boys lived separately, with Mehdi having 2 foster placements and Karim one stable placement. They had some contact with each other and their birth family until moving in with Penny and Nabil. Adopted through an independent agency, no support was in place once adoption was finalised, and although both boys were lively, Penny and Nabil didn't consider that they needed help. After adoption leave, Penny returned to work and Nabil stayed at home to parent, but things gradually deteriorated, particularly when Mehdi began school. Whilst at school, Mehdi behaved well, but struggled to concentrate and settle. At home his behaviour was erratic and could be challenging. Since the adoption was formalised, Penny had intermittent, informal support from an adoption worker from the adoption agency, but otherwise felt left to get on with dealing with challenges.

Between 2004 and 2009, Penny and Nabil's relationship began to break down. They became aware of differences in their parenting approaches, with Nabil taking a more traditional, authoritarian approach and not willing to try different approaches. Additionally, whilst Penny wanted to explain to the boys about their background, Nabil didn't want them to know of their adoption. Penny read many books, joined an adoptive parents' support network and gained advice from the adoption worker. By 2009, Nabil was being verbally and emotionally abusive towards Penny, and so the parents separated and Penny approached adoption support services for help. Play therapy was provided for both boys but Mehdi didn't engage. Additionally therapy was incredibly demanding, being half-an-hour away and Penny needing to take both boys separately. The therapy helped to an extent but both boys were struggling to cope with the separation from their dad.

Relationships with Nabil were difficult and support from professionals was ill-informed. In 2010, Mehdi began displaying ever more aggressive and violent behaviour and began to run away from home. The police needed to get involved. Karim's behaviour was much calmer but he began to copy his brother. Mehdi was

referred to CAMHS but they refused to help because of the instability and lack of safety within the family situation. Penny felt that without a mental health diagnosis, there was no help available. The post-adoption worker carried on providing some support and Penny attended a parenting course and seminars for adoptive parents. Six sessions of sensory processing therapy were funded through the local authority for each boy separately which also helped to an extent. However, as Mehdi began to realise it was therapy, he disengaged. School also became more of a challenge as Mehdi's new teacher struggled with his behaviour. The therapist advised the school, supported Penny to help better regulate her own emotions, and provided a report, making recommendations for school and home. The school though didn't implement all recommendations because they didn't want to change their rules or approaches for individual children.

Between 2011 and 2015, Penny continued to seek help, and would receive small packages of support that were often unhelpful with under-qualified staff. A Common Assessment Framework was set up to support Mehdi's transition to secondary school, which was incredibly difficult, and Disability Living Allowance was awarded for both boys. This helped the boys to attend out-of-school activities, which helped boost their confidence and build friendships. Support at school improved but things at home became more and more dangerous. Penny acquired Chronic Fatigue Syndrome, and although the boys continued contact with Nabil, there was little support for Nabil with his parenting. Both parents attended co-parenting counselling, but this was difficult. Penny's family provided help, but lived a long distance away. Help was discussed with professionals but nothing appropriate was provided.

In 2014, both boys' behaviour became increasingly destructive. Mehdi was violent to both Karim and Penny, Karim copied and both boys ran away from home. Home life was increasingly unsafe and so in 2015, Penny and the boys moved to an area of the country nearer Penny's family and support networks, and to an area which Penny thought would be more supportive to adoptive families. The family looked forward to a fresh start. However, soon after Mehdi began Year 10 in the new secondary school, he started refusing to attend. Penny liaised with the school to try and resolve the issues but Mehdi became fixated on playing video games in his bedroom. As he got older and bigger, he was becoming increasingly intimidating. In November 2015, Penny made contact with the local post-adoption team. By this point Penny had stopped working due to ill-health.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

The post-adoption worker began processing an application to the ASF for Penny and provided regular support. Whilst the worker and Penny explored appropriate

therapies to apply for, Penny took part in a Non-Violent Resistance training course and attended relevant seminars. These were incredibly useful and Penny learnt more about trauma, dissociation and relevant therapies. However, new skills couldn't be implemented because the family reached crisis point when social care had to be called. The violence had become so bad, the whole family were unsafe. It was agreed in March 2016 that Mehdi would move in with his aunt (Penny's sister) and uncle. The ASF application for a therapeutic assessment was submitted in the same month.

Funding for the assessment was approved in April 2016, and Karim attended with Penny although Mehdi refused to go. Penny was unsure what would happen with Karim now, but hoped that he would begin to engage and that therapy would start after the summer holidays. Penny was happy to wait as it had taken so long to get to this point, but at last it felt as if the family were being understood and help was being provided. Penny hoped that the therapy would help Mehdi move back home, that both boys would be able to regulate and understand their emotions better, and be able to progress to meaningful future lives.

Penny was happy with the ASF support so far, thought that many adopted families would need this help and that it was a worthwhile investment for society. Penny's long experience had been of incredibly disjointed services and piecemeal support and she thought that training for foster and adoptive parents needed to be more in-depth and thorough. Penny also thought that support needed to be more preventative to avoid crises occurring.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Eight months later, Penny was still waiting for therapy to begin. Since the last interview, Mehdi had attended a therapeutic assessment in July 2016. The therapist's reports for each boy didn't arrive until October, and in November, a meeting took place with Penny, her sister and brother-in-law, the therapist, therapy coordinator and post-adoption worker. This was needed to discuss the report's recommendations and agree what support to apply for. The process became bureaucratic, involving more paperwork, another referral of the family back to the therapist and completion of the ASF funding application for a programme of therapy for both boys.

Penny felt that this process was dominated by how they could ensure a successful funding application and whether to apply for a comprehensive, long-term package of work or just an initial package of therapy. At this time, the fair access limit was being introduced and although Penny wasn't aware this was happening, it was apparent there were delays linked to a higher level of competition for funds. The

applications for both boys were submitted before the fair access limit came in and an extensive programme of therapy was approved for Mehdi in December 2016. At the time of the second interview, Penny had not heard whether Karim's application was successful.

Penny felt disappointed with the ASF, the post-adoption team and therapy provider that communication hadn't been more transparent. Penny understood that services were increasingly stretched because of the ASF but felt incredibly let down that she was still waiting for therapy to start, 15 months after asking for help. An initial therapy appointment was eventually offered for Mehdi, following Penny chasing, at the end of February 2017, a week before the second interview, but Mehdi refused to attend and Penny was unsure of what would happen next. No information had yet been given about when Karim's therapy might start. Penny expected that when therapy started it would involve a range of appropriate therapies, from EMDR to CBT, and would include an intensive 5 day a week, 2 week-long, intensive therapy programme. Penny was concerned that Mehdi would not engage and thought that therapy providers needed to consider adapting their approaches to teenagers who may need more tailored and individualised support.

Having been so positive about the ASF and the therapy provider in the first interview, Penny felt that her family had been consistently let down. As a family who had sought support for so long and in such a difficult situation, Penny was disheartened that the services had not responded more quickly. Additionally, Penny had been diagnosed by the therapist as having secondary trauma but the ASF would not fund this support. Penny had struggled to access EMDR therapy through the NHS because she did not have a PTSD diagnosis and was unable to self-fund therapy. Since the first interview, Penny had returned to work full-time and her mother had recently died. Mehdi continued to live with his aunt and uncle but was beginning to move back home, beginning with weekend stays. Things were initially very challenging with Karim when Mehdi moved out, because he missed his brother and blamed Penny for not getting Mehdi back more quickly. The relationship between Penny and Mehdi was also initially difficult, but things had gradually improved, despite the lack of wider support.

Penny felt lucky that her sister and brother-in-law had been able to help. Without their support she believed the adoption would have broken down, and was hopeful that with their help it could be gradually repaired. Both boys were also more settled at school and getting good support there. On reflection, Penny felt that individual workers had understood her family's needs and tried their best to help. The initial process of being referred to the ASF and getting funding was smooth and quick, but had since slowed down a lot, with slow communication from both the post-adoption team and therapy provider.

Although life had improved for the family, Karim's behaviour could still be very challenging and Penny believed that therapy could still be useful. Penny believed that the family was muddling through as best they could but it was difficult and the family was dealing with a lot of loss. However, Penny was able now to use some of the skills learnt in the NVR training with Karim and this was proving helpful.

Penny was open-minded as to whether the therapy would be useful or not but did feel that it was still needed because of the potential problems that could arise in adulthood.

Recommendations and final views on the ASF

Penny recommended that communication with families was better during the ASF process, giving clarity on eligibility, the application process, timescales and waiting list times.

Whilst Penny was unsure whether the ASF should fund parents' therapy and other support, better coordination with mainstream services could help improve families' access to needed support funded elsewhere. Penny did believe that funding should be available for preventative support as well as for those in crisis situations. For instance, annual reviews that both post-adoption teams and families are committed to should be mandatory following adoption.

Finally, Penny suggested it would be helpful to have a directory of providers specialised in working with teenagers and further research might be needed on approaches that help teenagers who appear highly disengaged.

18. The Wright-Hipkiss family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Mel Wright and Adam Hipkiss adopted 17-year old Lewis and 14-year old Laura when they were 6 and 9 months old respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Whereas Lewis had settled in the family home quickly and smoothly, attaching well with both parents, it took about 6 months for Laura to settle, having bonded with her foster family which seemed to have provided quite a chaotic environment. Mel and Adam found the relationship with the grieving foster parent difficult but eventually things calmed down. However, on starting school, both children struggled in different ways. Lewis was moved to a smaller primary school but was bullied and became very anxious at the time of Year 6 tests. The bullying continued and increased at secondary school. Mel and Adam met the school during Year 7 but nothing seemed to change. In Year 8, Lewis withdrew to his bedroom and began refusing intermittently to attend school, even though academically he had been achieving well. The parents contacted the post-adoption team for help but they experienced a 'disintegrated' social care team, as post-adoption service was going through an infrastructure change and the family believed they were forgotten as a result. Since this change, they experienced great inconsistency in support given.</p> <p>Mel and Adam felt the school blamed Lewis for being lazy, when he was incredibly anxious. The situation continued to escalate until Year 10, when another boy was excluded for bullying Lewis, but this led to Lewis feeling responsible and blamed by others. Lewis began to smash things at home, though was never violent to other people. By Year 11, Lewis was refusing to attend school and so moved to a different school. However, he found the classroom a traumatic environment and so left school before taking his GCSE's. Lewis has since tried a Creative Arts BTEC but found the criticism from course tutors too harsh and left the course in February 2016.</p> <p>Although support was sought through CAMHS, Lewis's extreme anxiety meant he struggled to engage with support offered. The post-adoption team offered Cognitive Behavioural Therapy, but the family felt this was not appropriate. Something that suited Lewis's emotional stage rather than his age would have been better. The Education Welfare Officer became involved unsuccessfully. Having attended many meetings, being threatened with court action by the school and then being encouraged to home school Lewis, the parents felt demonised and</p>

blamed. Both they and Lewis felt they were treated punitively by the system, even though individual workers might have tried their best to help. It felt like a constant battle. Mel and Adam were fearful of the consequences of their situation, including the risk that if they were convicted for not sending their children to school, Adam could lose his job. Therefore, they felt compelled to use traditional parenting strategies even though they didn't feel it was right at the time. At the time of interview, Lewis was planning to start an animal care course in September.

Laura experienced similar difficulties to Lewis. From an early age, Laura had some medical problems around her toileting which led to missing a lot of early primary school years and being bullied. At the age of 6, school staff expected Laura to change her own clothes when needed, but she was unable to do this without help and so was left on her own, distressed and missed lessons. Mel and Adam believed that staff prioritised their fears of abuse allegations over Laura's need for practical assistance, neglecting her as a result. The bullying deteriorated so that by Year 4, Laura was moved to a different school, where a good relationship developed with the class teacher and the situation improved. During Year 5 and 6, although Laura had taken up drama and sport clubs, which helped increase her confidence, things became more difficult again.

After moving to secondary school, Laura became very anxious and so was given additional support, but she found this stigmatising and her anxiety continued to increase. Academically, Laura was doing well and the school were pleased with her. However, Mel and Adam could see that Laura was unduly anxious and asked for an educational psychological assessment, which was refused. Gradually, things deteriorated. If Laura had work sent back for improvement, her anxiety increased and confidence dropped. By Year 8, Laura was refusing to go to school. Together the school and parents tried to encourage Laura back and a local authority family worker was allocated to support for 3 months. From the family's perspective, this support was working well, as Laura was coming out of her bedroom and engaging with the worker. But because it didn't result in her attending school during this period, the service seemed to consider the support a failure and withdrew the worker. Laura then started barricading herself in her bedroom.

Both children were diagnosed with Generalised Anxiety Disorder, and different workers were sent to the home to assess and/or provide support. However, neither child responded to initial visits and therefore services were withdrawn. Mel and Adam believed that this short-term approach from services was incredibly unhelpful and they continued to find themselves in a battle with education and other services. Both parents felt that their children probably had some form of attachment disorder and Laura possibly mild autism. However, the family were referred to a family support programme, set up for 'troubled families', which they experienced as counter-productive and punitive. A police officer was assigned to

them who interviewed the parents, subsequently reported that the family's problems lay with the parenting, and after another bullying incident which precipitated a violent outburst towards property by Lewis, the officer referred the family to the social care team. Additionally, while Mel and Adam attempted to get the school to apply for an Education, Health and Care Plan (EHCP), the Family Support programme blocked this. Through personal contacts who were knowledgeable in the field, Mel and Adam realised they could apply themselves for an EHCP and so at the time of the first interview, they were progressing this to support Lewis's education.

Mel and Adam had been asking for intensive therapy for the past 2 years.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Having heard about the ASF in the news and hearing of friends in other parts of the country who were accessing intensive therapy through it, Mel and Adam approached their post-adoption service in Summer 2015. Although they were not aware of being assessed for the ASF, they did access some parenting training at the beginning of 2016 and were since told that this was ASF-funded. Mel also had some personal therapy, following the Family Support Programme referral to social care, and thought this might have been ASF-funded. No other support was forthcoming and whilst the Family Support Programme was in place, the family were told that they wouldn't be referred for the ASF support. Mel and Adam tried different approaches to communicate with the post-adoption team about the family's need for intensive therapy. However, they were refused a referral because post-adoption workers were not convinced the desired therapy was evidence-based. Mel and Adam expressed concern that there might be organisational agendas driving the behaviour of staff and the blocking of their ASF application.

At the first interview, Mel and Adam had just withdrawn the family from the Family Support Programme, but were dealing with the social care referral and still chasing for an assessment of adoption support needs for intensive therapy for the family.

Mel and Adam reported that the parenting training had been really useful and they had learnt a lot. It taught them to trust their instincts more as previously they were being told by education and other services that they needed to be stricter and more authoritative in instructing the children to attend school. Training helped them understand that this approach didn't work for many adopted children and that a therapeutic parenting approach was more suited. Following the training, they were more confident using therapeutic approaches and felt supported by the expert knowledge of the trainers.

Although Mel felt uncomfortable that her therapy referral came as a result of the policeman's report, the therapy itself was incredibly helpful. Delivered by a therapist specialised in adoption, it helped Mel understand more about the link between her children's early life experiences and their behaviour. It strengthened her ability to therapeutically parent and to understand that their behaviour wasn't because of her parenting.

Mel and Adam knew that a meeting between professionals was taking place on the day of the interview and so were hopeful that they would be supported to access the ASF support, but were not expecting that they would get the referral. If intensive trauma-focused therapy could be accessed, they felt hopeful that both children would become more resilient, less self-critical, and better able to articulate their feelings and ultimately build fulfilling lives.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Seven months after the first interview, Mel and Adam reported that following an appeal, their local authority had been compelled to assess Lewis for an EHCP. They were expecting a continued battle to get the support needed for Lewis's education because they had already self-funded a psychiatric assessment to inform the EHCP assessment. If they hadn't done this, there would not have been the professional evidence required for the EHCP. Through this, Lewis received diagnoses of anxiety and depression and was prescribed anti-depressants.

It continued to be a struggle to access the ASF support. With increased confidence as a result of the STOP parenting and therapeutic crisis intervention training attended in February 2016, Mel and Adam sought help from others including their local MP and GP, who supported them in their bid to be referred for intensive support through the ASF. This process eventually led to success and the family was referred to a therapeutic provider that they believed could meet their needs. However, they were now faced with a long waiting list for a therapeutic assessment and were told that the family had reached their funding limit for the year. They felt frustrated that if their request had been heard and acted on when the ASF was first launched, they would now be underway with therapy, and would have potentially received a significant package, whereas despite progress, the family was still without appropriate therapeutic support in January 2017.

As a result of the complaints process, the family felt they now had good support in place from the post-adoption team. Additionally, Mel and Adam reflected on the 2 parenting programmes received previously. Although unaware that it was ASF-funded at the time, both parents identified a range of changes that improved family life. Both parents felt that the trainers understood their situation and as a result

they didn't feel so isolated. They also learnt more about the possible meanings of the behaviours of their children and the different ways they could try responding. Mel and Adam felt they were empowered to be better parents, to trust themselves and to 'go with' their children, not seeking to fix everything.

Recommendations and final views on the ASF

Mel and Adam felt that they had experienced a postcode lottery in accessing ASF support. They would have liked the Department for Education to be more explicit and proactive in informing families about what the ASF was, what support could be funded and who was eligible for it. They believed that their local service had become an unintentional gatekeeper to the Fund, preventing access, and that post-adoption teams could do more to show understanding and support for parents, through consistent contact.

Parenting training would have been helpful years ago. Mel and Adam suggested that, because many adoptive families experienced issues at transitions, services could make proactive contact before key, common milestones, to let families know that these transitions could be difficult. They could have encouraged families to access support such as parenting training and/or therapy to help during difficult times. They also argued that there should be greater transparency pre-adoption, with the ASF promoted as available for early intervention. Less reliance should have been put on families chasing the help needed.

19. The Jennings Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Rose and Alistair Jennings adopted siblings, 13 year-old Thea and 12 year-old Nerissa, when they were 2 and a half and one and a half years old respectively.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>Both Thea and Nerissa arrived having experienced significant neglect and abuse in their early years. Whereas Thea presented as incredibly nervous, with sensory issues and trouble sleeping at night, Nerissa demonstrated very oppositional and controlling behaviour. After about a year, Rose and Alistair approached their local post-adoption team for help, but the service was being restructured and the family struggled to get a response. Family life had been difficult for the last 10 years, but because the girls were well-behaved at primary school, Rose and Alistair felt they didn't get the help needed. Another parent who was trained in sensory processing suggested that Thea might have sensory processing issues, and gave some informal advice which was helpful. The family moved to a different village and school when the girls were 11 and 10 years old, and although the transition was difficult, the new school was trained in attachment issues and supported the family.</p> <p>Thea found moving to secondary school difficult and began refusing to attend. Eventually Rose found a staff member who could help and they made a referral to family therapy and a youth worker was brought in to support. In the same year, Nerissa struggled in the final year of primary with her SATS, and although a Common Assessment Framework (CAF) was set up to support transition to secondary school in 2015, no tangible support was offered. That summer was horrendous for the family. Although Nerissa began secondary school relatively smoothly, she found the experience overwhelming. Whilst her behaviour was good at school, she became violent at home, punching walls and throwing furniture around, and soon stopped going to school. A school attendance officer was brought in to help and after a few meetings it became apparent that Nerissa hadn't been recorded as adopted, and so records were corrected. After Nerissa threatened to kill herself, a social care referral was made and a support worker provided. The support worker focused on training Rose and Alistair in setting boundaries, when the parents had already been on traditional parenting courses, but felt that these didn't meet their needs. A social worker visited 2 months after the referral and advised that the post-adoption team and school should be supporting the family, not social care.</p>

Another CAF was set up and the family agreed with the school to try and get Nerissa to attend school part-time. When she refused to go, the school began to threaten court action. Whilst Thea benefited from the school's support, Nerissa had been unable to engage with initial assessments and so no support was offered. Both parents felt blamed as bad parents, but having tried firm boundary setting, they knew this wasn't the right approach for their children.

The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews

Rose heard of the ASF through newsletters, support groups and conferences she had been on and so in November 2015, approached the post-adoption team for help. Rose asked the team to help her access sensory processing therapy for Thea, but the team were unaware of this and would not agree to fund an assessment through the ASF. They suggested that the family approach their GP for an occupational therapy assessment. Therefore, the family funded their own specialist assessment. Thea was diagnosed with sensory processing disorder and the post-adoption team agreed to refund the cost of the assessment and apply for the ASF support for appropriate therapy. At the time of interview, Thea had had 12 sessions of sensory processing therapy including brushing therapy, which led to improvements but stopped after Christmas. The family would have liked this to continue. Parenting training was recommended when Rose first got in contact, and she continued to chase this for over a year but nothing materialised. Since January 2016, another assessment was undertaken by a different worker from the team, who recommended a Theraplay assessment for both girls. Thea engaged in this, but Nerissa didn't. There were a few useful pointers from the therapist but Rose and Alistair didn't feel that this offered what was needed.

The post-adoption team told Rose and Alistair that therapy couldn't be provided for Nerissa if she wouldn't engage but Rose and Alistair believed that professionals weren't flexible or consistent enough to encourage Nerissa's engagement. For instance, they were referred for a CAMHS assessment, but Nerissa wouldn't get out of the car. The therapist in turn wouldn't come out to the car park to meet Nerissa. Likewise, a doctor and psychologist separately visited the family but Rose and Alistair felt that the professionals didn't make the effort or time to enable Nerissa to engage.

Rose requested a referral for an intensive trauma therapy assessment but the post-adoption team refused to make the referral and instead referred Rose for Cognitive-Analytic Therapy. Whilst Rose was incredibly frustrated that the post-adoption team were not listening, she did enjoy having the therapy time for herself and it helped mobilise her to continue fighting for the support her children needed. Her therapist, an adoption specialist, recommended that the children were

assessed and after 3 months of asking, the family were finally referred to the intensive trauma therapy provider in March 2016.

Although a long journey away, the family drove to the therapeutic assessment in April 2016 and when Nerissa wouldn't get out of the car, the therapist came out, spoke with Nerissa for 2 hours in the car park and was successful in encouraging her to go into the building in order to complete the assessment. At the time of first interview, the family had been waiting for 2 months for the assessment report and recommendations. Whilst the post-adoption team kept talking to Rose about parenting training, Rose and Alistair were hopeful that a long-term programme of family therapy would be offered. However, they were not optimistic that their post-adoption team would agree to this. In the meantime, CAMHS withdrew their involvement because of no identified mental health illness, the school attendance officer became involved again and Nerissa was doing school work from home for a couple of hours a day. The school were encouraging home education but Rose and Alistair didn't think this was the answer and did not want to be teachers as well as parents. At this stage, Rose and Alistair felt that intensive trauma therapy was the only help that would change their situation.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

Six months later, Rose and Alistair reported that following the therapeutic assessment, they received a report diagnosing both children with early trauma leading to a range of psychological problems including dissociation and learning difficulties. The ASF funding for 52 sessions for each child was approved and at the time of interview, the first 3 sessions had taken place. Because of the lack of local provision, the family were travelling 50 miles to get to the therapist. The first 3 sessions were with just Rose and Alistair, to find out their history and parenting challenges, supporting them to build new parenting approaches. They had also accessed online training around trauma and its effects. Therapy would eventually progress to involve the whole family and the therapist was also going to meet with the school.

Although Rose and Alistair believed they were at the beginning of the ASF support, they found the therapeutic assessment helpful in their communications with the school and were progressing an Education, Health and Care Plan. They were more confident in explaining their children's needs and in disagreeing with professionals who gave inappropriate advice. They were also more confident in using therapeutic parenting techniques, giving plenty of sensory input and adapting their language to the girls. Nerissa was still not attending school and Thea's attendance was sporadic but life at home was calmer. Rose and Alistair thought that they were now on the right path, even though this help was needed

years before. They felt their needs were being understood for the first time by the therapist and were hopeful that Thea and Nerissa could move out of their internal worlds more and become better able to express and cope with their emotions.

Rose and Alistair were relieved that their ASF application was processed just before the £5000 fair access limit was implemented. They found the ASF process to be very bureaucratic and they felt very unsupported by their post-adoption team. Rose and Alistair were concerned that the structure of their post-adoption service was having a negative effect on families' access to support. They felt that the post-adoption team wanted to deliver all services in-house and were very resistant to applying to the ASF and referring to external providers. They were concerned that organisational motives influenced how the Fund was implemented locally.

Recommendations and final views on the ASF

Rose and Alistair believed the ASF needed to be less bureaucratically managed and easier for families to access. Post-adoption, they recommended that all families got some ongoing support and that intensive therapy was provided as early as possible, before teenage years, to prevent crises. They also thought the fair access limit should be removed and that families got the help they needed, for as long as it was needed. They were delighted to have finally been awarded the support and hoped the ASF continued for the long term.

20. The Marino-Fox Family

Family set up (who's in the family, numbers of children, ages, age at adoption):
Birth siblings, 9 year old Rebecca and 7 year old Melissa were placed with Tania and Robin Marino-Fox shortly after being matched in February 2016. An older half-sibling was placed with a different family, although contact had been maintained.
Family background: what led to adoption, post-adoption challenges, previous support-seeking experiences
<p>As soon as Rebecca and Melissa arrived, they demonstrated high levels of anxiety, controlling and disruptive behaviour. On reflection, Tania and Robin recognised that they didn't know what support was needed at the beginning of the placement and they would have appreciated it if local services had been more proactive in offering support.</p> <p>Initially supported by a psychologist who visited 3 or 4 times following the placement, when Rebecca broke her leg the visits were stopped. However, the girls' behaviour escalated whilst social worker visits slowed down. Tania contacted the adoption team, gently asking for further help, as the sisters were becoming increasingly violent, throwing and smashing objects around and trying to take control of the house. Unfortunately, the parents' social worker was off for an extended period during this time. Tania and Robin were learning through trial and error that traditional behaviour management wasn't working. The situation was becoming unmanageable and it was affecting their wellbeing and relationship. After one particularly bad incident, when they found themselves locked in their bedroom for safety, they realised they needed extra guidance and started to feel angry at being deserted without support.</p>
The process of receiving the ASF support: What triggered application; assessment experience; therapy choice; satisfaction with process; hopes/fears in Wave 1 interviews
<p>In summer 2016, Tania phoned the social worker, who had returned to work, and over the course of about 15 calls in one day, the social worker helped mobilise a range of support around the family. This included an application to the ASF. Tania and Robin were not aware of an assessment of need taking place ahead of the ASF application but they thought this was because the social worker already had enough information about the family to complete it without their input.</p> <p>Rebecca and Melissa were referred to play therapy through their school, were provided with some educational support and Tania and Robin attended a PACE parenting course. They were concerned though, that once the adoption went through,</p>

the services would be less motivated to help. Therefore, although the formal adoption papers were being organised, Tania and Robin decided that they couldn't go through with the adoption, until a full post-adoption support plan was in place.

At the time of being interviewed, in September 2016, Tania and Robin had just received confirmation of 40 sessions with a psychologist. This was due to involve play therapies with Rebecca and Melissa, and therapeutic parenting support for the parents. Tania and Robin were delighted with the support and Tania was due to visit the psychologist the following week for an initial meeting. Both parents were concerned that they needed to be sure that the therapist would be right for their family. This was because in hindsight, they found the support of the previous psychologist to be of minimal help. Also, since that support finished, the family were without additional help for 6 months.

Tania set up a support group for adoptive parents, which was valuable and very popular. Additionally, things at home calmed down to an extent. Tania and Robin thought that Rebecca and Melissa seemed to be settling more. The girls showed some awareness of their behaviour and knew when they had broken the rules, whereas before they didn't seem to be aware. Although both parents could see there were underlying issues that the family needed help with, they were hopeful that with the right support, things would significantly improve. Tania and Robin were also developing their parenting styles and although they found it difficult, they were becoming familiar with using different approaches.

Both parents hoped that the therapy would help their children understand that they were safe and that they had a permanent home. They also wanted to learn more about why Rebecca and Melissa behaved the way they did, and how their behaviour as parents might present triggers for the girls. They wanted to be helped so that they could best help their daughters. Whilst really pleased to have this therapeutic support in place, Tania and Robin expected that they would need support again in the future, for instance as the girls went through adolescence. They were concerned that the ASF wouldn't be around then and were not sure what they would do instead. However, they felt at the time of the first interview, that their families' needs had been well understood.

Whilst grateful that the pressure to quickly process adoptions had helped mobilise support, Tania and Robin felt that this had still taken a long time. They hoped that the post-adoption support plan would be signed off very soon and that the adoption would be finalised. Tania and Robin were grateful to their adoption worker, without whom they wouldn't have known about the ASF, and who helped them access the support the family was awarded.

Follow-up interview: During/Post-therapy reflections; updates on support received; improvements or deterioration experienced since first interview; satisfaction with the ASF-funded support

The family was unable to be interviewed because they were in the middle of formalising Rebecca and Melissa's adoption.

Recommendations and final views on the ASF

Tania and Robin believed it could be very isolating as adopters, with little understanding from others, and difficulty in knowing what help was needed or available. They thought that post-adoption support should be more proactive with assessments informed by professional expertise and support starting as soon as possible. They also thought there should be funding to help with the purchase of specialist therapeutic books and other resources as these could be very expensive.

Information could be clearer for adoptive parents about other support available, for instance Pupil Premium. Tania and Robin thought that adoptive parents were so pressured, that it was difficult to find time to research and chase help, so any support with identifying and accessing help would be valued by parents.

Appendix 8 - Glossary

ADHD – Attention Deficit hyperactivity disorder

ASA – Adoption Support Agency

ASF – Adoption Support Fund

ASSA – Adoption Support Service Advisor

BAAF – British Association for Adoption and Fostering

BAC-A - Brief Assessment Checklist for Adolescents

BAC-C - Brief Assessment Checklist for Children

CAF – Common Assessment Framework

CAMHS – Child and Adolescent Mental Health Service

CIN – Child in Need

DDP – Dyadic Development Psychotherapy

DfE – Department for Education

ECHP – Education, Health and Care Plan

EHAT – Early Health Assessment

FAS – Foetal Alcohol Syndrome

FASD - Foetal Alcohol Spectrum Disorder

LAC – Looked After Children

NVR – Non Violent Resistance

OFSTED - Office for Standards in Education, Children's Services and Skills

PACE – Playfulness, Acceptance, Curiosity and Empathy

SDQ – Strengths and Difficulties Questionnaire

SENCO – Special Educational Needs Coordinator

SGO – Special Guardianship Order

SLA – Service Level Agreement

SWEMWBS – Short Warwick and Edinburgh Mental Wellbeing Scale

VAA – Voluntary Adoption Agency

VSO – Voluntary Sector Organisation



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